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® of West Virginia

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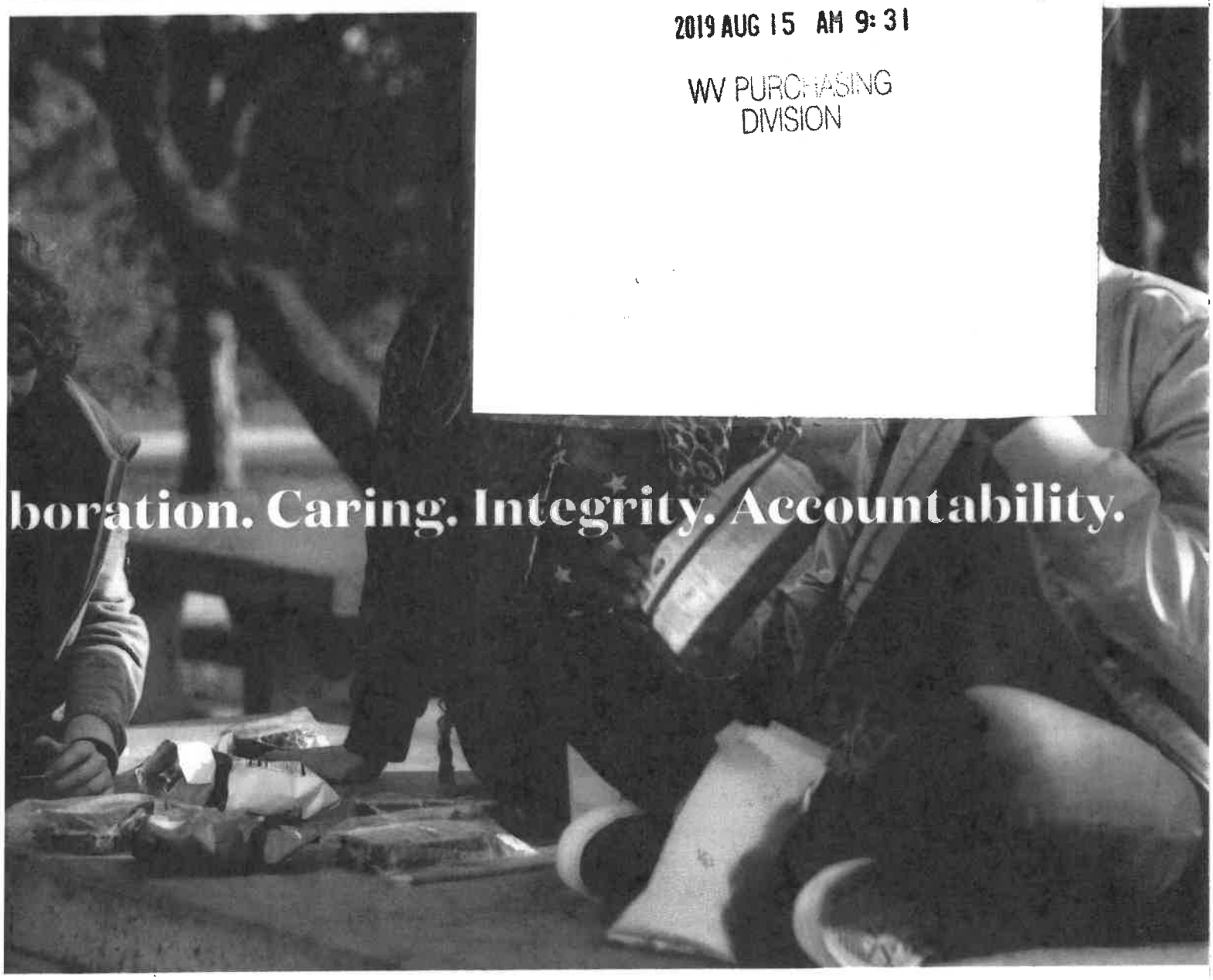
DIVISION



ginia
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n Resources
· Children and Youth

l1 BMS 1900000001

Technical Proposal
Original

BOOK 1

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.

Todd White, Chief Executive Officer
(Name, Title)
Todd White, CEO
(Printed Name and Title)
500 Virginia Street East, Suite 400, Charleston, WV 25301
(Address)
304-348-2041 / 959-282-1026
(Phone Number) / (Fax Number)
twhite@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contained herein; that this bid, offer or proposal constitutes an offer to the State that cannot be unilaterally withdrawn; that the product or service proposed meets the mandatory requirements contained in the Solicitation for that product or service, unless otherwise stated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)

Randy J. Hyun
CEO, Aetna Medicaid
(Authorized Signature) (Representative Name, Title)

Randy Hyun CEO, Aetna Medicaid
(Printed Name and Title of Authorized Representative)

8/13/19
(Date)

(602) 659-1160 / (844) 255-7027
(Phone Number) (Fax Number)

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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: 583126

Doc Description: Specialized Managed Care for Children and Youth

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2019-07-01	2019-08-15 13:30:00	CRFP 0511 BMS1900000001	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 Randy J. Hyun **FEIN #** 55-0712129 **DATE**

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

ADDITIONAL INFORMATION:

The West Virginia Purchasing Division is soliciting proposals for a vendor to provide statewide physical and behavioral health managed care services for children and youth in the foster care system and individuals receiving adoption assistance.

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	Vendor's Bid Amount for Managed Care				

Comm Code	Manufacturer	Specification	Model #
84131602			

Extended Description :

Vendor's Bid Amount for Managed Care

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	Vendor's Bid Amount for Administrative Services(SNS)				

Comm Code	Manufacturer	Specification	Model #
84131602			

Extended Description :

Vendor's Bid Amount for Administrative Services(SNS)

SCHEDULE OF EVENTS

Line	Event	Event Date
1	Pre-Bid Meeting	2019-07-16
2	Questions Due	2019-07-23

ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions

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: 583126

Doc Description: Addendum No.1 Specialized Managed Care Children and Youth

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2019-07-01	2019-08-15 13:30:00	CRFP 0511 BMS1900000001	2

BID RECEIVING LOCATION

BID CLERK
DEPARTMENT OF ADMINISTRATION
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2019 WASHINGTON ST E
CHARLESTON WV 25305
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VENDOR

Vendor Name, Address and Telephone Number:

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Signature X Randy J. Hyun **FEIN #** 55-0712129 **DATE**

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ADDITIONAL INFORMATION:

Addendum No. 1 - To attach the following exhibits inadvertently omitted from the CRFP BMS1900000001 originally published on 07/01/2019.

Attachments include:
FC_Redacted_Medical _201607_201806.zip
FC_Redacted_Elig_201607_201806.zip
FC_Redacted_Pharmacy_201607_201806.zip

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	Vendor's Bid Amount for Managed Care				

Comm Code	Manufacturer	Specification	Model #
84131602			

Extended Description :

Vendor's Bid Amount for Managed Care

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Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
2	Vendor's Bid Amount for Administrative Services(SNS)				

Comm Code	Manufacturer	Specification	Model #
84131602			

Extended Description :

Vendor's Bid Amount for Administrative Services(SNS)

SCHEDULE OF EVENTS

Line	Event	Event Date
1	Pre-Bid Meeting	2019-07-16
2	Questions Due	2019-07-23

ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions

Purchasing Divison
2019 Washington Street East
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Request for Proposal
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Proc Folder: 583126

Doc Description: Addendum No.2 Specialized Managed Care Children and Youth

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2019-07-16	2019-08-13 13:30:00	CRFP 0511 BMS1900000001	3

BID RECEIVING LOCATION

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VENDOR

Vendor Name, Address and Telephone Number:

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april.e.battle@wv.gov

Signature X Randy J. Hyun **FEIN #** 55-0712129 **DATE**

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ADDITIONAL INFORMATION:

Addendum No. 2 is issued to:

1) clarify the bid opening date is August 13, 2019, at 1:30 PM EST; and
2) to provide the pre-bid 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	Vendor's Bid Amount for Managed Care				

Comm Code	Manufacturer	Specification	Model #
84131602			

Extended Description :

Vendor's Bid Amount for Managed Care

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Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
2	Vendor's Bid Amount for Administrative Services(SNS)				

Comm Code	Manufacturer	Specification	Model #
84131602			

Extended Description :

Vendor's Bid Amount for Administrative Services(SNS)

SCHEDULE OF EVENTS

Line	Event	Event Date
1	Pre-Bid Meeting	2019-07-16
2	Questions Due	2019-07-23

ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions

Purchasing Divison
2019 Washington Street East
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Request for Proposal
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Proc Folder: 583126

Doc Description: Addendum #3 - Specialized Managed Care Children and Youth

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2019-07-18	2019-08-13 13:30:00	CRFP 0511 BMS1900000001	4

BID RECEIVING LOCATION

BID CLERK
DEPARTMENT OF ADMINISTRATION
PURCHASING DIVISION
2019 WASHINGTON ST E
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VENDOR

Vendor Name, Address and Telephone Number:

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(304) 348-2041

FOR INFORMATION CONTACT THE BUYER

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

Signature X Randy J. Hyun **FEIN #** 55-0712129 **DATE**

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

ADDITIONAL INFORMATION:

Addendum #3 is issued to provide the following documents as part of the solicitation:

1) 00 - Specialized Managed Care for Children and Youth;
2) 01 - Detailed Specifications;
3) 03 - SFY20 Draft MCO Foster Care Contract;
4) 07 - SFY18 SNS Foster Spend by Category;
5) 08 - SFY20 Foster Care Rate Databook Exhibits;
6) A - Cost Proposal;
7) D - Mandatory Requirements;
8) Provider Utilization and Reimbursement Report; and
9) Specialized Managed Care RFP Change Log.

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	Vendor's Bid Amount for Managed Care				

Comm Code	Manufacturer	Specification	Model #
84131602			

Extended Description :

Vendor's Bid Amount for Managed Care

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Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
2	Vendor's Bid Amount for Administrative Services(SNS)				

Comm Code	Manufacturer	Specification	Model #
84131602			

Extended Description :

Vendor's Bid Amount for Administrative Services(SNS)

SCHEDULE OF EVENTS

Line	Event	Event Date
1	Pre-Bid Meeting	2019-07-16
2	Questions Due	2019-07-23

ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions

Purchasing Divison
2019 Washington Street East
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State of West Virginia
Request for Proposal
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Proc Folder: 583126

Doc Description: Addendum #4 - Specialized Managed Care Children and Youth

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2019-07-19	2019-08-13 13:30:00	CRFP 0511 BMS1900000001	5

BID RECEIVING LOCATION

BID CLERK
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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 Randy J. Hyun **FEIN #** 55-0712129 **DATE**

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

ADDITIONAL INFORMATION:

Addendum #4 is issued to provide the corrected schedule of events.

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 WV 25301-3709 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	Vendor's Bid Amount for Managed Care				

Comm Code	Manufacturer	Specification	Model #
84131602			

Extended Description :

Vendor's Bid Amount for Managed Care

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 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	Vendor's Bid Amount for Administrative Services(SNS)				

Comm Code	Manufacturer	Specification	Model #
84131602			

Extended Description :

Vendor's Bid Amount for Administrative Services(SNS)

SCHEDULE OF EVENTS

Line	Event	Event Date
1	Pre-Bid Meeting	2019-07-16
2	Questions Due	2019-07-23

ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions

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: 583126

Doc Description: Addendum #5 - Specialized Managed Care Children and Youth

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2019-07-31	2019-08-13 13:30:00	CRFP 0511 BMS1900000001	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

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

Signature X Randy J. Hyun **FEIN #** 55-0712129 **DATE**

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

FORM ID : WV-PRC-CRFP-001

ADDITIONAL INFORMATION:

Addendum #5 is issued to provide the vendor questions and responses.

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	Vendor's Bid Amount for Managed Care				

Comm Code	Manufacturer	Specification	Model #
84131602			

Extended Description :

Vendor's Bid Amount for Managed Care

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	Vendor's Bid Amount for Administrative Services(SNS)				

Comm Code	Manufacturer	Specification	Model #
84131602			

Extended Description :

Vendor's Bid Amount for Administrative Services(SNS)

SCHEDULE OF EVENTS

Line	Event	Event Date
1	Pre-Bid Meeting	2019-07-16
2	Questions Due	2019-07-23

ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions

Purchasing Divison
2019 Washington Street East
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State of West Virginia
Request for Proposal
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Proc Folder: 583126

Doc Description: Addendum #6 - Specialized Managed Care Children and Youth

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2019-08-02	2019-08-16 13:30:00	CRFP 0511 BMS1900000001	7

BID RECEIVING LOCATION

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2019 WASHINGTON ST E
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US

VENDOR

Vendor Name, Address and Telephone Number:

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FOR INFORMATION CONTACT THE BUYER

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Signature X Randy J. Hyun **FEIN #** 55-0712129 **DATE**

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

ADDITIONAL INFORMATION:

Addendum #6 is issued:

1) to provide the UPDATED vendor questions and responses;
2) to extend the bid opening date to August 16, 2019, at 1:30 PM 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
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Comm Code	Manufacturer	Specification	Model #
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Extended Description :

Vendor's Bid Amount for Administrative Services(SNS)

SCHEDULE OF EVENTS

Line	Event	Event Date
1	Pre-Bid Meeting	2019-07-16
2	Questions Due	2019-07-23

ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: CRFP BMS1900000001

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
[ ]	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

Randy J. Hyun

Authorized Signature

8/13/19

Date

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

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: CRFQ 0511 BMS1900000001

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.

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[X]	Addendum No. 2	[ ]	Addendum No. 7
[ ]	Addendum No. 3	[ ]	Addendum No. 8
[ ]	Addendum No. 4	[ ]	Addendum No. 9
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dba Aetna Better Health® of West Virginia

Company

Randy J. Hyun

Authorized Signature

8/13/19

Date

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

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: CRFP 0511 BMS1900000001

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.

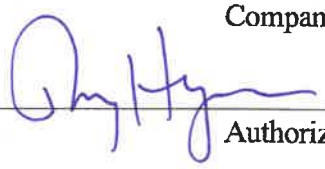
Addendum Numbers Received:
(Check the box next to each addendum received)

[ ]	Addendum No. 1	[ ]	Addendum No. 6
[ ]	Addendum No. 2	[ ]	Addendum No. 7
[X]	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



Randy J. Hyun

Authorized Signature

8/13/19

Date

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

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

Randy J. Hyun
Authorized Signature

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Date

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

Company

Randy J. Hyun

Authorized Signature

8/13/19

Date

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SOLICITATION NUMBER: CRFP 0511 BMS1900000001
Addendum Number: 6

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:

[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

[ ] Other

Description of Modification to Solicitation:

1) To provide the **UPDATED** vendor questions and responses;
2) To extend the bid opening date to August 16, 2019, at 1:30 PM 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 BMS1900000001

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

Randy J. Hyun
Authorized Signature

8/12/19
Date

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

Cost Evaluation Formula: Each cost proposal will have points assigned using the following formula for all Vendors not disqualified during the technical evaluation. The lowest cost of all proposals is divided by the cost of the proposal being evaluated, which generates a cost score percentage. That percentage is then multiplied by the points attributable to the cost proposal, which determines the number of points allocated to the cost proposal being evaluated.

Step 1: Lowest Cost of All Proposals/Cost of Proposal Being Evaluated = Cost Score Percentage

Step 2: Cost Score Percentage x Points Allocated to Cost Proposal = **Total Cost Score**

Example:

Proposal 1 Cost is $1,000,000

Proposal 2 Cost is $1,100,000

Points Allocated to Cost Proposal is 300

Proposal 1: Step 1 – $1,000,000/$1,000,000 = Cost Score Percentage of 1 (100%)

Step 2 – 1 x 300 = Total Cost Score of 300

Proposal 2: Step 1 – $1,000,000/$1,100,000 = Cost Score Percentage of 0.909091 (90.9091%)

Step 2 – 0.909091 x 300 = Total Cost Score of 270.27273

6.8 Availability of Information

Proposal submissions become public and are available for review immediately after opening pursuant to West Virginia Code §5A-3-11(h). 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.

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)

Randy J. Hyun
CEO, Aetna Medicaid

(Representative Name, Title)

(602) 659-1160 / (844) 255-7027

(Contact Phone/Fax Number)

8/13/19

(Date)

West Virginia Ethics Commission

Disclosure of Interested Parties to Contracts

Pursuant to *W. Va. Code* § 6D-1-2, a state agency may not enter into a contract, or a series of related contracts, that has/have an actual or estimated value of $1 million or more until the business entity submits to the contracting state agency a Disclosure of Interested Parties to the applicable contract. In addition, the business entity awarded a contract is obligated to submit a supplemental Disclosure of Interested Parties reflecting any new or differing interested parties to the contract within 30 days following the completion or termination of the applicable contract.

For purposes of complying with these requirements, the following definitions apply:

"Business entity" means any entity recognized by law through which business is conducted, including a sole proprietorship, partnership or corporation, but does not include publicly traded companies listed on a national or international stock exchange.

"Interested party" or *"Interested parties"* means:

(1) A business entity performing work or service pursuant to, or in furtherance of, the applicable contract, including specifically sub-contractors;
(2) the person(s) who have an ownership interest equal to or greater than 25% in the business entity performing work or service pursuant to, or in furtherance of, the applicable contract. (This subdivision does not apply to a publicly traded company); and
(3) the person or business entity, if any, that served as a compensated broker or intermediary to actively facilitate the applicable contract or negotiated the terms of the applicable contract with the state agency. (This subdivision does not apply to persons or business entities performing legal services related to the negotiation or drafting of the applicable contract.)

"State agency" means a board, commission, office, department or other agency in the executive, judicial or legislative branch of state government, including publicly funded institutions of higher education: Provided, that for purposes of W. Va. Code § 6D-1-2, the West Virginia Investment Management Board shall not be deemed a state agency nor subject to the requirements of that provision.

The contracting business entity must complete this form and submit it to the contracting state agency prior to contract award and to complete another form within 30 days of contract completion or termination.

This form was created by the State of West Virginia Ethics Commission, 210 Brooks Street, Suite 300, Charleston, WV 25301-1804. Telephone: (304)558-0664; fax: (304)558-2169; e-mail: ethics@wv.gov; website: www.ethics.wv.gov.

Revised June 8, 2018

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: Randy J. Hyun **Address:** 4500 E. Cotton Center Blvd., Phoenix, AZ

Contract Number: CRFP 0511 BMS190000001 **Contract Description:** Specialized Managed Care for Children and Youth

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: Randy Hyun Date Signed: 8/13/19

Notary Verification

State of Texas, County of Montgomery:

I, Eileen Harris, 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 13 day of August, 2019

Eileen Harris
Notary Public's Signature

EILEEN HARRIS
Notary Public, State of Texas
Comm. Expires 03-17-2020
Notary ID 130586739

To be completed by State Agency:

Date Received by State Agency: _____

Date submitted to Ethics Commission: _____

Governmental agency submitting Disclosure: _____

1. Subcontractors or other entities performing work or service under the contract:

* Active Health Management, Inc.
* Aetna Health Management, LLC
* Aetna Medicaid Administrators LLC
* APS Quality Review Inc. dba KEPRO
* 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
* First Choice Services
* Health Management Systems Inc.
* Inovolan
* MCMC LLC
* MedSolutions, Inc. a/k/a eviCore healthcare f/k/a Triad Healthcare, Inc.
* Skygen Dental, LLC
* SPH Analytics f/k/a The Myers Group
* Vision Service Plan, Inc.
* Welltok (Voxiva, Silverlink, Tracfone)

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: 8/13/19

State of Texas

County of Montgomery, to-wit:

Taken, subscribed, and sworn to before me this 13 day of August, 2019.

My Commission expires 3/17/2020, 2020.

AFFIX SEAL HERE

EILEEN HARRIS
Notary Public, State of Texas
Comm. Expires 03-17-2020
Notary ID 130586739

NOTARY PUBLIC Eileen Harris

REQUEST FOR PROPOSAL

Department of Health and Human Resources,
RFP CRFP 0511 BMS 1900000001

ATTACHMENT B: 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). The Vendor should complete the template 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 is NOT to change any of the pre-filled cells in the following tables. The Vendor should only delete <Response> and add text in its place.

Table 6: 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	142 full-time staff
Last Fiscal Year Company Revenue	Aetna Better Health of West Virginia's last fiscal year company revenue was $561,337,096 (2018).

[1]Aetna Better Health of West Virginia is a dba for Coventry Health Care of West Virginia, Inc. (Coventry) and is used for Coventry's Medicaid line of business. Separate from its Medicaid line of business, Coventry also conducts Medicare business. Unless otherwise indicated, the responses in Table 6, Vendor Overview, pertain to Aetna Better Health of West Virginia's Medicaid line of business. If the Department seeks information about Coventry's Medicare business, we will provide it upon request.

REQUEST FOR PROPOSAL

Department of Health and Human Resources, RFP CRFP 0511 BMS 1900000001

Vendor Overview	
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
Number of Years Vendor has been Providing the Type of Services Specified in the RFP	Aetna Better Health of West Virginia[2] 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	128 staff
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)	N/A
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 members in each county. *All counties must be served under the contract resulting from this solicitation.*

[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.

Coventry Health Care of West Virginia, Inc. dba Aetna Better Health of West Virginia (Aetna)[3] has received approval from the Department of Insurance and currently serves Medicaid members, including children in foster care, in all 55 West Virginia counties.

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

The Vendor should describe the legal status of the Vendor and its parent company, as applicable.

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 1.1-1** depicts the relationship between Aetna Better Health of West Virginia and its parent entities.

[3] 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.

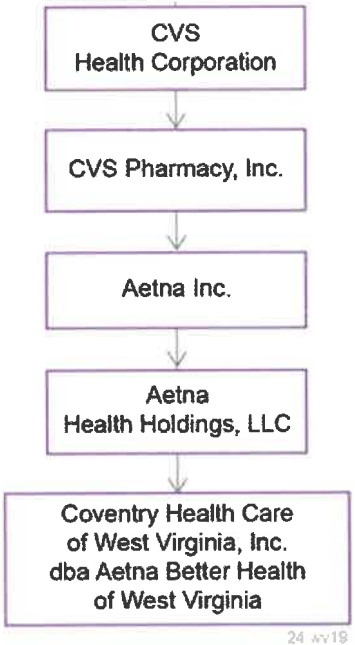


Figure 1.1-1 Aetna Better Health of West Virginia's Relationship to its Parent Entities
Aetna Better Health of West Virginia is a local health plan supported by national resources.

The Vendor should provide the number of current Medicaid 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.

For over 30 years, Aetna's Medicaid organization has honed its approach to serving high-acuity, medically frail, and low-income populations with diverse, member-focused benefits. Aetna's national Medicaid organization currently serves approximately 2 million people in 16 states. In our extensive Medicaid managed care experience, we have served families and children, including children and youth in the foster care system, individuals receiving adoption assistance, individuals accessing socially necessary services, and former foster care children. **Table 1.1-1** summarizes our current experience serving the full spectrum of Medicaid populations, including Aged Blind Disabled/Social Security Income (ABD/SSI), Affordable Care Act (ACA) adults, behavioral health, 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, as well as those we serve in West Virginia.

Table 1.1-1: Aetna's Medicaid Managed Care Experience Nationwide

State Approx. 2019 Q2 Enrollment	ABD /SSI	ACA Adults	BH Carve-in	CHIP	CSHCN	Duals	Foster Care	I/DD (for acute)	LTSS	SMI	TANF
Arizona[4] 383,000	•	•	•	•		•	•	•	•	•	•
California 17,000	•	•	•	•		•			•		•
Florida 141,000	•		•	•		•		•	•		•
Illinois[5] 7,000			•			•			•	•	
Kansas 102,000	•		•	•	•	•	•	•	•	•	•
Kentucky 220,000	•	•	•	•	•		•			•	•
Louisiana 120,000	•	•	•	•	•	•	•	•		•	•
Maryland 23,000	•	•		•	•		•				•
Michigan[6] 44,000	•	•	•	•	•	•	•		•	•	•
New Jersey 60,000	•	•		•	•	•	•	•	•		•
New York 8,000						•			•		
Ohio[7] 27,000			•			•			•	•	
Pennsylvania 222,000	•	•	•	•	•		•				•
Texas[8] 264,000	•		•	•	•	•		•	•	•	

[4] 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; Dual-Special Needs Plan (D-SNP)
[5] Dual Medicare Medicaid Plan (MMP)
[6] Dual MMP
[7] D-SNP and 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; D-SNP

State Approx. 2019 Q2 Enrollment	ABD /SSI	ACA Adults	BH Carve-in	CHIP	CSHCN	Duals	Foster Care	I/DD (for acute)	LTSS	SMI	TANF
Virginia[9] 148,000	•	•	•	•	•	•	•	•	•	•	•
West Virginia 137,000[10]	•	•	•		•						•

As a longstanding and committed partner to the people of West Virginia and the Department, Aetna Better Health of West Virginia has the structure and resources, a proven and flexible technical approach, and the innovative and collaborative drive to deliver high-quality, cost-effective health care services to Specialized Managed Care for Children and Youth members. Under the leadership of Chief Executive Officer Todd White, a proud West Virginian from Kanawha County, Aetna's experienced team has a deep understanding of the critical health issues and members' needs in the State. Chief Financial Officer Tina Bailes served as the deputy director of finance for the West Virginia Bureau for Medical Services for over 10 years, and Program Integrity Lead Alva "Fuzzy" Page III, Esq. was general counsel for the West Virginia Bureau for Medical Services for over six years and also served as a West Virginia assistant attorney general.

Since 1996, Aetna Better Health of West Virginia has provided access to care through the delivery of comprehensive services supporting the program's full scope of work. The Aetna Medicaid organization's established presence in the state as an original Medicaid managed care organization informs our organizational framework to provide coordinated services; our approach for administering services; the development and management of a provider network that exceeds Department requirements; and the implementation of innovations and initiatives to achieve improved health outcomes and support population health management.

Improving the lives of West Virginians through our focus on health outcomes inspires everything we do at Aetna Better Health of West Virginia. As a West Virginia-based health plan, Aetna Better Health of West Virginia brings our local presence supported by national expertise to work side-by-side with the Department in transforming the West Virginia health care landscape to deliver an innovative, whole person-centered, and well-coordinated system of care for children and youth. **The Aetna organization is honored to provide integrated managed care services for approximately 137,000 West Virginia Medicaid members, as well as over 53,000 commercial and nearly 28,000 Medicare members in West Virginia.**

Aetna Better Health of West Virginia understands that each population is unique, with unique service needs, and our local, member-devoted approach focuses on our individual members' holistic health needs. We are fully aligned with the Specialized Managed Care for Children and Youth objective to reduce fragmentation and offer a seamless approach to participants' needs, deliver needed supports and services in the most integrated and cost-effective way possible, provide a continuum of acute care services, and implement a comprehensive quality approach across the continuum of care services. We are 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

[9] D-SNP
[10] West Virginia's enrollment is as of July 1, 2019

national experience to provide individualized, quality care and exceptional customer service for members, caregivers, and providers.

The Vendor should describe any experience managing services for the foster care population.

Aetna's national Medicaid organization has experience managing services for the foster care population in nine states: Arizona[11], Kansas, Kentucky, Louisiana, Maryland, Michigan, New Jersey, Pennsylvania, and Virginia. Children in state custody are among the most vulnerable individuals in our society. They face unique challenges that require our unwavering commitment, collaboration, and compassion. Given these challenges, the Aetna Medicaid organization developed a System of Care model with integrated care coordination teams to help children and their families or caregivers create holistic, person-centered individual service plans focused on evidence-based best practices, trauma-informed care, and social determinants of health (SDOHs) that result in a positive impact on each child's life. Every day, Aetna aims to support safety and permanency for children, align psychotropic medication use with clinical practice guidelines, and improve health outcomes for these youth. In our experience with children, youth, and young adults, we have identified several core elements to a person-centered, integrated care coordination approach, including the following:

- Collaboration with the primary care providers (PCPs)/medical health homes, foster parents, and others to ensure timely completion of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, including well-child visits, dental visits, and immunizations
- Family and caregiver support (from birth parents, siblings, or other family members) to make certain all families have access to needed services and information so they can make informed decisions about the child they are caring for, thereby ensuring each child receives the love and care they need
- Collaboration with child welfare agencies, criminal and juvenile justice systems, community service organizations, targeted case management agencies, educational systems, and community-based provider organizations to develop initiatives with community-based organizations to improve accessibility, close health care gaps, promote health literacy, and address the SDOH
- Collaboration with schools to make sure we are fully supporting a child's individualized education program and addressing any gaps in care that support both the child and the school
- Referrals to Head Start for children under the age of 5 for enhancement of the child's cognitive, social, and emotional development; monitoring progress of children in Head Start
- Monitoring and tracking all service providers to ensure service continuity, prevent placement disruptions, and address barriers that may impact permanency
- Collaboration with community service organizations and educational systems to connect children with hobbies or extracurricular activities such as sports and outdoor activities, which can teach them lifelong habits to keep them physically and mentally fit, promote healthy ways of dealing with stress, avoid trouble, and encourage well-being

Aetna's Medicaid organization serves thousands of children, adolescents, and young adults like the West Virginia children and youth population. Some of the Aetna Medicaid organization's oldest health plans serve members in the Appalachian region. For example, Aetna Better Health Kids has served CHIP members in Pennsylvania since 1993, and like Aetna Better Health of West Virginia, Aetna Better Health of Virginia has been serving Medicaid members since 1996. Aetna health plans in other Appalachian states such as Kentucky, New York, Ohio, Pennsylvania, and Virginia face some of the same unique challenges experienced by West Virginia, including living in large rural areas with transportation and

[11] 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 national Medicaid organization.

provider access challenges, as well as the effects of the opioid epidemic. Each health plan has developed localized best-practice initiatives to serve this vulnerable population and demonstrated sustained improvements in member outcomes (health outcomes or social outcomes such as family reunification). To demonstrate Aetna's experience managing services for the foster care population, we provide a description of three examples of successful outcomes in Kentucky and Arizona.

Example 1: Kentucky's Six Points of Care Program

In Kentucky, Aetna has developed a model of care for children, youth, and young adults that embraces the following Children's Defense Fund recommendations:[12]

- At-risk young people fare best when raised in families equipped to either meet or understand how to assist them to meet their holistic needs, including addressing physical and behavioral health conditions and supporting function and unmet social resource needs. For example, Aetna understands the EPSDT benefit can help equip families to care for abused and neglected children in foster or kinship care and adoption assistance programs by giving them access to the range of physical and behavioral health services they need. We link members to EPSDT services when their unique needs indicate it would help improve their health and wellness or prevent a potential risk from worsening.
- Young people who age out of foster care are eligible for Medicaid to age 26. Aetna supports their access to care as they transition into young adulthood and pursue school and work. Through our care coordination process, members' care managers provide education regarding health care options, encourage young people to complete high school or equivalent, and encourage post-secondary education and job training as appropriate.
- Children's health and development depends on their physical environment, their family situation and personal relationships, and their unmet social needs. Aetna plays an important role in meeting members' whole-person needs and in supporting families/parents' health needs to strengthen families. For example, for Kentucky youth, parental access to mental health and substance use disorder treatment through Medicaid can help to alleviate health needs that may lead to children being placed in foster care.

Within our Kentucky foster care team, we employ Aetna's Six Points of Care approach aimed at engaging, assessing, and meeting the needs of children who face multiple challenges by building an interdisciplinary team composed of professionals from different areas of specialization each focusing on a particular subpopulation. The Six Points of Care include the following:

- Behavioral health conditions
- Medically complex conditions
- Adoption assistance and foster care children and youth
- Aging out/transition
- Neonatal abstinence syndrome
- Juvenile justice

Early on, Aetna Better Health of Kentucky recognized the benefits of proactively outreaching the families or caregivers of children, youth, and young adults involved in care. Children who are deemed medically complex by the state or an infant with a diagnosis of neonatal abstinence syndrome are paired with an Aetna-registered nurse care manager and are engaged in complex care coordination. We pair children who have a behavioral health diagnosis or claims with an Aetna-licensed behavioral health care manager. All six of the categories of children served in this program are supported with regular care management and care coordination by their interdisciplinary care team. Upon enrollment, Aetna staff

[12] Children's Defense Fund, "Medicaid Matters for Children in Foster Care," (2018); https://www.childrensdefense.org/wpcontent/uploads/2018/06/child-welfare-and-medicaid.pdf: Accessed June 14, 2019

outreach to the social services worker and foster parents to perform a health risk assessment and an Aetna-proprietary foster care assessment. In an integrated, person-centered planning process, where the child and their family are the lead participants, each child's unique whole-person needs are assessed, prioritized, and addressed as quickly as possible. To increase coordination of care, when applicable and if desired by the child or their family, a member of the Care Management team attends face-to-face meetings with PCPs, specialty physicians, and counselors. For example, registered nurse care managers accompany pregnant young women to appointments at treatment facilities for expecting mothers with a history of substance use.

Being proactive in our outreach makes sure all individuals working with the youth and associated stakeholders have a single point of contact at the health plan. This is a resource of support for State social workers, Department of Juvenile Justice workers, or foster/adoptive parents who may experience a barrier to their child receiving care. For example, a foster parent had difficulty getting a medication filled because the previous placement did not send the medication with the child, and it was too soon for a refill. Because Aetna outreached the member's foster parent, they called the health plan for support and were able to receive the medications timely. With this strong relationship, we will provide support and lead coordination so there is no treatment disruption. Additionally, we remind social workers, Department of Juvenile Justice workers, and/or foster/adoptive parents of any gaps in care so members get the care they need. This has led to improved Healthcare Effectiveness Data and Information Set (HEDIS) outcomes, but most importantly, youth are getting the care they need.

Aetna has developed numerous interventions that align with the Six Points of Care program to better serve members in the youth and family welfare system, including the Kentucky programs described in **Table 1.1-2**:

Table 1.1-2: Aetna Programs and Initiatives for Children, Youth, and Young Adults in Kentucky

Program	Description
Exploited Children's Help Organization (ECHO)	Aetna collaborates with the community-based organization that works to reduce the impact of child abuse. Aetna sponsors a children's room called the Kentucky Family Safe Zone in the Louisville courthouse. The room is designed as a children's environment and provides children with a safe place to play while their caregivers attend court proceedings. Without this room, many children either must sit in the courtroom or listen to the court cases or their parents/guardians will miss court altogether because they do not have anywhere to send their children.
Aetna Points of Care Duffle Bag Program	This program provides basic necessities for children as they come into the foster care system. Kentucky provides duffle bags for kids ages 8 through teenage years (over half of their 5,800 foster care children are teenagers). The duffle bags include a water bottle, shampoo, conditioner, toothbrush, toothpaste, hairbrush or comb, body wash, fleece blanket, and comfort and stress reduction items (e.g., journals, coloring books, colored pencils, stress balls, and fidget spinners).
Aetna Birthday Box Program	This program recognizes children's birthdays (focuses on medically fragile and transition-age children that would otherwise not be acknowledged). Each child receives a Birthday in a Box that includes party supplies (e.g., paper goods, party decorations), balloons, book/journal, puzzle/game, and a large cupcake. The Birthday in a Box is arranged and delivered by the foster care manager.

Example 1 Results: Aetna's Six Points of Care program leads sustained improved health outcomes for our foster care children. **Table 1.1-3** demonstrates Aetna's HEDIS measures for foster care children that have remained above the national benchmark (at the 50th percentile) for each of the past three years. In addition, our 2018

Antipsychotics in Children and Adolescents rate was 0.03 percent, compared to 2.09 percent for the national benchmark (nb: for this measure a lower percent is considered favorable.)

Table 1.1-3: Sustained HEDIS Outcomes for Foster Care Children

Measure	Aetna 2016	2016 National Benchmark	Aetna 2017	2017 National Benchmark	Aetna 2018	2018 National Benchmark
One dental visit: 2-21 years	70.3%	51.7%	75.7%	54.9%	75.8%	56.6%
Members with one or more well-child visits: 25 months—6 years	94.8%	87.7%	95.1%	87.9%	93.4%	87.5%
Members with one or more well-child visits: 12-19 years	89.6%	89.4%	94.8%	89.5%	94.8%	89.6%
Comprehensive well-care visit with a PCP or an OB/GYN: 12-21 years	50.7%	48.4%	55.4%	50.1%	56.4%	54.6%
Children's access to primary care: CAP 12-24 months old	96.1%	95.7%	100%	95.7%	96.3%	95.7%
Children's access to primary care: CAP 7-11 years old	96.2%	91.0%	91.7%	90.7%	95.3%	90.7%

Example 2: Supports for Vulnerable Youth in Arizona

Mercy Care[13] established initiatives to provide wraparound supports to foster care children and justice-involved youth in Arizona to increase the penetration rate of behavioral health services and decrease the number of children in out-of-home placement. For both initiatives, Mercy Care increased emphasis and expectations for trauma-informed care and regular trauma assessments. Mercy Care required all youth who were in child welfare programs to have at least one assessment per year, with a minimum of one trauma-informed contact each month. This allowed for a proactive approach so services and supports could be put in place at the onset of any concerns identified by the caregiver prior to it becoming a crisis.

Initiative 1: Increasing the Penetration Rate of Behavioral Health Services

Mercy Care worked with the Department of Child Services (DCS) child welfare specialists to identify youth who were receiving foster care services and not active in behavioral health treatment. Mercy Care coordinated engagement and outreach so that an intake was offered to the caregiver and youth with a local behavioral health provider. Throughout the care coordination process, Mercy Care staff met with child welfare specialists to review caseloads and to identify youth who are eligible, as well as review youth in shelters and group homes to identify whether they were engaged in behavioral health services including care coordination, behavior coaching, and/or therapy. When a youth was identified as not being connected, outreach was completed by direct care providers to the caregivers for engagement.

[13] Mercy Care is not a subsidiary of Aetna Inc. but is managed by Aetna's national Medicaid organization.

Each month, Mercy Care compares the list of youth removed from their home by child welfare against the children and families who had a rapid response assessment[14] completed, and Mercy Care identifies children and families who may have been missed. For any children and families who were not offered an assessment, Mercy Care conducts outreach and engagement activities. Mercy Care tracks all children and youth from the rapid response assessment to ongoing services to monitor that youth were engaged in behavioral health services. Doing so gives both Mercy Care and DCS the confidence that all children placed in child welfare are connected to behavioral health services and are receiving ongoing trauma-informed services and supports to help them through their family's journey while they are involved in child welfare.

Results of initiative 1: This Mercy Care initiative resulted in sustained improvements in service delivery for this vulnerable population. For example, the child welfare behavioral health penetration rate was 39 percent in 2014, increased to 69 percent in 2015, and has stabilized at around 78 percent since 2017, indicating a penetration **improvement of 100 percent**.

Initiative 2: Reducing the Number of Children in Out-of-home Care

Mercy Care developed a plan to increase the number of youth in foster care transitioning out of DCS and foster care services to reflect completion of their treatment goals, family reunification, or establishing permanency in a foster placement or through adoption. Mercy Care's goal was also to decrease children's time to permanency and stability by working with youth and their families to complete their care plan goals, inclusive of behavioral health treatment needs. The steps Mercy Care took to accomplish this include the following:

- Mercy Care increased collaborative efforts with DCS and local providers, which led to an increase in family reunification after their completion of their behavioral health service needs. All families that chose to continue with Arizona Health Care Cost Containment System Medicaid eligibility were offered continued services after reunification to offer support during the transition and address ongoing behavioral health needs.
- Mercy Care increased emphasis and support on adoption program efforts and on assisting parents with increasing the efficiency of the guardianship process. This process led to placement permanency, which was a primary reason that youth in child welfare achieved permanency before one year.
- Through the Mercy Care-DCS collaborative, Mercy Care discussed and focused on provider efforts to engage biological parents and relatives in activities and treatment to address the reasons why their child (or children) was removed. Mercy Care has created programs and processes to have family support partners (parents with lived experience) engage biological families early in the process, or as soon as DCS is involved, to create a bridge to outreach and draw those parents into the reunification process early. Discussions through the collaborative and through regular educational and training efforts with providers focus on engagement and reunification efforts being made as part of the care planning process.
- Mercy Care implemented efforts to increase the provider competency and capacity to meet the needs of younger children and their parents or other caregivers, while supporting the goals of safety and permanency.
- The development of the No Wrong Door policy allows family support agencies to directly enroll biological families with children in the child welfare system into their services. This initiative removed barriers to access to care by allowing clients to quickly and easily seek out services and enroll in

[14] Rapid response is an assessment completed within 72 hours of removal where the child and family participate in a comprehensive trauma-informed assessment and education is provided to the caregiver.

treatment services. This policy has also increased the use of family support partners to provide additional support to foster parents and biological parents.

- Mercy Care recognized that early engagement of the child's biological family is essential to successful reunification. To accomplish this goal, Mercy Care's providers co-located within DCS sites partnered with family-run organizations and their own family support partners to connect with youths' families/caregivers at the time of removal. The family support partner begins engagement of the biological family to provide support for the families' identified needs. The goal is to reunify the youth with their family and to reduce time in care under DCS.
- Mercy Care's collaboration with Jewish Family and Children's Service developed the Family Center of Excellence. The Family Center of Excellence is in an area where there is a high volume of youth in DCS custody. The goals of this program are to provide support to both the youth and their families to prevent placement in the DCS system or to help support the reunification process and decrease the time in DCS care.

Results of initiative 2: Mercy Care began serving more than 12,000 children and youth in foster and residential care in 2014. Between 2014 and 2019, the number of children and youth in out-of-home care has safely reduced to 8,000 and continues to fall. Assisting foster care children to move on from child protection, preferably back to their birth families, results in cost savings to the State. Mercy Care estimates that the reduction in children and youth in foster care and out-of-home placements saves over $3.5 million per year for the state Medicaid agency.

Example 3: Mercy Care Plan Co-location with Juvenile Justice

Mercy Care established an initiative to co-locate dedicated health plan staff within the county juvenile justice department as the first point of identification and diversion for detained juveniles enrolled in or eligible for Mercy Care services. The following initiatives were put in place to make certain planning is occurring and that needs are identified prior to being released from detention.

Mercy Care employs two Master's level clinicians to serve as juvenile justice liaisons (JJLs) within the Juvenile Justice Engagement team (JJET). The JJET staff, co-located with the Maricopa County Juvenile Probation Department, acts as first point of identification and diversion for detained juveniles and functions as a liaison to the range of justice stakeholders (i.e., DJJ, juvenile probation, law enforcement, the courts, legal advocates, county attorney, and court-appointed special advocates). The JJL partners with regional care coordinators, participates in the wraparound treatment team, attends court hearings, and assists eligible youth enroll in behavioral health services. This justice-focused staff is experienced with working at the intersection of the legal, justice, health care, and child welfare systems, and it provides technical assistance to key stakeholders regarding processes on how to navigate through the behavioral health system.

All referrals to JJET are initiated by the juvenile probation officer (JPO) to determine behavioral health eligibility and to rapidly initiate needed behavioral health services. If a child is placed in DCS custody, a rapid response referral is initiated. Once a referral is made, events unfold as follows:

- An initial case meeting (DCS specialist and JPO) is held within five working days.
- Discussion is held of the crossover case to ensure exchange of all relevant case information regarding the child and family.
- Development the five-day discussion guide occurs to provide consistency and uniformity in the type of information shared, gathered, and exchanged.
- JPOs include the Mercy Care JJET in all information exchanges.
- The initial monthly crossover team meeting with the child and family is held at the conclusion of the initial meeting.

- All crossover meetings are designed to make certain that families and probation, DCS, Mercy Care, education, and other service providers share information and collaborate to keep families engaged and connected to care and track with services, to result in better outcomes.

Crossover team meetings and the planning for them are guided by the Crossover Youth Practice Model Family Plan for Success. This plan tracks progress on goals, new information related to the case, new court orders, updates on the parent and/or child's progress on identified behavioral changes, treatment or other services, results of substance use tests for the child and/or parent, and any other family's concerns, barriers, or needs. The team will collaboratively identify ways to resolve the concerns, barriers, and needs and develop a joint court recommendation for the child's services and placement. Lastly, there is a review of upcoming meetings, court hearings, and appointments to avoid duplication. **Presiding judges are very complimentary of this model, as it provides real-time information that informs their decisions and provides confidence that all children will be connected and served by a community-based provider.**

Example 3 Results: From the beginning of the JJET program, the percentage of children who are both served through the foster care and juvenile justice system whose disposition was diversion as opposed to probation increased by 37 percent (from 9.5 percent to 13 percent).

For Specialized Managed Care for Children and Youth, Aetna will add a juvenile justice liaison position in Charleston. We will tailor the duties of the JLL position to the unique requirements of the West Virginia program to drive improved outcomes for at-risk children and youth. Aetna will work collaboratively with the Department and other stakeholders to help make sure we are meeting the State's expectations as well as to address the needs of children and youth, their families and caregivers, and the juvenile justice system.

The Vendor should provide the following information in accordance with 42 CFR § 455.104:

- 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. In the case of an individual, the date of birth and Social Security Number should be provided. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

  In **Table 1.1-4**, 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 1.1-4: Ownership and Control Interest Information

Name	Address[15]	Tax ID Number (entities)	Social Security Number and Date of Birth (Individuals)[16]
CVS Health Corporation (Ultimate Owner)	One CVS Drive Woonsocket, RI 02895	05-0494040	N/A
CVS Pharmacy, Inc. (Indirect Owner)	One CVS Drive Woonsocket, RI 02895	05-0340626	N/A
Aetna Inc. (Indirect Owner)	151 Farmington Drive Hartford, CT 06156	23-2229863	N/A
Aetna Health Holdings, LLC (Direct Owner)	151 Farmington Drive Hartford, CT 06156	30-0123754	N/A
Randy Hyun **Director, Principal Officer - Chief Executive Officer and President**	4500 E. Cotton Center Blvd. Phoenix, AZ 85040	N/A	To be provided—please refer to footnote 16
David P. Delaney **Director, Principal Officer - Chief Financial Officer**	4500 E. Cotton Center Blvd. Phoenix, AZ 85040	N/A	To be provided—please refer to footnote 16
Mary Louise E. Osborne **Director**	120 East Kensinger Drive Cranberry Twp., PA 1606	N/A	To be provided—please refer to footnote 16
Tracy L. Smith **Principal Officer - Vice President and Treasurer**	200 Highland Corporate Dr. Cumberland, RI 02864	N/A	To be provided—please refer to footnote 16
Robert M. Kessler **Principal Officer - Vice President and Secretary**	4500 E. Cotton Center Blvd. Phoenix, AZ 85040	N/A	To be provided—please refer to footnote 16
Kevin J. Casey **Principal Officer - Senior Investment Officer**	151 Farmington Drive Hartford, CT 06156	N/A	To be provided—please refer to footnote 16

[15] Please refer to **Appendix A** for a complete listing of office locations for CVS Health Corporation and Aetna Inc.
[16] Pursuant to the instructions included in the RFP indicating, "[t]he Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information," We have not provided dates of birth or Social Security numbers at this time. We will provide this information upon request by the Department, if we are selected as a contract awardee.

Name	Address[15]	Tax ID Number (entities)	Social Security Number and Date of Birth (Individuals)[16]
Edward C. Lee **Officer - Vice President and Assistant Secretary**	151 Farmington Drive Hartford, CT 06156	N/A	To be provided—please refer to footnote 16
Frank F. Chronister **Principal Officer - Corporate Controller**	3721 TecPort Drive Harrisburg, PA 17111	N/A	To be provided—please refer to footnote 16
Melissa B. Pavlovich **Officer - Vice President**	151 Farmington Ave. Hartford, CT 06156	N/A	To be provided—please refer to footnote 16
Robert T. O'Connor **Officer - Vice President**	11 Stanwix Street, Ste. 1400 Pittsburgh, PA 15237	N/A	To be provided—please refer to footnote 16
Anne Kelly Berg **Officer - Assistant Vice President**	151 Farmington Ave. Hartford, CT 06156	N/A	To be provided—please refer to footnote 16
Jennifer L. Pomponi **Officer- Assistant Vice President**	151 Farmington Ave. Hartford, CT 06156	N/A	To be provided—please refer to footnote 16
Michael M. Sinisgalli **Officer - Assistant Treasurer**	151 Farmington Ave. Hartford, CT 06156	N/A	To be provided—please refer to footnote 16
Lindsay A. Chuey **Officer - Assistant Treasurer**	One CVS Drive Woonsocket, RI 02895	N/A	To be provided—please refer to footnote 16
Robert S. Healy **Officer - Assistant Treasurer**	151 Farmington Ave. Hartford, CT 06156	N/A	To be provided—please refer to footnote 16
Marc A. Parr **Officer - Assistant Treasurer**	151 Farmington Ave. Hartford, CT 06156	N/A	To be provided—please refer to footnote 16
Diane E. Steponaitis **Officer - Assistant Treasurer**	151 Farmington Ave. Hartford, CT 06156	N/A	To be provided—please refer to footnote 16
Sheelagh M. Beaulieu **Officer - Assistant Treasurer**	One CVS Drive Woonsocket, RI 02895	N/A	To be provided—please refer to footnote 16
Jeffrey E. Clark **Officer - Assistant Treasurer**	One CVS Drive Woonsocket, RI 02895	N/A	To be provided—please refer to footnote 16

Name	Address[15]	Tax ID Number (entities)	Social Security Number and Date of Birth (Individuals)[16]
Sandra M. Coombes **Officer - Assistant Treasurer**	151 Farmington Ave. Hartford, CT 06156	N/A	To be provided—please refer to footnote 16
Deborah E. Finch **Officer - Assistant Treasurer**	6720-B Rockledge Dr. Ste. 800 Bethesda, MD 20817	N/A	To be provided—please refer to footnote 16
Caitlin M. Gould **Officer - Assistant Treasurer**	151 Farmington Ave. Hartford, CT 06156	N/A	To be provided—please refer to footnote 16
F. Ryan Keith **Officer - Assistant Treasurer**	9900 Corporate Campus Drive Ste. 1000 Louisville, KY 40223	N/A	To be provided—please refer to footnote 16
Cynthia A. Montano **Officer - Assistant Treasurer**	151 Farmington Ave. Hartford, CT 06156	N/A	To be provided—please refer to footnote 16
Thomas J. Rolwing **Officer - Assistant Treasurer**	6720-B Rockledge Dr. Ste. 800 Bethesda, MD 20817	N/A	To be provided—please refer to footnote 16
Melissa K. Ronski **Officer - Assistant Treasurer**	151 Farmington Ave. Hartford, CT 06156	N/A	To be provided—please refer to footnote 16
Timothy J. Roach **Officer - Assistant Treasurer**	151 Farmington Ave. Hartford, CT 06156	N/A	To be provided—please refer to footnote 16
Jeffrey J. Drzazgowski **Officer - Assistant Treasurer**	151 Farmington Ave. Hartford, CT 06156	N/A	To be provided—please refer to footnote 16

- 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.

  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 1.1-5** 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.

  In **Table 1.1-5** 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 1.1-5: 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)	Ultimate owner of Aetna Inc., Aetna Health Holdings, LLC, and CVS Pharmacy, Inc.
CVS Pharmacy, Inc. (Indirect Owner)	100%-owned by CVS Health Corporation
Aetna Inc. (Indirect Owner)	100%-owned by CVS Pharmacy, Inc.
Aetna Health Holdings, LLC (Direct Owner)	100%-owned by Aetna Inc.
Randy Hyun	None
David P. Delaney	None
Mary Louise E. Osborne	None
Tracy L. Smith	None
Robert M. Kessler	None
Kevin J. Casey	None
Edward C. Lee	None
Frank F. Chronister	None
Melissa B. Pavlovich	None
Robert T. O'Connor	None
Anne Kelly Berg	None
Jennifer L. Pomponi	None
Michael M. Sinisgalli	None
Lindsay A. Chuey	None
Robert S. Healy	None
Marc A. Parr	None
Diane E. Steponaitis	None
Sheelagh M. Beaulieu	None
Jeffrey E. Clark	None
Sandra M. Coombes	None
Deborah E. Finch	None

Name	Relationship to other Owners or others with Control Interest
Caitlin M. Gould	None
F. Ryan Keith	None
Cynthia A. Montano	None
Thomas J. Rolwing	None
Melissa K. Ronski	None
Timothy J. Roach	None
Jeffrey J. Drzazgowski	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.

  Aetna Better Health of West Virginia provides the information below in accordance with 42 CFR §455.104(b)(3).[17]

Aetna Inc. and Aetna Health Holdings, LLC

- Aetna Better Health of North Carolina Inc.
- Aetna Better Health of California Inc.
- Coventry Health Care of Florida, Inc. dba Aetna Better Health of Florida
- Aetna Better Health Inc., an Illinois Corporation dba Aetna Better Health of Illinois
- 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

[17] The second bullet point on page 48 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 47. As worded, the second bullet point on page 48 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 47, the information we provided in response to bullet point two on page 48 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 second bullet point on page 48, we will provide additional information upon request.

- 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.[18]

- 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.
- 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

[18] 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.

- The name, address, date of birth, and Social Security Number of an agent or a managing employee of the Vendor. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

  In **Table 1.1-6,** we provide information regarding agents or managing employees of Aetna Better Health of West Virginia.

Table 1.1-6: Agents or Managing Employees of Aetna Better Health of West Virginia

Name	Address	Social Security Number and Date of Birth (Individuals)[19]
Randy Hyun **Director, Principal Officer - Chief Executive Officer and President**	4500 E. Cotton Center Blvd. Phoenix, AZ 85040	To be provided—please refer to footnote 19
David P. Delaney **Director, Principal Officer - Chief Financial Officer**	4500 E. Cotton Center Blvd. Phoenix, AZ 85040	To be provided—please refer to footnote 19
Tracy L. Smith **Principal Officer - Vice President and Treasurer**	200 Highland Corporate Drive Cumberland, RI 02864	To be provided—please refer to footnote 19
Robert M. Kessler **Principal Officer - Vice President and Secretary**	4500 E. Cotton Center Blvd. Phoenix, AZ 85040	To be provided—please refer to footnote 19
Kevin J. Casey **Principal Officer - Senior Investment Officer**	151 Farmington Drive Hartford, CT 06156	To be provided—please refer to footnote 19
Frank F. Chronister **Principal Officer - Corporate Controller**	3721 TecPort Drive Harrisburg, PA 17111	To be provided—please refer to footnote 19
Todd White **Health plan Chief Executive Officer**	500 Virginia Street East, Suite 400 Charleston, WV 25301	To be provided—please refer to footnote 19
Tina Bailes **Health plan Chief Financial Officer**	500 Virginia Street East, Suite 400 Charleston, WV 25301	To be provided—please refer to footnote 19
Donald Gibbon, DO **Health plan Chief Medical Officer**	500 Virginia Street East, Suite 400 Charleston, WV 25301	To be provided—please refer to footnote 19
Gregory Carpenter **Health plan Chief Operations Officer**	500 Virginia Street East, Suite 400 Charleston, WV 25301	To be provided—please refer to footnote 19

[19] Pursuant to the instructions included in the RFP indicating, "The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information," we have not included dates of birth or Social Security numbers at this time. We will provide this information upon request by the Department, if we are selected as a contract awardee.

Please describe if the Vendor has ever sought, or is currently seeking, National Committee for Quality Assurance (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.*

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 currently is the only Medicaid managed care organization with Commendable status in West Virginia. Our accreditation term effective dates are October 18, 2016 through October 18, 2019. **[MR009]** Our focus on quality outcomes supports our mission to improve every life we serve.

ATTACHMENT B: VENDOR QUALIFICATIONS & EXPERIENCE

1.2 Subcontractor Overview (if applicable)

If the proposal includes the use of Subcontractor(s), provide all relevant information regarding the profile of each Subcontractor. This section may be duplicated in its entirety and a page created per Subcontractor included.

The Vendor is NOT to change any of the pre-filled cells in the following tables. The Vendor should only delete <Response> and add text in its place.

In **Table 7: 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 Specialized Managed Care for Children and Youth project, if awarded:

- Active Health Management, Inc.
- Aetna Health Management, LLC
- Aetna Medicaid Administrators LLC
- APS Quality Review Inc. dba Keystone Peer Review Organization, Inc. (KEPRO)
- 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.
- Inovolan, Inc.
- MCMC, 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.

Table 7: Subcontractor Overview

Subcontractor Overview	
Corporate (Legal) Name	Active Health Management, Inc. (ActiveHealth)
Name of Parent Company (If Applicable)	CVS Health Corporation
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 718 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)	To be provided – See footnote[2]
Last Fiscal Year Company Net Income	ActiveHealth's income is not reported separately, as it is part of CVS Health Corporation's financials.
% of Revenue From State Government Clients in the United States	To be provided – See footnote[2]
Number of Years in Business	21 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 12 years.
Number of Employees Providing the Type of Services Specified in the RFP	ActiveHealth has approximately 718 staff members, which are employed by Aetna Resources LLC (Aetna Resources), an Employee

[2] In Addendum 5, Q059, the Department confirmed that Vendors may exclude from their bids revenue information for Subcontractors which consider this information confidential and instead, provide the information post-award upon request by the Department. ActiveHealth considers its revenue information confidential because competitors can use this information to gain a competitive advantage against ActiveHealth in connection with RFPs and product positioning. As a result, we have not included ActiveHealth's last fiscal year company revenue or the percentage of revenue it receives from State government clients in ActiveHealth's response to Table 7, Subcontractor Overview. If Aetna Better Health of West Virginia is awarded a contract as a result of this RFP, it will provide ActiveHealth's revenue information post-award upon request by the Department, at which time we understand that the Department will protect the information from public disclosure.

Subcontractor Overview	
	Management Company and Aetna affiliate that provides labor services.
Headquarters in the United States	Yes
Headquarters Mailing Address	1333 Broadway, New York, NY 10018
Street Address	1333 Broadway, New York, NY 10018
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)	N/A
Name of Contact Person for Bid	Mohamed Diab, CEO

The Subcontractor should provide the following information in accordance with 42 CFR § 455.104:

- 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. In the case of an individual, the date of birth and Social Security Number should be provided. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

  We have included the requested information in **Table 1.2-1** for any person (individual or corporation) with an ownership or control interest in the Subcontractor, other than institutional investors with a beneficial ownership of 5% or more of CVS Health Corporation's common stock.

  Please note that Active Health Management, Inc.'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% 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 1.2-1: Name and Address of Any Person (Individual or Corporation) with an Ownership or Control Interest in Active Health Management

Name	Address[3]	Tax ID Number (entities)	Social Security Number & Date of Birth (Individuals)[4]
CVS Health Corporation (Ultimate Owner)	One CVS Drive Woonsocket, RI 02895	05-0494040	N/A
CVS Pharmacy, Inc. (Indirect Owner)	One CVS Drive Woonsocket, RI 02895	05-0340626	N/A
Aetna Inc. (Direct Owner)	151 Farmington Drive Hartford, CT 06156	23-2229863	N/A
Mohamed Diab **Sole Director - Principal Officer, Chief Executive Officer & President**	1333 Broadway New York, NY 10018	N/A	To be Provided – See footnote
Matthew J. Asmus **Principal Officer - Executive Vice President & Chief Financial Officer**	1333 Broadway New York, NY 10018	N/A	To be Provided – See footnote
Tracy L. Smith **Principal Officer - Vice President & Treasurer**	200 Highland Corporate Dr. Cumberland, RI 02864	N/A	To be Provided – See footnote
Edward Chung-I Lee **Principal Officer – Vice President & Secretary**	151 Farmington Drive Hartford, CT 06156	N/A	To be Provided – See footnote
Melissa Bush Pavlovich **Principal Officer - Vice President**	151 Farmington Drive Hartford, CT 06156	N/A	To be Provided – See footnote

- 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 Active Health Management, Inc. in **Table 1.2-1** in response to the question immediately preceding this one. Please note there are no subcontractors in which Active Health Management, Inc. has a five (5) percent or more ownership or control interest.

[3] Please see **Appendix A** for a complete listing of office locations for CVS Health Corporation and Aetna Inc.
[4] Pursuant to the instructions included in the RFP indicating "*The Subcontractor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*", we have not provided dates of birth or social security numbers at this time. We will provide the information upon request by the Department, if we are selected as a contract awardee.

- 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 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 1.2-2: Relationships Among Persons with Ownership or Control Interest in Active Health Management

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

  Active Health Management provides the following information in accordance with 42 CFR 455.104(b)(3), as applied to Subcontractors.[5]

  Aetna Inc.
  - Aetna Better Health of North Carolina Inc.
  - Aetna Better Health of California Inc.
  - Coventry Health Care of Florida, Inc. dba Aetna Better Health of Florida
  - Aetna Better Health Inc., an Illinois Corporation dba Aetna Better Health of Illinois
  - Aetna Better Health of Kansas Inc.

[5] 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." See RFP page 47. 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 47, 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 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
- 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.[6]

- 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.

[6] 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.

- 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 name, address, date of birth, and Social Security Number of an agent or a managing employee of the Subcontractor. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

  In **Table 1.2-3,** we provide the names and addresses of agents or managing employees of Active Health Management.

Table 1.2-3: Names and Addresses of Agents or Managing Employees of Active Health Management

Name	Address	Social Security Number & Date of Birth (Individuals) [7]
Mohamed Diab **Sole Director - Principal Officer, Chief Executive Officer & President**	1333 Broadway New York, NY 10018	To be Provided – See footnote
Matthew J. Asmus **Principal Officer - Executive Vice President & Chief Financial Officer**	1333 Broadway New York, NY 10018	To be Provided – See footnote
Tracy L. Smith **Principal Officer - Vice President & Treasurer**	200 Highland Corporate Dr. Cumberland, RI 02864	To be Provided – See footnote
Edward Chung-I Lee **Principal Officer – Vice President & Secretary**	151 Farmington Drive Hartford, CT 06156	To be Provided – See footnote
Melissa Bush Pavlovich **Principal Officer - Vice President**	151 Farmington Drive Hartford, CT 06156	To be Provided – See footnote

[7] Pursuant to the instructions included in the RFP indicating "The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information", we have not included dates of birth or social security numbers at this time. We will provide the information upon request by the Department, if we are selected as a contract awardee.

Table 7: Subcontractor Overview

Subcontractor Overview	
Corporate (Legal) Name	Aetna Medicaid Administrators LLC
Name of Parent Company (If Applicable)	Aetna Medicaid Administrators LLC's direct parent is Aetna Health Holdings, LLC. Aetna Inc. and CVS Pharmacy, Inc. are indirect parents of Aetna Medicaid Administrators LLC. CVS Health Corporation is Aetna Medicaid Administrators LLC's 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 LLC's 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 LLC's ultimate parent, CVS Health Corporation, is a publicly traded company.
Number of Full-Time Employees	6,089
Last Fiscal Year Company Revenue (from Unaffiliated Parties)	$341.7 million
Last Fiscal Year Company Net Income	$58.1 million
% 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	6,089
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)	N/A
Name of Contact Person for Bid	Randy Hyun

The Subcontractor should provide the following information in accordance with 42 CFR § 455.104:

- 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. In the case of an individual, the date of birth and Social Security Number should be provided. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

  We have included the requested information **Table 1.2-4** for any person (individual or corporation) with an ownership or control interest in the Subcontractor, other than institutional investors with a beneficial ownership of 5% or more of CVS Health Corporation's common stock.

  Please note that Aetna Medicaid Administrators LLC'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% 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 1.2-4: Name and Address of Any Person (Individual or Corporation) with an Ownership or Control Interest in Aetna Medicaid Administrators

Name	Address[8]	Tax ID Number (entities)	Social Security Number & Date of Birth (Individuals)[9]
CVS Health Corporation (Ultimate Owner)	One CVS Drive Woonsocket, RI 02895	05-0494040	N/A
CVS Pharmacy, Inc. (Indirect Owner)	One CVS Drive Woonsocket, RI 02895	05-0340626	N/A
Aetna Inc. (Indirect Owner)	151 Farmington Drive Hartford, CT 06156	23-2229863	N/A
Aetna Health Holdings, LLC (Direct Owner)	151 Farmington Drive Hartford, CT 06156	30-0123754	N/A
Randy Hyun **Principal Officer - President**	4500 E. Cotton Center Blvd. Phoenix, AZ 85040	N/A	To be Provided – See footnote
David P. Delaney **Principal Officer – Chief Financial Officer**	4500 E. Cotton Center Blvd. Phoenix, AZ 85040	N/A	To be Provided – See footnote
Tracy L. Smith **Principal Officer - Vice President & Treasurer**	200 Highland Corporate Dr. Cumberland, RI 02864	N/A	To be Provided – See footnote
Robert M. Kessler **Principal Officer - Secretary**	4500 E. Cotton Center Blvd. Phoenix, AZ 85040	N/A	To be Provided – See footnote

- 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 LLC in **Table 1.2-4** in response to the question immediately preceding this one. Please note there are no subcontractors in which Aetna Medicaid Administrators LLC has a five (5) percent or more ownership or control interest.

[8] Please see **Appendix A** for a complete listing of office locations for CVS Health Corporation and Aetna Inc.
[9] Pursuant to the instructions included in the RFP indicating "The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information", we have not provided dates of birth or social security numbers at this time. We will provide the information upon request by the Department, if we are selected as a contract awardee.

- 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 1.2-5,** 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 1.2-5: 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)	Ultimate owner of Aetna Inc., Aetna Health Holdings, LLC, and CVS Pharmacy, Inc.
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 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.
Randy Hyun	None
David P. Delaney	None
Tracy L. Smith	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[10].

[10] 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." See RFP page 47. 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 47, 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 Inc. and Aetna Health Holdings, LLC

- Aetna Better Health of North Carolina Inc.
- Aetna Better Health of California Inc.
- Coventry Health Care of Florida, Inc. dba Aetna Better Health of Florida
- Aetna Better Health Inc., an Illinois Corporation dba Aetna Better Health of Illinois
- 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
- 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.[11]

- 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.

[11] 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.

- 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.
- 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 name, address, date of birth, and Social Security Number of an agent or a managing employee of the Subcontractor. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

  In **Table 1.2-6,** we provide the names and addresses of agents or managing employees of Aetna Medicaid Administrators.

Table 1.2-6: Names and Addresses of Agents or Managing Employees of Aetna Medicaid Administrators

Name	Address	Social Security Number & Date of Birth (Individuals) [12]
Randy Hyun **Director, Principal Officer - Chief Executive Officer & President**	4500 E. Cotton Center Blvd. Phoenix, AZ 85040	To be Provided – See footnote
David P. Delaney **Director, Principal Officer - Chief Financial Officer**	4500 E. Cotton Center Blvd. Phoenix, AZ 85040	To be Provided – See footnote
Tracy L. Smith **Principal Officer - Vice President & Treasurer**	200 Highland Corporate Dr. Cumberland, RI 02864	To be Provided – See footnote
Robert M. Kessler **Principal Officer - Vice President & Secretary**	4500 E. Cotton Center Blvd. Phoenix, AZ 85040	To be Provided – See footnote
Matthias C. Cowley **Chief Operations Officer**	4500 E. Cotton Center Blvd. Phoenix, AZ 85040	To be Provided – See footnote
David Hiestand **Interim Chief Medical Officer**	4500 E. Cotton Center Blvd. Phoenix, AZ 85040	To be Provided – See footnote

[12] Pursuant to the instructions included in the RFP indicating "The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information", we have not included dates of birth or social security numbers at this time. We will provide the information upon request by the Department, if we are selected as a contract awardee.

Table 7: 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 and management of Aetna Health Management are employed by Aetna Resources LLC, an Employee Management Company and Aetna affiliate that provides labor services. Aetna utilizes a shared services staffing model; and therefore, some employees of Aetna Resources LLC who support Aetna Health Management may also support other subsidiaries of Aetna Inc. 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)	$3.6 million
Last Fiscal Year Company Net Income	$325.1 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	Aetna Health Management has been providing services to Aetna Medicaid health plans for 15 years.

Subcontractor Overview	
Specified in the RFP	
Number of Employees Providing the Type of Services Specified in the RFP	Aetna Health Management has no employees. All staff and management of Aetna Health Management are employed by Aetna Resources LLC, an Employee Management Company and Aetna affiliate that provides labor services. Aetna utilizes a shared services staffing model; and therefore, some employees of Aetna Resources LLC who support Aetna Health Management may also support other subsidiaries of Aetna Inc. 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)	N/A
Name of Contact Person for Bid	Sheryl Burke Adkins, CEO

The Subcontractor should provide the following information in accordance with 42 CFR § 455.104:

- 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. In the case of an individual, the date of birth and Social Security Number should be provided. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

  We have included the requested information in **Table 1.2-7** for any person (individual or corporation) with an ownership or control interest in the Subcontractor, other than institutional investors with a beneficial ownership of 5% or more of CVS Health Corporation's common stock.

Please note that Aetna Health Management, LLC'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% 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 1.2-7: Name, Address, and Tax ID Number of Any Person (Individual or Corporation) with an Ownership or Control Interest in Aetna Health Management

Name	Address[13]	Tax ID Number (Entities)	Social Security Number & Date of Birth (Individuals)[14]
CVS Health Corporation (Ultimate Owner)	One CVS Drive Woonsocket, RI 02895	05-0494040	N/A
CVS Pharmacy, Inc. (Indirect Owner)	One CVS Drive Woonsocket, RI 02895	05-0340626	N/A
Aetna Inc. (Indirect Owner)	151 Farmington Drive Hartford, CT 06156	23-2229863	N/A
Aetna Health Holdings, LLC (Direct Owner)	151 Farmington Drive Hartford, CT 06156	30-0123754	N/A
Sheryl Burke Adkins **Principal Officer - President**	151 Farmington Drive Hartford, CT 06156	N/A	To be Provided – See footnote
Lisa Perdikakis **Principal Officer – Vice President & Controller**	151 Farmington Drive Hartford, CT 06156	N/A	To be Provided – See footnote

- 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, LLC in **Table 1.2-7** in response to the question

[13] Please see **Appendix A** for a complete listing of office locations for CVS Health Corporation and Aetna Inc.
[14] Pursuant to the instructions included in the RFP indicating "The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.", we have not provided dates of birth or social security numbers at this time. We will provide the information upon request by the Department, if we are selected as a contract awardee.

immediately preceding this one. Please note there are no subcontractors in which Aetna Health Management, LLC 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 1.2-8,** 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 1.2-8: 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)	Ultimate owner of Aetna Inc., Aetna Health Holdings, LLC, and CVS Pharmacy, Inc.
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 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.
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[15].

[15] 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." See RFP page 47. 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 47, 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 Inc. and Aetna Health Holdings, LLC

- Aetna Better Health of North Carolina Inc.
- Aetna Better Health of California Inc.
- Coventry Health Care of Florida, Inc. dba Aetna Better Health of Florida
- Aetna Better Health Inc., an Illinois Corporation dba Aetna Better Health of Illinois
- 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
- 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.[16]

- 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.

[16] 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.

- 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.
- 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 name, address, date of birth, and Social Security Number of an agent or a managing employee of the Subcontractor. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

  In **Table 1.2-9,** we provide the names and addresses of agents or managing employees of Aetna Health Management.

Table 1.2-9: Name and Address of Agents or Managing Employees of Aetna Health Management

Name	Address	Social Security Number & Date of Birth (Individuals) [17]
Sheryl Burke Adkins **Principal Officer – President**	151 Farmington Drive Hartford, CT 06156	To be Provided – See footnote
Lisa Perdikakis **Principal Officer – Vice President & Controller**	151 Farmington Drive Hartford, CT 06156	To be Provided – See footnote
Tracy L. Smith **Principal Officer - Vice President & Treasurer**	200 Highland Corporate Dr. Cumberland, RI 02864	To be Provided – See footnote
Edward Chung-I Lee **Principal Officer – Vice President & Secretary**	151 Farmington Drive Hartford, CT 06156	To be Provided – See footnote

[17] Pursuant to the instructions included in the RFP indicating "*The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*", we have not included dates of birth or social security numbers at this time. We will provide the information upon request by the Department, if we are selected as a contract awardee.

Table 7: Subcontractor Overview

Subcontractor Overview	
Corporate (Legal) Name	APS Quality Review Inc. dba Keystone Peer Review Organization, Inc. (KEPRO)
Name of Parent Company (If Applicable)	Keystone Peer Review Organization Holdings, Inc.
Tax Identification Number	23-2348176
Industry (NAICS)	541611, 541628
Type of Legal Entity	Corporation
Company Ownership (e.g., Private/Public, Joint Venture)	Private
Number of Full-Time Employees	1,020
Last Fiscal Year Company Revenue (from Unaffiliated Parties)	$171,205,977
Last Fiscal Year Company Net Income	$(43,776,434)
% of Revenue From State Government Clients in the United States	49%
Number of Years in Business	34 years
Number of Years Subcontractor has been Providing the Type of Services Specified in the RFP	34 years
Number of Employees Providing the Type of Services Specified in the RFP	1,400
Headquarters in the United States	Yes
Headquarters Mailing Address	424 Church Street, Suite 1370, Nashville TN 37129
Street Address	424 Church Street, Suite 1370, Nashville TN 37129
Telephone Number	615-933-0235
Fax Number	717.564.3862
Locations in the United States	Yes
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid (if	**Name:** KEPRO WV **Mailing Address:** 1007 Bullitt Street, Suite 200, Charleston, WV 25301

Subcontractor Overview	
different from above)	**Street Address:** 1007 Bullitt Street, Suite 200, Charleston, WV 25301 **Telephone Number:** 1-800-461-1655 **Fax Number:** 866-473-2354
Name of Contact Person for Bid	Nancy Sullivan

The Subcontractor should provide the following information in accordance with 42 CFR § 455.104:

- 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. In the case of an individual, the date of birth and Social Security Number should be provided. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

  Keystone Peer Review Organization Holdings, Inc.
  777 East Park Drive
  Harrisburg, PA 17111

- 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.

  25-1821782

- 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

- The name, address, date of birth, and Social Security Number of an agent or a managing employee of the Subcontractor. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

  Joel Portice, CEO
  424 Church Street, Suite 1370
  Nashville, TN 37129

Table 7: 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	Redacted
Number of Years in Business	25+
Number of Years Subcontractor has been Providing the Type of Services Specified in the RFP	15-25 years Change Healthcare is one of the largest independent health care technology companies in the United States. We provide software and analytics, network solutions, and technology enabled services that help our customers like Aetna obtain actionable insights, exchange information, control costs, optimize revenue opportunities, increase cash flow, and effectively navigate the shift to value-based health care.
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 Aetna Medicaid. Behind the scenes operations and technical support include substantially more employees, but not in sole support of Aetna Medicaid.
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	ChangeHealthcare.com
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)	NA
Name of Contact Person for Bid	Ann Armstrong

The Subcontractor should provide the following information in accordance with 42 CFR § 455.104:

- 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. In the case of an individual, the date of birth and Social Security Number should be provided. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

  Change Healthcare, LLC
  3055 Lebanon Pike, Suite 1000, Nashville, TN 37214
  13209 Corporate Exchange Drive, Bridgeton, MO 63044
  Federal Tax ID 20-5716594

- 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

- The name, address, date of birth, and Social Security Number of an agent or a managing employee of the Subcontractor. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

  N/A

Table 7: Subcontractor Overview

Subcontractor Overview	
Corporate (Legal) Name	Cotiviti, Inc. (representing itself and its subsidiaries and affiliates)
Name of Parent Company (If Applicable)	N/A
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)	Due to its confidential nature, as a private company, we cannot release detailed financial information.
Last Fiscal Year Company Net Income	Due to its confidential nature, as a private company, we cannot release detailed financial information.
% of Revenue From State Government Clients in the United States	Due to its confidential nature, as a private company, we cannot release detailed financial information.
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 healthcare industry in 1998.
Number of Years Subcontractor has been Providing the Type of Services Specified in the RFP	Our legacy companies have been providing healthcare 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

Subcontractor Overview	
Headquarters Mailing Address	One Glenlake Parkway, Suite 1400, Atlanta, GA 30328
Street Address	One Glenlake Parkway, Suite 1400
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)	Variable depending on the project scope. Please see our locations listed above.
Name of Contact Person for Bid	Susan Murray

The Subcontractor should provide the following information in accordance with 42 CFR § 455.104:

- 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. In the case of an individual, the date of birth and Social Security Number should be provided. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

  The Vendor is indirectly wholly owned by Verscend Holdings, LLC (59.4%) and Verscend Holdings II, LLC (40.6%). The address of each of Verscend Holdings, LLC and Verscend Holdings II, LLC is c/o Veritas Capital, 9 West 57th Street, 29th Floor, New York, NY

- 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 Holdings, LLC FEIN: XX-XXX1015; Verscend Holdings II, LLC FEIN: XX-XXX7522

- 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.

  No

- 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.

  None

- The name, address, date of birth, and Social Security Number of an agent or a managing employee of the Subcontractor. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

  Emad Rizk, President, Chief Executive Officer, also a member of Cotiviti's Board of Directors, c/o Cotiviti, 1 Glenlake Parkway, Suite 1400, Atlanta, GA 30328

  Peter Csapo, Interim Chief Financial Officer, EVP of Transformation and International Operations; c/o Cotiviti, 1 Glenlake Parkway, Suite 1400, Atlanta, GA 30328s

  David F. Mason, Secretary, Chief Operations Officer, c/o Cotiviti, 1 Glenlake Parkway, Suite 1400, Atlanta, GA 30328

  Dr. Richard G. Pozen, Chief Medical Officer, c/o Cotiviti, 1 Glenlake Parkway, Suite 1400, Atlanta, GA 30328

  Ramzi M. Musallam, member of the Board of Directors, c/o Veritas Capital, 9 West 57th Street, 29th Floor, NY, NY 10019

  James J. Dimitri, member of the Board of Directors, c/o Veritas Capital, 9 West 57th Street, 29th Floor, NY, NY 10019

  Joseph P. Longosz, member of the Board of Directors, c/o Veritas Capital, 9 West 57th Street, 29th Floor, NY, NY 10019

Table 7: 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	53
Last Fiscal Year Company Revenue (from Unaffiliated Parties)	$12,678,484
Last Fiscal Year Company Net Income	$12,678,484
% of Revenue From State Government Clients in the United States	10%
Number of Years in Business	19
Number of Years Subcontractor has been Providing the Type of Services Specified in the RFP	19
Number of Employees Providing the Type of Services Specified in the RFP	32
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)	N/A

Subcontractor Overview	
Name of Contact Person for Bid	Alan Vernon

The Subcontractor should provide the following information in accordance with 42 CFR § 455.104:

- 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. In the case of an individual, the date of birth and Social Security Number should be provided. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

  Elisabete Miranda
  SS#: REDACTED
  Address: REDACTED

- 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

- The name, address, date of birth, and Social Security Number of an agent or a managing employee of the Subcontractor. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

  Elisabete Miranda
  SS#: REDACTED
  DOB: REDACTED
  Address: REDACTED

Table 7: 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)	Public (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)	N/A

Subcontractor Overview	
Name of Contact Person for Bid	Eban Lewis

The Subcontractor should provide the following information in accordance with 42 CFR § 455.104:

- 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. In the case of an individual, the date of birth and Social Security Number should be provided. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

  We have included the requested information in **Table 1.2-10** for any person (individual or corporation) with an ownership or control interest in the Subcontractor. Dates of birth and Social Security numbers are redacted/not provided in this disclosure.

Table 1.2-10: 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

- The name, address, date of birth, and Social Security Number of an agent or a managing employee of the Subcontractor. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

  Managing Employee: Paul Kallaur, Vice President for Surveys & Research. 1625 K Street, NW Suite 800, Washington, DC 20006. (SSN and DOB redacted).

Table 7: 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)	Healthcare
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)	Equian, LLC is a private company and does not disclose certain financial information.
Last Fiscal Year Company Net Income	Equian, LLC is a private company and does not disclose certain financial information.
% of Revenue From State Government Clients in the United States	Equian, LLC is a private company and does not disclose certain financial information.
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	Subrogation - 768 Itemized Bill Review - 130
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: Headquartered in Indianapolis, Indiana, Equian has 17 locations nationwide: Montgomery, AL; Scottsdale, AZ; Golden, CO; Norwalk, CT; W. Des Moines IA; Naperville, IL; Indianapolis, IN; Louisville, KY; Woburn, MA; Bethesda, MD; Southfield, MI; Portsmouth, NH; Tulsa OK; Pittsburgh, PA; Radnor, PA; Franklin, TN and Milwaukee, WI

Subcontractor Overview	
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid (if different from above)	**Subrogation Unit 1:** **Name:** Equian **Mailing Address:** 9390 Bunsen Parkway, Louisville, KY 40220 **Street Address:** 9390 Bunsen Parkway, Louisville, KY 40220 **Telephone Number:** 502-214-1340 **Fax Number:** N/A **Subrogation Unit 2:** **Name:** Equian **Mailing Address:** 26555 Evergreen Road, Suite 200, Southfield, MI 48076 **Street Address:** 26555 Evergreen Road, Suite 200, Southfield, MI 48076 **Telephone Number:** 866-449-4800 **Fax Number:** N/A **Itemized Bill Review Unit:** **Name:** Equian **Mailing Address:** 600 12th Street, Suite 300, Golden, CO 80401 **Street Address:** 600 12th Street, Suite 300, Golden, CO 80401 Telephone Number: 877-631-9080 **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:

- 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. In the case of an individual, the date of birth and Social Security Number should be provided. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

  Equian, LLC, 5975 Castle Creek Parkway, Suite 100, Indianapolis IN 46250

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

  Equian has 17 locations nationwide: Montgomery, AL; Scottsdale, AZ; Golden, CO; Norwalk, CT; W. Des Moines IA; Naperville, IL; Indianapolis, IN; Louisville, KY; Woburn, MA; Bethesda, MD;

Southfield, MI; Portsmouth, NH; Tulsa OK; Pittsburgh, PA; Radnor, PA; Franklin, TN and Milwaukee, WI.

- 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.

  No

- 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

- The name, address, date of birth, and Social Security Number of an agent or a managing employee of the Subcontractor. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

  None

Table 7: 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
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)	$48,650,000,000 (Cigna year-end 2018)
Last Fiscal Year Company Net Income	$2,637,000,000 (Cigna year-end 2018)
% of Revenue From State Government Clients in the United States	Confidential
Number of Years in Business	27 years
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	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 8 office locations across the continental United States. Below is a full list of office locations, detailing headquarters, and

Subcontractor Overview	
	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:

- 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. In the case of an individual, the date of birth and Social Security Number should be provided. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

  We have included the requested information in **Table 1.2-11** for any person (individual or corporation) with an ownership or control interest in the Subcontractor. Dates of birth and Social Security numbers are redacted/not provided in this disclosure.

Table 1.2-11: Name and Address of Any Person (Individual or Corporation) with an Ownership or Control Interest in eviCore healthcare

Full Name	DOB	Address	TIN	Percent Ownership
MedSolutions Holdings, Inc	N/A	400 Buckwalter Place Blvd, Bluffton, SC 29910	27-3801345	100% (Direct)
CareCore National, LLC	N/A	400 Buckwalter Place Blvd, Bluffton, SC 29910	14-1831391	100% (Indirect)
CareCore National Intermediate Holdings, LLC	N/A	400 Buckwalter Place Blvd, Bluffton, SC 29910	46-4861112	100% (Indirect)
CareCore National Group, LLC	N/A	400 Buckwalter Place Blvd, Bluffton, SC 29910	47-2500642	100% (Indirect)
eviCore 1, LLC	N/A	One Express Way, St. Louis, MO 63121	46-4676347	49.22% (Indirect)
eviCore 2, Inc.	N/A	One Express Way, St. Louis, MO 63121	47-2396957	2.4% (Indirect)
eviCore 3, LLC	N/A	One Express Way, St. Louis, MO 63121	47-2477846	25.56% (Indirect)
eviCore 4, LLC	N/A	One Express Way, St. Louis, MO 63121	36-4799616	1.8% (Indirect)
eviCore 5, LLC	N/A	One Express Way, St. Louis, MO 63121	46-5364336	59.29% (Indirect)
eviCore 6, LLC	N/A	One Express Way, St. Louis, MO 63121	81-1416563	50% (Indirect)
eviCore 8, LLC	N/A	One Express Way, St. Louis, MO 63121	30-0847201	39.84% (Indirect)
eviCore 9, LP	N/A	One Express Way, St. Louis, MO 63121	47-2500642	4.8% (Indirect)
Oz Parent, Inc.	N/A	One Express Way, St. Louis, MO 63121	82-3430587	100% (Indirect)
Express Scripts Holding Company	N/A	One Express Way, St. Louis, MO 63121	45-2884094	100% (Indirect)
Cigna Corporation	N/A	900 Cottage Grove Road, Bloomfield, CT 06002	82-4991898	100% (Indirect)

- 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.

  eviCore provides this information in **Table 1.2-11,** in response to the previous question.

- 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.

  No

- 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.

  In **Table 1.2-12,** eviCore provides information regarding other organizations in which a person with ownership or control interest in the Subcontractor also has an ownership or control interest.

Table 1.2-12: Organizations in Which Persons with Ownership or Control Interest in eviCore Also Have an Ownership or Control Interest

Name of Owner	Name of Other Disclosing Entity	Other Disclosing Entity's TIN
Cigna Corporation	Accredo Health Group, Inc	11-3358535
Cigna Corporation	AHG of New York, Inc.	13-3888838
Cigna Corporation	Bio Partners in Care, Inc.	43-1815573
Cigna Corporation	ESI Mail Pharmacy Service, Inc. dba Express Scripts	43-1867735
Cigna Corporation	Express Scripts Specialty Distribution Services, Inc.	43-1869712
Cigna Corporation	Lynnfield Drug, Inc. dba Freedom Fertility Pharmacy	04-3546044
Cigna Corporation	Cigna Healthcare of Arizona dba Cigna Medical Group	86-0334392
CareCore National, LLC	Landmark Healthcare, Inc.	95-4034089
CareCore National, LLC	Landmark Healthcare Services, Inc.	68-0393103
CareCore National, LLC	eviCore healthcare MSI, LLC (f/k/a MedSolutions, Inc.)	62-1615395
CareCore National, LLC	Palladian Independent Practice Association, LLC	16-1513067
CareCore National, LLC	Chiro Alliance Corporation	59-3466707
CareCore National, LLC	CareCore NJ, LLC	20-1089572
CareCore National, LLC	CCN-WNY IPA, LLC	33-1039759
CareCore National, LLC	MSI Health Organization of Texas, Inc.	32-0071543

- The name, address, date of birth, and Social Security Number of an agent or a managing employee of the Subcontractor. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

  In **Table 1.2-13,** we provide the names and addresses of agents or managing employees of eviCore healthcare. Dates of birth and Social Security numbers are redacted/not provided in this disclosure.

Table 1.2-13: Names and Addresses of Agents or Managing Employees of eviCore healthcare

Full Name	DOB	Address	SSN	Title
John Joseph Arlotta	DOB will be provided upon request	15 Castlebridge Court Hilton Head Island, SC 29928	SSN will be provided upon request	President & Chief Executive Officer
Scott Ronald Lambert	DOB will be provided upon request	195 Bethmour Road Bethany, CT 06524	SSN will be provided upon request	Treasurer
Laurie Borgerding Johnson	DOB will be provided upon request	22 Liberty Creek Drive Savannah, GA 31406	SSN will be provided upon request	Secretary, Chief Legal Officer
Timothy Martin Cook	DOB will be provided upon request	106 W. Jones Street Savannah, GA 31401	SSN will be provided upon request	Assistant Treasurer, Chief Financial Officer
Joanne Hart	DOB will be provided upon request	288 Essex Road Warminster, PA 18974	SSN will be provided upon request	Assistant Treasurer
Mark Paul Fleming	DOB will be provided upon request	120 Woodlyn Avenue Willow Grove, PA 19090	SSN will be provided upon request	Assistant Treasurer
Anna Krishtul	DOB will be provided upon request	8 Providence Drive Richboro, PA 18954	SSN will be provided upon request	Assistant Secretary
Sandra Jean Schmehl	DOB will be provided upon request	301 Race Street, No. 213 Philadelphia, PA 19106	SSN will be provided upon request	Assistant Secretary
Lynn Marguerite Perez	DOB will be provided upon request	1217 Glen Ridge Drive Glassboro, NJ 08028	SSN will be provided upon request	Assistant Secretary
William Durell Goodman, III	DOB will be provided upon request	20 Pine View Drive Bluffton, SC 29910	SSN will be provided upon request	Assistant Secretary
Matthew Morris	DOB will be provided upon request	900 Cottage Grove Hartford, CT 06152	SSN will be provided upon request	Vice President
Sanjiv Awasthi	DOB will be provided upon request	900 Cottage Grove Hartford, CT 06152	SSN will be provided upon request	Vice President

Table 7: Subcontractor Overview

Subcontractor Overview	
Corporate (Legal) Name	First Choice Services, Inc.
Name of Parent Company (If Applicable)	N/A
Tax Identification Number	N/A
Industry (NAICS)	Behavioral Healthcare
Type of Legal Entity	Call Center
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	N/A
% 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
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)	N/A
Name of Contact Person for Bid	D. Scott Jarrett

The Subcontractor should provide the following information in accordance with 42 CFR § 455.104:

- 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. In the case of an individual, the date of birth and Social Security Number should be provided. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

  First Choice Services, Inc. (Private Non-Profit 501c3)

- 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.

  26-2900507

- 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

- The name, address, date of birth, and Social Security Number of an agent or a managing employee of the Subcontractor. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

  D. Scott Jarrett
  Chief Executive Officer
  First Choice Services, Inc.

Table 7: 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, NC; Reno, NV; Sacramento, CA; Topeka, KS; Washington, DC;

Subcontractor Overview	
	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:

- 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. In the case of an individual, the date of birth and Social Security Number should be provided. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

  We have included the requested information in **Table 1.2-14** for any person (individual or corporation) with an ownership or control interest in the Subcontractor. Dates of birth and Social Security numbers are redacted/not provided in this disclosure.

Table 1.2-14: Name and Address of Any Person (Individual or Corporation) with an Ownership or Control Interest in Health Management Systems, Inc.

Name	Title	Address	DOB	TIN/SSN	% Ownership Interest
OFFICERS AND DIRECTORS					
Lucia, William C.	Director, President & Chief Executive Officer	5615 High Point Drive, Irving, TX 75038	Redacted	Redacted	0%
Alexander, David	SVP, Chief Human Resources and Chief Compliance Officer	5615 High Point Drive, Irving, TX 75038	Redacted	Redacted	0%
Aunan, Greg D	SVP, Chief Accounting Officer	5615 High Point Drive, Irving, TX 75038	Redacted	Redacted	0%
Bjorck, Meredith W.	EVP, Chief Legal Officer & Corporate Secretary	5615 High Point Drive, Irving, TX 75038	Redacted	Redacted	0%
O'Gara, Emmet	Group President, Population Health Management	75 Sylvan Street, Danvers, MA	Redacted	Redacted	0%

Name	Title	Address	DOB	TIN/SSN	% Ownership Interest
Perrin, Maria	EVP, Chief Marketing and Strategy Officer	5615 High Point Drive, Irving, TX 75038	Redacted	Redacted	0%
Sherman, Jeffrey S.	Director, EVP, Chief Financial Officer & Treasurer	5615 High Point Drive, Irving, TX 75038	Redacted	Redacted	0%
Sims, Jacob	SVP, Chief Technology Officer	5615 High Point Drive, Irving, TX 75038	Redacted	Redacted	0%
South, Tracy A.	EVP, Chief Administrative Officer	5615 High Point Drive, Irving, TX 75038	Redacted	Redacted	0%
Williams Jr., Douglas M.	EVP, Chief Operating Officer	5615 High Point Drive, Irving, TX 75038	Redacted	Redacted	0%
ENTITIES					
HMS Holdings Corp.(1)	Direct Owner	5615 High Point Drive, Irving, TX 75038	N/A	11-3656261	100%
BlackRock, Inc. (2)	Indirect Owner	55 East 52nd St., New York, NY 10022	N/A	32-0174431	14.80%
Wellington Management Group LLP and affiliated entities (3)	Indirect Owner	280 Congress Street, Boston, MA 02210	N/A	04-2683227	10.17%
The Vanguard Group (4)	Indirect Owner	100 Vanguard Blvd., Malvern, PA 19355	N/A	23-1945930	10.26%

(1) 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.
(2) Based solely on a Schedule 13G/A filed with the SEC on January 28, 2019. Information reported is as of December 31, 2018.
(3) Based solely on a Schedule 13G/A filed with the SEC on March 11, 2019. Information reported is as of February 28, 2019.
(4) Based solely on a Schedule 13G/A filed with the SEC on February 12, 2019. Information reported is as of December 31, 2018.

- 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 1.2-14** 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.

  1. HMS Holdings Corp.
  2. IntegriGuard, LLC, d/b/a HMS Federal
  3. Permedion, Inc.
  4. HealthDataInsights, Inc.
  5. Reimbursement Services Group Inc.
  6. Essette, Inc.
  7. Eliza Corporation

- The name, address, date of birth, and Social Security Number of an agent or a managing employee of the Subcontractor. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

  In **Table 1.2-15,** we provide the names and addresses of agents or managing employees of Health Management Systems, Inc. Dates of birth and Social Security numbers are redacted/not provided in this disclosure.

Table 1.2-15: Names and Addresses of Agents or Managing Employees of Health Management Systems, Inc.

Name	Title	Address	DOB	TIN/SSN
Lucia, William C.	President & Chief Executive Officer	5615 High Point Drive, Irving, TX 75038	Redacted	Redacted
Alexander, David	SVP, Chief Human Resources and Chief Compliance Officer	5615 High Point Drive, Irving, TX 75038	Redacted	Redacted
Aunan, Greg D	SVP, Chief Accounting Officer	5615 High Point Drive, Irving, TX 75038	Redacted	Redacted
Bjorck, Meredith W.	EVP, Chief Legal Officer & Corporate Secretary	5615 High Point Drive, Irving, TX 75038	Redacted	Redacted

Name	Title	Address	DOB	TIN/SSN
O'Gara, Emmet	Group President, Population Health Management	75 Sylvan Street, Danvers, MA	Redacted	Redacted
Perrin, Maria	EVP, Chief Marketing and Strategy Officer	5615 High Point Drive, Irving, TX 75038	Redacted	Redacted
Sherman, Jeffrey S.	EVP, Chief Financial Officer & Treasurer	5615 High Point Drive, Irving, TX 75038	Redacted	Redacted
Sims, Jacob	SVP, Chief Technology Officer	5615 High Point Drive, Irving, TX 75038	Redacted	Redacted
South, Tracy A.	EVP, Chief Administrative Officer	5615 High Point Drive, Irving, TX 75038	Redacted	Redacted
Williams Jr., Douglas M.	EVP, Chief Operating Officer	5615 High Point Drive, Irving, TX 75038	Redacted	Redacted

Table 7: 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)	$527,676 - in thousands
Last Fiscal Year Company Net Income	($39,164) - 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 NCQA HEDIS® submission process. As an NCQA-certified vendor for the past 18 years, Inovalon's experienced teams will support the Aetna Medicaid team as they complete the key milestones and tasks associated with the HEDIS® reporting requirements using Inovalon's quality measurement and reporting software. Production task included: data transformation and loading, building events and discharges, running 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 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

Subcontractor Overview	
	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	Over 2,500 employees including 2 products service managers (PSMs) 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:

- 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. In the case of an individual, the date of birth and Social Security Number should be provided. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

  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/.

- 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.

  No

- 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

- The name, address, date of birth, and Social Security Number of an agent or a managing employee of the Subcontractor. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

  Inovalon Holdings, Inc. is the sole owner of Inovalon, Inc. Inovalon Holdings, Inc. is a publicly traded company, and its principal stockholders and members of its Board of Directors are noted in the Company's proxy statement filed with the SEC on April 22, 2019 and available here.

Table 7: 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)	$26,518,360
Last Fiscal Year Company Net Income	$7,487,509 (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	Four
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.

Subcontractor Overview	
	Telephone Number: 617-375-7700 **Fax Number:** 617-375-7777
Name of Contact Person for Bid	Paul Lanning

The Subcontractor should provide the following information in accordance with 42 CFR § 455.104:

- 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. In the case of an individual, the date of birth and Social Security Number should be provided. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

  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.

  No

- 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

- The name, address, date of birth, and Social Security Number of an agent or a managing employee of the Subcontractor. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

  Name: Paul Lanning
  Address: Redacted
  DOB: Redacted
  SSN: Redacted

Table 7: 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 10201 N. Port Washington Road Mequon, WI 53092

Subcontractor Overview	
	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)	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:

- 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. In the case of an individual, the date of birth and Social Security Number should be provided. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*
  - Grambino Technologies, LLC, 37.5% ownership interest in SKYGEN USA, LLC, W140N89981 Lilly Rd., Menomonee Falls, WI 53051
  - MOA Investments, LLC, 37.5% ownership interest in SKYGEN USA, LLC, W140N89981 Lilly Rd., Menomonee Falls, WI 53051
  - Scion Holdings, Inc., 25% ownership interest in SKYGEN USA, LLC, W140N89981 Lilly Rd., Menomonee Falls, WI 53051
- 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.
  - Grambino Technologies, LLC, 20-8448188
  - MOA Investments, LLC, 39-01865244
  - Scion Holdings, Inc., 82-3326543
- 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.

  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.

  None

- The name, address, date of birth, and Social Security Number of an agent or a managing employee of the Subcontractor. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

  We will provide the Social Security Numbers directly to the department if the Vendor is selected.

Table 7: Subcontractor Overview

Subcontractor Overview	
Corporate (Legal) Name	Symphony Performance Health, Inc. d/b/a SPH Analytics
Name of Parent Company (If Applicable)	Not Applicable
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	427
Last Fiscal Year Company Revenue (from Unaffiliated Parties)	As a privately held company, SPH Analytics does not provide its financial statements.
Last Fiscal Year Company Net Income	As a privately held company, SPH Analytics does not provide its financial statements.
% of Revenue From State Government Clients in the United States	As a privately held company, SPH Analytics does not provide its financial statements.
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	900
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 Branford, CT Farmington Hills, MI

Subcontractor Overview	
	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:

- 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. In the case of an individual, the date of birth and Social Security Number should be provided. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

  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

- The name, address, date of birth, and Social Security Number of an agent or a managing employee of the Subcontractor. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

  Colin Rogoff, Chief Financial Officer (DOB, Address, SSN will be provided upon request)

Table 7: 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)	$4.8 billion
Last Fiscal Year Company Net Income	TBD (available by 7/25)
% 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 (if	Same as above

Subcontractor Overview	
different from above)	
Name of Contact Person for Bid	Larry DeAngelis

The Subcontractor should provide the following information in accordance with 42 CFR § 455.104:

- 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. In the case of an individual, the date of birth and Social Security Number should be provided. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

  N/A. 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

- The name, address, date of birth, and Social Security Number of an agent or a managing employee of the Subcontractor. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

  Larry DeAngelis
  3333 Quality Drive
  Rancho Cordova, California 95670
  Phone: Redacted
  Email: larry.denagelis@vsp.com
  DOB: Redacted
  SSN: Redacted

Table 7: 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 460
Last Fiscal Year Company Revenue (from Unaffiliated Parties)	As a private company, our financial information is not available for public disclosure.
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	As a private company, our financial information is not available for public disclosure.
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 460
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
Locations in the United States	In addition to our Denver headquarters, we also have offices Burlington, Massachusetts; Roswell, Georgia; and Newport Beach,

Subcontractor Overview	
	California.
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid (if different from above)	N/A
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:

- 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. In the case of an individual, the date of birth and Social Security Number should be provided. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

  Welltok has 100s of stockholders, which would be too numerous to list; however, following we include a list of our major stockholders who own 5% or more of the outstanding common stock equivalent of Welltok.

  - Everyday Health, Inc. – 11.55%
  - New Enterprise Associates – 10.72%
  - Emergence Capital – 8.30%
  - Interwest Partners – 8.21%
  - Bessemer Venture Partners – 5.50%

- 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.

  See above. If necessary, we can provide Tax ID numbers upon later request.

- 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.

  See above.

- The name, address, date of birth, and Social Security Number of an agent or a managing employee of the Subcontractor. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

  This response is signed by Robert Renzi, Health Plan Market (DOB 07/11/59). Rob can be reached in care of Welltok at 1515 Arapahoe Street; Tower 3 – Suite 700; Denver, CO 80202. Rob's SSN is not available for publication; however, Welltok's Federal Tax ID is 26-4622137.

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 note whether it meets the qualification and provide narrative demonstrating fulfillment of the requirement. 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.

The Vendor is NOT to change any of the pre-filled cells in the following table. The Vendor should only circle, highlight, or otherwise visibly and consistently indicate its "yes/no" response, then delete <Response> and add a brief narrative in its place.

Table 8: Mandatory Qualifications

Mandatory Qualification Item(s)	Vendor Meets?		Provide A Brief Narrative To Demonstrate Fulfillment Of Requirement
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 prior to contract start date.	YES	NO	Aetna Better Health of West Virginia has been a trusted partner to the State for 23 years[1] and has maintained good standing for the duration of our tenure in the state. We demonstrate our adherence to COA requirements by providing a copy of our COA in **Appendix B**. **[MR010]**
The Vendor must be a NCQA-accredited entity and remain so for the duration of the contract, or be in the process of becoming an NCQA-accredited entity. NCQA certification must be provided prior to contract start date.	YES	NO	Aetna Better Health of West Virginia maintains Commendable status as a National Committee for Quality Assurance (NCQA)-accredited entity and commits to remaining accredited at the highest possible level for the duration of the contract. Please refer to **Appendix B** for a copy of Aetna Better Health of West Virginia's NCQA certification. **[MR010]**

[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.

Mandatory Qualification Item(s)	Vendor Meets?		Provide A Brief Narrative To Demonstrate Fulfillment Of Requirement
The Vendor must provide an organizational chart outlining the internal organizational structure for this project.	YES	NO	Please refer to **Appendix B** for a copy of Aetna Better Health of West Virginia's organizational chart outlining the internal organizational structure for Specialized Managed Care for Children and Youth. As shown in the organizational chart, Aetna will dedicate additional West Virginia key staff in support of Specialized Managed Care for Children and Youth: a justice system of care (SOC) administrator, an adult SOC administrator, a child SOC administrator, and a recovery and resiliency SOC administrator.
The Vendor must provide a description of the roles, responsibilities, and skill sets associated with each position outlined in the organizational chart.	YES	NO	**Chief Executive Officer** This position is responsible for delivery of all requirements throughout all phases of the contract. The position requires prove health care industry and Medicaid managed care contract oversight experience. The skill set for this position includes exceptional executive leadership and communication skills, business acumen, and cultural sensitivity. **Contract Liaison/Medicaid Administrator** This position serves as a liaison with the Department throughout the contract term and is responsible for making contractual, operational, and financial decisions. The position requires substantial health care industry and Medicaid managed care contract oversight experience. The skill set for this position includes collaboration, cultural sensitivity, and executive leadership skills. **Chief Financial Officer** This position performs financial oversight, including oversight of provider payment arrangements. The position is responsible for certifying encounter and financial data as well as financial reporting.

Mandatory Qualification Item(s)	Vendor Meets?		Provide A Brief Narrative To Demonstrate Fulfillment Of Requirement
			The skill set for this position includes substantial experience serving as a financial lead for a managed care entity or other health insurance provider. **Medical Director** This position performs medical and care coordination oversight activities, including performing utilization management activities in collaboration with the medical management director and behavioral health medical director. This position is responsible for overseeing the Quality Assurance and Performance Improvement (QAPI) Committee. The skill set for this position includes substantial experience serving as a medical director for a Medicaid program and in pediatric care. **Medical Management Director** This position provides oversight of utilization management activities, including management of processing referrals and pre-authorization requirements. The position is responsible for managing the utilization management program and responding to Department requests. The skill set for this position includes substantial experience as a registered nurse, as well as clinical management and accreditation preparation experience. **Care Management Director** This position provides oversight of care management program operations as well as establishes and monitors care coordination staffing ratios and related activities. The position is responsible for overseeing the continuity and coordination of member care. The skill set for this position includes substantial experience in Medicaid in a case manager or care coordinator role. **Behavioral Health Medical Director** This position provides oversight of the clinical and quality activities of the behavioral health program.

Mandatory Qualification Item(s)	Vendor Meets?		Provide A Brief Narrative To Demonstrate Fulfillment Of Requirement
			The position is responsible for behavioral health service utilization review decisions and attending legislative meetings and hearings. The skill set for this position includes substantial experience working in behavioral health clinical care, as well as experience delivering trauma-informed care (TIC) and substance use disorder treatment. **Social Services Director** This position performs oversight of activities related to social services referrals and serves as the subject matter expert for multidisciplinary teams and Child Protective Services (CPS). The position is responsible for overseeing the socially necessary services (SNS) liaison and helping to ensure staff members connect program participants to social services and CPS resources. **SNS Liaison** This position monitors and coordinates SNS utilization. The position is responsible for collaborating with SNS providers to facilitate members' access to care and promote positive health and social outcomes. The skill set for this position includes experience working with SNS providers as well as child and adolescent behavioral health. **Quality Director** This position develops, administers, and provides oversight of the QAPI program. The position is responsible for support and oversight of accreditation activities, as well as initiating quality improvement projects. The skill set for this position includes substantial experience overseeing Medicaid quality programs in compliance with contractual and regulatory requirements. **Member Services Director** This position provides oversight of the Member Services department and member-related matters including call center operations and grievances.

Mandatory Qualification Item(s)	Vendor Meets?		Provide A Brief Narrative To Demonstrate Fulfillment Of Requirement
			The position is responsible for meeting performance requirements and collaborating with stakeholders to handle member-related issues and questions. The skill set for this position includes executive leadership skills and experience in community education activities related to health insurance matters. **Claims Payment Director** This position provides oversight of physical and behavioral health claims payment and encounters-related activities. The position is responsible for ensuring timely and accurate payment of provider claims for physical and behavioral health services and overseeing reprocessing of claims due to rate changes or claims resubmissions. The skill set for this position includes experience in claims processing and encounters with a health insurer. **Network Development Director** This position performs network development and contracting activities for physical and behavioral health services. The position is responsible for addressing access barriers by maintaining the provider network in locations that are geographically accessible for the population. The skill set for this position includes substantial experience serving as a network manager in the health insurance industry. **Provider Relations Director** This position performs provider relationship management and engagement activities, including responding to provider inquiries and complaints. The position is responsible for developing provider training programs and the annual provider satisfaction survey. The skill set for this position includes experience serving as a provider relations manager in the health insurance industry.

Mandatory Qualification Item(s)	Vendor Meets?		Provide A Brief Narrative To Demonstrate Fulfillment Of Requirement
			Program Integrity Lead This position oversees all compliance, program integrity, and fraud-related activities, including the Special Investigations Unit. The position is responsible for developing a formal Medicaid compliance plan and creating internal controls, policies, and procedures to prevent and detect fraud, waste, and abuse. The skill set for this position includes experience working on Medicaid fraud projects. **Information Technology Director** This position oversees all systems, data, and hardware activities, including electronic medical record, claims processing, and provider data systems. The position is responsible for submitting reports, forms, and responses to reque for information from the Department; maintaining data integrity; and managing system configuration, testing, and implementation activities. The skill set for this position includes experience working in Medicaid information technology (IT) solutions. **Community Engagement Director** This position provides oversight of community engagement activities, including marketing and public relations. The position is responsible for developing a written marketing plan and submitting all marketing materials to the Department for approval; as well as participating in community outreach events in accordance with marketing activity guidelines. The skill set for this position includes experience in public engagement activities in West Virginia. **Dental Director** This position provides oversight of the administration and utilization of covered dental services.

Mandatory Qualification Item(s)	Vendor Meets?		Provide A Brief Narrative To Demonstrate Fulfillment Of Requirement
			The position is responsible for performing dental utilization review decisions and responding to dental clinical issues, utilization review, and dental quality of care inquiries. The skill set for this position includes serving as a dental manager for a Medicaid program. **Medicaid Member Advocate** This position supports and addresses the needs of children and youth in foster care, including referring and connecting members and their families/caregivers to appropriate resources. The position is responsible for supporting members throughout grievance and appeal activities, assists members in obtaining materials in alternative formats, and provides member support related to enrollment, access, and continuity of care issues. The skill set for this position includes substantial experience working with low-income and foster care populations and cultural sensitivity. **Justice SOC Administrator** This position collaborates with the Department of Juvenile Justice, Department of Corrections, county jails, sheriff's offices, court and probation departments, and the Department to identify systemic changes and promote community integration. The position is responsible for developing training curricula for law enforcement, advocacy, and legal system stakeholders. The skill set for this position includes experience and knowledge of the various components of the justice system and justice process, and workflow development. **Adult SOC Administrator** This position collaborates with the Department and other stakeholders to assist members with waiver applications, durable medical equipment, and referrals for independent living skills supports.

Mandatory Qualification Item(s)	Vendor Meets?		Provide A Brief Narrative To Demonstrate Fulfillment Of Requirement
			The position is responsible for developing workflows for assessments and collaborating with the Provider Relations team to coordinate networks to serve the Specialized Managed Care for Children and Youth populations. The skill set for this position includes knowledge of community services and supports that are available for the adult population, effective collaboration and communication skills, and experience working with stakeholders to deliver covered services. **Child SOC Administrator** This position works to build stakeholder relationships for the purpose of planning and delivering services and community-based supports for members in all regions. The position is responsible for collaborating with the Provider Relations team to coordinate networks to serve the Specialized Managed Care for Children and Youth populations. The skill set for this position includes knowledge of school-aged populations and the foster care system along with an understanding of the needs of transition-aged youth. **Recovery and Resiliency SOC Administrator** This position develops and implements supportive programs and interventions to address mental health, substance use, foster care delivery, and coordination, including resiliency training and development, advocacy, foster family and biological family support, and recovery maintenance. The position is responsible for member advocacy and for identifying and removing barriers to access and supports. The skill set for this position includes experience collaborating with health system and community-based stakeholders and effective communication and cultural sensitivity skills, as well as experience in recovery and resiliency modalities.

Mandatory Qualification Item(s)	Vendor Meets?		Provide A Brief Narrative To Demonstrate Fulfillment Of Requirement
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.	YES	NO	**Todd White, Chief Executive Officer** Mr. White is a highly skilled and accomplished leader and health care industry professional with 13 years of Medicaid experience and 24 years of health care industry experience. Todd has been employed by Aetna Better Health of West Virginia and its predecessors for over 22 years. His expertise includes effective collaboration with system stakeholders, including low-income populations, cultural sensitivity, and executive leadership skills. **Greg Carpenter, Chief Operating Officer** Mr. Carpenter is an experienced executive with 12 years of health care industry experience and 5 years of managed Medicaid experience in West Virginia. His expertise includes interpersonal communication skills, sales management skills, and organizational and process improvement skills. **Tina Bailes, Chief Financial Officer** Ms. Bailes is a highly qualified 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, federal and statutory reporting requirements, as well as a strong financial and auditing background. **Donald Gibbon, DO, Medical Director (Chief Medical Officer)** Dr. Gibbon is an experienced physician and executive who has practiced medicine for 20 years. He has 6 years of managed Medicaid experience, 6 years serving as a medical director, and 5 years serving West Virginians. **Kimi King, BSN, Medical Management Director** Ms. King is an expert clinical services executive with 35 years of health care industry experience and 11 years of managed Medicaid experience in West Virginia.

Mandatory Qualification Item(s)	Vendor Meets?		Provide A Brief Narrative To Demonstrate Fulfillment Of Requirement
			Her expertise includes nursing, clinical management, accreditation preparation, and strategic insights into the medical management arena. **Johana Easter, RN, CCM, Care Management Director** Ms. Easter is an experienced care management executive with 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. **Frank T. Angotti, MD, Behavioral Health Medical Director** Dr. Angotti is an experienced psychiatrist and behavioral health management professional with 10 years of health care industry experience and 6 years of managed Medicaid experience. His expertise includes leadership roles in child and adolescent psychiatry, behavioral clinic health, and substance use/trauma arenas. He also has extensive experience managing children with complex behavioral health needs under the Medicaid system and within the state of West Virginia. **Margaret Heasley, Social Services Director** Ms. Heasley is an accomplished therapeutic and clinical professional. She has 28 years of health care industry experience and 19 years of experience supporting child welfare programs. Her expertise includes child and adolescent behavioral health and evidence-based practices and interventions. **Louann Petts, SNS Liaison** Ms. Petts is a highly qualified therapeutic and clinical leader. She has 20 years of health care industry experience and 4 years of managed Medicaid experience Her expertise includes child and adolescent behavioral health and

Mandatory Qualification Item(s)	Vendor Meets?		Provide A Brief Narrative To Demonstrate Fulfillment Of Requirement
			evidence-based practices and interventions. **Elaine Wickas, RN, BSN, Quality Director** Ms. Wickas has 34 years of health care industry experience and 6 years of managed Medicaid experience in quality management roles in West Virginia. Her expertise includes managed care quality improvement; managing large-scale teams and projects; regulatory and accreditation compliance; and audit oversight. **Kelly Mitchell, Member Services Director** Ms. Mitchell is experienced in developing proactive service models for high-volume providers. Her background includes working through a faith-based organization to assist low-income youth who have experienced having a parent incarcerated or involved in substance use. **April Ballengee, Claims Payment Director** Ms. Ballengee is a claims subject matter expert with 18 years of health care industry experience and 3 years of managed Medicaid experience in West Virginia. Her expertise includes claims projects and reviews, trend analysis, provider risk management, and customer service. **Dorsen McConnaughy, Network Development Director** Mr. McConnaughy is an experienced network development executive with 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. **Sarah White, Provider Relations Director** Ms. White has 17 years of health care industry experience and 11 years' experience in a provider relations

Mandatory Qualification Item(s)	Vendor Meets?		Provide A Brief Narrative To Demonstrate Fulfillment Of Requirement
			manager or specialist role in West Virginia. Her expertise includes provider relations, credentialing, provider billing, and process improvement. **Alva "Fuzzy" Page III, JD, Program Integrity Lead** Mr. Page is an executive with extensive health care law experience and success in the areas of government affairs and compliance. He has 15 years of health care and Medicaid industry experience and 3 years of managed Medicaid experience in West Virginia. His expertise includes effective collaboration with system stakeholders, including low-income populations, cultural sensitivity, and executive leadership skills. **Brad Liston, Information Technology Director** Mr. Liston is a subject matter expert in information systems with 22 years of health care industry experience and 4 years of managed Medicaid experience in West Virginia. He has a broad understanding of business processes, IT capabilities, IT operations, and IT integration. **Jim Smallridge, RN, Community Engagement Director** Mr. Smallridge is an accomplished community engagement professional. He has 26 years of health care industry experience and 7 years of managed Medicaid experience. His expertise includes nursing, adolescent behavioral health, emergency medicine, and long-term care. **Diane Paletta, DDS, Dental Director** Dr. Paletta 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. Dr. Paletta is employed by SKYGEN Dental, LLC (SKYGEN). To assure quality

Mandatory Qualification Item(s)	Vendor Meets?		Provide A Brief Narrative To Demonstrate Fulfillment Of Requirement
			and the timeliness of the work to be performed, Aetna Better Health of West Virginia requires her to participate in monthly Joint Operating Committee meetings in which we review performance data, identify opportunities for improvement, and collaboratively work toward solutions. **Virginia Tignor White, Medicaid Member Advocate** Ms. White is a qualified case management and counseling professional who has 6 years of health care industry experience and 6 years of managed Medicaid experience. Her expertise includes case management, TIC, and mental health first aid. If awarded, Aetna Better Health of West Virginia will add these positions: • Contract liaison/Medicaid administrator • Justice SOC administrator • Adult SOC administrator • Child SOC administrator • Recovery and resiliency SOC administrator Certain management functions are delegated to other Aetna organizations to leverage operational efficiencies. These affiliate organizations share Aetna's passion and long-term vision for transforming health care and for improving the lives of the Medicaid members we serve, assuring the quality and timeliness of the work to be done. Other than the dental director role, all of Aetna Better Health of West Virginia's key staff are employed by our affiliated subcontractor Aetna Medicaid Administrators LLC, which performs various administrative services for Aetna Better Health of West Virginia, including payroll and other human resources and employment-related functions. Staff supporting Aetna Better Health of West Virginia are locally based and are dedicated to providing excellent service to our West Virginia Medicaid members.

Mandatory Qualification Item(s)	Vendor Meets?		Provide A Brief Narrative To Demonstrate Fulfillment Of Requirement
The Vendor must require at least one member of its care coordination team to participate in all multi-disciplinary team (MDT) meetings, as deemed necessary by the Department caseworker or court system.	YES	NO	Aetna Better Health of West Virginia will require at least one member of its Care Coordination team to participate in all MDT meetings as deemed necessary by the Department caseworker or court system. Aetna Better Health of West Virginia team members are well-versed in collaborating with interdisciplinary care teams (ICT), such as participating in treatment reviews at psychiatric residential facilities as well as monthly meetings for children with special health care needs. An Aetna Better Health of West Virginia case manager forms and leads the ICT. To ensure a multidisciplinary approach, the ICT is composed of the member and any other person the member chooses, including caregivers, health care and service providers such as the primary c provider (PCP), specialists, home- and community-based services (HCBS) providers, the member's family and/or representative, community supports, external stakeholders from judicial and/or education systems, and peer support specialists. The ICT may also include Aetna staff such as the medical director(s), behavioral health specialists, pharmacist, utilization management, care management staff, or other appropriate health plan staff. This team works together to coordinate service delivery for the member. For example, Aetna Better Health of West Virginia collaborates with Lily's Place, a neonatal abstinence syndrome (NAS) treatment center. Aetna care managers meet face-to-face with the mother and father (if present) and develop a plan of care and follow up. The care manager will follow infants for a year or more, if needed. With our experience collaborating with various stakeholders to improve outcomes, Aetna Better Health of West Virginia is ready to participate in MDT meetings as needed.

Mandatory Qualification Item(s)	Vendor Meets?		Provide A Brief Narrative To Demonstrate Fulfillment Of Requirement
The Vendor must contract with specialists to assist in making medical or social service decisions, should the Vendor not be proficient in a given area.	YES	NO	For medical services decisions, we delegate certain responsibilities to SKYGEN Dental, LLC, eviCore healthcare, Vision Service Plan, Inc., PREST, and MCMC LLC. For example, Aetna Better Health of West Virginia will contract with PREST to assist with psychiatric, addiction medicine, and behavioral health services and MCMC for medical reviews and other related services for multiple medical specialties. Aetna Better Health of West Virginia will contract with KEPRO, which has served as a West Virginia administrative services organization since 2000, to support social service decisions. As we do with all our subcontractors, we will evaluate KEPRO's ability to perform the functions of the Contract and will monitor their performance, in accordance with the requirements of the Service Provider Agreement.
The Vendor must have experience working with children and youth populations requiring specialized care.	YES	NO	Aetna Better Health of West Virginia is experienced working with children and youth populations requiring specialized care, supported by the national experience and resources of the Aetna Medicaid organization. We currently serve approximately 61,000 children in West Virginia, including 139 classified as children with special health care needs. Aetna Better Health of West Virginia has several specialized care programs for children, including the following: **Medicaid Children with Special Health Care Needs (CSHCN) policy and processes:** Designed to improve outcomes by coordinating care for identified CSHCN members and encouraging these members to visit their PCP within 90 days of enrollment; processes include additional outreach to these members, working to complete health risk assessments over the telephone, and monthly meetings with the State.

Mandatory Qualification Item(s)	Vendor Meets?		Provide A Brief Narrative To Demonstrate Fulfillment Of Requirement
			NAS program: Aims to provide the specialized care newborns need by first identifying and engaging pregnant women with significant opiate use or opiate addiction in prenatal care management; 1,475 mothers and their babies have participated in our NAS program since 2014. **Cabin Creek Health Systems System of Care for High Risk Youth program**: Designed to develop and implement an intensive care coordination with fidelity wraparound system of care for at-risk youth in Kanawha County. **Family Information Support and Health (FISH) program:** Provides education to families about common mental health conditions that affect children and youth including Adverse Childhood Experiences (ACEs). Inspired by the loss of a child, FISH was created to raise awareness and provide support and resources regarding mental health in children. Training is provided by our behavioral health medical director in concert with our training collaborative.

Mandatory Qualification Item(s)	Vendor Meets?		Provide A Brief Narrative To Demonstrate Fulfillment Of Requirement
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 and/or ASO capacity, where the proposed solution of similar size and scope is currently being or has been implemented.	YES	NO	The Aetna Medicaid organization is a leader in Medicaid managed care with over 30 years of experience managing care for the most medically vulnerable. The Aetna Medicaid organization, as the prime contractor, manages health plans that serve approximately 2 million people in 16 states. The national Aetna Medicaid organization has experience providing managed care services for health plans with similar of larger size and scope than the West Virginia Specialized Managed Care for Children and Youth project, including current plans in the following states: • Arizona[2]: 383,000 members[3] • Texas: 264,000 • Pennsylvania: 222,000 • Kentucky: 220,000 • Virginia: 148,000 • Florida: 141,000 • West Virginia: 137,000 • Louisiana: 120,000 • Kansas: 102,000 • New Jersey: 60,000 • Michigan: 44,000 • Ohio: 27,000 • Maryland: 23,000 • California: 17,000 • New York: 8,000 • Illinois: 7,000 In the aggregate, the Aetna Medicaid organization services approximately 19,000 children in foster care in 9 states: Arizona[4] (7,762), Kansas (2,600), Kentucky (5,803), Louisiana (341), Maryland (128), Michigan (397), New Jersey (400), Pennsylvania (115), and Virginia (400).

[2] Aetna's experience in Arizona is through Mercy Care, which is not a subsidiary of Aetna Inc. but is managed by Aetna's Medicaid organization. In Arizona, Mercy Care is the prime contractor that holds the direct contract with the state agency. Aetna Medicaid Administrators provides services to Mercy Care as a subcontractor through a Plan Management Services Agreement.
[3] Approximate membership numbers as of June 30, 2019.
[4] Please refer to footnote 2.

Mandatory Qualification Item(s)	Vendor Meets?		Provide A Brief Narrative To Demonstrate Fulfillment Of Requirement
The Vendor must demonstrate at least five (5) years' experience in Medicaid and Health and Human Services.	YES	NO	Aetna Better Health of West Virginia has proudly served Medicaid populations in West Virginia for 23 years[5]. Aetna's national Medicaid organization has administered Medicaid managed care programs for over three decades. With over 160 years of experience in the insurance industry, Aetna is a well-established organization that has been recognized for its capacity to perform. Aetna's qualifications and experience, including an innovative integrated service coordination model, quality-driven provider networks, innovative value-added benefits, and high rates of member satisfaction, provide the framework necessary to achieve West Virginia's objectives for Specialized Managed Care for Children and Youth.
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 strongly prefers three (3) references from different state engagements where the proposed approach is currently in progress or has been implemented.	YES	NO	Aetna Better Health of West Virginia provides the following references from clients served by affiliated health plans in New Jersey, Pennsylvania, and Virginia, and from Mercy Care[6], for which an Aetna affiliate, Aetna Medicaid Administrators LLC, performs services as the subcontractor under a plan management services agreement: • **New Jersey Department of Human Services** – Marc Gonzer, Contract Manager – 609-575-9389 – Mark.Gonzer@dhs.state.nj.us

[5] 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.

[6] Mercy Care is not a subsidiary of Aetna Inc. but is managed by Aetna's Medicaid organization.

Mandatory Qualification Item(s)	Vendor Meets?		Provide A Brief Narrative To Demonstrate Fulfillment Of Requirement
			• **Pennsylvania Department of Human Services** – Laurie Rock, Bureau Director – 717-772-6197 – lrock@pa.gov • **Virginia Department of Social Services** – Daniel Plain, Director – 804-588-4883 – Daniel.Plain@dmas.virginia.gov • **Mercy Care** – Linda Hunt, Chair, Board of Directors – 602-406-6090 – Linda.Hunt@dignityhealth.org
The approach proposed by the Vendor must have been previously implemented successfully in a State environment.	YES	NO	Aetna Better Health of West Virginia has a child welfare model that achieves the Department's goals, notably our full integration of a more robust and holistic coordinated System of Care framework that aligns with Charting the LifeCourse™, evidence-based assessments, TIC, planning and services, and adoption of technology, including our FamilyConnect on-demand medical record data home. These programs and systems are guided by a team of child welfare experts that understand the resources needed and system framed strategies that work collaboratively to support stability, build on members' capabilities, and help them achieve their life goals. The Aetna Medicaid organization has proudly served child welfare members since 1995, and individual staff at all levels of the organization have the deep expertise and commitment necessary to serve the vulnerable populations included in West Virginia Specialized Managed Care for Children and Youth. The Aetna Medicaid organization administers care coordination for nearly 19,000 foster children and youth in 9 states: Arizona[7], Kansas, Kentucky, Louisiana, Maryland, Michigan, New

[7] See footnote 2.

Mandatory Qualification Item(s)	Vendor Meets?		Provide A Brief Narrative To Demonstrate Fulfillment Of Requirement
			Jersey, Pennsylvania, and Virginia. For example, Aetna Better Health of Virginia uses the coordinated system of care framework to develop case management tailored for children with special health care needs including assessment, integrated care planning, ongoing case management to foster positive health outcomes, and infrastructure and other resources to deliver exceptional care. This includes the Virginia health plan's procedure for post or non-crisis support. To supplement services, the Virginia Recovery and Resiliency Administrator, in collaboration with Provider Relations, developed a contract with the Virginia warmline provider to provide non-crisis peer to pe services to Aetna members. Aetna Bette Health of Virginia supports members who are in a non-crisis state but need more support than what is offered by member service. This service is provided through a warm call transfer to the warmline, at which peers provide real-time support to children and their families. Like Aetna Better Health of West Virginia, affiliate health plan Aetna Better Health of Maryland embraces a community-oriented approach to increase awareness of and utilization of Mental Health First Aid (MHFA) and TIC principles. All Aetna Better Health of Maryland staff must attend MHFA training, and two staff members are certified trainers who have conducted trainings for adults and youth in the community. The manager of care management is certified as an ACEs master presenter and conducts presentations for providers and community members, as well as serves as a facilitator for review and discussion of the movie *Resilience*, a documentary about ACEs and toxic stress. In addition, Aetna Bett

Mandatory Qualification Item(s)	Vendor Meets?		Provide A Brief Narrative To Demonstrate Fulfillment Of Requirement
			Health of Maryland works closely with the Maryland Department of Health and other state agencies to educate staff and care providers, facilitate care coordination, and promote better oversight for children and youth in foster care. This includes developing fact sheets and training programs for Department of Social Services workers directly involved with this population. Backed by the experience and expertise of the Aetna Medicaid organization, Aetna Better Health of West Virginia is steadfast in our mission to support West Virginia in becoming a national leader engaging in a systemwide transformation using a preventive-focused approach to support children and youth.
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 and/or ASO capacity, in compliance with all federal and state regulations.	YES	NO	The Aetna Medicaid organization has a long history implementing our proposed approach with organizations of similar size and scope to the State, in a managed care organization and/or an administrative services organization capacity, in compliance with all federal and state regulations. Aetna has developed and refined its implementation approach and brought best practices based on three decades of Medicaid managed care experience. Our 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. Our local health plan expertise is supported by the unparalleled backing of Aetna'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

Mandatory Qualification Item(s)	Vendor Meets?		Provide A Brief Narrative To Demonstrate Fulfillment Of Requirement
			regulatory and technical requirements into our clinical services, administrative operations, transactional platforms, and program management. The national Aetna Medicaid organization has implemented over 30 Medicaid programs in the past 10 years. Aetna Better Health of West Virginia can use the lessons learned in implementing Specialized Managed Care for Children and Youth, including the following: • Develop strong relationships early and set up regularly occurring meetings with child welfare agencies • Configure health plan data systems to securely share information with child welfare data systems • Hold regular membership feedback forums specifically for stakeholders serving children in the child welfare system • Train all staff, including those in member services, utilization management, integrated care management, long-term services and supports, pharmacy, and quality, about the special needs and requirements of this population • Train all staff in TIC and ACEs • Ensure members of the System of Care team and team members in other departments fully understand one another's roles 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 Specialized Managed Care for Children and Youth 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. Through our Care Coordination team model and integrated, person-centered system of care, Aetna Better Health of West Virginia has the expertise to manage the logistics and securely

Mandatory Qualification Item(s)	Vendor Meets?		Provide A Brief Narrative To Demonstrate Fulfillment Of Requirement
			handle health records transfers during transitions. 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 children and youth. Aetna Better Health of West Virginia is flexible and focused on solutions that work for our communities.

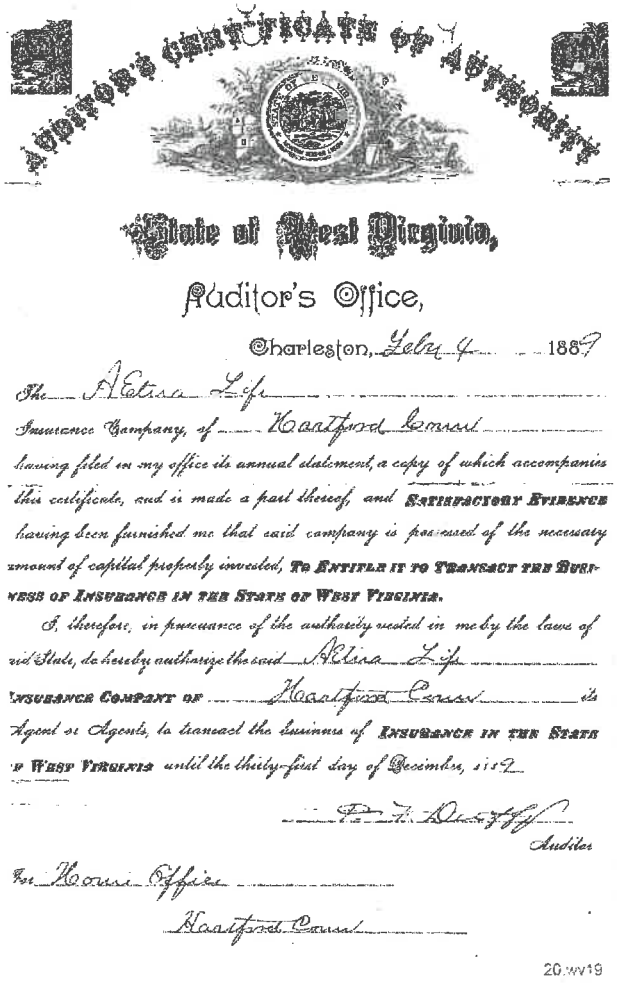
3. Existing Business Relationships with the State

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 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 is over a century old, dating to 1889, when our affiliate, Aetna Life Insurance Company, was first granted authority to do business in West Virginia, as depicted by the Certificate of Authority shown in **Figure 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 since 2015.

Aetna Better Health of West Virginia's Business Relationships

In **Table 3.1-1**, we provide information about Coventry Health Care of West Virginia, Inc.'s business relationships with the State of West Virginia in the last five years. The table includes contracts that Coventry Health Care of West Virginia holds 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. Aetna Better Health of West Virginia has not had any business relationships with any of the State's counties or local municipalities in the last five years.



Auditor's Certificate of Authority

State of West Virginia,

Auditor's Office,

Charleston, Febry 4 1889

The Aetna Life Insurance Company, of Hartford Conn. having filed in my office its 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 properly invested, 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 December, 1889.

P. D. Dougherty
Auditor

By Home Office
Hartford Conn.

20:wv19

Figure 3.1-1: Affiliate Aetna Life Insurance Company's 1889 Certificate of Authority

Aetna began proudly serving West Virginians 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.

Table 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.	State of West Virginia Bureau for Medical Services	Contract signed 6/25/2019; effective 1/1/2020-12/31/2020	Dual Eligible Special Needs Plan

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

In **Table 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 3.1-2: 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
Active Health Management, Inc.	West Virginia Public Employees Insurance Agency	2009-2014	Medical management for utilization management and care management for State of West Virginia employee health program
Aetna Behavioral Health, LLC	WVU 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 Benefits Solutions, as successor to Wells Fargo TPA, and West Virginia Public Employees Insurance Agency	2010-2014	Network access and stop loss for the State of West Virginia employee health program
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

[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
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
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	2011-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 members
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, CVS Pharmacy has enrolled each retail pharmacy location 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, which serves the state's low-income population. The enrollment process consists of the submission of an individual application for each pharmacy location. At present, we currently have 57 retail pharmacy locations physically located in West Virginia, as well as 24 out-of-state pharmacies, enrolled in West Virginia Medicaid. We are required to periodically revalidate each location in order to continue to participate in the 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 Subcontractors[3]

In **Table 3.1-3**, we describe any existing or recent business relationships that unaffiliated subcontractors of Aetna Better Health of West Virginia have with the State of West Virginia, its counties, or local municipalities.

[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 3.1-2** above titled "Aetna Better Health of West Virginia Affiliates' Business Relationships in West Virginia."

Table 3.1-3: Aetna Better Health of West Virginia Unaffiliated Subcontractors' 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
APS Quality Review Inc. dba KEPRO	Bureau for Medical Services, Bureau for Children and Families, and Bureau for Behavioral Health and Health Facilities	8/1/2000 – present	We have been the administrative services organization (ASO) contractor for the 3 bureaus for the last 19 years; ASO services for medical, behavioral health, socially necessary services, Substance Use Disorder Waiver, Serious Emotional Disturbance Waiver, Intellectual/Developmental Disability Waiver, Aged and Disabled Waiver, Traumatic Brain Injury Waiver, health homes, nursing home, personal care, federal block grant reporting, school-based health reviews, Take Me Home program, and consultation/research for the Department.
Health Management Systems, Inc.	Department of Health and Human Resources, Bureau for Medical Services	9/1/2011 – 2/29/2020 (renewal possible)	Credit Balance Audit; Cost Avoidance; Health Insurance Premium Protection; Casualty Recovery Services; Estate Recovery Services, Medicaid Buy-in; CHIP population
SPH Analytics	West Virginia Family Health	2015 – 2019	Medicaid Consumer Assessment of Healthcare Providers and Systems West Virginia Family Health

4. Business Disputes

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

Aetna Better Health of West Virginia has not been subject to an investigation within the last two years. No other Medicaid health plan managed by Aetna's Medicaid organization has been the subject of an investigation[1] in the last two years other than that 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, HHS-OCR found that there was not enough evidence to show that Aetna violated any law and closed the investigation.

For Aetna Better Health of West Virginia and other health plans managed by Aetna's national Medicaid organization, in **Appendix C** we provide list of regulatory actions, sanctions, citations, deficiencies, audit findings, or recommendations received in any state within the last two years, along with the health plan's response and plan of correction.

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. In such instances, 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.

Aetna Better Health of West Virginia is proud that we have no contract terminations or non-renewals to report pertaining to our health plan.[2]

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 4.1-1** discloses 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.

[1] As regulated entities, Aetna Better Health of West Virginia and other Medicaid health plans managed by Aetna's national Medicaid organization 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. If our understanding is incorrect, we will produce additional information upon request.

[2] 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.

REQUEST FOR PROPOSAL

Department of Health and Human Resources, RFP CRFP 0511 BMS 1900000001

Table 4.1-1: Contract Terminations Related to Managed Care Subsidiaries of Aetna Better Health of West Virginia's Ultimate Parent[3]

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 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 (FHP-ACA) 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 is now 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 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 is now in runout through 12/31/19.	N/A

[3] 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 members. 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.

REQUEST FOR PROPOSAL

Department of Health and Human Resources, RFP CRFP 0511 BMS 1900000001

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 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 is now in runout through 12/31/19.	N/A
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 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

REQUEST FOR PROPOSAL

Department of Health and Human Resources, RFP CRFP 0511 BMS 1900000001

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 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
Aetna Better Health Inc. dba Aetna Better Health of New York	Centers for Medicare & Medicaid Services and New York Department of Health	12/2017[4]	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

[4] Reporting responsibilities continue through December 31, 2019

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.

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

The Vendor may add additional Reference Tables as necessary.

Table 9: Vendor References

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:	Marc Gonzer
	Contact Title:	Contract Manager
Customer Address: 7 Quakerbridge Plaza, 2nd Floor, Room 203, Mercerville, New Jersey 08619	Contact Phone:	609-575-9389
	Contact Email:	Mark.Gonzer@dhs.state.nj.us
Project Information		
Total Vendor Staff:	188	
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 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).		

REQUEST FOR PROPOSAL

Department of Health and Human Resources, RFP CRFP 0511 BMS 1900000001

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 services, 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 for children in foster care and all individuals with intellectual/developmental disabilities; this includes development of a treatment plan and monitoring to address access to well-child care for foster children and children with disabilities. Aetna Better Health of New Jersey collaborates with the relevant State agencies and community resources in accordance with contract requirements and Aetna's Children with Special Health Care Needs and 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. Families of members receiving care management 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 children and youth 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 (for which private duty nursing is a benefit for both children and adults).

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: Jerry Mammano	Role: Chief Operating Officer			
Name: Heather Hoopes	Role: 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: 60,478			
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 & Completion Dates:	From:	Current Contract: 12/1/2014	To:	N/A; evergreen contract
Actual Start & Completion Dates:	From:	Current Contract: 12/1/2014 Tenure in State: Since 2014	To:	N/A; evergreen contract
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 9: Vendor References

Vendor Information		
Vendor Name: Coventry Health Care of Virginia, Inc. dba Aetna Better Health of Virginia (Aetna Better Health of Virginia)	Contact Name:	Roger Gunter, CEO
	Contact Phone:	804-527-6403
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:	465	

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 (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 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 contracts with DMAS to provide Medicaid (Medallion), Family Access to Medical Insurance Security (FAMIS) a.k.a. Children's Health Insurance Program (CHIP), Commonwealth Coordinated Care Plus (CCC Plus), and Dual Eligible Special Needs Plans (D-SNP) managed care services to our members.

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.

With over 465 dedicated employees throughout the Commonwealth, 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.

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.

Medicaid covers 1 in every 3 births in Virginia and almost 1 in 3 children. Virginia Medicaid provides access to medical services, such as the following: 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 Better Health of Virginia was one of six MCOs selected through a competitive RFP to provide managed care services to qualified Virginians under the Medallion 4.0 Program.

The new program will build 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 (ABHVA) 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 does the following:

- Continues to serve children, pregnant women and parents
- Covers and coordinates services, such as early intervention and non-traditional behavioral health services, that 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

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 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 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 possesses a full understanding of the non-traditional community mental health services that are delivered under the Medallion 4.0 program. We provide non-traditional services such as intensive in-home services, therapeutic day treatment, and residential treatment for children and adolescents, day treatment/partial hospitalization, psychosocial rehabilitation, crisis services (including trauma-informed care and adverse childhood events), intensive community treatment, and mental health skill building for adults.

In Virginia, we collaborate by conducting interdisciplinary care team meetings with Magellan of Virginia to discuss members who would benefit from any of these non-traditional services. We have designated a team to ensure that those needing a more intense level of care management are recipients of it. We collaboratively engage with Magellan, DMAS, and community-based providers to help ensure a seamless transition for members within the Commonwealth that meets all Community Mental Health Rehabilitation Services network adequacy standards. We understand the importance of relationships and continuity of care, and we will demonstrate this commitment by doubling the stated requirement and ensuring that members can continue to see their existing providers for at up to 180 days post-transition if they are not currently in our network. Moreover, our provider network team actively works to recruit providers of traditional and non-traditional services into our network.

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.

Our care coordinators currently attend individualized education plan (IEP) meetings as active participants to determine jointly the needs of the child and their family, assign accountability and responsibility across organizations, and make sure services are integrated and coordinated. We work directly with teachers and school-based providers to obtain a copy of the IEP and share any additional information with the child's traditional and/or non-traditional providers. Our care coordinators encourage open communication and elevate the goals and objectives of the child and of their parent or guardian. With a focus on avoiding the duplication of services, we invite the school-based team to be a contributing part of our interdisciplinary care team provided we have all the appropriate consents.

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 provide 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. Our peer support model utilizes techniques to ensure safety and establish rapport with the 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 spacing between births and positive birth outcomes.

Key Personnel	
Name: Roger Gunter	Role: Project Director
Name: Joanne Landry	Role: Project Manager
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: 113,000		
Reason(s) for change in membership: N/A				
Estimated Start & Completion Dates:	From:	Contract Start: 8/1/18	To:	June 30, 2020, with the possibility of 6 12-month renewals
Actual Start & 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 9: Vendor References

Vendor Information		
Vendor Name: Aetna Better Health Inc. dba Aetna Better Health of Pennsylvania (Aetna Better Health of Pennsylvania)	Contact Name:	Jason Rottman
	Contact Phone:	215-282-3503
Customer Information		
Customer Organization: Pennsylvania Department of Human Services (Department)	Contact Name:	Sally Kozak
	Contact Title:	Deputy Secretary, Office of Medical Assistance Programs (OMAP)
Customer Address: Room 515, 625 Forster St., Harrisburg PA 17120	Contact Phone:	717-214-4206
	Contact Email:	sakozak@pa.gov
Project Information		
Total Vendor Staff:	**291**	

Project Objectives:

To provide mandatory managed health care as part of the HealthChoices Program, Pennsylvania's 1915(b) waiver program, for Medical Assistance Recipients. HealthChoices objectives include the following:

- Promote the achievement of the Triple AIM (better health, better care, lower cost)
- Improve care coordination between physical and behavioral health services
- Promote the expansion of value-based purchasing of health care services
- Promote the expansion of team-based approaches to care delivery (for example, patient-centered care medical homes)
- Promote community-based public health initiatives
- Increase consumer access to needed services, especially in rural and underserved areas of the Commonwealth
- Improve the efficiency of the HealthChoices program
- Improve the provider experience with the HealthChoices program

Project Description:

Aetna Better Health of Pennsylvania and Aetna Better Health Kids provide health benefits and manage care for people enrolled in the Commonwealth of Pennsylvania's Medical Assistance program (Medicaid). The program engages members through an integrated care management model fully integrating physical and behavioral health care as well as chronic care and disease management programs for persons with complex medical concerns. The local, community-based model ensures Pennsylvanian providers and participants live side-by-side with Aetna staff.

Aetna Better Health of Pennsylvania improves the overall health care delivery to our HealthChoices members by doing the following:

- Acting as a single point of contact to serve the member
- Providing complete health and social services and support for members through our Fully
- Integrated System of Care

- Pursuing strategies to strengthen the local delivery systems using community health workers and peer support specialists
- Leveraging the use of our proprietary predictive modeling tool to identify members at risk for emergency department utilization or an inpatient admission

Vendor's Involvement:

Aetna Better Health of Pennsylvania is a Physical Health Managed Care Organization with an agreement with the Department to manage the purchase and provision of Physical Health Services Statewide under the HealthChoices Program. Aetna Better Health of Pennsylvania is committed to addressing the system challenges and making improvements in the services we provide for children in care where they live.

Some of our strategies include the following:

- Assigning a point of contact to develop and implement community support programs and processes. This subject matter expert is the liaison with local agencies including child welfare, juvenile corrections, juvenile justice, and other agencies that serve children.
- Providing training and education on the role of the managed care organization to the child welfare agencies
- Working with youth to prepare them for "aging out" of substitute care—e.g., assist them in completing applications for Medicaid, housing, and employment
- Partnering with foster care agencies to provide education about the appropriate use of antipsychotics
- Assisting in scheduling primary care physician and dental appointments
- Coordinating an annual forum in each zone to bring the child welfare agencies and other stakeholders together for planning and collaborating on issues regarding children in substitute care
- Improving tracking and reporting on children in care receiving a physical within 60 days of entering care

In the event a member in substitute care has difficulty obtaining access to medically necessary services within the state, Aetna Better Health of Pennsylvania's Case Management and Network Management departments collaborate to find a provider within the state that will meet the member's needs and work to execute a single-case agreement to ensure a member continued to receive care within the state.

Children in substitute care are enrolled in case management to ensure they receive the proper preventive care that can help reduce inpatient admissions. Aetna Better Health of Pennsylvania utilizes an Integrated Care Management program to address the member's medical, behavioral (in coordination with the behavioral health managed care organizations [BH-MCOs]), and social needs in individual and distinctive ways. Aetna Better Health of Pennsylvania recognizes that these needs interact with each other, often in unpredictable ways, and that a member's care is driven by several unique physical and behavioral health conditions. To target members who will benefit most from integrated care management, we use predictive modeling through our Consolidated Outreach and Risk Evaluation (CORE™) tool. This tool is custom designed for the Medicaid population. CORE predicts both financial and clinical performance over the next 12 months, with a positive predictive value of up to 95.4 percent. CORE identifies members for whom intensive or complex care management will promote improved health and well-being and prevent high-cost utilization. We also identify members using provider and pharmacy referrals.

Our CORE proprietary predictive modeling tool enables us to identify high-acuity members who are also high-risk. Our Integrated Care Management program prioritizes outreach to the top 1 percent of members who are also at high-risk for emergency department visits in the next 12 months and high-risk for inpatient utilization in the next 12 months (identified as CORE 4).

One of the special challenges is children who "age out" of the system. Many of the children in the child welfare system are over the age of 16 and "age out" at 18. These children have very little control over their lives and/or how they receive the medical services they need. We include these children in the development

of their care management plan, and they have choices they can make as their plans are developed. We begin that process when they turn 16 and follow them until they "age out." Children between the ages of 16 and 18 not only need care management for their medical services, but also for psychosocial services. These children are facing the biggest opportunity and the biggest challenge of their young lives. Many have spent all their years in substitute care and have no idea how to live independently. Through our comprehensive care management program, we can aid these children and identify community resources available to assist them in living independently.

Project Benefits:

Aetna Better Health of Pennsylvania achieved NCQA Commendable level accreditation in December 2017. Aetna Better Health of Pennsylvania delivers care through a collaborative approach. We partner with providers who deliver quality and effective care to achieve the best outcomes for our members. The programs encourage members to take charge of their health. Through the care management program, members set goals for their health. Aetna Better Health of Pennsylvania's team of case managers, providers, and caregivers work with the member to help them achieve their goals.

Aetna Better Health of Pennsylvania utilizes clinical intervention programs to address children in substitute care. Aetna Better Health of Pennsylvania recognizes that children and adolescents in substitute care have a higher rate of utilization of psychotropic medication than their peers who are in their homes. Many factors contribute to the potential for inappropriate psychotropic prescribing practices including the national shortage of child and adolescent psychiatrists. The issue is compounded by the lack of access to effective non-pharmacological interventions, lack of communication between behavioral health and physical health practitioners, lack of complete medical records due to changes in the primary caregiver, and lack of adherence to evidence-based prescribing by physicians and nurse practitioners.

Aetna Better Health of Pennsylvania uses two pharmacy and clinical management programs that address the appropriate use of psychotropics in children and adolescents. Both programs are founded on evidence-based, clinical practice guidelines and U.S. Food and Drug Administration-approved indications promoting safe and effective prescribing in individuals under the age of 21. The approach aligns with the Department's goals. These programs support the appropriate diagnostic evaluation, consultation, and coordination with specialists, appropriate treatment monitoring, continuity/coordination of care, and medication adherence. Aetna Better Health of Pennsylvania works collaboratively with the behavioral health managed care organizations to achieve goals.

Program Goals
The program goals include reducing the inappropriate use of attention-deficit/hyperactivity disorder (ADHD) stimulants in children and adolescents in foster care; improving the Healthcare Effectiveness and Data Information Set measure; increasing follow-up care for children prescribed ADHD medication; and increasing specialty consultation by primary care practitioners.

INTERVENTIONS
- Behavioral health utilization data, reviewed in collaboration with the behavioral health managed care organizations, is used to monitor and increase access to behavioral therapy for members
- Use of provider profiling and collaboration with the behavioral health managed care organization to develop more targeted interventions for prescribers
- Telephonic Psychiatric Services (TiPS) program using telehealth to expand access to psychiatric consultations to primary care practitioners
- Comprehensive, evidence-based pharmacy prior authorization guidelines for ADHD stimulants

Appropriate Use of Antipsychotic Medication in Children and Adolescents Pharmacy and Clinical Management Program
Our pharmacy and clinical activities support the use of evidence-based clinical practice guidelines, appropriate diagnostic evaluation, consultation, and coordination with specialists when indicated, second

opinions, effective monitoring, continuity and coordination of care, member/caregiver education, improved medication adherence, and formulary adherence.

We collaborate with the behavioral health managed care organizations to identify members under age 21 on antipsychotic medication who have not had the appropriate monitoring for metabolic effects. We also use behavioral health utilization data and collaboration with the BH-MCOs to monitor members under age 21 on antipsychotic medication that are not receiving nonmedication behavioral health treatment. Additionally, deployment of the TiPS program will enable psychiatric consultations to primary care practitioners.

Key Personnel	
Name: Jason Rottman	Role: Chief Executive Officer
Name: Stephanie Ledesma	Role: Chief Operating Officer
Name: Dr. Bernard Lewin	Role: Chief Medical Officer
Name: Heather Hoopes	Role: Chief Financial Officer
Name: Sosi Hovagimian	Role: Director of Compliance

Project Measurements:	
Projected Membership of Vendor's Contract: N/A	Actual Membership of Vendor's Contract: 203,749 total membership as of June 2019
Reason(s) for change in membership: N/A	

Estimated Start & Completion Dates:	From:	N/A	To:	N/A
Actual Start & Completion Dates: **Southeast Zone:** Philadelphia, Bucks, Delaware, Montgomery, and Chester counties	From:	Contract Start: April 1, 2010 Tenure in the State: Since 1993	To:	Current Agreement in effect until 12/31/19. Contract will be extended until the contract is re-procured.
Actual Start & Completion Dates: **Lehigh Capital Zone:** Huntington, Fulton, Franklin, Perry, Cumberland, Adams, Dauphin, York, Lebanon, Lancaster, Berks, Lehigh, and Northampton counties	From:	April 1, 2010	To:	Current Agreement in effect until 12/31/19. Contract will be extended until the contract is re-procured.

Actual Start & Completion Dates: **Southwest Zone**: Lawrence, Armstrong, Butler, Beaver, Allegheny, Westmoreland, Indiana, Washington, Greene, Fayette, Somerset, Cambria, Blair, and Bedford counties	From:	April 1, 2012	To:	Current Agreement in effect until 12/31/19. Contract will be extended until the contract is re-procured.
Actual Start & Completion Dates: **Northwest Zone:** Erie, Crawford, Vernango, Mercer, Clarion, Forest, McKean, Potter, Elk, Jefferson, Clearfield, Cameron, and Warren counties	From:	October 1, 2012	To:	Current Agreement in effect until 12/31/19. Contract will be extended until the contract is re-procured.
Actual Start & Completion Dates: **Northeast Zone:** Juniata, Mifflin, Centre, Snyder, Union, Clinton, Lycoming, Montour, Schuykill, Northumberland, Carbon, Columbia, Sullivan, Luzerne, Monroe, Pike, Wayne, Lackawanna, Susquehanna, Bradford, Wyoming, and Tioga counties.	From:	March 1, 2013	To:	Current Agreement in effect until 12/31/19. Contract will be extended until the contract is re-procured.
Actual Start & Completion Dates: **Southwest Zone**: Lawrence, Armstrong, Butler, Beaver, Allegheny, Westmoreland, Indiana, Washington, Greene, Fayette, Somerset, Cambria, Blair, and Bedford counties	From:	April 1, 2012	To:	Current Agreement in effect until 12/31/19. Contract will be extended until the contract is re-procured.
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 9: Vendor References

Vendor Information		
Vendor Name: Aetna Medicaid Administrators LLC (Aetna Medicaid Administrators)	Contact Name:	Lorry Bottrill
	Contact Phone:	602-453-8317
Customer Information		
Customer Organization: Mercy Care	Contact Name:	Linda Hunt
	Contact Title:	Board of Director Chair
Customer Address: 4755 S. 44th Place, Phoenix, Arizona 85040	Contact Phone:	602-406-6001
	Contact Email:	linda.hunt@dignityhealth.org

Project Information	
Total Vendor Staff:	Aetna Medicaid Administrators has approximately 1,200 individuals dedicated to serving the contracts Mercy Care holds with Arizona Health Care Cost Containment System (AHCCCS) and the Arizona Department of Economic Services (DES) Division of Developmental Disabilities (DDD).

Project Objectives:

Mercy Care holds four contracts with AHCCCS to provide Medicaid Managed Care for Arizona Medicaid recipients, including the following that serve populations similar to those under the Specialized Managed Care for Children and Youth project:

- **Regional Behavioral Health Authority (RBHA) contract** covering the TANF, General Mental Health and Substance Use (GMH/SU), ABD, serious mental illness (SMI), and Affordable Care Act (ACA) populations, including children and adolescents, children in foster and adoptive care, adults with a serious mental illness determination, adults with general mental health issues, adults with substance abuse issues, suicide prevention, and individuals experiencing a behavioral health crisis

Arizona Long Term Care System (ALTCS) contract covering people who are 65 years or older and/or physically disabled or developmentally disabled and need the services of a Skilled Nursing Facility or Assisted Living Facility

Project Description:

RHBA: Mercy Care has served members of the RBHA contract since 2014 and has remained in good standing. There have been over 949,000 children and adult members served with physical health, BH, and biopsychosocial needs. The members served include priority populations, such as children and families involved in child welfare, justice-involved members, tribal members, and members with opioid use disorders. Through Aetna Medicaid Administrators' contract with Mercy Care, we have assisted Mercy Care in increasing access and utilization of services, implementing evidence-based practices to address SDOH (i.e. housing, employment, etc.); engaging community partners and multi-systemic stakeholders in collaborative protocols to close gaps and reduce duplication; and working to reduce administrative burden on providers and maximize cost savings for the State.

ALTCS: The current enrollment is approximately 12,000 members, making Mercy Care the largest ALTCS contractor serving enrollees in Maricopa, Gila, Pinal, and Pima counties. Mercy Care has been actively contracted with AHCCCS for these services and has remained in good standing since October 2000. Long-term care services are fully integrated with general mental health and substance use treatment. Through Mercy Care's contract with AHCCCS, we serve over 1,000 individuals who have

been determined seriously mentally ill and 250 members with Children's Rehabilitative Services (CRS) conditions. Additionally, we serve over 4,000 members who are involved in the Children's Rehabilitative Services program, offering primary care and behavioral health services.

NOTE: General Mental Health Substance Use members are moving from the RBHA contract to the Arizona Complete Contract and the Adult DDD and Child DDD are moving under the DDD contract effective 10/1/2019.

Vendor's Involvement:

Aetna Medicaid Administrators has approximately 1,200 individuals dedicated to serving Arizona's Medicaid members across Mercy Care's contracts with AHCCS and DES. Mercy Care is distinguished as the only Arizona health plan with experience and expertise administering services for all AHCCCS programs serving Medicaid members, and Aetna Medicaid Administrators is responsible for providing most of those administrative services. We bring unparalleled experience in developing high-quality service delivery systems, which has resulted in Mercy Care being recognized as a quality leader by AHCCCS, the Center for Medicare & and Medicaid Services, and NCQA. For example, through our work, Mercy Care achieved 97 percent compliance on its most recent Operational Review for the ALTCS program and has established a reputation as a leader in serving children and adolescents in Department of Child Safety (DCS) custody by developing a strong understanding of the unique needs of the population and creating programs to support them. Key to this approach has been bringing providers, foster parents, and kinship groups together with DCS staff in a collaborative process. Together, Aetna Medicaid Administrators and Mercy Care focus on four key areas: network development, staff training, stakeholder engagement, and community forums and trainings.

Project Benefits:

All children and adolescents in foster, adoptive, and kinship care in Arizona are eligible to receive behavioral health services. Aetna Medicaid Administrators helps Mercy Care to connect them—and the families who have opened their homes to them – with high-quality care. Together, Aetna Medicaid Administrators and Mercy Care work with the Department of Child Safety, the Comprehensive Medical and Dental Program (CMDP), and community provider agencies to provide and coordinate behavioral health services for CMDP members. CMDP provides physical, dental, and vision coverage to children in DCS care, while Mercy Care provides carved-out behavioral health services to those individuals in Maricopa County and certain ZIP codes of Pinal County. Aetna Medicaid Administrators manages those carved-out behavioral health services, and in concert with Mercy Care, serves approximately 9,000 CMDP members.

Aetna Medicaid Administrators forges innovations for collaborative, integrated, outcomes-based care. Through this work, Mercy Care was recently recognized by NCQA for our approach to promoting quality care for ALTCS members when it was selected as 1 of 9 participants to provide input on accreditation standards for long-term care programs. Aetna Medicaid Administrators' approach is to think creatively to help Mercy Care's members live independently in the setting of their choice while ensuring that Mercy Care meets and exceeds AHCCCS performance measures and national benchmarks. As a result of our programs, 75 percent of Mercy Care's ALTCS members can live in and remain in community-based settings.

Our program resulted in Mercy Care expanding in-state service options to minimize or alleviate the need for out-of-state placements. Mercy Care staff traveled to Idaho to visit a facility run by Sequel Care that specializes in the treatment of Sexual Maladaptive Behavior (SMB). As a result, Sequel Care is currently looking for properties in the Phoenix area with plans to open a 60- to 80-bed boys SMB and a general mental health program within a year. Aetna Medicaid Administrators and Mercy Care recognize that we need more residential options as the number of youth approved and placed in residential facilities continues to increase. In recognition of the need to continue to enhance current services to avoid out-of-state placements, we will continue to explore areas that may need to be developed and/or expanded such as enhancing community supports and outpatient programs, securing additional in-state options for residential treatment, and developing contracting and payment strategies to incentivize providers. To improve clinical

oversight, Aetna Medicaid Administrators has worked with Mercy Care to institute several evidence-based practices for working with children in out-of-home placements.	
Key Personnel	
Name: Lorry Bottrill	Role: Contract Liaison/Medicaid Administrator
Name: Karrie Steving	Role: Children's System of Care Administrator
Name: Randy Ek	Role: Chief Financial Officer
Name: Dr. Charlton Wilson	Role: Medical Director
Name: Suzanne Buhrow	Role: Medical Management Director
Name: Carol Turpin	Role: Care Management Director
Name: Dr. Ann Negri	Role: Behavioral Health Medical Director
Name: Randy Grover	Role: Social Services Director
Name: Blythe FitzHarris	Role: Socially Necessary Services Liaison
Name: Elaina Dimiceli-Serwin	Role: Quality Director
Name: Luis Sanchez	Role: Member Services Director
Name: David Vargas	Role: Claims Payment Director
Name: Charlotte Whitmore	Role: Network Development Director
Name: Patricia Weidman	Role: Provider Relations Director
Name: James Maguire	Role: Program Integrity Lead
Name: Trisha Stuart	Role: Community Engagement Director
Name: Dr. Hillary Peck	Role: Dental Director
Name: Erneshia Pinder	Role: Medicaid Member Advocate
Project Measurements:	
Projected Membership of Vendor's RBHA Contract: • 780,173 projected for 12/2014 • 797,296 projected for 12/2015 • 911,411 projected for 12/2016 • 941,950 projected for 12/2017 • 48,838 projected for 12/2018	Actual Membership of Vendor's RBHA Contract: • 821,560 enrollees 12/1/2014 • 877,620 enrollees 12/1/2015 • 926,192 enrollees 12/1/2016 • 918,140 enrollees 12/1/2017 • 48,662 enrollees 12/1/2018
Reason(s) for change in membership: The two biggest changes in membership are the 10/1/2018 change related to the General Mental Health Substance Use members moving from the RBHA contract to the Arizona Complete Contract and the Adult DDD and Child DDD moving under the DDD contract effective 10/1/2019.	

Estimated Start & Completion Dates:	From:	Aetna Medicaid Administrators has been providing plan management services to Mercy Care since 2002. Mercy Care's Current RBHA Contract Start: 04/01/2014	To:	9/30/19
Actual Start & Completion Dates:	From:	Aetna Medicaid Administrators has been providing plan management services to Mercy Care since 2002. Mercy Care's Current RBHA Contract Start: 04/01/2014	To:	9/30/22

Reason(s) for difference between Estimated and Actual dates:

Due the integration of the Department of Behavioral Health Services with the Arizona Health Care Cost Containment System, the RBHA contract was extended by the regulators in the interest of allowing the most seamless transition for members and their families. The RBHA contract has been extended to 9/30/2022 by AHCCCS.

If the Vendor performed the work as a Subcontractor, the Vendor should describe the scope of subcontracted activities:

Aetna Medicaid Administrators provides plan management services to Mercy Care, which is not a subsidiary of Aetna Inc. but is managed by Aetna's Medicaid organization, in connection with Mercy Care's contracts covering the TANF, GMH/SU, ABD, SMI, and ACA populations, including children and adolescents, children in foster and adoptive care, adults with a serious mental illness determination, adults with general mental health issues, adults with substance abuse issues, and individuals experiencing a BH crisis. Aetna Medicaid Administrators provides most plan management services for Mercy Care, including, enrollment processing, claims payment, program integrity monitoring, internal audit, executive oversight, information systems, finance, actuarial, procurement, insurance, risk management, and compliance oversight. Additionally, they provide oversight and guidance for disease management, quality management, and utilization management.

5.2 Subcontractor References (if applicable)

If the Vendor's proposal includes the use of Subcontractor(s), provide three (3) references for each subcontractor. **The State prefers references that demonstrate where the Prime and Subcontractors have worked together in the past.**

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

The Vendor may add additional Reference Tables as necessary.

Table 10: Subcontractor Reference #1[1]

Subcontractor Information		
Vendor Name: Active Health Management, Inc.	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:	Marc Gonzer
	Contact Title:	Contract Manager
Customer Address: 7 Quakerbridge Plaza, 2nd Floor, Room 203, Mercerville, New Jersey 08619	Contact Phone:	609-575-9389
	Contact Email:	Mark.Gonzer@dhs.state.nj.us
Project Information		
Total Vendor Staff:	188	
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 home- and community-based services (HCBS).		

[1] The types of references provided by our Subcontractors in response to Section 5.2, Subcontractor References, varied. For example, some subcontractors provided references from the state agencies that contract with Aetna health plans and other subcontractors provided references from the Aetna health plans themselves. If the Department seeks information different than what has been submitted, we will provide it upon request.

REQUEST FOR PROPOSAL

Department of Health and Human Resources, RFP CRFP 0511 BMS 1900000001

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 healthcare 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.

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 children and youth 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 EPSDT benefit) or the MLTSS program (for which private duty nursing is a benefit for both children and adults).

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 on a daily basis.

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 managed long-term services and supports (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: Glenn MacFarlane	Role: Chief Executive Officer
Name: Jerry Mammano	Role: Chief Operating Officer
Name: Heather Hoopes	Role: Chief Financial Officer
Name: Cheryl Reid, M.D.	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: 60,478
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 & Completion Dates:	From:	Current Contract: 12/01/2014	To:	N/A; evergreen contract
Actual Start & Completion Dates:	From:	Current Contract: 12/01/2014	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 10: Subcontractor Reference #2

Subcontractor Information		
Vendor Name: Active Health Management, Inc.	Contact Name:	Jacquelyn Dunphy
	Contact Phone:	917-774-2622
Customer Information		

REQUEST FOR PROPOSAL

Department of Health and Human Resources, RFP CRFP 0511 BMS 1900000001

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:	465

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 (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'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 a health management organization (HMO) and as a Managed Care Health Insurance Plan (MCHIP) in the State of Virginia. Aetna Better Health of Virginia is also a National Committee for Quality Assurance (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: ActiveHealth provides a disease management program, tools, and services; services relating to NCQA accreditation.

Aetna Better Health of Virginia was one of six MCOs selected through a competitive RFP to provide managed care services to qualified Virginians under the Medallion 4.0 Program.

The new program will build on the strengths and experience of the twenty-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 (ABHVA) 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, that 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:

- 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 system-wide 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

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.

Behavioral Health

Aetna Better Health of Virginia possesses a full understanding of the non-traditional community mental health services that are delivered under the Medallion 4.0 program. We provide nontraditional services such as intensive in-home services, therapeutic day treatment, and residential treatment for children and adolescents, day treatment/partial hospitalization, psychosocial rehabilitation, crisis services (including trauma informed care and adverse childhood events), intensive community treatment, and mental health skill building for adults.

In Virginia, we collaborate by conducting interdisciplinary care team meetings with Magellan of Virginia to discuss members who would benefit from any of these non-traditional services. We have designated a team to ensure that those needing a more intense level of care management are recipients of it. We collaboratively engage with Magellan, DMAS, and community-based providers to help ensure a seamless transition for members within the Commonwealth that meets all Community Mental Health Rehabilitation

Services network adequacy standards. We understand the importance of relationships and continuity of care, and we will demonstrate this commitment by doubling the stated requirement and ensuring that members can continue to see their existing providers for at up to 180 days post-transition if they are not currently in our network. Moreover, our provider network team actively works to recruit providers of traditional and non-traditional services into our network.

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.

Our care coordinators currently attend individualized education plan (IEP) meetings as active participants to determine jointly the needs of the child and their family, assign accountability and responsibility across organizations, and make sure services are integrated and coordinated. We work directly with teachers and school-based providers to obtain a copy of the IEP and share any additional information with the child's traditional and/or non-traditional providers. Our care coordinators encourage open communication and elevate the goals and objectives of the child and of their parent or guardian. With a focus on avoiding the duplication of services, we invite the school-based team to be a contributing part of our interdisciplinary care team provided we have all of the appropriate consents.

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 provide 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 facilitate adjustments (as needed) to enhance access and

engagement of members. Our peer support model utilizes techniques to ensure safety and establish rapport with the 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 spacing between births and positive birth outcomes.				
Key Personnel				
Name: Roger Gunter		Role: Project Director		
Name: Joanne Landry		Role: Project Manager		
Name: Ira Bloomfield, M.D.		Role: Medical Director		
Name: Neil Hines, M.D.		Role: Behavioral Health Lead		
Name: Lani Spencer, R.N.		Role: Care Coordination Manager		
Name: Kimberly Grifasi		Role: Quality Improvement Program Manager		
Project Measurements:				
Projected Membership of Vendor's Contract: N/A		Actual Membership of Vendor's Contract: 113,000		
Reason(s) for change in membership: N/A				
Estimated Start & Completion Dates:	From:	Contract Start: 8/1/18	To:	June 30, 2020, with the possibility of six (6) twelve month renewals
Actual Start & Completion Dates:	From:	Contract Start: 8/1/18	To:	June 30, 2020, with the possibility of six (6) twelve month renewals
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 10: Subcontractor Reference #3

Subcontractor Information		
Vendor Name: Active Health Management, Inc.	Contact Name:	Jacquelyn Dunphy
	Contact Phone:	917-774-2622
Customer Information		
Customer Organization: Pennsylvania Department of Human Services (Department)	Contact Name:	Sally Kozak
	Contact Title:	Deputy Secretary, Office of Medical Assistance Programs (OMAP)
Customer Address: Room 515, 625 Forster St, Harrisburg PA 17120	Contact Phone:	717-214-4206
	Contact Email:	sakozak@pa.gov
Project Information		
Total Vendor Staff:	291	

Project Objectives:

- To provide mandatory managed health care as part of the HealthChoices Program, Pennsylvania's 1915(b) waiver program, for Medical Assistance Recipients. HealthChoices Objectives include:
- Promote the achievement of the Triple AIM (better health, better care, lower cost);
- Improve care coordination between physical and behavioral health services;
- Promote the expansion of value-based purchasing of health care services;
- Promote the expansion of team-based approaches to care delivery (for example, patient-centered care medical homes);
- Promote community-based public health initiatives;
- Increase consumer access to needed services, especially in rural and underserved areas of the commonwealth;
- Improve the efficiency of the HealthChoices program; and
- Improve the provider experience with the HealthChoices program.

Project Description: Aetna Better Health of Pennsylvania and Aetna Better Health Kids provide health benefits and manage care for people enrolled in the Commonwealth of Pennsylvania's Medical Assistance program (Medicaid). Engaging members through an integrated care management model fully integrating physical and behavioral health care as well as chronic care and disease management programs for persons with complex medical concerns. The local, community-based model ensures Pennsylvanian providers and participants live side-by-side with Aetna staff.

ABHP improves the overall health care delivery to our HealthChoices members by:

- Acting as a single point-of-contact to serve the member
- Providing complete health and social services and support for members through our Fully
- Integrated System of Care (FISOC)
- Pursuing strategies to strengthen the local delivery systems using community health workers, and peer support specialists
- Leveraging the use of our proprietary predictive modeling tool to identify members at risk for emergency department utilization or an inpatient admission

Vendor's Involvement:

ActiveHealth provides a disease management program, tools, and services; services relating to NCQA accreditation. Aetna Better Health of Pennsylvania is a Physical Health Managed Care Organization with an agreement with the Department to manage the purchase and provision of Physical Health Services Statewide under the HealthChoices Program. Aetna Better Health of Pennsylvania is committed to addressing the system challenges and making improvements in the services we provide for children in care where they live. Some of our strategies include:

- Assigning a point of contact to develop and implement community support programs and processes. This subject matter expert is the liaison with local agencies including child welfare, juvenile corrections, juvenile justice, and other agencies that serve children.
- Providing training and education on the role of the managed care organization to the child welfare agencies
- Working with youth to prepare them for "aging out" of substitute care—e.g., assist them in completing applications for Medicaid, housing, and employment
- Partnering with foster care agencies to provide education about the appropriate use of antipsychotics
- Assisting in scheduling primary care physician and dental appointments
- Coordinating an annual forum in each zone to bring the child welfare agencies and other stakeholders together for planning and collaborating on issue regarding children in substitute care
- Improving tracking and reporting on children in care receiving a physical within 60 days of entering care

In the event a member in substitute care has difficulty obtaining access to medically necessary services within the state, Aetna Better Health of Pennsylvania Case Management and Network Management departments collaborate to find a provider within the state that will meet the member's needs and work to execute a Single Case Agreement to ensure a member continued to receive care within the State.

Children in substitute care are enrolled in case management to ensure that they receive the proper preventative care that can help reduce inpatient admissions. Aetna Better Health of Pennsylvania utilizes an Integrated Care Management program to address the member's medical, behavioral, in coordination with the BH MCO's, and social needs in individual and distinctive ways. Aetna Better Health of Pennsylvania recognizes that these needs interact with each other, often in unpredictable ways, and that a member's care is driven by a number of unique physical and behavioral health conditions. To target members who will benefit most from integrated care management, we use predictive modeling through our Consolidated Outreach and Risk Evaluation (CORE) tool. This tool is custom designed for the Medicaid population. CORE predicts both financial and clinical performance over the next 12 months, with a positive predictive value of up to 95.4 percent. CORE identifies members for whom intensive or

complex care management will promote improved health and well-being and prevent high cost utilization. We also identify members using provider and pharmacy referrals.

Our CORE proprietary predictive modeling tool enables us to identify high-acuity members who are also high-risk. Our Integrated Care Management program prioritizes outreach to the top 1% members who are also at high-risk for emergency department visits in the next 12 months and high-risk for inpatient utilization in the next 12 months (identified as CORE 4).

One of the special challenges is children who "age out" of the system. Many of the children in the child welfare system are over the age of 16 and "age out" at 18. These children have very little control over their lives and/or how they receive the medical services they need. We include these children in the development of their care management plan and they have choices they can make as their plans are developed. We begin that process when they turn 16 and follow them until they "age out." Children between the ages of 16 and 18 not only need care management for their medical services, but also for psychosocial services. These children are facing the biggest opportunity and the biggest challenge of their young lives. Many have spent all of their years in substitute care and have no idea how to live independently. Through our comprehensive care management program, we are able to aid these children and identify community resources available to assist them in living independently.

Project Benefits: Aetna Better Health of Pennsylvania achieved NCQA Commendable level accreditation in December 2017. Aetna Better Health of Pennsylvania delivers care through a collaborative approach. We partner with providers who deliver quality and effective care to achieve the best outcomes for our members. The programs encourage members to take charge of their health. Through the care management program, members set goals for their health. Aetna Better Health of Pennsylvania's team of case managers, providers, and caregivers work with the member to help them achieve their goals.

Aetna Better Health of Pennsylvania utilizes clinical intervention programs to address children in substitute care. Aetna Better Health of Pennsylvania recognizes that children and adolescents in substitute care have a higher rate of utilization of psychotropic medication than their peers who are in their homes. Many factors contribute to the potential for inappropriate psychotropic prescribing practices including the national shortage of child and adolescent psychiatrists. The issue is compounded by the lack of access to effective non-pharmacological interventions, lack of communication between behavioral health and physical health practitioners, lack of complete medical records due to changes in the primary caregiver, and lack of adherence to evidence-based prescribing by physicians and nurse practitioners.

Aetna Better Health of Pennsylvania uses two pharmacy and clinical management programs that address the appropriate use of psychotropics in children and adolescents. Both programs are founded on evidence-based, clinical practice guidelines and U.S. Food and Drug Administration-approved indications promoting safe and effective prescribing in individuals under the age of 21. The approach aligns with the Department's goals. These programs support the appropriate diagnostic evaluation, consultation and coordination with specialists, appropriate treatment monitoring, continuity/coordination of care, and medication adherence. Aetna Better Health of Pennsylvania works collaboratively with the behavioral health managed care organizations to achieve goals.

PROGRAM GOALS

The program goals include reducing the inappropriate use of ADHD stimulants in children and adolescents in foster care; improving the HEDIS measure; increasing follow-up care for children prescribed ADHD medication; and increasing specialty consultation by primary care practitioners.

INTERVENTIONS

- Behavioral health utilization data, reviewed in collaboration with the behavioral health managed care organizations, is used to monitor and increase access to behavioral therapy for members
- Use of provider profiling and collaboration with the behavioral health managed care organization to develop more targeted interventions for prescribers
- Telephonic Psychiatric Services (TiPS) program using telehealth to expand access to psychiatric consultations to primary care practitioners
- Comprehensive, evidence-based pharmacy prior authorization guidelines for ADHD stimulants
- Appropriate Use of Antipsychotic Medication in Children and Adolescents Pharmacy and Clinical Management Program

Our pharmacy and clinical activities support the use of evidence-based clinical practice guidelines, appropriate diagnostic evaluation, consultation and coordination with specialists when indicated, second opinions, effective monitoring, continuity and coordination of care, member/caregiver education, improved medication adherence, and formulary adherence.

We collaborate with the behavioral health managed care organizations to identify members under age 21 on antipsychotic medication who have not had the appropriate monitoring for metabolic effects. We also use behavioral health utilization data and collaboration with the BH-MCOs to monitor members under age 21 on antipsychotic medication that are not receiving nonmedication behavioral health treatment. Additionally, deployment of the TiPS program will enable psychiatric consultations to primary care practitioners.

Key Personnel	
Name: Jason Rottman	Role: Chief Executive Officer
Name: Stephanie Ledesma	Role: Chief Operations Officer
Name: Dr. Bernard Lewin	Role: Chief Medical Officer
Name: Heather Hoopes	Role: Chief Financial Officer
Name: Sosi Hovagimian	Role: Director of Compliance

Project Measurements:	
Projected Membership of Vendor's Contract: N/A	Actual Membership of Vendor's Contract: 203,749 total membership as of June 2019
Reason(s) for change in membership: N/A	

Estimated Start & Completion Dates:	From:	N/A	To:	N/A

Actual Start & Completion Dates:	From:	Contract Start: April 1, 2010 Tenure in the State: Since 1993	To:	Current Agreement in effect until 12/31/19. Contract will be extended until the contract is re-procured.
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 10: Subcontractor Reference #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:	Marc Gonzer
	Contact Title:	Contract Manager
Customer Address: 7 Quakerbridge Plaza, 2nd Floor, Room 203, Mercerville, New Jersey 08619	Contact Phone:	609-575-9389
	Contact Email:	Mark.Gonzer@dhs.state.nj.us
Project Information		
Total Vendor Staff:	188	
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 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 healthcare 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 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 children and youth 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 EPSDT benefit) or the MLTSS program (for which private duty nursing is a benefit for both children and adults). 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 on a daily basis.
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 managed long-term services and supports (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: Glenn MacFarlane	Role: Chief Executive Officer

Name: Jerry Mammano	Role: Chief Operating Officer
Name: Heather Hoopes	Role: Chief Financial Officer
Name: Cheryl Reid, M.D.	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: 60,478
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 & Completion Dates:	From:	Current Contract: 12/01/2014	To:	N/A; evergreen contract
Actual Start & Completion Dates:	From:	Current Contract: 12/01/2014	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: Aetna Health Management provides after-hours call center, provider credentialing, and Aetna's nurse-staffed Informed Health Line, among other functions.

Table 10: Subcontractor Reference #2

Subcontractor Information		
Vendor Name: Aetna Health Management, LLC	Contact Name:	Edward Lee

REQUEST FOR PROPOSAL

Department of Health and Human Resources, RFP CRFP 0511 BMS 1900000001

	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:	465

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 (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'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 a health management organization (HMO) and as a Managed Care Health Insurance Plan (MCHIP) in the State of Virginia. Aetna Better Health of Virginia is also a National Committee for Quality Assurance (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 Health Management provides after-hours call center, provider credentialing, and Aetna's nurse-staffed Informed Health Line, among other functions.

Aetna Better Health of Virginia was one of six MCOs selected through a competitive RFP to provide managed care services to qualified Virginians under the Medallion 4.0 Program.

The new program will build on the strengths and experience of the twenty-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 (ABHVA) 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, that 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:

- 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 system-wide 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

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.

Behavioral Health

Aetna Better Health of Virginia possesses a full understanding of the non-traditional community mental health services that are delivered under the Medallion 4.0 program. We provide nontraditional services such as intensive in-home services, therapeutic day treatment, and residential treatment for children and adolescents, day treatment/partial hospitalization, psychosocial rehabilitation, crisis services (including trauma informed care and adverse childhood events), intensive community treatment, and mental health skill building for adults.

In Virginia, we collaborate by conducting interdisciplinary care team meetings with Magellan of Virginia to discuss members who would benefit from any of these non-traditional services. We have designated a team to ensure that those needing a more intense level of care management are recipients of it. We collaboratively engage with Magellan, DMAS, and community-based providers to help ensure a seamless transition for members within the Commonwealth that meets all Community Mental Health Rehabilitation Services network adequacy standards. We understand the importance of relationships and continuity of care, and we will demonstrate this commitment by doubling the stated requirement and ensuring that members can continue to see their existing providers for at up to 180 days post-transition if they are not currently in our network. Moreover, our provider network team actively works to recruit providers of traditional and non-traditional services into our network.

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.

Our care coordinators currently attend individualized education plan (IEP) meetings as active participants to determine jointly the needs of the child and their family, assign accountability and responsibility across organizations, and make sure services are integrated and coordinated. We work directly with teachers and school-based providers to obtain a copy of the IEP and share any additional information with the child's traditional and/or non-traditional providers. Our care coordinators encourage open communication and elevate the goals and objectives of the child and of their parent or guardian. With a focus on avoiding the duplication of services, we invite the school-based team to be a contributing part of our interdisciplinary care team provided we have all of the appropriate consents.

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 provide 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 facilitate adjustments (as needed) to enhance access and engagement of members. Our peer support model utilizes techniques to ensure safety and establish rapport with the 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 spacing between births and positive birth outcomes.

Key Personnel	
Name: Roger Gunter	Role: Project Director
Name: Joanne Landry	Role: Project Manager
Name: Ira Bloomfield, M.D.	Role: Medical Director
Name: Neil Hines, M.D.	Role: Behavioral Health Lead
Name: Lani Spencer, R.N.	Role: Care Coordination Manager
Name: Kimberly Grifasi	Role: Quality Improvement Program Manager

Project Measurements:	
Projected Membership of Vendor's Contract: N/A	Actual Membership of Vendor's Contract: 113,000
Reason(s) for change in membership: N/A	

Estimated Start & Completion Dates:	From:	Contract Start: 8/1/18	To:	June 30, 2020, with the possibility of six (6) twelve month renewals
Actual Start & Completion Dates:	From:	Contract Start: 8/1/18	To:	June 30, 2020, with the possibility of six (6) twelve month renewals

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 10: Subcontractor Reference #3

Subcontractor Information		
Vendor Name: Aetna Health Management, LLC	Contact Name:	Edward Lee
	Contact Phone:	860-273-3177
Customer Information		
Customer Organization: Pennsylvania Department of Human Services (Department)	Contact Name:	Sally Kozak
	Contact Title:	Deputy Secretary, Office of Medical Assistance Programs (OMAP)
Customer Address: Room 515, 625 Forster St, Harrisburg PA 17120	Contact Phone:	717-214-4206
	Contact Email:	sakozak@pa.gov
Project Information		
Total Vendor Staff:	291	

Project Objectives: To provide mandatory managed health care as part of the HealthChoices Program, Pennsylvania's 1915(b) waiver program, for Medical Assistance Recipients. HealthChoices Objectives include:

- Promote the achievement of the Triple AIM (better health, better care, lower cost);
- Improve care coordination between physical and behavioral health services;
- Promote the expansion of value-based purchasing of health care services;
- Promote the expansion of team-based approaches to care delivery (for example, patient-centered care medical homes);
- Promote community-based public health initiatives;
- Increase consumer access to needed services, especially in rural and underserved areas of the commonwealth;
- Improve the efficiency of the HealthChoices program; and
- Improve the provider experience with the HealthChoices program.

Project Description: Aetna Better Health of Pennsylvania and Aetna Better Health Kids provide health benefits and manage care for people enrolled in the Commonwealth of Pennsylvania's Medical Assistance program (Medicaid). Engaging members through an integrated care management model fully integrating physical and behavioral health care as well as chronic care and disease management

programs for persons with complex medical concerns. The local, community-based model ensures Pennsylvanian providers and participants live side-by-side with Aetna staff.

ABHP improves the overall health care delivery to our HealthChoices members by:

- Acting as a single point-of-contact to serve the member
- Providing complete health and social services and support for members through our Fully
- Integrated System of Care (FISOC)
- Pursuing strategies to strengthen the local delivery systems using community health workers, and peer support specialists
- Leveraging the use of our proprietary predictive modeling tool to identify members at risk for emergency department utilization or an inpatient admission

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 Better Health of Pennsylvania is a Physical Health Managed Care Organization with an agreement with the Department to manage the purchase and provision of Physical Health Services Statewide under the HealthChoices Program. Aetna Better Health of Pennsylvania is committed to addressing the system challenges and making improvements in the services we provide for children in care where they live. Some of our strategies include:

- Assigning a point of contact to develop and implement community support programs and processes. This subject matter expert is the liaison with local agencies including child welfare, juvenile corrections, juvenile justice, and other agencies that serve children.
- Providing training and education on the role of the managed care organization to the child welfare agencies
- Working with youth to prepare them for "aging out" of substitute care—e.g., assist them in completing applications for Medicaid, housing, and employment
- Partnering with foster care agencies to provide education about the appropriate use of antipsychotics
- Assisting in scheduling primary care physician and dental appointments
- Coordinating an annual forum in each zone to bring the child welfare agencies and other stakeholders together for planning and collaborating on issue regarding children in substitute care
- Improving tracking and reporting on children in care receiving a physical within 60 days of entering care

In the event a member in substitute care has difficulty obtaining access to medically necessary services within the state, Aetna Better Health of Pennsylvania Case Management and Network Management departments collaborate to find a provider within the state that will meet the member's needs and work to execute a Single Case Agreement to ensure a member continued to receive care within the State.

Children in substitute care are enrolled in case management to ensure that they receive the proper preventative care that can help reduce inpatient admissions. Aetna Better Health of Pennsylvania utilizes an Integrated Care Management program to address the member's medical, behavioral, in coordination with the BH MCO's, and social needs in individual and distinctive ways. Aetna Better Health of Pennsylvania recognizes that these needs interact with each other, often in unpredictable ways, and that a member's care is driven by a number of unique physical and behavioral health conditions. To target members who will benefit most from integrated care management, we use predictive modeling through

our Consolidated Outreach and Risk Evaluation (CORE) tool. This tool is custom designed for the Medicaid population. CORE predicts both financial and clinical performance over the next 12 months, with a positive predictive value of up to 95.4 percent. CORE identifies members for whom intensive or complex care management will promote improved health and well-being and prevent high cost utilization. We also identify members using provider and pharmacy referrals.

Our CORE proprietary predictive modeling tool enables us to identify high-acuity members who are also high-risk. Our Integrated Care Management program prioritizes outreach to the top 1% members who are also at high-risk for emergency department visits in the next 12 months and high-risk for inpatient utilization in the next 12 months (identified as CORE 4).

One of the special challenges is children who "age out" of the system. Many of the children in the child welfare system are over the age of 16 and "age out" at 18. These children have very little control over their lives and/or how they receive the medical services they need. We include these children in the development of their care management plan and they have choices they can make as their plans are developed. We begin that process when they turn 16 and follow them until they "age out." Children between the ages of 16 and 18 not only need care management for their medical services, but also for psychosocial services. These children are facing the biggest opportunity and the biggest challenge of their young lives. Many have spent all of their years in substitute care and have no idea how to live independently. Through our comprehensive care management program, we are able to aid these children and identify community resources available to assist them in living independently.

Project Benefits: Aetna Better Health of Pennsylvania achieved NCQA Commendable level accreditation in December 2017. Aetna Better Health of Pennsylvania delivers care through a collaborative approach. We partner with providers who deliver quality and effective care to achieve the best outcomes for our members. The programs encourage members to take charge of their health. Through the care management program, members set goals for their health. Aetna Better Health of Pennsylvania's team of case managers, providers, and caregivers work with the member to help them achieve their goals.

Aetna Better Health of Pennsylvania utilizes clinical intervention programs to address children in substitute care. Aetna Better Health of Pennsylvania recognizes that children and adolescents in substitute care have a higher rate of utilization of psychotropic medication than their peers who are in their homes. Many factors contribute to the potential for inappropriate psychotropic prescribing practices including the national shortage of child and adolescent psychiatrists. The issue is compounded by the lack of access to effective non-pharmacological interventions, lack of communication between behavioral health and physical health practitioners, lack of complete medical records due to changes in the primary caregiver, and lack of adherence to evidence-based prescribing by physicians and nurse practitioners.

Aetna Better Health of Pennsylvania uses two pharmacy and clinical management programs that address the appropriate use of psychotropics in children and adolescents. Both programs are founded on evidence-based, clinical practice guidelines and U.S. Food and Drug Administration-approved indications promoting safe and effective prescribing in individuals under the age of 21. The approach aligns with the Department's goals. These programs support the appropriate diagnostic evaluation, consultation and coordination with specialists, appropriate treatment monitoring, continuity/coordination of care, and medication adherence. Aetna Better Health of Pennsylvania works collaboratively with the behavioral health managed care organizations to achieve goals.

PROGRAM GOALS

The program goals include reducing the inappropriate use of ADHD stimulants in children and adolescents in foster care; improving the HEDIS measure; increasing follow-up care for children prescribed ADHD medication; and increasing specialty consultation by primary care practitioners.

INTERVENTIONS

- Behavioral health utilization data, reviewed in collaboration with the behavioral health managed care organizations, is used to monitor and increase access to behavioral therapy for members
- Use of provider profiling and collaboration with the behavioral health managed care organization to develop more targeted interventions for prescribers
- Telephonic Psychiatric Services (TiPS) program using telehealth to expand access to psychiatric consultations to primary care practitioners
- Comprehensive, evidence-based pharmacy prior authorization guidelines for ADHD stimulants
- Appropriate Use of Antipsychotic Medication in Children and Adolescents Pharmacy and Clinical Management Program

Our pharmacy and clinical activities support the use of evidence-based clinical practice guidelines, appropriate diagnostic evaluation, consultation and coordination with specialists when indicated, second opinions, effective monitoring, continuity and coordination of care, member/caregiver education, improved medication adherence, and formulary adherence.

We collaborate with the behavioral health managed care organizations to identify members under age 21 on antipsychotic medication who have not had the appropriate monitoring for metabolic effects. We also use behavioral health utilization data and collaboration with the BH-MCOs to monitor members under age 21 on antipsychotic medication that are not receiving nonmedication behavioral health treatment. Additionally, deployment of the TiPS program will enable psychiatric consultations to primary care practitioners.

Key Personnel	
Name: Jason Rottman	Role: Chief Executive Officer
Name: Stephanie Ledesma	Role: Chief Operations Officer
Name: Dr. Bernard Lewin	Role: Chief Medical Officer
Name: Heather Hoopes	Role: Chief Financial Officer
Name: Sosi Hovagimian	Role: Director of Compliance
Project Measurements:	
Projected Membership of Vendor's Contract: N/A	Actual Membership of Vendor's Contract: 203,749 total membership as of June 2019
Reason(s) for change in membership: N/A	

Estimated Start & Completion Dates:	From:	N/A	To:	N/A
Actual Start & Completion Dates:	From:	Contract Start: April 1, 2010 Tenure in the State: Since 1993	To:	Current Agreement in effect until 12/31/19. Contract will be extended until the contract is re-procured.
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 10: Subcontractor Reference #1

Subcontractor Information		
Vendor Name: Aetna Medicaid Administrators, LLC	Contact Name:	Scott Markovich
	Contact Phone:	860-273-3928
Customer Information		
Customer Organization: New Jersey Department of Human Services, Division of Medical Assistance and Health Services	Contact Name:	Marc Gonzer
	Contact Title:	Contract Manager
Customer Address: 7 Quakerbridge Plaza, 2nd Floor, Room 203, Mercerville, New Jersey 08619	Contact Phone:	609-575-9389
	Contact Email:	Mark.Gonzer@dhs.state.nj.us
Project Information		
Total Vendor Staff:	188	
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 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 healthcare services, depending on the person's eligibility category.

Vendor's Involvement: 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.

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 children and youth 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 EPSDT benefit) or the MLTSS program (for which private duty nursing is a benefit for both children and adults).

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 on a daily basis.

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 managed long-term services and supports (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: Glenn MacFarlane	Role: Chief Executive Officer
Name: Jerry Mammano	Role: Chief Operating Officer
Name: Heather Hoopes	Role: Chief Financial Officer
Name: Cheryl Reid, M.D.	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: 60,478		
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 & Completion Dates:	From:	Current Contract: 12/01/2014	To:	N/A; evergreen contract
Actual Start & Completion Dates:	From:	Current Contract: 12/01/2014	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: 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 10: Subcontractor Reference #2

Subcontractor Information		
Vendor Name: Aetna Medicaid Administrators, LLC	Contact Name:	Scott Markovich
	Contact Phone:	860-273-3928
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:	465	

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 (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'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 a health management organization (HMO) and as a Managed Care Health Insurance Plan (MCHIP) in the State of Virginia. Aetna Better Health of Virginia is also a National Committee for Quality Assurance (NCQA) accredited Medicaid health plan.

REQUEST FOR PROPOSAL

Department of Health and Human Resources, RFP CRFP 0511 BMS 1900000001

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 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.

The new program will build on the strengths and experience of the twenty-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 (ABHVA) 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, that 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:

- 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 system-wide 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

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.

Behavioral Health

Aetna Better Health of Virginia possesses a full understanding of the non-traditional community mental health services that are delivered under the Medallion 4.0 program. We provide nontraditional services

such as intensive in-home services, therapeutic day treatment, and residential treatment for children and adolescents, day treatment/partial hospitalization, psychosocial rehabilitation, crisis services (including trauma informed care and adverse childhood events), intensive community treatment, and mental health skill building for adults.

In Virginia, we collaborate by conducting interdisciplinary care team meetings with Magellan of Virginia to discuss members who would benefit from any of these non-traditional services. We have designated a team to ensure that those needing a more intense level of care management are recipients of it. We collaboratively engage with Magellan, DMAS, and community-based providers to help ensure a seamless transition for members within the Commonwealth that meets all Community Mental Health Rehabilitation Services network adequacy standards. We understand the importance of relationships and continuity of care, and we will demonstrate this commitment by doubling the stated requirement and ensuring that members can continue to see their existing providers for at up to 180 days post-transition if they are not currently in our network. Moreover, our provider network team actively works to recruit providers of traditional and non-traditional services into our network.

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.

Our care coordinators currently attend individualized education plan (IEP) meetings as active participants to determine jointly the needs of the child and their family, assign accountability and responsibility across organizations, and make sure services are integrated and coordinated. We work directly with teachers and school-based providers to obtain a copy of the IEP and share any additional information with the child's traditional and/or non-traditional providers. Our care coordinators encourage open communication and elevate the goals and objectives of the child and of their parent or guardian. With a focus on avoiding the duplication of services, we invite the school-based team to be a contributing part of our interdisciplinary care team provided we have all of the appropriate consents.

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 provide 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 facilitate adjustments (as needed) to enhance access and engagement of members. Our peer support model utilizes techniques to ensure safety and establish rapport with the 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 spacing between births and positive birth outcomes.

Key Personnel	
Name: Roger Gunter	Role: Project Director
Name: Joanne Landry	Role: Project Manager
Name: Ira Bloomfield, M.D.	Role: Medical Director
Name: Neil Hines, M.D.	Role: Behavioral Health Lead
Name: Lani Spencer, R.N.	Role: Care Coordination Manager
Name: Kimberly Grifasi	Role: Quality Improvement Program Manager

Project Measurements:	
Projected Membership of Vendor's Contract: N/A	Actual Membership of Vendor's Contract: 113,000
Reason(s) for change in membership: N/A	

Estimated Start & Completion Dates:	From:	Contract Start: 8/1/18	To:	June 30, 2020, with the possibility of six (6) twelve month renewals
Actual Start & Completion Dates:	From:	Contract Start: 8/1/18	To:	June 30, 2020, with the possibility of six (6) twelve month renewals
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 10: Subcontractor Reference #3

Subcontractor Information		
Vendor Name: Aetna Medicaid Administrators, LLC	Contact Name:	Scott Markovich
	Contact Phone:	860-273-3928
Customer Information		
Customer Organization: Pennsylvania Department of Human Services (Department)	Contact Name:	Sally Kozak
	Contact Title:	Deputy Secretary, Office of Medical Assistance Programs (OMAP)
Customer Address: Room 515, 625 Forster St, Harrisburg PA 17120	Contact Phone:	717-214-4206
	Contact Email:	sakozak@pa.gov
Project Information		
Total Vendor Staff:	291	
Project Objectives: To provide mandatory managed health care as part of the HealthChoices Program, Pennsylvania's 1915(b) waiver program, for Medical Assistance Recipients. HealthChoices Objectives include: • Promote the achievement of the Triple AIM (better health, better care, lower cost); • Improve care coordination between physical and behavioral health services; • Promote the expansion of value-based purchasing of health care services; • Promote the expansion of team-based approaches to care delivery (for example, patient-centered care medical homes); • Promote community-based public health initiatives; • Increase consumer access to needed services, especially in rural and underserved areas of the commonwealth;		

- Improve the efficiency of the HealthChoices program; and
- Improve the provider experience with the HealthChoices program.

Project Description: Aetna Better Health of Pennsylvania and Aetna Better Health Kids provide health benefits and manage care for people enrolled in the Commonwealth of Pennsylvania's Medical Assistance program (Medicaid). Engaging members through an integrated care management model fully integrating physical and behavioral health care as well as chronic care and disease management programs for persons with complex medical concerns. The local, community-based model ensures Pennsylvanian providers and participants live side-by-side with Aetna staff.

ABHP improves the overall health care delivery to our HealthChoices members by:

- Acting as a single point-of-contact to serve the member
- Providing complete health and social services and support for members through our Fully
- Integrated System of Care (FISOC)
- Pursuing strategies to strengthen the local delivery systems using community health workers, and peer support specialists
- Leveraging the use of our proprietary predictive modeling tool to identify members at risk for emergency department utilization or an inpatient admission

Vendor's Involvement:

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.

Aetna Better Health of Pennsylvania is a Physical Health Managed Care Organization with an agreement with the Department to manage the purchase and provision of Physical Health Services Statewide under the HealthChoices Program. Aetna Better Health of Pennsylvania is committed to addressing the system challenges and making improvements in the services we provide for children in care where they live. Some of our strategies include:

- Assigning a point of contact to develop and implement community support programs and processes. This subject matter expert is the liaison with local agencies including child welfare, juvenile corrections, juvenile justice, and other agencies that serve children.
- Providing training and education on the role of the managed care organization to the child welfare agencies
- Working with youth to prepare them for "aging out" of substitute care—e.g., assist them in completing applications for Medicaid, housing, and employment
- Partnering with foster care agencies to provide education about the appropriate use of antipsychotics
- Assisting in scheduling primary care physician and dental appointments
- Coordinating an annual forum in each zone to bring the child welfare agencies and other stakeholders together for planning and collaborating on issue regarding children in substitute care
- Improving tracking and reporting on children in care receiving a physical within 60 days of entering care

In the event a member in substitute care has difficulty obtaining access to medically necessary services within the state, Aetna Better Health of Pennsylvania Case Management and Network Management

departments collaborate to find a provider within the state that will meet the member's needs and work to execute a Single Case Agreement to ensure a member continued to receive care within the State.

Children in substitute care are enrolled in case management to ensure that they receive the proper preventative care that can help reduce inpatient admissions. Aetna Better Health of Pennsylvania utilizes an Integrated Care Management program to address the member's medical, behavioral, in coordination with the BH MCO's, and social needs in individual and distinctive ways. Aetna Better Health of Pennsylvania recognizes that these needs interact with each other, often in unpredictable ways, and that a member's care is driven by a number of unique physical and behavioral health conditions. To target members who will benefit most from integrated care management, we use predictive modeling through our Consolidated Outreach and Risk Evaluation (CORE) tool. This tool is custom designed for the Medicaid population. CORE predicts both financial and clinical performance over the next 12 months, with a positive predictive value of up to 95.4 percent. CORE identifies members for whom intensive or complex care management will promote improved health and well-being and prevent high cost utilization. We also identify members using provider and pharmacy referrals.

Our CORE proprietary predictive modeling tool enables us to identify high-acuity members who are also high-risk. Our Integrated Care Management program prioritizes outreach to the top 1% members who are also at high-risk for emergency department visits in the next 12 months and high-risk for inpatient utilization in the next 12 months (identified as CORE 4).

One of the special challenges is children who "age out" of the system. Many of the children in the child welfare system are over the age of 16 and "age out" at 18. These children have very little control over their lives and/or how they receive the medical services they need. We include these children in the development of their care management plan and they have choices they can make as their plans are developed. We begin that process when they turn 16 and follow them until they "age out." Children between the ages of 16 and 18 not only need care management for their medical services, but also for psychosocial services. These children are facing the biggest opportunity and the biggest challenge of their young lives. Many have spent all of their years in substitute care and have no idea how to live independently. Through our comprehensive care management program, we are able to aid these children and identify community resources available to assist them in living independently.

Project Benefits: Aetna Better Health of Pennsylvania achieved NCQA Commendable level accreditation in December 2017. Aetna Better Health of Pennsylvania delivers care through a collaborative approach. We partner with providers who deliver quality and effective care to achieve the best outcomes for our members. The programs encourage members to take charge of their health. Through the care management program, members set goals for their health. Aetna Better Health of Pennsylvania's team of case managers, providers, and caregivers work with the member to help them achieve their goals.

Aetna Better Health of Pennsylvania utilizes clinical intervention programs to address children in substitute care. Aetna Better Health of Pennsylvania recognizes that children and adolescents in substitute care have a higher rate of utilization of psychotropic medication than their peers who are in their homes. Many factors contribute to the potential for inappropriate psychotropic prescribing practices including the national shortage of child and adolescent psychiatrists. The issue is compounded by the lack of access to effective non-pharmacological interventions, lack of communication between behavioral health and physical health practitioners, lack of complete medical records due to changes in the primary caregiver, and lack of adherence to evidence-based prescribing by physicians and nurse practitioners.

Aetna Better Health of Pennsylvania uses two pharmacy and clinical management programs that address the appropriate use of psychotropics in children and adolescents. Both programs are founded on evidence-based, clinical practice guidelines and U.S. Food and Drug Administration-approved indications promoting safe and effective prescribing in individuals under the age of 21. The approach aligns with the Department's goals. These programs support the appropriate diagnostic evaluation, consultation and coordination with specialists, appropriate treatment monitoring, continuity/coordination of care, and medication adherence. Aetna Better Health of Pennsylvania works collaboratively with the behavioral health managed care organizations to achieve goals.

PROGRAM GOALS

The program goals include reducing the inappropriate use of ADHD stimulants in children and adolescents in foster care; improving the HEDIS measure; increasing follow-up care for children prescribed ADHD medication; and increasing specialty consultation by primary care practitioners.

INTERVENTIONS

- Behavioral health utilization data, reviewed in collaboration with the behavioral health managed care organizations, is used to monitor and increase access to behavioral therapy for members
- Use of provider profiling and collaboration with the behavioral health managed care organization to develop more targeted interventions for prescribers
- Telephonic Psychiatric Services (TiPS) program using telehealth to expand access to psychiatric consultations to primary care practitioners
- Comprehensive, evidence-based pharmacy prior authorization guidelines for ADHD stimulants
- Appropriate Use of Antipsychotic Medication in Children and Adolescents Pharmacy
- and Clinical Management Program

Our pharmacy and clinical activities support the use of evidence-based clinical practice guidelines, appropriate diagnostic evaluation, consultation and coordination with specialists when indicated, second opinions, effective monitoring, continuity and coordination of care, member/caregiver education, improved medication adherence, and formulary adherence.

We collaborate with the behavioral health managed care organizations to identify members under age 21 on antipsychotic medication who have not had the appropriate monitoring for metabolic effects. We also use behavioral health utilization data and collaboration with the BH-MCOs to monitor members under age 21 on antipsychotic medication that are not receiving nonmedication behavioral health treatment. Additionally, deployment of the TiPS program will enable psychiatric consultations to primary care practitioners.

Key Personnel	
Name: Jason Rottman	Role: Chief Executive Officer
Name: Stephanie Ledesma	Role: Chief Operations Officer
Name: Dr. Bernard Lewin	Role: Chief Medical Officer
Name: Heather Hoopes	Role: Chief Financial Officer
Name: Sosi Hovagimian	Role: Director of Compliance

Project Measurements:				
Projected Membership of Vendor's Contract: N/A		Actual Membership of Vendor's Contract: 203,749 total membership as of June 2019		
Reason(s) for change in membership: N/A				
Estimated Start & Completion Dates:	From:	N/A	To:	N/A
Actual Start & Completion Dates:	From:	Contract Start: April 1, 2010 Tenure in the State: Since 1993	To:	Current Agreement in effect until 12/31/19. Contract will be extended until the contract is re-procured.
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 10: Subcontractor Reference #1

Subcontractor Information		
Vendor Name: : APS Quality Review Inc. dba KEPRO Virginia	Contact Name:	Michelle Dickerson, DNP, MSN, RN
	Contact Phone:	804-622-8900, Ext. 8096
Customer Information		
Customer Organization: Commonwealth of Virginia, Department of Medical Assurance Services	Contact Name:	Cheryl Roberts
	Contact Title:	Contract Manager

REQUEST FOR PROPOSAL

Department of Health and Human Resources, RFP CRFP 0511 BMS 1900000001

Customer Address: Richmond, Virginia	Contact Phone:	804-786-6147
	Contact Email:	Cheryl.Roberts@dmas.virginia.gov

Project Information	
Total Vendor Staff:	12
Project Objectives: Utilization Management and Service Authorizations	
Project Description: KEPRO began providing Utilization Management and Service Authorization services to the Commonwealth of Virginia's Department of Medical Assistance Services in 2006. KEPRO performs Medicaid medical necessity and quality reviews for the fee-for-service population and for Managed Care Organizations (MCO) carved-out services such as Home and Community Based Services (HCBS) waivers and Community Behavioral health. We work with stakeholders and providers in Virginia to ensure delivery of the right care at right time through contract activities. These activities include precertification and retrospective reviews, reconsiderations, and fair hearings for inpatient medical/surgical hospital care, inpatient psychiatric, inpatient rehabilitation, home health, outpatient, imaging, Durable Medical Equipment (DME), prosthetics, transplants, behavioral health Residential Treatment Centers (RTC) / group home community behavioral health, specialized care/long-stay hospital, HCBS waivers, and Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services. The annual review volume exceeds 350,000 authorizations for nearly 900,000 Medicaid and SCHIP fee-for-service members and, for MCO carve-out services (such as HCBS waivers and community behavioral health), Medicaid, and SCHIP MCO members.	
Vendor's Involvement: KEPRO is the prime contractor	
Project Benefits: Right Care at the Right Time – Utilization Management/Service Authorizations	

Key Personnel	
Name: Michelle Dickerson, DNP, MSN, RN	Role: Executive Director
Name: Denise Reese	Role: Operations Manager

Project Measurements:	
Projected Membership of Vendor's Contract: N/A	Actual Membership of Vendor's Contract: N/A
Reason(s) for change in membership: N/A	

Estimated Start & Completion Dates:	From:	4/2012	To:	Present
Actual Start & Completion Dates:	From:	4/2012	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: N/A

Table 10: Subcontractor Reference #2

Subcontractor Information		
Vendor Name: APS Quality Review Inc. dba KEPRO Maine	Contact Name:	Robert Nobel, Executive Director
	Contact Phone:	866-521-0027, ext.4373
Customer Information		
Customer Organization: State of Maine, Department of Health and Human Services	Contact Name:	Stephen Turner
	Contact Title:	Director OMS Contract Management
Customer Address: Augusta, ME 04333-0011	Contact Phone:	207-287-3828
	Contact Email:	Stephen.Turner@maine.gov
Project Information		
Total Vendor Staff:	48	
Project Objectives: Utilization Management for Behavioral Health and Substance Abuse Services		
Project Description: 1. KEPRO has worked with the Maine Department of Health and Human Services since 2007. Our dedicated team delivers the Utilization Management program for both behavioral health and substance abuse services, including the review of home and community based mental health and substance abuse services. • KEPRO conducts pre-certifications, concurrent and retrospective reviews averaging 20,000 per month. • The call center averages 1200 calls per week with an abandonment rate of less than 2%. • There are currently 30 different service types reviewed by our team of experienced reviewers and physicians. • We provide over 130 specialized ad hoc reports to the State.		

2. KEPRO is the prime contractor 3. The services we currently provide in Maine are similar in scope and requirements to the services outlined in this RFP				
Vendor's Involvement: KEPRO is the prime contractor				
Project Benefits: All services to the State were provided timely and within budget				
Key Personnel				
Name: Robert Nobel		Role: Executive Director		
Project Measurements:				
Projected Membership of Vendor's Contract: 10,000		Actual Membership of Vendor's Contract: 320,425		
Reason(s) for change in membership: Case Load				
Estimated Start & Completion Dates:	From:	7/2017	To:	Present
Actual Start & Completion Dates:	From:	7/2017	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: N/A				

Table 10: Subcontractor Reference #3

Subcontractor Information		
Vendor Name: APS Quality Review Inc. dba KEPRO Pennsylvania	Contact Name:	Christine Marriott, Program Manager
	Contact Phone:	833-880-4207, ext 7089
Customer Information		
Customer Organization: Commonwealth of Pennsylvania, Department of Human Services	Contact Name:	Jennifer Fraker

REQUEST FOR PROPOSAL

Department of Health and Human Resources, RFP CRFP 0511 BMS 1900000001

	Contact Title:	Quality Oversight and Supports Coordination Director
Customer Address: 151 Farmington Avenue, Hartford, CT 06156	Contact Phone:	717-787-2771
	Contact Email:	jefraker@pa.gov

Project Information	
Total Vendor Staff:	32
Project Objectives: Conducting in-person SIS assessments for individuals under a statewide IDD Waiver	
Project Description: 1. Responsible for scheduling, tracking and conducting in-person SIS assessments for individuals under a statewide IDD Waiver. 2. KEPRO conducts approximately 11,000 SIS assessments on an annual basis. Relevant Scope: Assessments, Supports Intensity Scale (SIS) Relevant Population: IDD Waiver Members	
Vendor's Involvement: KEPRO is the prime contractor	
Project Benefits: All services to the State were provided timely and within budget	

Key Personnel	
Name: Kevin McElligott	Role: Executive Director

Project Measurements:	
Projected Membership of Vendor's Contract: N/A	Actual Membership of Vendor's Contract: N/A
Reason(s) for change in membership: N/A	

Estimated Start & Completion Dates:	From:	10/2018	To:	Present
Actual Start & Completion Dates:	From:	10/2018	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: N/A

Table 10: Subcontractor Reference #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: New Jersey Department of Human Services, Division of Medical Assistance and Health Services	Contact Name:	Marc Gonzer
	Contact Title:	Contract Manager
Customer Address: 7 Quakerbridge Plaza, 2nd Floor, Room 203, Mercerville, New Jersey 08619	Contact Phone:	609-575-9389
	Contact Email:	Mark.Gonzer@dhs.state.nj.us
Project Information		
Total Vendor Staff:	188	
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 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 healthcare services, depending on the person's eligibility category.		
Vendor's Involvement: CSS provides member satisfaction surveys for Aetna Better Health of New Jersey, which offers Medicaid services, Children's Health Insurance Programs (CHIP) and Managed Long Term		

Care Services and Support (MLTSS) to NJ FamilyCare members in all 21 counties. Aetna Better Health of New Jersey administers care management for children in foster care and all individuals with intellectual/developmental disabilities; this includes development of a treatment plan and monitoring to address access to well child care for foster children and children with disabilities. Aetna Better Health of New Jersey collaborates with the relevant state agencies and community resources in accordance with contract requirements and Aetna's Children with Special Health Care Needs and 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. Families of members receiving care management 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 children and youth 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 EPSDT benefit) or the MLTSS program (for which private duty nursing is a benefit for both children and adults).

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 on a daily basis.

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 managed long-term services and supports (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: Glenn MacFarlane	Role: Chief Executive Officer
Name: Jerry Mammano	Role: Chief Operating Officer
Name: Heather Hoopes	Role: Chief Financial Officer

Name: Cheryl Reid, M.D.	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: 60,478			
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 & Completion Dates:	From:	Current Contract: 12/01/2014	To:	N/A; evergreen contract
Actual Start & Completion Dates:	From:	Current Contract: 12/01/2014	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: CSS provides member satisfaction surveys.				

Table 10: Subcontractor Reference #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

REQUEST FOR PROPOSAL

Department of Health and Human Resources, RFP CRFP 0511 BMS 1900000001

	Contact Phone:	202-454-3041
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:	465	

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 (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'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 contracts with the Department of Medical Assistance Services (DMAS) to provide Medicaid (Medallion), Family Access to Medical Insurance Security (FAMIS) a.k.a. Children's Health Insurance Program (CHIP), Commonwealth Coordinated Care Plus (CCC+), and Dual Eligible Special Needs Plans (DSNP) managed care services to our members.

Aetna Better Health of Virginia is licensed as a health management organization (HMO) and as a Managed Care Health Insurance Plan (MCHIP) in the State of Virginia. Aetna Better Health of Virginia is also a National Committee for Quality Assurance (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: CSS provides member satisfaction surveys for Aetna Better Health of Virginia, which was one of six MCOs selected through a competitive RFP to provide managed care services to qualified Virginians under the Medallion 4.0 Program.

The new program will build on the strengths and experience of the twenty-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 (ABHVA) 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, that 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:

- 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 system-wide 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

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.

Behavioral Health

Aetna Better Health of Virginia possesses a full understanding of the non-traditional community mental health services that are delivered under the Medallion 4.0 program. We provide nontraditional services such as intensive in-home services, therapeutic day treatment, and residential treatment for children and adolescents, day treatment/partial hospitalization, psychosocial rehabilitation, crisis services (including trauma informed care and adverse childhood events), intensive community treatment, and mental health skill building for adults.

In Virginia, we collaborate by conducting interdisciplinary care team meetings with Magellan of Virginia to discuss members who would benefit from any of these non-traditional services. We have designated a team to ensure that those needing a more intense level of care management are recipients of it. We collaboratively

engage with Magellan, DMAS, and community-based providers to help ensure a seamless transition for members within the Commonwealth that meets all Community Mental Health Rehabilitation Services network adequacy standards. We understand the importance of relationships and continuity of care, and we will demonstrate this commitment by doubling the stated requirement and ensuring that members can continue to see their existing providers for at up to 180 days post-transition if they are not currently in our network. Moreover, our provider network team actively works to recruit providers of traditional and non-traditional services into our network.

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.

Our care coordinators currently attend individualized education plan (IEP) meetings as active participants to determine jointly the needs of the child and their family, assign accountability and responsibility across organizations, and make sure services are integrated and coordinated. We work directly with teachers and school-based providers to obtain a copy of the IEP and share any additional information with the child's traditional and/or non-traditional providers. Our care coordinators encourage open communication and elevate the goals and objectives of the child and of their parent or guardian. With a focus on avoiding the duplication of services, we invite the school-based team to be a contributing part of our interdisciplinary care team provided we have all of the appropriate consents.

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 provide 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 facilitate adjustments (as needed) to enhance access and engagement of members. Our peer support model utilizes techniques to ensure safety and establish rapport with the 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 spacing between births and positive birth outcomes.				
Key Personnel				
Name: Roger Gunter	Role: Project Director			
Name: Joanne Landry	Role: Project Manager			
Name: Ira Bloomfield, M.D.	Role: Medical Director			
Name: Neil Hines, M.D.	Role: Behavioral Health Lead			
Name: Lani Spencer, R.N.	Role: Care Coordination Manager			
Name: Kimberly Grifasi	Role: Quality Improvement Program Manager			
Project Measurements:				
Projected Membership of Vendor's Contract: N/A	Actual Membership of Vendor's Contract: 113,000			
Reason(s) for change in membership: N/A				
Estimated Start & Completion Dates:	From:	Contract Start: 8/1/18	To:	June 30, 2020, with the possibility of six (6) twelve month renewals
Actual Start & Completion Dates:	From:	Contract Start: 8/1/18	To:	June 30, 2020, with the possibility of six (6) twelve month renewals
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 satisfaction survey.				

Table 10: Subcontractor Reference #3

Vendor Information		
Vendor Name: Center for the Study of Services (CSS)	Contact Name:	Jackie Pearce Garrett, Director of Business Development
	Contact Phone:	Center for the Study of Services
Customer Information		
Customer Organization: Pennsylvania Department of Human Services (Department)	Contact Name:	Sally Kozak
	Contact Title:	Deputy Secretary, Office of Medical Assistance Programs (OMAP)
Customer Address: 515, 625 Forster St, Harrisburg PA 17120	Contact Phone:	717-214-4206
	Contact Email:	sakozak@pa.gov
Project Information		
Total Vendor Staff:	291	

Project Objectives: To provide mandatory managed health care as part of the HealthChoices Program, Pennsylvania's 1915(b) waiver program, for Medical Assistance Recipients. HealthChoices Objectives include:

- Promote the achievement of the Triple AIM (better health, better care, lower cost);
- Improve care coordination between physical and behavioral health services;
- Promote the expansion of value-based purchasing of health care services;
- Promote the expansion of team-based approaches to care delivery (for example, patient-centered care medical homes);
- Promote community-based public health initiatives;
- Increase consumer access to needed services, especially in rural and underserved areas of the commonwealth;
- Improve the efficiency of the HealthChoices program; and Improve the provider experience with the HealthChoices program.

Project Description: Aetna Better Health of Pennsylvania and Aetna Better Health Kids provide health benefits and manage care for people enrolled in the Commonwealth of Pennsylvania's Medical Assistance program (Medicaid). Engaging members through an integrated care management model fully integrating physical and behavioral health care as well as chronic care and disease management programs for persons with complex medical concerns. The local, community-based model ensures Pennsylvanian providers and participants live side-by-side with Aetna staff.

ABHP improves the overall health care delivery to our HealthChoices members by:

- Acting as a single point-of-contact to serve the member
- Providing complete health and social services and support for members through our Fully
- Integrated System of Care (FISOC)
- Pursuing strategies to strengthen the local delivery systems using community health workers, and peer support specialists

- Leveraging the use of our proprietary predictive modeling tool to identify members at risk for emergency department utilization or an inpatient admission

Vendor's Involvement: Annual member satisfaction survey for Aetna Better Health of Pennsylvania, which is a Physical Health Managed Care Organization with an agreement with the Department to manage the purchase and provision of Physical Health Services Statewide under the HealthChoices Program. Aetna Better Health of Pennsylvania is committed to addressing the system challenges and making improvements in the services we provide for children in care where they live. Some of our strategies include:

- Assigning a point of contact to develop and implement community support programs and processes. This subject matter expert is the liaison with local agencies including child welfare, juvenile corrections, juvenile justice, and other agencies that serve children.
- Providing training and education on the role of the managed care organization to the child welfare agencies
- Working with youth to prepare them for "aging out" of substitute care—e.g., assist them in completing applications for Medicaid, housing, and employment
- Partnering with foster care agencies to provide education about the appropriate use of antipsychotics
- Assisting in scheduling primary care physician and dental appointments
- Coordinating an annual forum in each zone to bring the child welfare agencies and other stakeholders together for planning and collaborating on issue regarding children in substitute care
- Improving tracking and reporting on children in care receiving a physical within 60 days of entering care

In the event a member in substitute care has difficulty obtaining access to medically necessary services within the state, Aetna Better Health of Pennsylvania Case Management and Network Management departments collaborate to find a provider within the state that will meet the member's needs and work to execute a Single Case Agreement to ensure a member continued to receive care within the State.

Children in substitute care are enrolled in case management to ensure that they receive the proper preventative care that can help reduce inpatient admissions. Aetna Better Health of Pennsylvania utilizes an Integrated Care Management program to address the member's medical, behavioral, in coordination with the BH MCO's, and social needs in individual and distinctive ways. Aetna Better Health of Pennsylvania recognizes that these needs interact with each other, often in unpredictable ways, and that a member's care is driven by a number of unique physical and behavioral health conditions. To target members who will benefit most from integrated care management, we use predictive modeling through our Consolidated Outreach and Risk Evaluation (CORE) tool. This tool is custom designed for the Medicaid population. CORE predicts both financial and clinical performance over the next 12 months, with a positive predictive value of up to 95.4 percent. CORE identifies members for whom intensive or complex care management will promote improved health and well-being and prevent high cost utilization. We also identify members using provider and pharmacy referrals.

Our CORE proprietary predictive modeling tool enables us to identify high-acuity members who are also high-risk. Our Integrated Care Management program prioritizes outreach to the top 1% members who are also at high-risk for emergency department visits in the next 12 months and high-risk for inpatient utilization in the next 12 months (identified as CORE 4).

One of the special challenges is children who "age out" of the system. Many of the children in the child welfare system are over the age of 16 and "age out" at 18. These children have very little control over their lives and/or how they receive the medical services they need. We include these children in the development of their care management plan and they have choices they can make as their plans are developed. We begin

that process when they turn 16 and follow them until they "age out." Children between the ages of 16 and 18 not only need care management for their medical services, but also for psychosocial services. These children are facing the biggest opportunity and the biggest challenge of their young lives. Many have spent all of their years in substitute care and have no idea how to live independently. Through our comprehensive care management program, we are able to aid these children and identify community resources available to assist them in living independently.

Project Benefits: Aetna Better Health of Pennsylvania achieved NCQA Commendable level accreditation in December 2017. Aetna Better Health of Pennsylvania delivers care through a collaborative approach. We partner with providers who deliver quality and effective care to achieve the best outcomes for our members. The programs encourage members to take charge of their health. Through the care management program, members set goals for their health. Aetna Better Health of Pennsylvania's team of case managers, providers, and caregivers work with the member to help them achieve their goals.

Aetna Better Health of Pennsylvania utilizes clinical intervention programs to address children in substitute care. Aetna Better Health of Pennsylvania recognizes that children and adolescents in substitute care have a higher rate of utilization of psychotropic medication than their peers who are in their homes. Many factors contribute to the potential for inappropriate psychotropic prescribing practices including the national shortage of child and adolescent psychiatrists. The issue is compounded by the lack of access to effective non-pharmacological interventions, lack of communication between behavioral health and physical health practitioners, lack of complete medical records due to changes in the primary caregiver, and lack of adherence to evidence-based prescribing by physicians and nurse practitioners.

Aetna Better Health of Pennsylvania uses two pharmacy and clinical management programs that address the appropriate use of psychotropics in children and adolescents. Both programs are founded on evidence-based, clinical practice guidelines and U.S. Food and Drug Administration-approved indications promoting safe and effective prescribing in individuals under the age of 21. The approach aligns with the Department's goals. These programs support the appropriate diagnostic evaluation, consultation and coordination with specialists, appropriate treatment monitoring, continuity/coordination of care, and medication adherence. Aetna Better Health of Pennsylvania works collaboratively with the behavioral health managed care organizations to achieve goals.

PROGRAM GOALS

The program goals include reducing the inappropriate use of ADHD stimulants in children and adolescents in foster care; improving the HEDIS measure; increasing follow-up care for children prescribed ADHD medication; and increasing specialty consultation by primary care practitioners.

INTERVENTIONS

- Behavioral health utilization data, reviewed in collaboration with the behavioral health managed care organizations, is used to monitor and increase access to behavioral therapy for members
- Use of provider profiling and collaboration with the behavioral health managed care organization to develop more targeted interventions for prescribers
- Telephonic Psychiatric Services (TiPS) program using telehealth to expand access to psychiatric consultations to primary care practitioners
- Comprehensive, evidence-based pharmacy prior authorization guidelines for ADHD stimulants
- Appropriate Use of Antipsychotic Medication in Children and Adolescents Pharmacy and Clinical Management Program

Our pharmacy and clinical activities support the use of evidence-based clinical practice guidelines, appropriate diagnostic evaluation, consultation and coordination with specialists when indicated, second opinions, effective monitoring, continuity and coordination of care, member/caregiver education, improved medication adherence, and formulary adherence.

We collaborate with the behavioral health managed care organizations to identify members under age 21 on antipsychotic medication who have not had the appropriate monitoring for metabolic effects. We also use behavioral health utilization data and collaboration with the BH-MCOs to monitor members under age 21 on antipsychotic medication that are not receiving nonmedication behavioral health treatment. Additionally, deployment of the TiPS program will enable psychiatric consultations to primary care practitioners.

Key Personnel	
Name: Jason Rottman	Role: Chief Executive Officer
Name: Stephanie Ledesma	Role: Chief Operations Officer
Name: Dr. Bernard Lewin	Role: Chief Medical Officer
Name: Heather Hoopes	Role: Chief Financial Officer
Name: Sosi Hovagimian	Role: Director of Compliance

Project Measurements:	
Projected Membership of Vendor's Contract: N/A	Actual Membership of Vendor's Contract: 203,749 total membership as of June 2019
Reason(s) for change in membership: N/A	

Estimated Start & Completion Dates:	From:	N/A	To:	N/A
Actual Start & Completion Dates:	From:	Contract Start: April 1, 2010 Tenure in the State: Since 1993	To:	Current Agreement in effect until 12/31/19. Contract will be extended until the contract is re-procured.

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 satisfaction survey.

Table 10: Subcontractor Reference #1[2]

Subcontractor Information		
Vendor Name: Cotiviti a/k/a iHT Services, LLC a/k/a iHealth Technologies a/k/a Connolly LLC	Contact Name:	Susan Murray
	Contact Phone:	475-393-6058
Customer Information		
Customer Organization: Aetna	Contact Name:	Jackyln Biever
	Contact Title:	Director of Service Operations
Customer Address: 151 Farmington Avenue, Hartford, CT 06156	Contact Phone:	717-541-5977
	Contact Email:	jbiever@aetna.com
Project Information		
Total Vendor Staff:	Variable depending on the project scope.	
Project Objectives: Payment Accuracy/Billing Accuracy		
Project Description: Prospective Claims Accuracy		
Vendor's Involvement: Prospective Claims Accuracy activities.		
Project Benefits: Avoid payment errors before claims get paid.		
Key Personnel		
Name: Gwin Teasdale	Role: SVP	
Project Measurements:		
Projected Membership of Vendor's Contract: N/A.	Actual Membership of Vendor's Contract: N/A.	
Reason(s) for change in membership: N/A.		

[2] The types of references provided by our Subcontractors in response to Section 5.2, Subcontractor References, varied. For example, some subcontractors provided references from the state agencies that contract with Aetna health plans and other subcontractors provided references from the Aetna health plans themselves. If the Department seeks information different than what has been submitted, we will provide it upon request.

Estimated Start & Completion Dates:	From:	2004	To:	Current
Actual Start & 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. And our comprehensive policy recommendations apply across all provider settings and lines of business.				

Table 10: Subcontractor Reference #2

Subcontractor Information		
Vendor Name: Cotiviti a/k/a iHT Services, LLC a/k/a iHealth Technologies a/k/a Connolly LLC	Contact Name:	Susan Murray
	Contact Phone:	475-393-6058
Customer Information		
Customer Organization: Aetna	Contact Name:	Amanda Purvis
	Contact Title:	Senior Director Vendor Management and COB Integrity
Customer Address: 151 Farmington Avenue, Hartford, CT 06156	Contact Phone:	336-801-7048
	Contact Email:	abpurvis@aetna.com
Project Information		
Total Vendor Staff:	Variable depending on the 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: Gwin Teasdale		Role: SVP		
Project Measurements:				
Projected Membership of Vendor's Contract: N/A.		Actual Membership of Vendor's Contract: N/A.		
Reason(s) for change in membership: N/A.				
Estimated Start & Completion Dates:	From:	2004	To:	Current
Actual Start & 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. And our comprehensive policy recommendations apply across all provider settings and lines of business.				

Table 10: Subcontractor Reference #3

Subcontractor Information		
Vendor Name: Cotiviti a/k/a iHT Services, LLC a/k/a iHealth Technologies a/k/a Connolly LLC	Contact Name:	Susan Murray
	Contact Phone:	475-393-6058
Customer Information		
Customer Organization: Aetna	Contact Name:	Amanda Purvis
	Contact Title:	Senior Director Vendor Management and COB Integrity
Customer Address: 151 Farmington Avenue, Hartford, CT 06156	Contact Phone:	336-801-7048
	Contact Email:	abpurvis@aetna.com

Project Information				
Total Vendor Staff:	Variable depending on the 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: Gwin Teasdale		Role: SVP		
Project Measurements:				
Projected Membership of Vendor's Contract: N/A.		Actual Membership of Vendor's Contract: N/A.		
Reason(s) for change in membership: N/A.				
Estimated Start & Completion Dates:	From:	2004	To:	Current
Actual Start & 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: 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 don't 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.				

Table 10: Subcontractor Reference #1

Subcontractor Information		
Vendor Name: CQ Fluency	Contact Name:	Alan Vernon
	Contact Phone:	201-487-8007
Customer Information		
Customer Organization: Aetna	Contact Name:	Cathy Rivera
	Contact Title:	Operations & Experience Manager, Multicultural Marketing
Customer Address: 151 Farmington Avenue, Hartford, CT 06156	Contact Phone:	703-687-2138
	Contact Email:	Riverac6@aetna.com
Project Information		
Total Vendor Staff:	6	
Project Objectives: Translate required documents and make them 508 compliant		
Project Description: Translation and 508 compliance of Centers for Medicare & Medicaid (CMS) required documents for PY2020		
Vendor's Involvement: CQ fluency provides the translation and 508 compliance services		
Project Benefits: Aetna maintains compliance with CMS		
Key Personnel		
Name: Alan Vernon	Role: Account Manager	
Name: Marcel Yang	Role: Production Manager	
Project Measurements:		
Projected Membership of Vendor's Contract: N/A	Actual Membership of Vendor's Contract: N/A	
Reason(s) for change in membership: N/A		
Estimated Start & Completion Dates:	From: 8/1/2018	To: 10/15/2018

Actual Start & Completion Dates:	From:	8/1/2018	To:	10/15/2018
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: Translation and 508 compliance				

Table 10: Subcontractor Reference #2

Subcontractor Information		
Vendor Name: CQ Fluency	Contact Name:	Alan Vernon
	Contact Phone:	201-487-8007
Customer Information		
Customer Organization: Anthem	Contact Name:	Christine Corr
	Contact Title:	Strategic Sourcing Manager, Procurement
Customer Address: 4553 La Tienda Drive, Thousand Oaks, CA 91362	Contact Phone:	818-383-5235
	Contact Email:	Christine.corr@anthem.com
Project Information		
Total Vendor Staff:	8	
Project Objectives: Translate required documents and make them 508 compliant.		
Project Description: Translation and 508 compliance of Centers for Medicare & Medicaid (CMS) required documents for PY2020		
Vendor's Involvement: CQ fluency provides the translation and 508 compliance services		
Project Benefits: Anthem maintains compliance with CMS		
Key Personnel		
Name: Alan Vernon	Role: Account Manager	

Name: Marcel Yang		Role: Production Director		
Project Measurements:				
Projected Membership of Vendor's Contract: N/A		Actual Membership of Vendor's Contract: N/A		
Reason(s) for change in membership: N/A				
Estimated Start & Completion Dates:	From:	8/1/2018	To:	10/15/2018
Actual Start & Completion Dates:	From:	8/1/2018	To:	10/15/2018
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: Translation and 508 compliance				

Table 10: Subcontractor Reference #3

Subcontractor Information		
Vendor Name: CQ Fluency	Contact Name:	Alan Vernon
	Contact Phone:	201-487-8007
Customer Information		
Customer Organization: Cigna	Contact Name:	John Hornlein
	Contact Title:	Third Party Management | Global
Customer Address: 900 Cottage Grove Road, Bloomfield, CT 06002	Contact Phone:	860-226-4557
	Contact Email:	John.Hornlein@Cigna.com
Project Information		

Total Vendor Staff:	6			
Project Objectives: Translate required documents and make them 508 compliant.				
Project Description: Translation and 508 compliance of Centers for Medicare & Medicaid (CMS) required documents for PY2020				
Vendor's Involvement: CQ fluency provides the translation and 508 compliance services				
Project Benefits: Cigna maintains compliance with CMS				
Key Personnel				
Name: Alan Vernon		Role: Account Manager		
Project Measurements:				
Projected Membership of Vendor's Contract: N/A		Actual Membership of Vendor's Contract: N/A		
Reason(s) for change in membership: N/A				
Estimated Start & Completion Dates:	From:	8/1/2018	To:	10/1/2018
Actual Start & Completion Dates:	From:	8/1/2018	To:	10/1/2018
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: Translation and 508 compliance				

Table 10: Subcontractor Reference #1

Subcontractor Information		
Vendor Name: Emdeon a/k/a Envoy LLC and Chamberlin Edmonds & Associates d/b/a Change Healthcare	Contact Name:	Ann Armstrong Senior Client Executive, Payer Services
	Contact Phone:	414-405-8651
Customer Information		

REQUEST FOR PROPOSAL

Department of Health and Human Resources, RFP CRFP 0511 BMS 1900000001

Customer Organization: New Jersey Department of Human Services, Division of Medical Assistance and Health Services	Contact Name:	Marc Gonzer
	Contact Title:	Contract Manager
Customer Address: 7 Quakerbridge Plaza, 2nd Floor, Room 203, Mercerville, New Jersey 08619	Contact Phone:	609-575-9389
	Contact Email:	Mark.Gonzer@dhs.state.nj.us

Project Information	
Total Vendor Staff:	188

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 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 healthcare services, depending on the person's eligibility category.

Vendor's Involvement: Change Healthcare distributes electronic and hardcopy payment information to providers and members (check printing/EDI service, EFT, ERA/real-time admin simplification/837); processing of paper claims and electronic data conversion (Future Vision Technologies); customized member-advocacy program to identify and qualify enrollees most likely to be eligible for federal disability benefits (SSI); license for access to WebMD technology/materials.

Aetna Better Health of New Jersey offers Medicaid services, Children's Health Insurance Programs (CHIP) and Managed Long Term Care Services and Support (MLTSS) to NJ FamilyCare members in all 21 counties. Aetna Better Health of New Jersey administers care management for children in foster care and all individuals with intellectual/developmental disabilities; this includes development of a treatment plan and monitoring to address access to well child care for foster children and children with disabilities. Aetna Better Health of New Jersey collaborates with the relevant state agencies and community resources in accordance with contract requirements and Aetna's Children with Special Health Care Needs and 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. Families of members receiving care management 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 children and youth 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 EPSDT benefit) or the MLTSS program (for which private duty nursing is a benefit for both children and adults).

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 on a daily basis.

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 managed long-term services and supports (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: Glenn MacFarlane	Role: Chief Executive Officer
Name: Jerry Mammano	Role: Chief Operating Officer
Name: Heather Hoopes	Role: Chief Financial Officer
Name: Cheryl Reid, M.D.	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: 60,478		
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 & Completion Dates:	From:	Current Contract: 12/01/2014	To:	N/A; evergreen contract
Actual Start & Completion Dates:	From:	Current Contract: 12/01/2014	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: Change Healthcare distributes electronic and hardcopy payment information to providers and members (check printing/EDI service, EFT, ERA/real-time admin simplification/837); processing of paper claims and electronic data conversion (Future Vision Technologies); customized member-advocacy program to identify and qualify enrollees most likely to be eligible for federal disability benefits (SSI); license for access to WebMD technology/materials.				

Table 10: Subcontractor Reference #2

Subcontractor Information		
Vendor Name: Emdeon a/k/a Envoy LLC and Chamberlin Edmonds & Associates d/b/a Change Healthcare	Contact Name:	Ann Armstrong Senior Client Executive, Payer Services
	Contact Phone:	414-405-8651
Customer Information		

REQUEST FOR PROPOSAL

Department of Health and Human Resources, RFP CRFP 0511 BMS 1900000001

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:	465

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 (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'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 contracts with the Department of Medical Assistance Services (DMAS) to provide Medicaid (Medallion), Family Access to Medical Insurance Security (FAMIS) a.k.a. Children's Health Insurance Program (CHIP), Commonwealth Coordinated Care Plus (CCC+), and Dual Eligible Special Needs Plans (DSNP) managed care services to our members.

Aetna Better Health of Virginia is licensed as a health management organization (HMO) and as a Managed Care Health Insurance Plan (MCHIP) in the State of Virginia. Aetna Better Health of Virginia is also a National Committee for Quality Assurance (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: Change Healthcare distributes electronic and hardcopy payment information to providers and members (check printing/EDI service, EFT, ERA/real-time admin simplification/837); processing of paper claims and electronic data conversion (Future Vision Technologies); customized member-advocacy program to identify and qualify enrollees most likely to be eligible for federal disability benefits (SSI); license for access to WebMD technology/materials.

Aetna Better Health of Virginia was one of six MCOs selected through a competitive RFP to provide managed care services to qualified Virginians under the Medallion 4.0 Program.The new program will build on the strengths and experience of the twenty-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 (ABHVA) 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, that 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:

- 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 system-wide 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

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.

Behavioral Health

Aetna Better Health of Virginia possesses a full understanding of the non-traditional community mental health services that are delivered under the Medallion 4.0 program. We provide nontraditional services such as intensive in-home services, therapeutic day treatment, and residential treatment for children and adolescents, day treatment/partial hospitalization, psychosocial rehabilitation, crisis services (including trauma informed care and adverse childhood events), intensive community treatment, and mental health skill building for adults.

In Virginia, we collaborate by conducting interdisciplinary care team meetings with Magellan of Virginia to discuss members who would benefit from any of these non-traditional services. We have designated a team to ensure that those needing a more intense level of care management are recipients of it. We collaboratively engage with Magellan, DMAS, and community-based providers to help ensure a seamless transition for members within the Commonwealth that meets all Community Mental Health Rehabilitation Services network adequacy standards. We understand the importance of relationships and continuity of care, and we will demonstrate this commitment by doubling the stated requirement and ensuring that members can continue to see their existing providers for at up to 180 days post-transition if they are not currently in our network. Moreover, our provider network team actively works to recruit providers of traditional and non-traditional services into our network.

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.

Our care coordinators currently attend individualized education plan (IEP) meetings as active participants to determine jointly the needs of the child and their family, assign accountability and responsibility across organizations, and make sure services are integrated and coordinated. We work directly with teachers and school-based providers to obtain a copy of the IEP and share any additional information with the child's traditional and/or non-traditional providers. Our care coordinators encourage open communication and elevate the goals and objectives of the child and of their parent or guardian. With a focus on avoiding the duplication of services, we invite the school-based team to be a contributing part of our interdisciplinary care team provided we have all of the appropriate consents.

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 provide 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 facilitate adjustments (as needed) to enhance access and engagement of members. Our peer support model utilizes techniques to ensure safety and establish rapport with the 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 spacing between births and positive birth outcomes.

Key Personnel	
Name: Roger Gunter	Role: Project Director
Name: Joanne Landry	Role: Project Manager
Name: Ira Bloomfield, M.D.	Role: Medical Director
Name: Neil Hines, M.D.	Role: Behavioral Health Lead
Name: Lani Spencer, R.N.	Role: Care Coordination Manager
Name: Kimberly Grifasi	Role: Quality Improvement Program Manager

Project Measurements:	
Projected Membership of Vendor's Contract: N/A	Actual Membership of Vendor's Contract: 113,000
Reason(s) for change in membership: N/A	

Estimated Start & Completion Dates:	From:	Contract Start: 8/1/18	To:	June 30, 2020, with the possibility of six (6) twelve month renewals
Actual Start & Completion Dates:	From:	Contract Start: 8/1/18	To:	June 30, 2020, with the possibility of six (6) twelve month renewals

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:

Change Healthcare distributes electronic and hardcopy payment information to providers and members (check printing/EDI service, EFT, ERA/real-time admin simplification/837); processing of paper claims and electronic data conversion (Future Vision Technologies); customized member-advocacy program to identify and qualify enrollees most likely to be eligible for federal disability benefits (SSI); license for access to WebMD technology/materials.

Table 10: Subcontractor Reference #3

Subcontractor Information		
Vendor Name: Emdeon a/k/a Envoy LLC and Chamberlin Edmonds & Associates d/b/a Change Healthcare	Contact Name:	Ann Armstrong Senior Client Executive, Payer Services
	Contact Phone:	414-405-8651
Customer Information		
Customer Organization: Pennsylvania Department of Human Services (Department)	Contact Name:	Sally Kozak
	Contact Title:	Deputy Secretary, Office of Medical Assistance Programs (OMAP)
Customer Address: Room 515, 625 Forster St, Harrisburg PA 17120	Contact Phone:	717-214-4206
	Contact Email:	sakozak@pa.gov
Project Information		
Total Vendor Staff:	291	

Project Objectives: To provide mandatory managed health care as part of the HealthChoices Program, Pennsylvania's 1915(b) waiver program, for Medical Assistance Recipients. HealthChoices Objectives include:

- Promote the achievement of the Triple AIM (better health, better care, lower cost);
- Improve care coordination between physical and behavioral health services;
- Promote the expansion of value-based purchasing of health care services;
- Promote the expansion of team-based approaches to care delivery (for example, patient-centered care medical homes);
- Promote community-based public health initiatives;
- Increase consumer access to needed services, especially in rural and underserved areas of the commonwealth;
- Improve the efficiency of the HealthChoices program; and
- Improve the provider experience with the HealthChoices program.

Project Description: Aetna Better Health of Pennsylvania and Aetna Better Health Kids provide health benefits and manage care for people enrolled in the Commonwealth of Pennsylvania's Medical

Assistance program (Medicaid). Engaging members through an integrated care management model fully integrating physical and behavioral health care as well as chronic care and disease management programs for persons with complex medical concerns. The local, community-based model ensures Pennsylvanian providers and participants live side-by-side with Aetna staff.

ABHP improves the overall health care delivery to our HealthChoices members by:

- Acting as a single point-of-contact to serve the member
- Providing complete health and social services and support for members through our Fully
- Integrated System of Care (FISOC)
- Pursuing strategies to strengthen the local delivery systems using community health workers, and peer support specialists
- Leveraging the use of our proprietary predictive modeling tool to identify members at risk for emergency department utilization or an inpatient admission

Vendor's Involvement: Change Healthcare distributes electronic and hardcopy payment information to providers and members (check printing/EDI service, EFT, ERA/real-time admin simplification/837); processing of paper claims and electronic data conversion (Future Vision Technologies); customized member-advocacy program to identify and qualify enrollees most likely to be eligible for federal disability benefits (SSI); license for access to WebMD technology/materials.

Aetna Better Health of Pennsylvania is a Physical Health Managed Care Organization with an agreement with the Department to manage the purchase and provision of Physical Health Services Statewide under the HealthChoices Program. Aetna Better Health of Pennsylvania is committed to addressing the system challenges and making improvements in the services we provide for children in care where they live. Some of our strategies include:

- Assigning a point of contact to develop and implement community support programs and processes. This subject matter expert is the liaison with local agencies including child welfare, juvenile corrections, juvenile justice, and other agencies that serve children.
- Providing training and education on the role of the managed care organization to the child welfare agencies
- Working with youth to prepare them for "aging out" of substitute care—e.g., assist them in completing applications for Medicaid, housing, and employment
- Partnering with foster care agencies to provide education about the appropriate use of antipsychotics
- Assisting in scheduling primary care physician and dental appointments
- Coordinating an annual forum in each zone to bring the child welfare agencies and other stakeholders together for planning and collaborating on issue regarding children in substitute care
- Improving tracking and reporting on children in care receiving a physical within 60 days of entering care

In the event a member in substitute care has difficulty obtaining access to medically necessary services within the state, Aetna Better Health of Pennsylvania Case Management and Network Management departments collaborate to find a provider within the state that will meet the member's needs and work to execute a Single Case Agreement to ensure a member continued to receive care within the State.

Children in substitute care are enrolled in case management to ensure that they receive the proper preventative care that can help reduce inpatient admissions. Aetna Better Health of Pennsylvania utilizes

an Integrated Care Management program to address the member's medical, behavioral, in coordination with the BH MCO's, and social needs in individual and distinctive ways. Aetna Better Health of Pennsylvania recognizes that these needs interact with each other, often in unpredictable ways, and that a member's care is driven by a number of unique physical and behavioral health conditions. To target members who will benefit most from integrated care management, we use predictive modeling through our Consolidated Outreach and Risk Evaluation (CORE) tool. This tool is custom designed for the Medicaid population. CORE predicts both financial and clinical performance over the next 12 months, with a positive predictive value of up to 95.4 percent. CORE identifies members for whom intensive or complex care management will promote improved health and well-being and prevent high cost utilization. We also identify members using provider and pharmacy referrals.

Our CORE proprietary predictive modeling tool enables us to identify high-acuity members who are also high-risk. Our Integrated Care Management program prioritizes outreach to the top 1% members who are also at high-risk for emergency department visits in the next 12 months and high-risk for inpatient utilization in the next 12 months (identified as CORE 4).

One of the special challenges is children who "age out" of the system. Many of the children in the child welfare system are over the age of 16 and "age out" at 18. These children have very little control over their lives and/or how they receive the medical services they need. We include these children in the development of their care management plan and they have choices they can make as their plans are developed. We begin that process when they turn 16 and follow them until they "age out." Children between the ages of 16 and 18 not only need care management for their medical services, but also for psychosocial services. These children are facing the biggest opportunity and the biggest challenge of their young lives. Many have spent all of their years in substitute care and have no idea how to live independently. Through our comprehensive care management program, we are able to aid these children and identify community resources available to assist them in living independently.

Project Benefits: Aetna Better Health of Pennsylvania achieved NCQA Commendable level accreditation in December 2017. Aetna Better Health of Pennsylvania delivers care through a collaborative approach. We partner with providers who deliver quality and effective care to achieve the best outcomes for our members. The programs encourage members to take charge of their health. Through the care management program, members set goals for their health. Aetna Better Health of Pennsylvania's team of case managers, providers, and caregivers work with the member to help them achieve their goals.

Aetna Better Health of Pennsylvania utilizes clinical intervention programs to address children in substitute care. Aetna Better Health of Pennsylvania recognizes that children and adolescents in substitute care have a higher rate of utilization of psychotropic medication than their peers who are in their homes. Many factors contribute to the potential for inappropriate psychotropic prescribing practices including the national shortage of child and adolescent psychiatrists. The issue is compounded by the lack of access to effective non-pharmacological interventions, lack of communication between behavioral health and physical health practitioners, lack of complete medical records due to changes in the primary caregiver, and lack of adherence to evidence-based prescribing by physicians and nurse practitioners.

Aetna Better Health of Pennsylvania uses two pharmacy and clinical management programs that address the appropriate use of psychotropics in children and adolescents. Both programs are founded on evidence-based, clinical practice guidelines and U.S. Food and Drug Administration-approved indications promoting safe and effective prescribing in individuals under the age of 21. The approach aligns with the

Department's goals. These programs support the appropriate diagnostic evaluation, consultation and coordination with specialists, appropriate treatment monitoring, continuity/coordination of care, and medication adherence. Aetna Better Health of Pennsylvania works collaboratively with the behavioral health managed care organizations to achieve goals.

PROGRAM GOALS

The program goals include reducing the inappropriate use of ADHD stimulants in children and adolescents in foster care; improving the HEDIS measure; increasing follow-up care for children prescribed ADHD medication; and increasing specialty consultation by primary care practitioners.

INTERVENTIONS

- Behavioral health utilization data, reviewed in collaboration with the behavioral health managed care organizations, is used to monitor and increase access to behavioral therapy for members
- Use of provider profiling and collaboration with the behavioral health managed care organization to develop more targeted interventions for prescribers
- Telephonic Psychiatric Services (TiPS) program using telehealth to expand access to psychiatric consultations to primary care practitioners
- Comprehensive, evidence-based pharmacy prior authorization guidelines for ADHD stimulants
- Appropriate Use of Antipsychotic Medication in Children and Adolescents Pharmacy
- and Clinical Management Program

Our pharmacy and clinical activities support the use of evidence-based clinical practice guidelines, appropriate diagnostic evaluation, consultation and coordination with specialists when indicated, second opinions, effective monitoring, continuity and coordination of care, member/caregiver education, improved medication adherence, and formulary adherence.

We collaborate with the behavioral health managed care organizations to identify members under age 21 on antipsychotic medication who have not had the appropriate monitoring for metabolic effects. We also use behavioral health utilization data and collaboration with the BH-MCOs to monitor members under age 21 on antipsychotic medication that are not receiving nonmedication behavioral health treatment. Additionally, deployment of the TiPS program will enable psychiatric consultations to primary care practitioners.

Key Personnel	
Name: Jason Rottman	Role: Chief Executive Officer
Name: Stephanie Ledesma	Role: Chief Operations Officer
Name: Dr. Bernard Lewin	Role: Chief Medical Officer
Name: Heather Hoopes	Role: Chief Financial Officer
Name: Sosi Hovagimian	Role: Director of Compliance
Project Measurements:	
Projected Membership of Vendor's Contract: N/A	Actual Membership of Vendor's Contract: 203,749 total membership as of June 2019

Reason(s) for change in membership: N/A				
Estimated Start & Completion Dates:	From:	N/A	To:	N/A
Actual Start & Completion Dates:	From:	Contract Start: April 1, 2010 Tenure in the State: Since 1993	To:	Current Agreement in effect until 12/31/19. Contract will be extended until the contract is re-procured.
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: Change Healthcare distributes electronic and hardcopy payment information to providers and members (check printing/EDI service, EFT, ERA/real-time admin simplification/837); processing of paper claims and electronic data conversion (Future Vision Technologies); customized member-advocacy program to identify and qualify enrollees most likely to be eligible for federal disability benefits (SSI); license for access to WebMD technology/materials.				

Table 10: Subcontractor Reference #1

Subcontractor Information		
Vendor Name: Equian, LLC f/k/a The Assist Group	Contact Name:	Stephanie Elliott VP, Sales & Client Managing
	Contact Phone:	720-259-4367
Customer Information		
Customer Organization: New Jersey Department of Human Services, Division of Medical Assistance and Health Services	Contact Name:	Marc Gonzer
	Contact Title:	Contract Manager
Customer Address: 7 Quakerbridge Plaza, 2nd Floor, Room 203, Mercerville, New Jersey 08619	Contact Phone:	609-575-9389
	Contact Email:	Mark.Gonzer@dhs.state.nj.us

REQUEST FOR PROPOSAL

Department of Health and Human Resources, RFP CRFP 0511 BMS 1900000001

Project Information	
Total Vendor Staff:	188
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 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 healthcare services, depending on the person's eligibility category.	
Vendor's Involvement: Equian provides pre-payment review of inpatient claims with high-dollar DRG outlier liability/payables; overpayment recovery services; itemized benefit billing; and clinical claims review. Aetna Better Health of New Jersey, which offers Medicaid services, Children's Health Insurance Programs (CHIP) and Managed Long Term Care Services and Support (MLTSS) to NJ FamilyCare members in all 21 counties. Aetna Better Health of New Jersey administers care management for children in foster care and all individuals with intellectual/developmental disabilities; this includes development of a treatment plan and monitoring to address access to well child care for foster children and children with disabilities. Aetna Better Health of New Jersey collaborates with the relevant state agencies and community resources in accordance with contract requirements and Aetna's Children with Special Health Care Needs and 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. Families of members receiving care management 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 children and youth 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 EPSDT benefit) or the MLTSS program (for which private duty nursing is a benefit for both children and adults).	

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 on a daily basis.

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 managed long-term services and supports (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: Glenn MacFarlane	Role: Chief Executive Officer
Name: Jerry Mammano	Role: Chief Operating Officer
Name: Heather Hoopes	Role: Chief Financial Officer
Name: Cheryl Reid, M.D.	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: 60,478
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 & Completion Dates:	From:	Current Contract: 12/01/2014	To:	N/A; evergreen contract
Actual Start & Completion Dates:	From:	Current Contract: 12/01/2014	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: Equian provides pre-payment review of inpatient claims with high-dollar DRG outlier liability/payables; overpayment recovery services; itemized benefit billing; and clinical claims review.				

Table 10: Subcontractor Reference #2

Subcontractor Information		
Vendor Name: Equian, LLC f/k/a The Assist Group	Contact Name:	Stephanie Elliott VP, Sales & Client Managing
	Contact Phone:	720-259-4367
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:	465	
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.		

REQUEST FOR PROPOSAL

Department of Health and Human Resources, RFP CRFP 0511 BMS 1900000001

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'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 contracts with the Department of Medical Assistance Services (DMAS) to provide Medicaid (Medallion), Family Access to Medical Insurance Security (FAMIS) a.k.a. Children's Health Insurance Program (CHIP), Commonwealth Coordinated Care Plus (CCC+), and Dual Eligible Special Needs Plans (DSNP) managed care services to our members.

Aetna Better Health of Virginia is licensed as a health management organization (HMO) and as a Managed Care Health Insurance Plan (MCHIP) in the State of Virginia. Aetna Better Health of Virginia is also a National Committee for Quality Assurance (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: Equian provides pre-payment review of inpatient claims with high-dollar DRG outlier liability/payables; overpayment recovery services; itemized benefit billing; and clinical claims review.

Aetna Better Health of Virginia, which was one of six MCOs selected through a competitive RFP to provide managed care services to qualified Virginians under the Medallion 4.0 Program.

The new program will build on the strengths and experience of the twenty-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 (ABHVA) 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, that 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:

- 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 system-wide 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

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.

Behavioral Health

Aetna Better Health of Virginia possesses a full understanding of the non-traditional community mental health services that are delivered under the Medallion 4.0 program. We provide nontraditional services such as intensive in-home services, therapeutic day treatment, and residential treatment for children and adolescents, day treatment/partial hospitalization, psychosocial rehabilitation, crisis services (including trauma informed care and adverse childhood events), intensive community treatment, and mental health skill building for adults.

In Virginia, we collaborate by conducting interdisciplinary care team meetings with Magellan of Virginia to discuss members who would benefit from any of these non-traditional services. We have designated a team to ensure that those needing a more intense level of care management are recipients of it. We collaboratively engage with Magellan, DMAS, and community-based providers to help ensure a seamless transition for members within the Commonwealth that meets all Community Mental Health Rehabilitation Services network adequacy standards. We understand the importance of relationships and continuity of care, and we will demonstrate this commitment by doubling the stated requirement and ensuring that members can continue to see their existing providers for at up to 180 days post-transition if they are not currently in our network. Moreover, our provider network team actively works to recruit providers of traditional and non-traditional services into our network.

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.

Our care coordinators currently attend individualized education plan (IEP) meetings as active participants to determine jointly the needs of the child and their family, assign accountability and responsibility across organizations, and make sure services are integrated and coordinated. We work directly with teachers and school-based providers to obtain a copy of the IEP and share any additional information with the child's traditional and/or non-traditional providers. Our care coordinators encourage open communication and elevate the goals and objectives of the child and of their parent or guardian. With a focus on avoiding the duplication of services, we invite the school-based team to be a contributing part of our interdisciplinary care team provided we have all of the appropriate consents.

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 provide 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 facilitate adjustments (as needed) to enhance access and engagement of members. Our peer support model utilizes techniques to ensure safety and establish rapport with the 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 spacing between births and positive birth outcomes.

Key Personnel	
Name: Roger Gunter	Role: Project Director
Name: Joanne Landry	Role: Project Manager
Name: Ira Bloomfield, M.D.	Role: Medical Director
Name: Neil Hines, M.D.	Role: Behavioral Health Lead

Name: Lani Spencer, R.N.		Role: Care Coordination Manager		
Name: Kimberly Grifasi		Role: Quality Improvement Program Manager		
Project Measurements:				
Projected Membership of Vendor's Contract: N/A		Actual Membership of Vendor's Contract: 113,000		
Reason(s) for change in membership: N/A				
Estimated Start & Completion Dates:	From:	Contract Start: 8/1/18	To:	June 30, 2020, with the possibility of six (6) twelve month renewals
Actual Start & Completion Dates:	From:	Contract Start: 8/1/18	To:	June 30, 2020, with the possibility of six (6) twelve month renewals
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: Equian provides pre-payment review of inpatient claims with high-dollar DRG outlier liability/payables; overpayment recovery services; itemized benefit billing; and clinical claims review.				

Table 10: Subcontractor Reference #3

Subcontractor Information		
Vendor Name: Equian, LLC f/k/a The Assist Group	Contact Name:	Stephanie Elliott VP, Sales & Client Managing
	Contact Phone:	720-259-4367
Customer Information		
Customer Organization: Pennsylvania Department of Human Services (Department)	Contact Name:	Sally Kozak
	Contact Title:	Deputy Secretary, Office of Medical Assistance Programs (OMAP)

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Department of Health and Human Resources, RFP CRFP 0511 BMS 1900000001

Customer Address: Room 515, 625 Forster St, Harrisburg PA 17120	Contact Phone:	717-214-4206
	Contact Email:	sakozak@pa.gov

Project Information

Total Vendor Staff:	291

Project Objectives: To provide mandatory managed health care as part of the HealthChoices Program, Pennsylvania's 1915(b) waiver program, for Medical Assistance Recipients. HealthChoices Objectives include:

- Promote the achievement of the Triple AIM (better health, better care, lower cost);
- Improve care coordination between physical and behavioral health services;
- Promote the expansion of value-based purchasing of health care services;
- Promote the expansion of team-based approaches to care delivery (for example, patient-centered care medical homes);
- Promote community-based public health initiatives;
- Increase consumer access to needed services, especially in rural and underserved areas of the commonwealth;
- Improve the efficiency of the HealthChoices program; and
- Improve the provider experience with the HealthChoices program.

Project Description: Aetna Better Health of Pennsylvania and Aetna Better Health Kids provide health benefits and manage care for people enrolled in the Commonwealth of Pennsylvania's Medical Assistance program (Medicaid). Engaging members through an integrated care management model fully integrating physical and behavioral health care as well as chronic care and disease management programs for persons with complex medical concerns. The local, community-based model ensures Pennsylvanian providers and participants live side-by-side with Aetna staff.

ABHP improves the overall health care delivery to our HealthChoices members by:

- Acting as a single point-of-contact to serve the member
- Providing complete health and social services and support for members through our Fully
- Integrated System of Care (FISOC)
- Pursuing strategies to strengthen the local delivery systems using community health workers, and peer support specialists
- Leveraging the use of our proprietary predictive modeling tool to identify members at risk for emergency department utilization or an inpatient admission

Vendor's Involvement: Equian provides pre-payment review of inpatient claims with high-dollar DRG outlier liability/payables; overpayment recovery services; itemized benefit billing; and clinical claims review. Aetna Better Health of Pennsylvania, which is a Physical Health Managed Care Organization with an agreement with the Department to manage the purchase and provision of Physical Health Services Statewide under the HealthChoices Program. Aetna Better Health of Pennsylvania is committed to addressing the system challenges and making improvements in the services we provide for children in care where they live. Some of our strategies include:

- Assigning a point of contact to develop and implement community support programs and processes. This subject matter expert is the liaison with local agencies including child welfare, juvenile corrections, juvenile justice, and other agencies that serve children.
- Providing training and education on the role of the managed care organization to the child welfare agencies
- Working with youth to prepare them for "aging out" of substitute care—e.g., assist them in completing applications for Medicaid, housing, and employment
- Partnering with foster care agencies to provide education about the appropriate use of antipsychotics
- Assisting in scheduling primary care physician and dental appointments
- Coordinating an annual forum in each zone to bring the child welfare agencies and other stakeholders together for planning and collaborating on issue regarding children in substitute care

Improving tracking and reporting on children in care receiving a physical within 60 days of entering care

In the event a member in substitute care has difficulty obtaining access to medically necessary services within the state, Aetna Better Health of Pennsylvania Case Management and Network Management departments collaborate to find a provider within the state that will meet the member's needs and work to execute a Single Case Agreement to ensure a member continued to receive care within the State.

Children in substitute care are enrolled in case management to ensure that they receive the proper preventative care that can help reduce inpatient admissions. Aetna Better Health of Pennsylvania utilizes an Integrated Care Management program to address the member's medical, behavioral, in coordination with the BH MCO's, and social needs in individual and distinctive ways. Aetna Better Health of Pennsylvania recognizes that these needs interact with each other, often in unpredictable ways, and that a member's care is driven by a number of unique physical and behavioral health conditions. To target members who will benefit most from integrated care management, we use predictive modeling through our Consolidated Outreach and Risk Evaluation (CORE) tool. This tool is custom designed for the Medicaid population. CORE predicts both financial and clinical performance over the next 12 months, with a positive predictive value of up to 95.4 percent. CORE identifies members for whom intensive or complex care management will promote improved health and well-being and prevent high cost utilization. We also identify members using provider and pharmacy referrals.

Our CORE proprietary predictive modeling tool enables us to identify high-acuity members who are also high-risk. Our Integrated Care Management program prioritizes outreach to the top 1% members who are also at high-risk for emergency department visits in the next 12 months and high-risk for inpatient utilization in the next 12 months (identified as CORE 4).

One of the special challenges is children who "age out" of the system. Many of the children in the child welfare system are over the age of 16 and "age out" at 18. These children have very little control over their lives and/or how they receive the medical services they need. We include these children in the development of their care management plan and they have choices they can make as their plans are developed. We begin that process when they turn 16 and follow them until they "age out." Children between the ages of 16 and 18 not only need care management for their medical services, but also for psychosocial services. These children are facing the biggest opportunity and the biggest challenge of their young lives. Many have spent all of their years in substitute care and have no idea how to live

independently. Through our comprehensive care management program, we are able to aid these children and identify community resources available to assist them in living independently.

Project Benefits: Aetna Better Health of Pennsylvania achieved NCQA Commendable level accreditation in December 2017. Aetna Better Health of Pennsylvania delivers care through a collaborative approach. We partner with providers who deliver quality and effective care to achieve the best outcomes for our members. The programs encourage members to take charge of their health. Through the care management program, members set goals for their health. Aetna Better Health of Pennsylvania's team of case managers, providers, and caregivers work with the member to help them achieve their goals.

Aetna Better Health of Pennsylvania utilizes clinical intervention programs to address children in substitute care. Aetna Better Health of Pennsylvania recognizes that children and adolescents in substitute care have a higher rate of utilization of psychotropic medication than their peers who are in their homes. Many factors contribute to the potential for inappropriate psychotropic prescribing practices including the national shortage of child and adolescent psychiatrists. The issue is compounded by the lack of access to effective non-pharmacological interventions, lack of communication between behavioral health and physical health practitioners, lack of complete medical records due to changes in the primary caregiver, and lack of adherence to evidence-based prescribing by physicians and nurse practitioners.

Aetna Better Health of Pennsylvania uses two pharmacy and clinical management programs that address the appropriate use of psychotropics in children and adolescents. Both programs are founded on evidence-based, clinical practice guidelines and U.S. Food and Drug Administration-approved indications promoting safe and effective prescribing in individuals under the age of 21. The approach aligns with the Department's goals. These programs support the appropriate diagnostic evaluation, consultation and coordination with specialists, appropriate treatment monitoring, continuity/coordination of care, and medication adherence. Aetna Better Health of Pennsylvania works collaboratively with the behavioral health managed care organizations to achieve goals.

PROGRAM GOALS

The program goals include reducing the inappropriate use of ADHD stimulants in children and adolescents in foster care; improving the HEDIS measure; increasing follow-up care for children prescribed ADHD medication; and increasing specialty consultation by primary care practitioners.

INTERVENTIONS

- Behavioral health utilization data, reviewed in collaboration with the behavioral health managed care organizations, is used to monitor and increase access to behavioral therapy for members
- Use of provider profiling and collaboration with the behavioral health managed care organization to develop more targeted interventions for prescribers
- Telephonic Psychiatric Services (TiPS) program using telehealth to expand access to psychiatric consultations to primary care practitioners
- Comprehensive, evidence-based pharmacy prior authorization guidelines for ADHD stimulants
- Appropriate Use of Antipsychotic Medication in Children and Adolescents Pharmacy and Clinical Management Program

Our pharmacy and clinical activities support the use of evidence-based clinical practice guidelines, appropriate diagnostic evaluation, consultation and coordination with specialists when indicated, second

opinions, effective monitoring, continuity and coordination of care, member/caregiver education, improved medication adherence, and formulary adherence.

We collaborate with the behavioral health managed care organizations to identify members under age 21 on antipsychotic medication who have not had the appropriate monitoring for metabolic effects. We also use behavioral health utilization data and collaboration with the BH-MCOs to monitor members under age 21 on antipsychotic medication that are not receiving nonmedication behavioral health treatment. Additionally, deployment of the TiPS program will enable psychiatric consultations to primary care practitioners.

Key Personnel	
Name: Jason Rottman	Role: Chief Executive Officer
Name: Stephanie Ledesma	Role: Chief Operations Officer
Name: Dr. Bernard Lewin	Role: Chief Medical Officer
Name: Heather Hoopes	Role: Chief Financial Officer
Name: Sosi Hovagimian	Role: Director of Compliance

Project Measurements:	
Projected Membership of Vendor's Contract: N/A	Actual Membership of Vendor's Contract: 203,749 total membership as of June 2019
Reason(s) for change in membership: N/A	

Estimated Start & Completion Dates:	From:	N/A	To:	N/A
Actual Start & Completion Dates:	From:	Contract Start: April 1, 2010 Tenure in the State: Since 1993	To:	Current Agreement in effect until 12/31/19. Contract will be extended until the contract is re-procured.

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:

Equian provides pre-payment review of inpatient claims with high-dollar DRG outlier liability/payables; overpayment recovery services; itemized benefit billing; and clinical claims review.

Table 10: Subcontractor Reference #1

Subcontractor Information		
Vendor Name: First Choice Services, Inc.	Contact Name:	D. Scott Jarrett
	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 WV Tobacco Quitline	
Project Description: Operates The WV Tobacco Quitline	
Vendor's Involvement: Operates The WV Tobacco Quitline	
Project Benefits: Guiding participants through enrollment process to obtain Tobacco Cessation product.	

Key Personnel	
Name: Lindsy Hatfield	Role: Program Director

Project Measurements:	
Projected Membership of Vendor's Contract: N/A	Actual Membership of Vendor's Contract: N/A
Reason(s) for change in membership: N/A	

Estimated Start & Completion Dates:	From:	7/1/2017	To:	On Going
Actual Start & 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 10: Subcontractor Reference #2

Subcontractor Information		
Vendor Name: First Choice Services, Inc.	Contact Name:	D. Scott Jarrett
	Contact Phone:	304-400-4802
Customer Information		
Customer Organization: WVDHHR Bureau for Behavioral Health and Health Facilities	Contact Name:	Damon E. Iarossi
	Contact Title:	Deputy Commissioner
Customer Address: 350 Capitol St Room 350 Charleston WV 25301	Contact Phone:	(304) 356-4832
	Contact Email:	Damon.E.Iarossi@wv.gov

Project Information	
Total Vendor Staff:	20
Project Objectives: Increase access for WV citizens to behavioral health and substance abuse treatment	
Project Description: 24/7 Helpline staffed by agents to refer folks for treatment	
Vendor's Involvement: Operates HELP4WV	
Project Benefits: Increased access to addiction services	

Key Personnel	
Name: Britt Shawver	Role: Director
Name: 19 Helpline agents	Role: Call agents

Project Measurements:	
Projected Membership of Vendor's Contract: N/A	Actual Membership of Vendor's Contract: N/A
Reason(s) for change in membership: N/A	

Estimated Start & Completion Dates:	From:	6/2015	To:	Ongoing
Actual Start & Completion Dates:	From:	6/2015	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				

Table 10: Subcontractor Reference #3

Subcontractor Information		
Vendor Name: First Choice Services, Inc.	Contact Name:	D. Scott Jarrett
	Contact Phone:	304-400-4802
Customer Information		
Customer Organization: Virginia Council on Problem Gambling	Contact Name:	C. E. Hawley
	Contact Title:	President of VACPG
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		
Key Personnel		
Name: Jennifer Davis Walton	Role: Director	

Name: Program Coordinators		Role: Counseling and referral to treatment		
Project Measurements:				
Projected Membership of Vendor's Contract: N/A		Actual Membership of Vendor's Contract: N/A		
Reason(s) for change in membership: N/A				
Estimated Start & Completion Dates:	From:	7/2005	To:	Ongoing
Actual Start & Completion Dates:	From:	7/2005	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 10: Subcontractor Reference #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:	N/A	

Project Objectives: CAV and Direct Bill Services				
Project Description: COB Services				
Vendor's Involvement: MCO activities				
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.				
Key Personnel				
Name: David Pollack		Role: CEO		
Name: Claudia Lamazares		Role: COO		
Project Measurements:				
Projected Membership of Vendor's Contract: N/A		Actual Membership of Vendor's Contract: 50,505 (as of 6/2019)		
Reason(s) for change in membership: N/A				
Estimated Start & Completion Dates:	From:	1/1/2017	To:	N/A
Actual Start & 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 10: Subcontractor Reference #2

Subcontractor Information		
Vendor Name: Health Management Systems, Inc.	Contact Name:	Robert Dickerson
	Contact Phone:	212-857-5270

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Department of Health and Human Resources, RFP CRFP 0511 BMS 1900000001

Customer Information		
Customer Organization: Aetna Better Health of Pennsylvania	Contact Name:	Stephanie Ledesma
	Contact Title:	Chief Operations Officer
Customer Address: 2000 Market Street Philadelphia, PA 1910	Contact Phone:	215-282-3504
	Contact Email:	LedesmaS@Aetna.com

Project Information	
Total Vendor Staff:	291
Project Objectives: CAV and Direct Bill Services	
Project Description: COB Services	
Vendor's Involvement: MCO activities	
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.	

Key Personnel	
Name: Jason Rottman	Role: Chief Executive Officer
Name: Stephanie Ledesma	Role: Chief Operations Officer
Name: Dr. Bernard Lewin	Role: Chief Medical Officer
Name: Heather Hoopes	Role: Chief Financial Officer
Name: Sosi Hovagimian	Role: Director of Compliance

Project Measurements:	
Projected Membership of Vendor's Contract: N/A	Actual Membership of Vendor's Contract: 203,749 total membership as of June 2019
Reason(s) for change in membership: N/A	

Estimated Start & Completion Dates:	From:	1/1/2011	To:	N/A

Actual Start & 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 10: Subcontractor Reference #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:	Joanna Landry
	Contact Title:	Chief Operations Officer
Customer Address: 9881 Mayland Drive, Richmond VA, 23233	Contact Phone:	804-968-4951
	Contact Email:	LandryJ@Aetna.com
Project Information		
Total Vendor Staff:	465	
Project Objectives: CAV and Direct Bill Services		
Project Description: COB Services		
Vendor's Involvement: MCO activities		
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.		
Key Personnel		
Name: Roger Gunter	Role: Project Director	

Name: Joanne Landry		Role: Project Manager		
Project Measurements:				
Projected Membership of Vendor's Contract: N/A		Actual Membership of Vendor's Contract: 66,631 (as of 6/2019)		
Reason(s) for change in membership: N/A				
Estimated Start & Completion Dates:	From:	1/1/2016	To:	N/A
Actual Start & 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				

Table 10: Subcontractor Reference #1

Subcontractor Information		
Vendor Name: Inovalon, Inc.	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: 151 Farmington AveHartford, CT 06105	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, 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 & Completion Dates:	From:	6/1/2016	To:	8/31/2020 (with a 1-year auto-renewal)
Actual Start & 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/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 10: Subcontractor Reference #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, IL 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 & Completion Dates:	From:	1/1/2017	To:	12/31/2021 (with a 2-year auto-renewal)
Actual Start & 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.

Health Care Services Corporation's (HCSC) HEDIS® project(s) are managed in Inovalon's private Cloud environment, under the Client Cloud Access (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 10: Subcontractor Reference #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 & Completion Dates:	From:	8/17/2010	To:	6/30/2020
Actual Start & 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.

Table 10: Subcontractor Reference #1

Subcontractor Information		
Vendor Name: MCMC LLC	Contact Name:	Paul Lanning
	Contact Phone:	516-806-2425
Customer Information		
Customer Organization: Oklahoma Insurance Department	Contact Name:	Donna Dorr
	Contact Title:	Life and Health Analyst Senior Claims Processor/Reviewer
Customer Address: Consumer Assistance Department, Oklahoma Insurance Department, 3625 NW 56th Street, Suite 100, Oklahoma City, Oklahoma 73112-4511	Contact Phone:	405-521-2991
	Contact Email:	Donna.dorr@oid.ok.gov
Project Information		
Total Vendor Staff:	20+	
Project Objectives: Provide unbiased external review determinations on behalf of members, health plans and providers that address medical necessity, appropriateness, health care setting, and level of care or effectiveness, including treatment that has been designated as experimental or investigational per regulations set by the state insurance department.		
Project Description: MCMC receives external review referrals from the state, member, provider or health plan. MCMC notifies all parties of the pending review. A qualified and independent reviewer considers all the documentation and medical records submitted for review and makes a binding determination. MCMC then notifies all parties of the final decision.		
Vendor's Involvement: Independent Medical Review which includes communication and notification to members, providers, health plans per regulatory time frames and processes.		
Project Benefits: • 100% turnaround time • Recruitment of credentialed panel specialists who are experienced in recently developed medical treatment protocols		

• Consistent 96%+ client satisfaction results				
Key Personnel				
Name: Paul Gilleece		Role: Vice President, Peer Review		
Name: Joelle Georges		Role: Director, State/Federal External Review		
Project Measurements:				
Projected Membership of Vendor's Contract: 500,000+		Actual Membership of Vendor's Contract: 500,000+		
Reason(s) for change in membership: Any person not covered by federal health insurance plans have the ability to send MCMC external reviews cases in the state of Oklahoma under this contract.				
Estimated Start & Completion Dates:	From:	1/1/2019	To:	12/31/2020
Actual Start & Completion Dates:	From:	1/1/2019	To:	12/31/2020
Reason(s) for difference between Estimated and Actual dates: There is no difference in the Estimated ad Actual dates. The project was implemented on-time without any issues. MCMC has been licensed with the state of Oklahoma as an IRO since 10/23/2002.				
If the Subcontractor performed the work as a subcontractor, the Subcontractor should describe the scope of subcontracted activities: Independent Medical Review, specifically state external review for this contract.				

Table 10: Subcontractor Reference #2

Subcontractor Information		
Vendor Name: MCMC LLC	Contact Name:	Paul Lanning
	Contact Phone:	516-806-2425
Customer Information		
Customer Organization: Kentucky Department of Insurance	Contact Name:	Kathy S. Horsley, APIR, CPM
	Contact Title:	Health Policy Specialist II

REQUEST FOR PROPOSAL

Department of Health and Human Resources, RFP CRFP 0511 BMS 1900000001

		Health Policy Utilization Review Branch
Customer Address: Kentucky Department of Insurance, Insurance Product Regulation Division, 215 West Main Street, Frankfort, Kentucky 40602	Contact Phone:	502-782-5271
	Contact Email:	Kathy.horsley@ky.gov

Project Information	
Total Vendor Staff:	20+
Project Objectives: Provide unbiased external review determinations on behalf of members, health plans and providers that address medical necessity, appropriateness, health care setting, and level of care or effectiveness, including treatment that has been designated as experimental or investigational per regulations set by the state insurance department.	
Project Description: MCMC receives external review referrals from the state, member, provider or health plan. MCMC notifies all parties of the pending review. A qualified and independent reviewer considers all the documentation and medical records provided for review and makes a binding determination. MCMC then notifies all parties of the final decision.	
Vendor's Involvement: Independent Medical Review which includes communication and notification to members, providers, health plans per regulatory time frames and processes.	
Project Benefits: • 100% turnaround time • Recruitment of credentialed panel specialists who are experienced in recently developed medical treatment protocols • Consistent 96%+ client satisfaction results • Improved reporting to the state (and public) due to IE Form submission	

Key Personnel	
Name: Paul Gilleece	Role: Vice President, Peer Review
Name: Joelle Georges	Role: Director, State/Federal External Review

Project Measurements:	
Projected Membership of Vendor's Contract: 500,000+	Actual Membership of Vendor's Contract: 500,000+
Reason(s) for change in membership: Any person not covered by federal health insurance plans have the ability to send MCMC external reviews cases in the state of Kentucky under this contract.	

Estimated Start & Completion Dates:	From:	05/1/2019	To:	05/1/2021
Actual Start & Completion Dates:	From:	05/1/2019	To:	05/1/2021
Reason(s) for difference between Estimated and Actual dates: There is no difference in the Estimated and Actual dates. The project was implemented on-time without any issues. MCMC has been licensed with the state of Kentucky as an IRO since 5/1/2005.				
If the Subcontractor performed the work as a subcontractor, the Subcontractor should describe the scope of subcontracted activities: Independent Medical Review, specifically state external review for this contract.				

Table 10: Subcontractor Reference #3

Subcontractor Information		
Vendor Name: MCMC LLC	Contact Name:	Paul Lanning
	Contact Phone:	516-806-2425
Customer Information		
Customer Organization: Washington State Office of the Insurance Commissioner	Contact Name:	Chris Pattison
	Contact Title:	Market Conduct Examiner
Customer Address: Washington State Office of the Insurance Commissioner, 5000 Capitol Blvd. SE, Tumwater, Washington 98501	Contact Phone:	206-389-2916
	Contact Email:	ChrisP@oic.wa.gov
Project Information		
Total Vendor Staff:	20+	
Project Objectives: Provide unbiased external review determinations on behalf of members, health plans and providers that address medical necessity, appropriateness, health care setting, and level of care or effectiveness, including treatment that has been designated as experimental or investigational per regulations set by the state insurance department.		
Project Description: MCMC receives external review referrals from the state, member, provider or health plan. MCMC notifies all parties of the pending review. A qualified and independent reviewer considers all the documentation and medical records provided for review and makes a binding determination. MCMC then notifies all parties of the final decision.		

Vendor's Involvement: Independent Medical Review which includes communication and notification to members, providers, health plans per regulatory time frames and processes.

Project Benefits:

- 100% turnaround time
- Recruitment of credentialed panel specialists who are experienced in recently developed medical treatment protocols
- Consistent 96%+ client satisfaction results
- Improved reporting to the state (and public) due to online submission of outcomes

Key Personnel	
Name: Paul Gilleece	Role: Vice President, Peer Review
Name: Joelle Georges	Role: Director, State/Federal External Review

Project Measurements:	
Projected Membership of Vendor's Contract: 500,000+	Actual Membership of Vendor's Contract: 500,000+

Reason(s) for change in membership:

Any person not covered by federal health insurance plans have the ability to send MCMC external reviews cases in the state of Washington under this contract.

Estimated Start & Completion Dates:	From:	7/21/2005	To:	N/A; Does Not Expire
Actual Start & Completion Dates:	From:	7/21/2005	To:	N/A; Does Not Expire

Reason(s) for difference between Estimated and Actual dates:

There is no difference in the Estimated and Actual dates. The project was implemented on-time without any issues. MCMC has been licensed with the state of Washington as an IRO since 07/21/2005.

If the Subcontractor performed the work as a subcontractor, the Subcontractor should describe the scope of subcontracted activities:

Independent Medical Review, specifically state external review for this contract.

Table 10: Subcontractor Reference #1

Subcontractor Information		
Vendor Name: MedSolutions, Inc. a/k/a eviCore healthcare f/k/a Triad Healthcare, Inc.	Contact Name:	Patrick Dawson Client Experience Director
	Contact Phone:	800-918-8924
Customer Information		
Customer Organization: New Jersey Department of Human Services, Division of Medical Assistance and Health Services	Contact Name:	Marc Gonzer
	Contact Title:	Contract Manager
Customer Address: 7 Quakerbridge Plaza, 2nd Floor, Room 203, Mercerville, New Jersey 08619	Contact Phone:	609-575-9389
	Contact Email:	Mark.Gonzer@dhs.state.nj.us
Project Information		
Total Vendor Staff:	188	
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 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 healthcare services, depending on the person's eligibility category.		
Vendor's Involvement: eviCore healthcare provides delegated radiology-management and musculoskeletal pain-management services, including utilization management. Aetna Better Health of New Jersey, which offers Medicaid services, Children's Health Insurance Programs (CHIP) and Managed Long Term Care Services and Support (MLTSS) to NJ FamilyCare members in all 21 counties. Aetna Better Health of New Jersey administers care management for children in foster care and all individuals with intellectual/developmental disabilities; this includes		

development of a treatment plan and monitoring to address access to well child care for foster children and children with disabilities. Aetna Better Health of New Jersey collaborates with the relevant state agencies and community resources in accordance with contract requirements and Aetna's Children with Special Health Care Needs and 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. Families of members receiving care management 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 children and youth 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 EPSDT benefit) or the MLTSS program (for which private duty nursing is a benefit for both children and adults).

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 on a daily basis.

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 managed long-term services and supports (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: Glenn MacFarlane	Role: Chief Executive Officer
Name: Jerry Mammano	Role: Chief Operating Officer
Name: Heather Hoopes	Role: Chief Financial Officer
Name: Cheryl Reid, M.D.	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: 60,478		
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 & Completion Dates:	From:	Current Contract: 12/01/2014	To:	N/A; evergreen contract
Actual Start & Completion Dates:	From:	Current Contract: 12/01/2014	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: eviCore healthcare provides delegated radiology-management and musculoskeletal pain-management services, including utilization management.				

Table 10: Subcontractor Reference #2

Subcontractor Information		
Vendor Name: MedSolutions, Inc. a/k/a eviCore healthcare f/k/a Triad Healthcare, Inc.	Contact Name:	Patrick Dawson Client Experience Director
	Contact Phone:	800-918-8924

REQUEST FOR PROPOSAL

Department of Health and Human Resources, RFP CRFP 0511 BMS 1900000001

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:	465

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 (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'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 contracts with the Department of Medical Assistance Services (DMAS) to provide Medicaid (Medallion), Family Access to Medical Insurance Security (FAMIS) a.k.a. Children's Health Insurance Program (CHIP), Commonwealth Coordinated Care Plus (CCC+), and Dual Eligible Special Needs Plans (DSNP) managed care services to our members.

Aetna Better Health of Virginia is licensed as a health management organization (HMO) and as a Managed Care Health Insurance Plan (MCHIP) in the State of Virginia. Aetna Better Health of Virginia is also a National Committee for Quality Assurance (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: eviCore healthcare provides delegated radiology-management and musculoskeletal pain-management services, including utilization management.

Aetna Better Health of Virginia, which was one of six MCOs selected through a competitive RFP to provide managed care services to qualified Virginians under the Medallion 4.0 Program.

The new program will build on the strengths and experience of the twenty-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 (ABHVA) 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, that 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:

- 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 system-wide 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

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.

Behavioral Health

Aetna Better Health of Virginia possesses a full understanding of the non-traditional community mental health services that are delivered under the Medallion 4.0 program. We provide nontraditional services such as intensive in-home services, therapeutic day treatment, and residential treatment for children and adolescents, day treatment/partial hospitalization, psychosocial rehabilitation, crisis services (including

trauma informed care and adverse childhood events), intensive community treatment, and mental health skill building for adults.

In Virginia, we collaborate by conducting interdisciplinary care team meetings with Magellan of Virginia to discuss members who would benefit from any of these non-traditional services. We have designated a team to ensure that those needing a more intense level of care management are recipients of it. We collaboratively engage with Magellan, DMAS, and community-based providers to help ensure a seamless transition for members within the Commonwealth that meets all Community Mental Health Rehabilitation Services network adequacy standards. We understand the importance of relationships and continuity of care, and we will demonstrate this commitment by doubling the stated requirement and ensuring that members can continue to see their existing providers for at up to 180 days post-transition if they are not currently in our network. Moreover, our provider network team actively works to recruit providers of traditional and non-traditional services into our network.

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.

Our care coordinators currently attend individualized education plan (IEP) meetings as active participants to determine jointly the needs of the child and their family, assign accountability and responsibility across organizations, and make sure services are integrated and coordinated. We work directly with teachers and school-based providers to obtain a copy of the IEP and share any additional information with the child's traditional and/or non-traditional providers. Our care coordinators encourage open communication and elevate the goals and objectives of the child and of their parent or guardian. With a focus on avoiding the duplication of services, we invite the school-based team to be a contributing part of our interdisciplinary care team provided we have all of the appropriate consents.

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 provide 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 facilitate adjustments (as needed) to enhance access and engagement of members. Our peer support model utilizes techniques to ensure safety and establish rapport with the 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 spacing between births and positive birth outcomes.

Key Personnel	
Name: Roger Gunter	Role: Project Director
Name: Joanne Landry	Role: Project Manager
Name: Ira Bloomfield, M.D.	Role: Medical Director
Name: Neil Hines, M.D.	Role: Behavioral Health Lead
Name: Lani Spencer, R.N.	Role: Care Coordination Manager
Name: Kimberly Grifasi	Role: Quality Improvement Program Manager

Project Measurements:	
Projected Membership of Vendor's Contract: N/A	Actual Membership of Vendor's Contract: 113,000
Reason(s) for change in membership: N/A	

Estimated Start & Completion Dates:	From:	Contract Start: 8/1/18	To:	June 30, 2020, with the possibility of six (6) twelve month renewals
Actual Start & Completion Dates:	From:	Contract Start: 8/1/18	To:	June 30, 2020, with the possibility of six (6) twelve month renewals
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 healthcare provides delegated radiology-management and musculoskeletal pain-management services, including utilization management.

Table 10: Subcontractor Reference #3

Subcontractor Information		
Vendor Name: MedSolutions, Inc. a/k/a eviCore healthcare f/k/a Triad Healthcare, Inc.	Contact Name:	Patrick Dawson Client Experience Director
	Contact Phone:	800-918-8924
Customer Information		
Customer Organization: Pennsylvania Department of Human Services (Department)	Contact Name:	Sally Kozak
	Contact Title:	Deputy Secretary, Office of Medical Assistance Programs (OMAP)
Customer Address: Room 515, 625 Forster St, Harrisburg PA 17120	Contact Phone:	717-214-4206
	Contact Email:	sakozak@pa.gov
Project Information		
Total Vendor Staff:	291	

Project Objectives: To provide mandatory managed health care as part of the HealthChoices Program, Pennsylvania's 1915(b) waiver program, for Medical Assistance Recipients. HealthChoices Objectives include:

- Promote the achievement of the Triple AIM (better health, better care, lower cost);
- Improve care coordination between physical and behavioral health services;
- Promote the expansion of value-based purchasing of health care services;
- Promote the expansion of team-based approaches to care delivery (for example, patient-centered care medical homes);
- Promote community-based public health initiatives;
- Increase consumer access to needed services, especially in rural and underserved areas of the commonwealth;
- Improve the efficiency of the HealthChoices program; and
- Improve the provider experience with the HealthChoices program.

REQUEST FOR PROPOSAL

Department of Health and Human Resources, RFP CRFP 0511 BMS 1900000001

Project Description: Aetna Better Health of Pennsylvania and Aetna Better Health Kids provide health benefits and manage care for people enrolled in the Commonwealth of Pennsylvania's Medical Assistance program (Medicaid). Engaging members through an integrated care management model fully integrating physical and behavioral health care as well as chronic care and disease management programs for persons with complex medical concerns. The local, community-based model ensures Pennsylvanian providers and participants live side-by-side with Aetna staff.

ABHP improves the overall health care delivery to our HealthChoices members by:

- Acting as a single point-of-contact to serve the member
- Providing complete health and social services and support for members through our Fully
- Integrated System of Care (FISOC)
- Pursuing strategies to strengthen the local delivery systems using community health workers, and peer support specialists
- Leveraging the use of our proprietary predictive modeling tool to identify members at risk for emergency department utilization or an inpatient admission

Vendor's Involvement: eviCore healthcare provides delegated radiology-management and musculoskeletal pain-management services, including utilization management. Aetna Better Health of Pennsylvania is a Physical Health Managed Care Organization with an agreement with the Department to manage the purchase and provision of Physical Health Services Statewide under the HealthChoices Program. Aetna Better Health of Pennsylvania is committed to addressing the system challenges and making improvements in the services we provide for children in care where they live. Some of our strategies include:

- Assigning a point of contact to develop and implement community support programs and processes. This subject matter expert is the liaison with local agencies including child welfare, juvenile corrections, juvenile justice, and other agencies that serve children.
- Providing training and education on the role of the managed care organization to the child welfare agencies
- Working with youth to prepare them for "aging out" of substitute care—e.g., assist them in completing applications for Medicaid, housing, and employment
- Partnering with foster care agencies to provide education about the appropriate use of antipsychotics
- Assisting in scheduling primary care physician and dental appointments
- Coordinating an annual forum in each zone to bring the child welfare agencies and other stakeholders together for planning and collaborating on issue regarding children in substitute care

Improving tracking and reporting on children in care receiving a physical within 60 days of entering care In the event a member in substitute care has difficulty obtaining access to medically necessary services within the state, Aetna Better Health of Pennsylvania Case Management and Network Management departments collaborate to find a provider within the state that will meet the member's needs and work to execute a Single Case Agreement to ensure a member continued to receive care within the State.

Children in substitute care are enrolled in case management to ensure that they receive the proper preventative care that can help reduce inpatient admissions. Aetna Better Health of Pennsylvania utilizes an Integrated Care Management program to address the member's medical, behavioral, in coordination with the BH MCO's, and social needs in individual and distinctive ways. Aetna Better Health of

Pennsylvania recognizes that these needs interact with each other, often in unpredictable ways, and that a member's care is driven by a number of unique physical and behavioral health conditions. To target members who will benefit most from integrated care management, we use predictive modeling through our Consolidated Outreach and Risk Evaluation (CORE) tool. This tool is custom designed for the Medicaid population. CORE predicts both financial and clinical performance over the next 12 months, with a positive predictive value of up to 95.4 percent. CORE identifies members for whom intensive or complex care management will promote improved health and well-being and prevent high cost utilization. We also identify members using provider and pharmacy referrals.

Our CORE proprietary predictive modeling tool enables us to identify high-acuity members who are also high-risk. Our Integrated Care Management program prioritizes outreach to the top 1% members who are also at high-risk for emergency department visits in the next 12 months and high-risk for inpatient utilization in the next 12 months (identified as CORE 4).

One of the special challenges is children who "age out" of the system. Many of the children in the child welfare system are over the age of 16 and "age out" at 18. These children have very little control over their lives and/or how they receive the medical services they need. We include these children in the development of their care management plan and they have choices they can make as their plans are developed. We begin that process when they turn 16 and follow them until they "age out." Children between the ages of 16 and 18 not only need care management for their medical services, but also for psychosocial services. These children are facing the biggest opportunity and the biggest challenge of their young lives. Many have spent all of their years in substitute care and have no idea how to live independently. Through our comprehensive care management program, we are able to aid these children and identify community resources available to assist them in living independently.

Project Benefits: Aetna Better Health of Pennsylvania achieved NCQA Commendable level accreditation in December 2017. Aetna Better Health of Pennsylvania delivers care through a collaborative approach. We partner with providers who deliver quality and effective care to achieve the best outcomes for our members. The programs encourage members to take charge of their health. Through the care management program, members set goals for their health. Aetna Better Health of Pennsylvania's team of case managers, providers, and caregivers work with the member to help them achieve their goals.

Aetna Better Health of Pennsylvania utilizes clinical intervention programs to address children in substitute care. Aetna Better Health of Pennsylvania recognizes that children and adolescents in substitute care have a higher rate of utilization of psychotropic medication than their peers who are in their homes. Many factors contribute to the potential for inappropriate psychotropic prescribing practices including the national shortage of child and adolescent psychiatrists. The issue is compounded by the lack of access to effective non-pharmacological interventions, lack of communication between behavioral health and physical health practitioners, lack of complete medical records due to changes in the primary caregiver, and lack of adherence to evidence-based prescribing by physicians and nurse practitioners.

Aetna Better Health of Pennsylvania uses two pharmacy and clinical management programs that address the appropriate use of psychotropics in children and adolescents. Both programs are founded on evidence-based, clinical practice guidelines and U.S. Food and Drug Administration-approved indications promoting safe and effective prescribing in individuals under the age of 21. The approach aligns with the Department's goals. These programs support the appropriate diagnostic evaluation, consultation and coordination with specialists, appropriate treatment monitoring, continuity/coordination of care, and

medication adherence. Aetna Better Health of Pennsylvania works collaboratively with the behavioral health managed care organizations to achieve goals.

PROGRAM GOALS

The program goals include reducing the inappropriate use of ADHD stimulants in children and adolescents in foster care; improving the HEDIS measure; increasing follow-up care for children prescribed ADHD medication; and increasing specialty consultation by primary care practitioners.

INTERVENTIONS

- Behavioral health utilization data, reviewed in collaboration with the behavioral health managed care organizations, is used to monitor and increase access to behavioral therapy for members
- Use of provider profiling and collaboration with the behavioral health managed care organization to develop more targeted interventions for prescribers
- Telephonic Psychiatric Services (TiPS) program using telehealth to expand access to psychiatric consultations to primary care practitioners
- Comprehensive, evidence-based pharmacy prior authorization guidelines for ADHD stimulants
- Appropriate Use of Antipsychotic Medication in Children and Adolescents Pharmacy
- and Clinical Management Program

Our pharmacy and clinical activities support the use of evidence-based clinical practice guidelines, appropriate diagnostic evaluation, consultation and coordination with specialists when indicated, second opinions, effective monitoring, continuity and coordination of care, member/caregiver education, improved medication adherence, and formulary adherence.

We collaborate with the behavioral health managed care organizations to identify members under age 21 on antipsychotic medication who have not had the appropriate monitoring for metabolic effects. We also use behavioral health utilization data and collaboration with the BH-MCOs to monitor members under age 21 on antipsychotic medication that are not receiving nonmedication behavioral health treatment. Additionally, deployment of the TiPS program will enable psychiatric consultations to primary care practitioners.

Key Personnel	
Name: Jason Rottman	Role: Chief Executive Officer
Name: Stephanie Ledesma	Role: Chief Operations Officer
Name: Dr. Bernard Lewin	Role: Chief Medical Officer
Name: Heather Hoopes	Role: Chief Financial Officer
Name: Sosi Hovagimian	Role: Director of Compliance
Project Measurements:	
Projected Membership of Vendor's Contract: N/A	Actual Membership of Vendor's Contract: 203,749 total membership as of June 2019
Reason(s) for change in membership: N/A	

Estimated Start & Completion Dates:	From:	N/A	To:	N/A
Actual Start & Completion Dates:	From:	Contract Start: April 1, 2010 Tenure in the State: Since 1993	To:	Current Agreement in effect until 12/31/19. Contract will be extended until the contract is re-procured.
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 healthcare provides delegated radiology-management and musculoskeletal pain-management services, including utilization management.				

Table 10: Subcontractor Reference #1

Subcontractor 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, NJ 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.		

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Department of Health and Human Resources, RFP CRFP 0511 BMS 1900000001

Project Description: SKYGEN performs all services necessary to administer the dental benefit to Horizon NJ 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 NJ.

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 BCBS of NJ, SKYGEN reduced their PMPM costs, resulting in significant saving while achieving over 80% provider satisfaction from 2015 to 2017. We also consulted with Horizon BCBS of NJ 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: Arica Buretta	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
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 & Completion Dates:	From:	12/1/12	To:	Present
Actual Start & Completion Dates:	From:	12/1/12	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: 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 10: Subcontractor Reference #2

Subcontractor 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, PA 17110	Contact Phone:	717-260-7182
	Contact Email:	daniel.wright@highmark.com
Project Information		
Total Vendor Staff:	Approximately 600	

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Department of Health and Human Resources, RFP CRFP 0511 BMS 1900000001

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: Relationship Manager
Name: Arica Buretta	Role: Service Manager
Name: Cheryl Lightheart	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 & Completion Dates:	From:	4/1/12	To:	Present
Actual Start & Completion Dates:	From:	4/1/12	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: 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 10: Subcontractor Reference #3

Subcontractor Information		
Vendor Name: SKYGEN USA lpaul@amerihealthcaritas.com	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: 1427 Wyckoff Road, Farmingdale, NJ 07727	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, Washing D.C., Delaware, and Michigan, including implementation, member services, quality, and reporting.		

Vendor's Involvement: SKYGEN has been the dental administrator managing AmeriHealth Caritas's Medicaid members since 2011.

SKYGEN USA performs the following activities for United Concordia:

- 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. Project benefits include improved access to care, reduced program overhead, containing benefit costs, and safeguarding patients.

Key Personnel	
Name: Mark Dasek	Role: Relationship Manager
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 & Completion Dates:	From:	6/1/11	To:	Present
Actual Start & Completion Dates:	From:	6/1/11	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:
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.

Table 10: Subcontractor Reference #1

Subcontractor Information		
Vendor Name: Symphony Performance Health, Inc. d/b/a SPH Analytics f/k/a The Myers Group	Contact Name:	John DiCesare
	Contact Phone:	404-425-3246
Customer Information		
Customer Organization: Alameda Alliance for Health	Contact Name:	Dr. Sanjay Bhatt
	Contact Title:	QI Medical Director
Customer Address: 1240 S Loop Rd, Alameda, CA 94502	Contact Phone:	510-747-6152
	Contact Email:	sbhatt@alamedaalliance.org
Project Information		
Total Vendor Staff:	5 Staff Members	
Project Objectives: Surveys are conducted to assess member and provider satisfaction		
Project Description: HRA, CAHPS, Provider Access, Provider Satisfaction, Member Satisfaction (CG CAHPS) surveys		
Vendor's Involvement: SPH Analytics provides survey administration services		
Project Benefits: Certification and process improvement		
Key Personnel		
Name: Dr. Sanjay Bhatt	Role: QI Medical Director	
Project Measurements:		
Projected Membership of Vendor's Contract: N/A	Actual Membership of Vendor's Contract: N/A	
Reason(s) for change in membership: N/A		

Estimated Start & Completion Dates:	From:	2012	To:	2019
Actual Start & Completion Dates:	From:	2012	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: N/A

Table 10: Subcontractor Reference #2

Subcontractor Information		
Vendor Name: : Symphony Performance Health, Inc. d/b/a SPH Analytics f/k/a The Myers Group	Contact Name:	John DiCesare
	Contact Phone:	404-425-3246
Customer Information		
Customer Organization: Promise Health Plan (Previously Care1st Health Plan)	Contact Name:	Norma Perez
	Contact Title:	Senior QI Accreditation Project Manager
Customer Address: 601 Potrero Grande Dr., Monterey Park, CA 91755	Contact Phone:	323-827-6627
	Contact Email:	Norma.Perez@blueshieldca.com
Project Information		
Total Vendor Staff:	5 Staff Members	
Project Objectives: Surveys are conducted to assess member and provider satisfaction		
Project Description: CG CAHPS, Provider Satisfaction, CAHPS 5.0H, Rx Adherence Outreach, Medicare CAHPS, HOS, Call Center Satisfaction, Medicare CAHPS Drill Down Surveys, CM & DM Satisfaction Surveys		
Vendor's Involvement: SPH Analytics provides survey administration services		
Project Benefits: Certification and process improvement		
Key Personnel		
Name: Norma Perez	Role: Senior QI Accreditation Project Manager	
Project Measurements:		

Projected Membership of Vendor's Contract: N/A		Actual Membership of Vendor's Contract: N/A		
Reason(s) for change in membership: N/A				
Estimated Start & Completion Dates:	From:	2012	To:	2019
Actual Start & Completion Dates:	From:	2012	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: N/A				

Table 10: Subcontractor Reference #3

Subcontractor Information		
Vendor Name: Symphony Performance Health, Inc. d/b/a SPH Analytics f/k/a The Myers Group	Contact Name:	John DiCesare
	Contact Phone:	404-425-3246
Customer Information		
Customer Organization: Kern Health Systems	Contact Name:	Alan Avery
	Contact Title:	Chief Operating Officer
Customer Address: 9700 Stockdale Highway, Bakersfield, CA 93311	Contact Phone:	661-664-5005
	Contact Email:	alan.avery@khs-net.com
Project Information		
Total Vendor Staff:	5 Staff Members	
Project Objectives: Surveys are conducted to assess member and provider satisfaction		

Project Description: Provider Satisfaction, Custom Off-Season Member Satisfaction, CAHPS Simulation Surveys, Pre and Post Natal Experience Surveys				
Vendor's Involvement: SPH Analytics provides survey administration services				
Project Benefits: Certification and process improvement				
Key Personnel				
Name: Alan Avery		Role: Chief Operating Officer		
Project Measurements:				
Projected Membership of Vendor's Contract: N/A		Actual Membership of Vendor's Contract: N/A		
Reason(s) for change in membership: N/A				
Estimated Start & Completion Dates:	From:	2016	To:	2016
Actual Start & Completion Dates:	From:	2019	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: N/A				

Table 10: Subcontractor Reference #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

REQUEST FOR PROPOSAL

Department of Health and Human Resources, RFP CRFP 0511 BMS 1900000001

Customer Address: :I-20 at Alpine Road, Columbia, SC 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

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:

No changes in membership, all the references mentioned are active contracts, where VSP is covering the entire population

Estimated Start & Completion Dates:	From:	7/1/2010	To:	Present
Actual Start & 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 as identified by the State of WV or as requested by Aetna Better Health of WV.

Table 10: Subcontractor Reference #2

Subcontractor Information		
Vendor Name: Vision Service Plan (VSP)	Contact Name:	Larry DeAngelis
	Contact Phone:	330-209-0172
Customer Information		
Customer Organization: Community Health Plan of Washington	Contact Name:	Julie Keeffe
	Contact Title:	Director, Marketplace Strategy
Customer Address: 1111 Third Avenue, Seattle, WA 98101	Contact Phone:	206.521.8834
	Contact Email:	Julie.Keeffe@chpw.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				
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: 500		Actual Membership of Vendor's Contract: 500		
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 & Completion Dates:	From:	1/1/2013	To:	Present
Actual Start & Completion Dates:	From:	1/1/2013	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: VSP provided network support, development (as needed), credentialing/recredentialing activities, claims processing, call center support (both member and provider), activities associated with member health and wellness, and all reporting identified in the contract.				

Table 10: Subcontractor Reference #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

REQUEST FOR PROPOSAL

Department of Health and Human Resources, RFP CRFP 0511 BMS 1900000001

	Contact Title:	Vendor Manager
Customer Address: 7400 West Campus Rd.,New Albany, OH 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: 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	

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 & Completion Dates:	From:	1/1/2012	To:	Present

Actual Start & 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 provided network support, development (as needed), credentialing/recredentialing activities, claims processing, call center support (both member and provider), activities associated with member health and wellness, and all reporting identified in the contract.				

Table 10: Subcontractor Reference #1

Subcontractor Information		
Vendor Name: Welltok (Voxiva, Silverlink, Tracfone)	Contact Name:	Beth Cappucci
	Contact Phone:	720-414-1476
Customer Information		
Customer Organization: Virginia Premier Health Plan	Contact Name:	Carol Wilson
	Contact Title:	Director, Disease Management
Customer Address: 10800 Nuckols Rd., Glen Allen, VA 23060	Contact Phone:	804-819-5151 ext. 55274
	Contact Email:	Carol.wilson@virginiapremier.com
Project Information		
Total Vendor Staff:	6	
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 and pediatric preventative health ("Txt4health" and "Text4kids"), maternal health ("Text4baby"), diabetes health ("Care4life") and smoking cessation ("Text2quit").		

Quality campaign 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. Welltok works with Customer to scope messaging needs and adapt Templates as necessary to meet Customer goals.				
Vendor's Involvement: Member engagement through text messaging				
Project Benefits: Welltok has messages 120,799 members and have sent out 811,356 messages on behalf of Virginia Premier with Txt4health, Text4kids, Text4baby, ER-Diversion Campaign, Asthma Support Campaign, and the Benefit and Resource campaign.				
Key Personnel				
Name: Mike Degrano	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: 220,000	Actual Membership of Vendor's Contract: 93,682			
Reason(s) for change in membership: 'Able to message' list lower than average because client is not providing family link IDs and valid mobile phone number validation results				
Estimated Start & Completion Dates:	From:	6/1/2018	To:	6/1/2018
Actual Start & Completion Dates:	From:	6/1/2018	To:	6/1/2018
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 10: Subcontractor Reference #2

Subcontractor Information		
Vendor Name: Welltok (Voxiva, Silverlink, Tracfone)	Contact Name:	Beth Cappucci
	Contact Phone:	720-414-1476
Customer Information		
Customer Organization: Optima Health – a Service of Sentara	Contact Name:	Susan Peterson
	Contact Title:	Director of Communications
Customer Address: 4417 Corporation Lane, Virginia Beach, VA 234632	Contact Phone:	877-552-7401
	Contact Email:	SMPETERS@sentara.com
Project Information		
Total Vendor Staff:	6	
Project Objectives: To provide automated, interactive, evidence-based text messaging health programs, quality campaign templates, and the person to person platform 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 and pediatric preventative health ("Txt4health" and "Text4kids"), maternal health ("Text4baby"), diabetes health ("Care4life") and smoking cessation ("Text2quit"). Quality campaign 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. Welltok works with Customer to scope messaging needs and adapt Templates as necessary to meet Customer goals. The Person to Person platform allows health plan staff to communicate with members in real time. Use cases include, but are not limited to, reaching hard to reach members, appointment reminders, medication adherence, hospital discharge follow up, chronic condition management, member satisfaction surveys, prenatal outreach, and care management.		
Vendor's Involvement: Member engagement through text messaging		

Project Benefits: Welltok has messages 107,685 members and have sent out 190,666 messages on behalf of Optima Health with Benefit & Resource, Behavioral Health Campaign, and Person to Person for Behavioral Health Discharge. Members will be start receiving messages from Text4baby, Text4kids, Event Reminders, Health Risk Assessment in Q3 of this year.

Key Personnel	
Name: Mike Degrano	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: 500,000	Actual Membership of Vendor's Contract: 500,000
Reason(s) for change in membership: N/A	

Estimated Start & Completion Dates:	From:	3/1/2018	To:	2/28/2023
Actual Start & Completion Dates:	From:	3/1/2018	To:	2/28/2023

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 10: Subcontractor Reference #3

Subcontractor Information		
Vendor Name: Welltok (Voxiva, Silverlink, Tracfone)	Contact Name:	Beth Cappucci
	Contact Phone:	720-414-1476

REQUEST FOR PROPOSAL

Department of Health and Human Resources, RFP CRFP 0511 BMS 1900000001

Customer Information		
Customer Organization: Aetna Health Plan (Corporate)	Contact Name:	Robyn Steiman
	Contact Title:	Manager, Member Behavior Learning Pods
Customer Address: Aetna Health Plan, 151 Farmington Avenue, Hartford, CT 06156	Contact Phone:	718-938-7934
	Contact Email:	Steimanr@aetna.com

Project Information	
Total Vendor Staff:	6
Project Objectives: To test and compare member outreach to engage and activate members, through a series of pilot programs.	
Project Description: Welltok and Aetna have collaborated on 10+ pilot programs using Interactive Voice Response (IVR Calls) to test the efficiency of messages with a variety of clinical goals around removing barriers to care. Educational calls also alerted members to benefit changes or financial savings opportunities. Welltok technology allowed members to express intent, report on barriers to care, and hear 'barrier busting tips' in a dynamic fashion. Together, Aetna and Welltok conduct A/B messaging to determine the most effective messaging, and iterate in the next round of the campaign.	
Vendor's Involvement: Welltok provides IVR messaging and scripting consultations for Aetna's multi-channel member engagement pilots	
Project Benefits: Aetna has continued to refine and strengthen outreach methodologies to engage with members in personalized and efficient matters. Pilot programs are run before scaling the program to the larger population.	

Key Personnel	
Name: Beth Cappucci	Role: Sales/ Account Relationship Lead
Name: Brian Murphy	Role: Engagement Manager
Name: Tracy Clements	Role: Content Manager
Name: Mila Nutter	Role: Director of Implementation

Project Measurements:	
Projected Membership of Vendor's Contract: N/A	Actual Membership of Vendor's Contract: Target membership varies by campaign

Reason(s) for change in membership: N/A				
Estimated Start & Completion Dates:	From:	8/1/2018	To:	7/31/2019
Actual Start & Completion Dates:	From:	8/1/2018	To:	7/31/2019
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: N/A				

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 firms (and some firms of other nationalities) by the U.S. firm D&B. These ratings are based on a firm's worth and composite credit appraisal. Additional information is given in credit reports (published by D&B) that contain the firm's financial statements and credit payment history.

Coventry Health Care of West Virginia, Inc. dba Aetna Better Health of West Virginia (Aetna)[1] 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. Aetna is proud of our history as a West Virginia Medicaid health plan, working as such with the State since its transition to managed care in 1996[2] to improve health outcomes and reduce health disparities while serving as a responsible steward of State resources. Our excellent quality scores and strong financials, both currently and over the past 23 years, demonstrate our commitment to providing exceptional member service while ensuring fiscal sustainability.

We provide the current D&B Ratings Report for Aetna Better Health of West Virginia in **Appendix D**. The ratings include a Favorable viability rating (2) and identify Aetna Better Health of West Virginia as low risk of insolvency. To support our commitment to full transparency and to ensure that the Department has all financial documentation that may be relevant to confirming the fiscal soundness of our business, we have also provided the current D&B Ratings Report for Aetna Better Health of West Virginia's ultimate parent, CVS Health Corporation, which includes both a Favorable viability score (1) and a Fair D&B Rating of 5A3 with Low credit risk.

To further support and confirm the fiscal soundness of Aetna Better Health of West Virginia, 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 29, 2018, demonstrate an Excellent financial strength rating of A with stable outlook and an Excellent issuer credit rating of 'a' with stable outlook.

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[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.

[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.

In **Appendix D**, we provide the following:

- Dun and Bradstreet rating for Coventry Health Care of West Virginia, Inc. dba Aetna Better Health of West Virginia
- Dun and Bradstreet rating for CVS Health
- AM Best rating 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.

Aetna has served Medicaid members in West Virginia since 1996 and has maintained financial solvency and stability throughout our tenure in the State. Should there be a concern at any time regarding net worth, solvency, or surplus requirements, Aetna will 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. If the net worth of the subsidiary is deficient after the quarterly closing, the deficiency is noted on the Notes to the Financial Statements and a capital contribution is requested from the Capital Management team for immediate transfer of funds prior to the release of the financial statement. 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 requirements. There is no maximum limit to the financial support that Aetna Health Holdings will provide. 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 B** as part of the requirements for **Attachment B, Section 2, Mandatory Qualifications**. We have provided the contact information for the West Virginia OIC in **Table 11** 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 11**.

In the following table, please list credit references that can verify the financial standing of your company.

Table 11: Credit References

INSTITUTION	ADDRESS	PHONE NUMBER
West Virginia Office of the Insurance Commissioner	West Virginia Lottery Building 900 Pennsylvania Avenue	304-558-2100

INSTITUTION	ADDRESS	PHONE NUMBER
	Charleston, WV 25302	
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

ATTACHMENT C: PROJECT ORGANIZATION AND STAFFING APPROACH

Instructions: The Vendor is to 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 C: 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 key personnel resumes, 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 D: 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 (SOW) 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.
    - Whether the Vendor plans to co-locate a liaison within the Department, and if so, which position(s) the Vendor proposes to fulfill this liaison role.

- Identification of Subcontractor staff, if applicable.

- An organizational chart showing how Subcontractor(s) 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 the foster care and other 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/Medicaid 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 winning Vendor 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 the medical, social, or any other benefit. 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 in the event that 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 in the event that 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.

Coventry Health Care of West Virginia, Inc. dba Aetna Better Health of West Virginia (Aetna)[1] is ready to continue supporting the Department through a holistic system of specialized managed care to assist vulnerable children and youth statewide. Our mission is to keep kids safe in families and communities. We will promote and provide health services that improve the quality of the lives and futures of these children and youth through the Specialized Managed Care for Children and Youth project. Aetna already serves many of these members through the Medicaid population, which has been statewide since 1996[2]. Caring for these populations under a formal program will help us further delineate our approach to offering these members services and benefits. Our goal is to continue to improve their well-being and physical health while delivering these needed supports and services in the most integrated, appropriate, and cost-effective way.

Initial Staffing Plan

We will exceed West Virginia Code §9-5-27, which requires 80 percent of the full-time equivalent positions to be in West Virginia. The determination of appropriate staffing levels for this project is dependent upon several factors, including but not limited to the number of projected members and consideration of the special needs of the populations. Aetna's staffing plan uses a staffing ratio algorithm that includes clinical, non-clinical, and community-based support workers.

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As a current and successful West Virginia health plan **that is authentically West Virginian— shaped by state pride, deep roots, local knowledge, and strong personal connections—our staff is rich in experience serving these proposed populations, as we have been providing Medicaid benefits to West Virginians for more than 23 years.** Therefore, we need only to augment and scale up our current seasoned staff to an adequate number to support these new members. In addition to the current staff members already in place at our plan, we will hire upon contract award additional key staff for the children and youth populations to address the uniqueness of the contract requirements. **All staff positions will be headquartered and based in our Charleston office, but staff will be in all the regions, within the communities we serve, working face-to-face with our members and their families.** We will also have one staff member co-located within the Department.

Aetna's national Medicaid organization currently serves similar child and youth welfare populations in nine states: Arizona, Kansas, Kentucky, Louisiana, Maryland, Michigan, New Jersey, Pennsylvania, and Virginia. From the experience we have gained managing these programs, the Aetna Medicaid organization developed our System of Care (SOC) model with integrated Care Coordination teams to help children and their families or caregivers create holistic, person-centered individual service plans focused on evidence-based best practices, trauma-informed care (TIC), and social determinants of health. Aetna will combine our local experience with the best practices and staff experience, such as the SOC from our affiliated health plans and plans we manage, to bring unique and proven solutions to the state. The local West Virginia leadership team will be supported throughout the life of the contract by our national organization and will have access to additional support from the Finance, Claims, Encounters, and Compliance departments, as well as our Special Investigations Unit (SIU).

Our national Medicaid organization will support the Aetna local staffing process through expertise gained from 30 years of experience providing Medicaid services. Currently serving 16 states, the Aetna Medicaid organization continuously re-evaluates and revises staffing levels based on member growth and membership needs to help ensure consistent delivery of services. We have the flexibility to hire and train additional staff, refine processes, provide backup resources, and institute other changes to meet Department requirements. We base our staffing analysis on our national Medicaid organization's standard operating model, which projects staff needed by proven ratios or other metrics appropriate to each position type. While extensive experience serving similar child and youth welfare populations in nine states across the nation drives our project staffing model, we also use evidence-based guidelines built on time studies and complexity of care.

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 and dedicated West Virginia health plan and Medicaid experience. Staff experience specific to support the populations in this contract set us apart and include working with state-based organizations including Lily's Place, substance use and TIC expertise, serving on the Perinatal Partnership Substance Use in Pregnancy Committee, child and adolescent behavioral health and evidence-based practices and interventions, as well as the many staff members who assist with a variety of safe, child-friendly, family-oriented events at the Marcum Terrace Family Resource Center. In addition, we will be adding five new key staff positions upon contract award to support this population: the contract liaison/Medicaid administrator, a child SOC administrator, an adult SOC administrator, a justice SOC administrator, and a recovery and resiliency SOC administrator, as discussed in **Table C.1-1**. Each of these positions will be 100 percent dedicated to this new contract to bolster our strong foster care connections in the state and further our understanding of the unique issues that exist in each region. Additional proposed key staff knowledge and experience follow the key staff information. A complete description of all staff knowledge is listed in **Table C.1-2**. A high percentage of our staff is native to the

state, and our staff therefore inherently understands and relates to the issues relevant to these populations. In addition, each staff member is well connected in the community both personally and professionally. When there are changes in key staff, we will notify the Department within 14 days in writing and provide an updated organizational chart within 14 days of a request from the Department; all requests will be responded to by appropriately designated staff within 3 business days as well.

Table C.1-1: Key Staff Knowledge and Experience

Proposed Project Team Key Staff	Role	Brief Description: Knowledge and Experience to Support the Project
To Be Hired Upon Contract Award	Contract Liaison/ Medicaid Administrator	We are committed to having the best resource in each role so that we can effectively meet the Department's goals. The person filling this role will be highly qualified, with the experience and expertise to lead our contract serving children and families. They will be 100% dedicated to the new contract and will fulfill all the Department's requirements, including the following: • Attending meetings, legislative committees, and hearings in person as requested by the Department • Establishing and maintaining a positive client relationship • Providing timely and informed responses to operational and administrative inquiries that arise • Making contractual, operational, and financial decisions, including but not limited to claims payment and provider relations/contracting • Meeting with Department staff or other person(s) as designated by the Department on a regular basis to provide oral and written status reports and other information as required • Responding to issues involving information systems and reporting, appeals, quality improvement, member services, service management, pharmacy management, medical management, care coordination, and issues related to the health, safety, and welfare of the member • Ensuring that each member 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 member, per 42 CFR § 438.208(b)(1)
Todd White	Chief Executive Officer	During his 24 years of health care industry 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 syndrome (NAS) facilities, Lily's Place. He has been employed by Aetna (through its predecessor Coventry Health Care of West Virginia) for over 22 years. Prior to his experience working at the health plan, Mr. White worked with vulnerable youth at the West Virginia Rehabilitation Center and is a longtime member of the West Virginia Association of Health Plans, serving as the secretary/treasurer.
Tina Bailes	Chief Financial Officer	Tina Bailes' experience includes 16 years of service working in the Medicaid program, holding various fiscal roles prior to transitioning to her current role as chief financial officer. She previously 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 members it servers, as well as the financing structure for access to needed services and provider participation to ensure services are delivered.

Proposed Project Team Key Staff	Role	Brief Description: Knowledge and Experience to Support the Project
Donald Gibbon, DO (CMO)	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. His expertise includes leadership roles in the emergency, occupational, and urgent care medicine fields, adult and child trauma treatment, and substance use/trauma arenas. He has been treating children since he graduated from medical school in 1990. 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.
Frank Angotti III, MD	Behavioral Health Medical Director	Dr. Frank Angotti III participates with the Shared Services team on transforming the Aetna Medicaid organization into a trauma-informed organization. He developed and steered the pilot for TIC for Aetna Better Health of West Virginia—over 70% of the plan has completed foundational training in TIC. He is also a member of the Governor's Council on Substance Use.
Kimi King, BSN	Medical Management Director	Kimi King serves as a member of the Perinatal Partnership Substance Use in Pregnancy Committee. Ms. King is also the West Virginia representative for March of Dimes for West Virginia and Kentucky and works with pregnant mothers with substance use disorder and babies with NAS. She has developed and implemented programs in West Virginia for babies with NAS and high-risk youth.
Johna Easter, RN, CCM	Care Management Director	Johna Easter is a certified transplant specialist who has served infants and children needing organ and bone marrow transplants. Through these efforts, she provided education to members and families, including various resources available for this specialized care. Ms. Easter has served children and youth in foster care throughout her career.
Margaret Heasley, MSW	Social Services Director	Margaret Heasley is a longtime West Virginian and is an experienced therapeutic and clinical professional with 28 years of health care industry experience and 19 years of experience supporting child welfare programs. Her expertise includes child and adolescent behavioral health and evidence-based practices and interventions. She is well-versed on the health and well-being of children who have experienced trauma, particularly in early childhood.
Louann Petts	SNS Liaison	Louann Petts is a key member of the TIC Core Implementation team and works to transform our plan into a trauma-informed organization. Along with the behavioral health medical director, Ms. Petts met with community organizations to discuss opportunities for our plan to help fund programs at Mission West Virginia, for a school mentoring program for foster youth, and Crittenton Services for a program that assists parents/guardians of adolescents who are pregnant or parenting.
Elaina Wickas, RN, BSN	Quality Director	Through her role in quality management, Elaina Wickas has worked with individuals in foster care custody. Ms. Wickas is a native West Virginian raised in the Point Pleasant area; she has 34 years of health care industry experience and 6 years of managed Medicaid experience in West Virginia, including managed care quality improvement, managing large-scale teams and projects, regulatory and accreditation compliance, and audit oversight. She is responsible for developing and implementing the Quality Assessment and Performance Improvement (QAPI) programs and policies in addition to running the department's operations.

Proposed Project Team Key Staff	Role	Brief Description: Knowledge and Experience to Support the Project
Alva "Fuzzy" Page III, JD	Program Integrity Lead	During his time as both the assistant attorney general and the general counsel for the Bureau for Medical Services, Mr. Page worked closely with the Bureau for Children and Families on individual cases as well as joint policy matters, and he assisted in the successful defense of a $23 million disallowance brought by the Centers for Medicare & Medicaid Services involving school-based health services provided under the Medicaid program.
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 19 years of managed Medicaid experience, including network development, contract negotiation, provider relations, credentialing, provider billing, and process improvement. Currently he is responsible for overseeing the network development and contracting activities for physical and behavioral health 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 to develop the provider network.
Sarah White, MBA	Provider Relations Director	Sarah White, a native West Virginian, 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. 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. Prior to joining Aetna, she served as a senior provider relations representative for Coventry, where she oversaw credentialing and contracting new providers and updated existing providers' credentialing and contracts. In her personal time, she volunteers at her church caring for foster children in the nursery and youth group.
Brad Liston, MS	Information Technology Director	A native West Virginian, Brad Liston is a subject matter expert in information systems and 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. Prior to joining Aetna, he was a database administrator of management information systems for the West Virginia Department of Health and Human Resources, where he was responsible for data loads, backups, validation, and general financial and medical reporting.
Kelley Mitchell	Member Services Director	Kelley Mitchell currently oversees the day-to-day operations of our member services operation by monitoring calls, educating staff, and ensuring all metrics are met and/or exceeded. Prior to joining Aetna, she served as a customer service supervisor for CareFirst BlueCross BlueShield, where she was responsible for developing a proactive service model for high-volume providers, including those who served vulnerable children and youth population. As a pastor's wife, Ms. White also works with low-income youth who have a parent who is incarcerated or involved in substance use. Her church helps these children attend church camp at no cost each summer, takes them to events, and has provided food, clothing, and school supplies.

Proposed Project Team Key Staff	Role	Brief Description: Knowledge and Experience to Support the Project
April Ballengee	Claims Payment Director	April Ballengee is a native West Virginian who has lived experience being homeless during her high school years; this experience drove her desire to train in TIC. Currently, she is a claims subject matter expert with 18 years of health care industry experience and 3 years of managed Medicaid experience in West Virginia; this includes experience in claims projects and reviews, trend analysis, provider risk management, and customer service. Ms. Ballengee also served as a network relations manager for CareFirst BlueCross BlueShield, where she managed risk to providers and maintained positive provider relationships.
Jim Smallridge, RN	Community Engagement Director	Jim Smallridge developed and coordinated the collaboration between our health plan and the state's two food banks in a mobile pantry program. He also collaborated with community groups so our plan could sponsor monthly food and health care information distribution events at one of the largest government-funded housing facilities in the state; this is part of an ongoing program at the Marcum Terrace Family Resource Center, at which our plan staff assists with a variety of safe, child-friendly, family-oriented events.
Diane Paletta, DDS	Dental Director	Dr. Diane Paletta has practiced dentistry for over 40 years serving West Virginians. 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. 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. She also serves as the West Virginia dental director for SKYGEN; 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.
Virginia White	Medicaid Member Advocate	Virginia White, a West Virginia native, is an experienced case management and counseling professional with 6 years of health care industry experience and 6 years of managed Medicaid experience. Her expertise includes case management, TIC, and Mental Health First Aid.

Additional Key Staff

In addition to the key staff proposed by the Department for the Specialized Managed Care for Children and Youth project, Aetna proposes four key staff positions (to be hired upon contract award). They are a recovery and resiliency SOC administrator, a child SOC administrator, an adult SOC administrator, and a justice SOC administrator. The knowledge and experience required of these positions/staff are highlighted in **Table C.1-2**.

Table C.1-2: Additional Proposed Key Staff Knowledge and Experience

Additional Proposed Project Key Team Staff	Role	Brief Description: Knowledge and Experience that will be Required to Support the Project
To Be Hired Upon Contract Award	Recovery and Resiliency SOC Administrator	This position will develop and implement supportive programs and interventions to address mental health, substance use, foster care delivery, and coordination, including resiliency training and development, advocacy, foster family and biological family support, and recovery maintenance. The position is responsible for member advocacy and for identifying and

Additional Proposed Project Key Team Staff	Role	Brief Description: Knowledge and Experience that will be Required to Support the Project
		removing barriers to access and supports. The skill set for this position must include experience collaborating with health system and community-based stakeholders, effective communication and cultural sensitivity skills, and experience in recovery and resiliency modalities.
	Child SOC Administrator	This position will work to build stakeholder relationships for the purpose of planning and delivering services and community-based supports for members in all regions. The position is responsible for collaborating with the Provider Relations team to coordinate networks to serve the Specialized Managed Care for Children and Youth project populations. The skill set for this position must include knowledge of school-aged populations and the foster care system, along with an understanding of the needs of transition-aged youth.
	Adult SOC Administrator	This position will collaborate with the Department and other stakeholders to assist members with waiver applications, durable medical equipment, and referrals for independent living skills supports. The position is responsible for developing workflows for assessments and collaborating with the Provider Relations team to coordinate networks to serve Specialized Managed Care for Children and Youth populations. The skill set for this position must include knowledge of community services and supports that are available for the adult population, effective collaboration and communication skills, and experience working with stakeholders to deliver covered services.
	Justice SOC Administrator	This position will collaborate with the Department of Juvenile Justice, Department of Corrections, county jails, sheriff's offices, court and probation departments, and the Department to identify systemic changes and promote community integration. The position is responsible for developing training curricula for law enforcement, advocacy, and legal system stakeholders. The skill set for this position must include experience and knowledge of the various components of the justice system and justice process and workflow development.

Support Staff

Aetna proposes 95 support staff positions (to be hired upon contract award). These positions will include care management, customer service, quality, clinical liaison, special needs representative, and network operations roles, among many others. The knowledge and experience required of these positions/staff are highlighted in **Table C.1-3.**

Table C.1-3: Proposed Support Staff Knowledge and Experience to be Required

Proposed Project Support Staff	Role	Brief Description: Knowledge and Experience that will be Required to Support the Project
To Be Hired Upon Contract Award	Community Development Coordinator	This role will develop, facilitate, and implement 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	This role will provide overall supervision of customer service employees and will be accountable for member/provider satisfaction, retention, and growth by efficiently delivering competitive services to members/providers.
	Care Management Associate	This role will provide comprehensive health care management to facilitate delivery of appropriate quality health care and will promote cost-effective outcomes and improve program/operational efficiency involving clinical issues.
	Contract Negotiator	This role will negotiate, execute, review, and analyze contracts and/or handle dispute resolution and settlement negotiations with smaller providers (i.e., local individual providers, small groups/systems) within company standards to maintain and enhance provider networks and will meet/exceed accessibility, compliance, quality, and financial goals/cost initiatives.
	Clinical Liaison	This role will be the clinical lead focusing on integrating member care and clinical coordination, leading the development, implementation, and ongoing monitoring of program and quality initiatives to address member needs. The role will also represent plan and collaborate with State government, key stakeholders, community organizations, advocacy groups, and our chief medical officer/leadership team to enhance the quality of services and to ensure adherence to performance.
	Case Management Coordinator	This role will collaborate and inform the case management process to facilitate appropriate health care outcomes for members by providing care coordination, support, and education for members through care management tools and resources.
	Customer Service Representative	This role will serve 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. The incumbent will engage, consult, and educate members based upon the member's unique needs, preferences, and understanding of plans, tools, and resources to help guide members along their care path.
	Case Manager RN	This role will be responsible for assessing, planning, implementing, and coordinating all case management activities with members to evaluate medical needs to facilitate overall wellness. The incumbent will develop proactive course of action to enhance short- and long-term outcomes and to enhance members' overall wellness, including providing input for strategies, policies, and programs for network management and clinical coverage policies.
	Senior Inbound/ Outbound Queue Associate	This role will support comprehensive coordination of medical services including intake, screening, and referrals; promotes and supports quality effectiveness of health care services. The incumbent will serve as a training resource, mentor, and subject matter expert.

Proposed Project Support Staff	Role	Brief Description: Knowledge and Experience that will be Required to Support the Project
	Manager, Clinical Health Services	This role will perform oversight and management of clinical team processes, including the organization and development of high-performing teams.
	Special Needs Representative	This role will be responsible for the proactive identification of members with special needs based on referrals from within or outside the health plan; he or she will coordinate access to care and services that are appropriate to the member's condition or circumstance.
	Network Contract Specialist	This role will be responsible for loading, implementation, and maintenance of standard provider contracts, schedules, and agreements and files in support of business segment contracting initiatives.
	Health Care Quality Management Consultant	This role participates in the development and ongoing implementation of quality management (QM) work plan activities; he or she improves quality products and services by using measurement and analysis to process, evaluate, and make recommendations to meet QM objectives.
	Supervisor, Clinical Health Service	This role will be responsible for oversight of health care management staff, including the organization and development of high-performing teams; he or she will work closely with functional area managers to ensure consistency in clinical interventions supporting our members; this role will also be accountable for meeting the financial, operational, and quality objectives of the unit.
	Network Operations Consultant	This role serves as the subject matter expert in support of contracting initiatives and data audits to enhance provider networks while meeting and exceeding accessibility, compliance, quality, and financial goals; he or she will be responsible for reviewing, building, and auditing complex contract and network data; the incumbent will support recruitment efforts and collaborates on negotiations as needed.
	Outreach Coordinator, HEDIS	This role will facilitate provider and member outreach to ensure member receipt of important clinical services to improve member health outcomes; the incumbent will provide 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; he or she will support effective medical record capture for HEDIS medical record review and abstraction of supplemental data.
	Analyst	This role will gather initial data in support of research on various projects and may generate reports for internal programs; the incumbent will ensure data quality and program or retrieve simple reports and generate standard reports for unit; he or she may assist with the analysis and research of data.
	Network Relations Consultant	This role acts as the primary resource for assigned, high-profile providers or groups (e.g., local individual providers, small groups/systems) to establish, oversee, and maintain positive relationships by assisting with/responding to complex issues regarding policies and procedures, plan design, contract language, service, claims, or compensation issues, and provider education needs.

Proposed Project Support Staff	Role	Brief Description: Knowledge and Experience that will be Required to Support the Project
	Clinical Solutions Medical Director	This role will include a balance of internal/external-facing activities that support a shift to a higher-touch, patient-centric focus; the incumbent will develop, implement, support, and promote population health strategies, tactics, policies, and programs that drive the delivery of high-value health care; he or she will manage strategies, policies, and programs comprised of care management, utilization management, quality improvement, and network management as well as clinical coverage protocol; the incumbent will be provider- and patient-facing and have fluency in data analytics.
	Health Care QM Analyst	This role will provide data collection and administrative/technical support to the QM staff to support completion of QM department business plans.
	Manager, Quality Management	This role will maintain oversight of the quality management functions. The incumbent will consult and work cross-functionally to influence and promote change to deliver quality service to our internal and external customers.
	Director, Clinical Pharmacy	This role will develop and promote strategies and policies that enhance quality of pharmaceutical care in a cost-effective manner.
	Finance	This role will assist in the fulfillment of the company's internal and external financial reporting obligations, internal control objectives, and financial system design and operation.
	Complaint and Appeal Analyst	This role will be responsible for managing resolution complaint/appeal scenarios for all products, which may contain multiple issues and may require coordination of responses from multiple business units; the incumbent will ensure timely, customer-focused response to complaints/appeals. He or she will identify trends and emerging issues and report and recommends solutions.
	Inbound/ Outbound Queue Associate	This role will support comprehensive coordination of medical services including intake, screening, and referrals to medical services programs; the incumbent will promote/support quality effectiveness of health care services.
	Complaint and Appeal Program Manager	This role will establish and maintain, in collaboration with all segments and business units, consistent policies and procedures defining the administration and resolution of complaints, grievances, and appeals from member and providers compliant with legislative, regulatory, and accreditation requirements; the incumbent will maintain this infrastructure to assure ease of use and consistent resolution responses are accessible to all operational resolution teams and business units and subject matter experts.
	Risk Management Associate	This role will manage the negotiations of self-funded agreements (such as administrative services agreements/master services agreements/business associate agreements), stop-loss contracts, and other special contractual arrangements and exhibits, by using delegated response databases and selectively engaging legal and financial teams and other business decisionmakers in contract negotiations when standard responses are unavailable or insufficient; the incumbent will develop language for those self-funded agreements/contracts based on information provided by subject matter experts and guidance by the Legal department.

Proposed Project Support Staff	Role	Brief Description: Knowledge and Experience that will be Required to Support the Project
	Clinical Case Manager, Behavioral Health	This role will use advanced clinical judgment and critical thinking skills to facilitate appropriate member physical health and behavioral health care through assessment and care planning, direct provider coordination/collaboration, and coordination of psychosocial wraparound services to promote effective utilization of available resources and optimal, cost-effective outcomes.

Children and Youth Program Experts Provide Additional Support to our Proposed Staff

The cornerstone of our staffing plan is highly experienced leadership with extensive local, program-specific knowledge. Aetna national Medicaid organization child welfare expert Joshua Boynton, executive director/vice president for Aetna Better Living, will stand with Aetna Better Health of West Virginia to help guide and direct care for these populations. Mr. Boynton has 20 years of community-based health care industry leadership experience and 6 years of managed Medicaid experience. In this role, he is responsible for segment strategy, business growth, and development of the complex care intellectual and developmental disabilities (I/DD), child welfare/foster care, and managed long-term services and supports segments. His expertise includes managing business change and strategic planning. Mr. Boynton is a successful entrepreneur who founded LifeShare, a nationally recognized, multi-million-dollar company that supports people with I/DD and children in the child welfare system.

Kevin Campbell will also provide expertise and training to Aetna Better Health of West Virginia. Mr. Campbell is an internationally known youth permanency expert, founder of the Center for Family Finding and Youth Connectedness, and developer of the Family Finding model, a set of strategies now used throughout the United States and Canada to establish lifelong supports for youth in foster care. Prior to developing Family Finding, Mr. Campbell was an administrator, director, and vice president in the social service sector for over 28 years. Currently, he develops strategies to address the epidemic levels of loneliness that youth in foster care experience while waiting for a chance to go home to family or be adopted. He has helped over 10,000 youth achieve permanency and continues to help up to 80 foster youth a week through his advanced permanency trainings and technical assistance with agencies nationwide. To date, he has worked with over 200 jurisdictions across more than 40 states and Canada.

Resources Necessary to Fulfill the Requirements for Key Staff and Support Staff

Aetna Better Health of West Virginia, in collaboration with the national Aetna Medicaid organization, will employ a clearly defined staffing model designed to fulfill all RFP requirements and to adjust to the changing needs of the State's program. This includes an Implementation team, Aetna Medicaid organization subject matter experts, and West Virginia health plan experts. Our proposed staffing plan is continuous, integrated, and scalable. It is built on the principle of West Virginians serving West Virginians—developing a staff with a personal and professional passion for serving children in foster care and similar populations and managed by key staff and health plan leaders to help ensure adequacy of staffing to a growing membership or any new contract requirements.

Our staffing plan is built on highly experienced leadership with extensive local, program-specific knowledge. To support this contract, we are committed to attracting additional professional staff with significant experience serving populations like the Specialized Managed Care Children and Youth project. Our project leadership will seek local candidates who are experienced and familiar with the local Medicaid health care delivery system and culture in the state and have the West Virginia licensures and

certifications required by law and the contract. Our proposal for providing all the resources necessary to adequately fulfill the requirements for key staff is discussed in the following narrative.

Our Implementation Team

Our Implementation team uses a focused and proven protocol to serve the needs of our members. Our implementation processes have passed all State readiness reviews and met all go-live deadlines within required timeframes. **In 30 years, Aetna's national Medicaid organization has never failed a readiness review**, and we will use this experience and proven work plan process to implement the West Virginia Specialized Managed Care for Children and Youth project in a timely and compliant manner.

The Aetna national Medicaid organization's 30 years of experience serving members will help position us for a seamless implementation of the children and youth populations in West Virginia. We view the Department as a partner in ensuring successful implementation and minimizing disruption to members. Our Implementation team is comprised of highly experienced, cross-functional leaders, subject matter experts, and employees from physical health, social, and behavioral health areas. Our implementation director has more than 40 years of clinical experience and over 18 years of experience implementing Medicaid programs. The dedicated experts on the team follow a proven implementation process grounded in numerous successful implementations and program expansions.

Our local Implementation team includes the regional vice president for Aetna Better Health of West Virginia, as well as the plan's chief executive officer (CEO), chief operating officer (COO), chief medical officer, chief financial officer, and other valued health plan staff. It also includes many departments within the health plan. The following local plan departments are represented on the Implementation team: Grievances and Appeals, Marketing, Medical Management, Member Services, Network, Pharmacy, Program Integrity, Provider Services, Quality Management, Compliance, and Community Advocacy. Additionally, our national Medicaid organization's Implementation team includes the implementation director, implementation senior project manager, implementation project manager, after-hours manager, check run manager, and claims project manager. Staff members from System Configuration, Encounters and Enrollment, Human Capital, Informatics, Information Technology, Learning and Performance, Provider Data Management, Real Estate, Telecomm, and Vendor Management complete the Implementation team.

Implementation Success Story

When Aetna implemented the Long-Term Services and Supports program in Virginia, we were able to hire more than 300 new staff quickly using a detailed hiring project plan that included posting positions on the Aetna website, LinkedIn, and other electronic venues; at local colleges, universities, and community-based organizations; and at local health care associations. We conducted 10 major job fairs across Virginia in 7 different regions over 4 months. We offered positions to 107 job fair candidates among more than 400 total candidates. We received over 10,000 resumes; screened more than 1,000 candidates; and conducted more than 800 individual interviews, as well as second, third, and fourth interviews depending on the position. Aetna completed background checks and hired 331 new employees in 4 months.

Organizational Chart Showing Corporate Structure and Relation to Proposed Service Areas including Staffing and Functions Performed at the Local Level

As illustrated in **Figure C.1-1,** our West Virginia leadership team will be led by Todd White, CEO of Aetna Better Health of West Virginia. The new contract liaison/Medicaid administrator (hired upon contract award) will lead the Specialized Managed Care Children and Youth Contract project. Our integrated, collaborative team will support this new initiative through consultation, including lessons learned from previous implementations and programs managed. The West Virginia Children and Youth project leadership team will manage the delivery and operations of the program, leveraging our

longstanding, positive relationships with providers, community resources, advocacy groups, regulatory agencies, and other organizations throughout the state. Our project leadership team will leverage from foster care program experience 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.

REQUEST FOR PROPOSAL

Department of Health and Human Resources, RFP CRFP 0511 BMS 1900000001

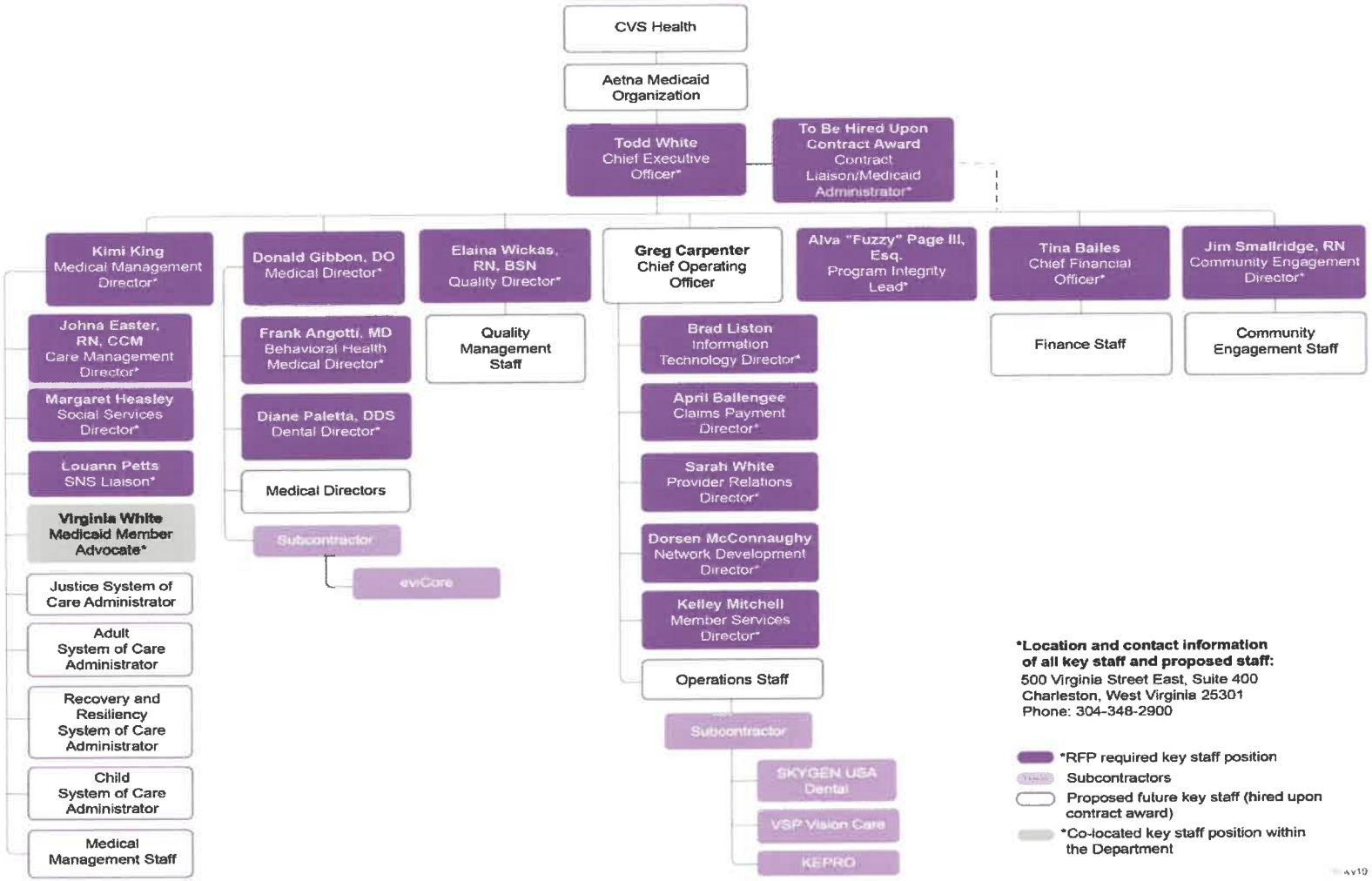

Figure C.1-1: Aetna Better Health of West Virginia's Key Staff and Proposed Service Areas Organizational Chart
Our key staff and proposed service area organizational chart emphasizes experience, accountability, and flexibility.

Organizational Chart Showing Subcontractor Management

Figure C.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.

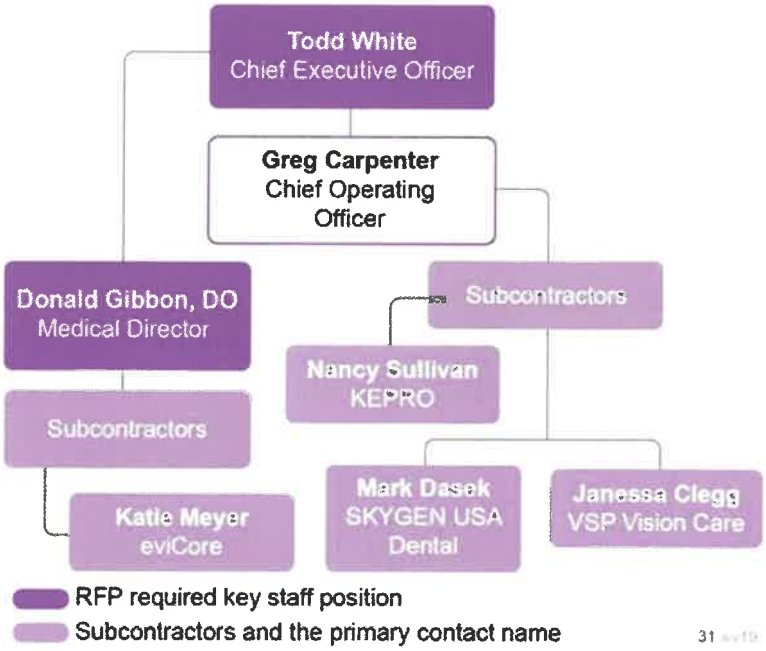

Figure C.1-2: Aetna Better Health of West Virginia Subcontractor Organizational Chart
Our subcontractor organization chart emphasizes oversight for accountability, compliance, and conscientious stewardship of West Virginia resources.

Aetna proposes a cohesive leadership and governance structure to support the Specialized Managed Care Children and Youth project, providing expert personnel committed to ensuring quality and innovative programming in fulfillment of all contract requirements. The following explains the organizational charts:

Key Staff and Proposed Service Area Organizational Chart

Figure C.1-1 illustrates our functional operating structure of the health plan and how each of our key staff report up to top-line plan management. Our medical management functions including care management, social services, and socially necessary services (SNS) liaison and Medicaid member advocate functions, as well as behavioral health medical management, dental services, and quality management, will ultimately report to Todd White, CEO. Mr. White will also supervise community engagement, program integrity, and health plan finance as well as our four additional key staff specific to our SOC plan. The contract liaison/Medicaid administrator will oversee the day-to-day operations of the new contract operations, including attending in person, upon Department request, meetings and hearings of legislative committees and interested governmental bodies, agencies, and officers; will make contractual, operational, and financial decisions such as claims payment; will oversee provider relations/contracting; and will ensure that each member 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 member, per 42 CFR § 438.208(b)(1), among other requirements stipulated by the Department.

Greg Carpenter, our chief operating officer, will oversee claims payment, information technology, provider relations, network development, and member services, as well as three additional subcontractors: SKYGEN; VSP Vision Care; and KEPRO.

Subcontractor Management Chart

Figure C.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. Our contract liaison/Medicaid administrator will oversee all medical covered and excluded services listed in **Appendix A** of the draft managed care organization (MCO) foster care contract as it pertains to dental, vision, and other applicable subcontracted services. For example, dental services would include diagnostic, preventive, therapeutic, or palliative care or the treatment of an injury, and vision services would include lens, glasses frames, and preventive checkups. Our medical director, Dr. Donald Gibbon, has direct, daily responsibility for our high-end radiology and pain management subcontractor, eviCore, and maintains all oversight, reporting, and monitoring activities between eviCore and the health plan as well as our oversight committees: our Joint Oversight Committee (JOC) and our Delegated Vendor Oversight Committee (DVOC). Dr. Gibbon will report eviCore oversight directly to Todd White, our CEO. Our dental, vision, and SNS subcontractors, SKYGEN, VSP Vision Care, and KEPRO, respectively, will report into our operations function, which will maintain oversight and all reporting, and monitoring activities related to their contract requirements. These subcontractors will also be monitored by the JOC and DVOC.

Tools and Processes Used to Screen Available Staff to Fill Positions

Aetna uses proven methodologies for completing startup and expansion activities and maintaining ongoing operational staffing. We only hire experienced candidates who meet the qualifications and requirements of the job, and we use screening and hiring tools and techniques that define by position the knowledge, education, skills, and competencies candidates must possess.

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**.

The hiring process for internal staff and external candidates includes the following:

- Use of job descriptions to define and communicate to candidates properly 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 finalist candidates
- Posting positions specific to experience serving children, youth, and foster care populations and publications, websites, and other outlets such as organizations that assist those with disabilities and those that support diversity; postings will be available on both internal and external job sites, advertising on recruiting websites, job boards, and niche sites
- Launching pipelining activities that include virtual job fairs and open houses; social sharing of job postings on LinkedIn, leadership networking, resume mining, and web sourcing
- Promoting our internal REACH employee referral program and using employee referral campaigns
- Review of candidate applications by our recruiters
- Telephonic prescreening of candidates by our recruiters
- Utilization of 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 prior to offer extension
- Offering recruitment incentives to boost candidate interest (e.g., sign-on bonuses, flex scheduling, and relocation assistance)

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's pre-employment screening is another component of our hiring process when we hire externally. Our Human Resources department thoroughly 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 appropriate qualifications, knowledge, and experience. Aetna is committed to the safety of our members and employees, and we conduct background screening and criminal background checks on all our employees at time of hire. Our background screening process includes validation that the potential employee is not on the Medicaid or Medicaid exclusion list or 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.

Aetna will not employ or contract with any individual who has been debarred, suspended, or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities. Aetna does not expect to encounter any issues in recruiting or retaining competent professionals for this new contract. 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, **Aetna is one of only nine companies, and the only one in our industry, to have achieved a 100 percent rating each year since the Human Rights Campaign Foundation introduced their Corporate Equality Index in 2002**. In 2016, the National Association of Female Executives honored Aetna in its Hall of Fame as one of only five companies making their list of **Top 60 Companies for Executive Women** for at least 15 years. Through the high-performing people we hire, we are committed to creating an inclusive environment fueled by innovative ideas. Our employees have diverse cultural backgrounds, beliefs, perspectives, and lifestyles; however, they have one thing in common: their ability to excel.

Process for Replacing Key Staff and Backfilling Positions Within Timeframes

Our key staff will align with and include all staff required in the RFP. If a key staff opening occurs before or after the contract signing, Aetna has a robust talent acquisition and talent succession process designed to ensure continuity and stability in the deliverance of services under the contract. We place a high priority on identifying the best talent from a diverse pool of candidates throughout West Virginia to build a key team integral to the delivery system and dedicated to making a difference in people's lives. We only hire replacement/backfill candidates who meet the qualifications outlined in the job. Once hired, these new employees undergo a structured orientation to their job. We use a comprehensive recruitment approach, deploying our Talent Acquisition team experts immediately upon learning of a key staff opening. As part of our hiring plan, concurrent with external sourcing activities, we also identify internal interim replacement staff who are subject matter experts until permanent replacement staff are hired.

Aetna will handle the notification of all key staff vacancies as defined in the RFP, in accordance with State requirements. Our West Virginia-based compliance officer will do all the following:

- Notify the State at least 30 calendar days in advance of any plans to change, hire, or re-assign key personnel; we understand and confirm that any key staff new hires will be of equal or greater experience and qualifications **[MR036]** than the individual they are replacing
- Employ key staff, one person per position, to be assigned to the project on a full-time basis, and all key staff members will begin employment with the project within 30 calendar days of the contract award **[MR0037]**
- Report key personnel changes to the State no later than 10 business days **[MR0038]** from learning of the intended departure
- Fill all key positions within 30 business days of departure **[MR0039]**, unless a different timeline is approved by the State. We understand and confirm that the replacement personnel must be of equal or greater experience and qualifications than the individual they are replacing
- Remove any staff the Department determines has interfered or could interfere with the Department interests **[MR0040]**
- Identify a minimum staffing level (which will be defined over time) and maintain that staffing level during designated business hours

Hiring Plan for Administration of the Contract Awarded Through This Solicitation

We project hiring our additional key staff and additional Care Management staff within 30 days of notification of award to allow enough time for onboarding and training. By the time our full roster is hired, we will have a total support from 142 full-time equivalents (FTEs), reflecting the resources planned to execute on the management of services and to serve the new population for the Specialized Managed Care for Children and Youth project. Since 1996, the health plan has been building the relationships necessary to find and identify potential candidates. We have a clearly defined staffing model designed to fulfill all RFP requirements and to adjust to the changing needs of the new program. Our staffing plan is managed by local health plan leaders to help ensure adequacy of staffing for growing membership or any new contract requirements.

The cornerstone of a successful staffing plan is highly experienced leadership with deep, local, program-specific knowledge. Staff recruitment will be led by Todd White, CEO, a native West Virginian and health plan executive, with the support of our Implementation, Human Capital, and Talent Acquisition team experts. With more than 23 years of West Virginia Medicaid experience, Mr. White will play a key role in hiring. He will be supported by the highly experienced, qualified, and talented Aetna team identified in **Table C.1-3** to bridge any gaps between contract award and the implementation of new staff. To support this contract effectively, Aetna is committed to attracting professional staff with significant experience managing care for the project's child and youth populations. Mr. White and his leadership team will seek local candidates who are experienced and familiar with local health care delivery system in West Virginia and have all the appropriate West Virginia licenses and certifications required by state law and the contract. Approximately 90 percent of key and support staff will be based in West Virginia.

Initially, our staffing plan assumes a total membership of approximately 19,000 members. Based on our experience in 16 states, Aetna continuously reevaluates and revises staffing levels to ensure consistent delivery of services. 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 should there be an unexpected increase in volume.

Additionally, we leverage staff from other Aetna health plans. Through the sharing of programs, policies, procedures, outcomes, and individuals with Medicaid expertise serving families, children, and youth; children and youth in foster care/adoption/guardianship circumstances; aging-out youth; and individuals with special needs and disabilities, we are able to bring more diverse staff training and mentoring as needed. The local West Virginia leadership team will be supported throughout the life of the contract by

our national organization and will have access to the full and undiluted strength, breadth, and depth of resources available through our national Medicaid organization.

Employee Onboarding and Training

Our employee training program provides the appropriate orientation, training, and education necessary for the contract liaison/Medicaid administrator and 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 building of competencies, and topics relevant to the Medicaid population in West Virginia.

Our approach to training and knowledge transfer ensures continuity of operations and provider relationships as staff members join the team or transition to new roles within the organization. New staff members in key positions are also linked with more experienced health plan staff for mentorship and support. 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**. Then they must submit an attestation confirming they have completed the training and understand how to use the tools and information to do their job. Training is delivered by onsite trainers, web-based tools, role-playing, and adult learning approaches.

Specialized Managed Care for Children and Youth project training will occur throughout the year for new hires and ongoing training will be held annually for all incumbent staff. We have developed numerous tools to help member services staff while on the job. Additional details for the Aetna training plan include, but are not limited to, the following:

- Two- to six-week general new hire onboarding followed by functional job training (length of training varies by position)
- TIC training of all staff to achieve the plan's goal of 100 percent trained staff
- Comprehensive overview of our culture, including our values and ethics, and dedication to providing an environment that is focused on our members and providers
- Cultural competency initiatives and training to address members' specific social, behavioral, cultural, and language needs that might challenge their ability to access care or understand healthy practices
- Health literacy and cultural competency training program as a critical component of our employee orientation
- Training to dispel the myths and stigmas related to disabilities and the negative attitudes often associated with mental illness and physical/sensorial disabilities
- Mandatory compliance and ethics training, including but not limited to topics such as the Health Insurance Portability and Accountability Act; ethics and 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, and identification of risks and issues as well as 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 Children and Youth project -specific assessments and timeframes
- Benefits and coordination of benefits and services

All Aetna employees must complete annual retraining of required policies and procedures such as the following:

- Medicare Compliance and Fraud, Waste, and Abuse Training (course #210159)

- CVS Health Code of Conduct (course #209782)
- Recognizing and Preventing Workplace Violence (course #209725)

How Staffing Numbers Reflect Adequate Access

We have planned our full-time employee numbers around how to most effectively meet our members' needs as they evolve. We recognize the complex care needs that are important for children, youth, their families, and aging-out adults, and we have included that consideration in the development of our FTEs. We anticipate approximately 128 FTEs with 4 additional key staff. Seventeen will be support from our national Medicaid organization, such as from the Claims, Encounters, Grievance and Appeals, and Finance departments. West Virginia-based staff will support our health plan in the first year of the program. While we based our initial staffing plan on the assumption that our plan enrollment will equal one-third of the statewide enrollment, we will continuously reevaluate and revise.

Care management: In addition to matching members' care needs to the care manager with the most relevant experience, appropriate staffing ratios are essential to a balanced and successful Care Management (CM) 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, training, supervision, and documentation. When we approach the caseload maximum thresholds, our leadership team conducts a staffing review. Based on the results of this review, we submit a requisition to hire additional care managers or reallocate resources without exceeding the maximum target ratios.

To meet all contract requirements and meet the needs of this population, Aetna will hire additional care coordinators to provide services across three tiers of the care management stratification, accordingly:

- Health promotion and wellness, 1:750
- Chronic condition management, 1:36
- Complex care management, 1:17

Additionally, **Table C.1-4** lists our proposed CM ratios, predicated on an enrollment assumption of approximately 19,000 new children and youth members.

Table C.1-4: FTEs for the Children and Youth Project

Functional Departments	Total FTEs
Leadership and Administration	3.0
Care Management Staff	83.0
Community Engagement Staff	2.0
Operations Staff	15.0
Quality Management Staff	7.0
Utilization Management Staff	10.0
Medical Management Staff	6.0
Finance Staff	2.0
TOTAL	**128.0**

Additional Training Materials for the Contract Liaison/Medicaid Administrator to Support Enrollment

In addition to the training offered to all new staff discussed previously under **Employee Onboarding and Training** in this section, our proposed contract liaison/Medicaid administrator will be mentored by CEO Todd White. Mr. White brings a depth of experience to the Department concerning these populations, the communities in which they live, and the best paths to take to achieve our mission of caring for these children and youth. The contract liaison/Medicaid administrator will also receive mentoring and training from other staff as appropriate. Training content for this new position will include in-depth tutorials on program requirements; cultural awareness among different communities and the needs of these populations; daily meetings with State agencies and the Department; State policies and procedures and federal guidelines, laws, and regulations; and West Virginia Specialized Managed Care Children and

Youth requirements, deliverables, and timelines. Ongoing training will also include child welfare/foster care and children/youth/aging-out adult-specific training such as TIC and workshops presented by experts in the child welfare field. Methods of training will include face-to-face meetings; computer-generated courses; external meetings with State agencies, the Department, and stakeholders; and conferences, forums, provider relations, and Joint Operating Committee and Delegate Vendor Operating Committee meetings. The timeframe to initiate and complete training will extend from the first day of onboarding through 30 days with additional weeks of intense training and orientation; ongoing training will reflect this being a position that requires constant education.

Subcontractor Monitoring Plan

Aetna undertakes subcontracts only when doing so adds value for our members. 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 members by providing appropriate, coordinated care and services in a financially responsible manner. Our current subcontractors (VSP Vision Care, eviCore, and SKYGEN) have an established relationship with our health plan and our internal network relations manager and currently demonstrate sustained quality performance serving our Medicaid members, fulfilling all required quality metrics. Aetna accepts financial, legal, ethical, and all other forms of responsibility for the conduct of all business partners, independent contractors, subcontractors, and other entities supporting or working on the Children and Youth project. **[MR0041]**.

Activities and Monitoring Tools for Our Vision, Dental, and High-end Radiology and Pain Management Subcontractors

Prior to contracting with a subcontractor, Aetna evaluates the prospective organization's ability to perform the activities to be subcontracted. 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. All aspects of the contract are evaluated through our Compliance Committee to ensure compliance with contractual requirements. The subcontractors we will use for this new contract are VSP Vision Care as our vision provider, SKYGEN as our dental provider, eviCore as our high-end radiology and pain management subcontractor, and KEPRO as our SNS provider. The following narrative discusses the local oversight processes/activities for monitoring these providers:

- Monitoring VSP Vision Care includes the following process:
  - A monthly reporting file
  - A monthly provider complaint and appeals file
  - A monthly provider liaison meeting
  - A monthly meeting either in person or telephonically
  - A quarterly DVOC meeting which is attended by representatives from all areas of the plan including the medical director, vendor liaison, COO, chief security officer (CSO), CEO, compliance officer, quality representative, provider relations manager, and member services manager, and the vendor's representative where meeting minutes are reviewed, issues are discussed, and resolution to any issues is tracked
  - A quarterly JOC meeting
  - SIU meeting as needed when there is a possible fraud issue
- Monitoring SKYGEN Dental includes the following process:

  - A meeting either in person or telephonically
  - All MCO meetings as all the West Virginia health plans that provide Medicaid benefits use SKYGEN
  - A DVOC meeting which is attended by representatives from all areas of the plan, including the medical director, vendor liaison, chief operating officer, CSO, CEO, compliance officer, quality representative, provider relations manager, member services manager, and the vendor's representative, where minutes from meetings are reviewed, issues are discussed, and resolution to any issues is tracked
  - A quarterly JOC meeting that is attended by representatives from all areas of the plan, including the medical director, vendor liaison, COO, CSO, CEO, compliance officer, quality representative, provider relations manager, member services manager, and the vendor's representative
  - Field representative/provider meetings as needed to support providers with issues/concerns/education
  - An annual health plan provider forum activity, which is attended by the SKYGEN representative
  - SIU meeting as needed when there is a possible fraud issue
- Monitoring eviCore includes the following process:
  - A daily out-of-network report for review
  - A quarterly metric report showing all the metrics required of eviCore
  - A monthly eviCore issues log review report
  - A quarterly DVOC meeting, which is attended by representatives from all areas of the plan, including the medical director, vendor liaison, COO, CSO, CEO, compliance officer, quality representative, provider relations manager, and member services manager, where minutes from meetings are reviewed, issues are discussed, and resolution to any issues is tracked
  - A quarterly JOC meeting, which is attended by representatives from all areas of the plan, including the medical director, vendor liaison, COO, CSO, CEO, compliance officer, quality representative, provider relations manager, member services manager, and the vendor's representative
  - SIU meeting as needed when there is a possible fraud issue
- Monitoring KEPRO will include the following proposed process:
  - Daily implementation update calls for the first 90 days of service (or as deemed necessary)
  - A daily issues log (for the first six months during the transition), then monthly thereafter
  - A quarterly metric report showing all the mutually agreed-upon metrics required of KEPRO
  - A quarterly DVOC meeting, which is attended by representatives from all areas of the plan, including the medical director, vendor liaison, COO, CSO, CEO, compliance officer, quality representative, provider relations manager, and member services manager, where minutes from meetings are reviewed, issues are discussed, and resolution to any issues is tracked
  - A quarterly JOC meeting, which is attended by representatives from all areas of the plan, including the medical director, vendor liaison, COO, CSO, CEO, compliance officer, quality representative, provider relations manager, and member services manager, and the vendor's representative
  - SIU meeting as needed/when there is a possible fraud issue
  - Attend care coordination meetings as necessary

Ongoing oversight also includes a national, local, and financial focus, which are explained in the following narrative:

- **National oversight:** At the national level, we have a centralized team of delegation oversight experts that manage the oversight process across the Aetna Medicaid organization lines of business to make certain that all of our 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 members from our national Delegation Management, Quality Management, and Finance departments. The 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. As part of our financial due diligence, we perform a financial review of all delegated entities at least annually to provide oversight of the contractor's continuing compliance with and ability to meet Aetna standards. Our Finance team reviews audited and unaudited financial statements such as the subcontractor's balance sheet, income statement, statements of cash flow, and interim reports. The Finance team 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 assists us in determining the risk exposure to Aetna and provides a basis for calculating a letter of credit or insolvency reserve, if needed. The Finance team will make recommendations regarding increasing the frequency of additional reviews. Finally, the financial report is distributed 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 E** are three 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 E**. For any proposed new subcontractors such as KEPRO, we will provide the Department with the Subcontractor agreement within the timeframe required.

Benefits Manager

Aetna confirms that we will do the following:

- Use four external non-affiliated subcontractors (SKYGEN, VSP Vision Care, eviCore, and KEPRO that will contract providers to complete their own networks that are part of our agreements
- Use an internal West Virginia-based network relations manager who will oversee and administer all other benefits functions, including provider recruitment, member and provider calls, medical and behavioral services utilization management, reporting, provider education, and others

Types of Reports/Data Subcontractors Will Provide

Our subcontractors supply us with specific data, metrics, and information, which we analyze to track member access and continuity of care, as well as member and provider satisfaction. Specific reports received are listed by name, content, and frequency, and include the following:

- VSP Vision Care reports:
  - Provider complaint and appeals file report; tracks member complaints; monthly

  - Customer service report; tracks calls answered in 30 seconds, total calls received, calls abandoned, and average rate; monthly
  - Claims processing turnaround times; number of claims processed in 1-30, 31-45, 46-90, and 90+ days; and claims not adjudicated and adjudicated financial, payment, and overall accuracy; monthly
  - Complaint summary; measures member and provider complaints received; monthly
  - Provider appointment survey; measures waiting times for emergency/urgent/routine care, office contacted, number completed, providers surveyed, and number of compliant providers; monthly
  - Utilization management (UM); inter-rater reliability; UM prior and retro authorization; monthly
- SKYGEN reports:
  - Managed care FWA report; information on FWA; monthly and quarterly
  - Provider appointment survey; measures waiting times for emergency/urgent/routine care, office contacted, number completed, providers surveyed, and number of compliant providers; monthly
  - Third-party recovery report; monthly
  - Appeals report; appeals information; monthly
  - Complaints report; complaints from members; monthly
  - Provider directory report; accuracy of directory; monthly
  - Payments to providers; tracks payments; monthly
  - Received claims; claims received by Aetna; monthly
  - Claims paid interest; interest paid by Aetna; monthly
  - Claims summary report; summary of all claims; monthly
  - Claims denial report; claims denied by Aetna; monthly
  - Claims aging report; tracks claim aging; monthly
  - Credentialing term-suspend report; providers suspended due to credentialing issues; monthly
- eviCore reports:
  - Out-of-network report for review; measures out-of-network use; monthly
  - Metric report; showing all the metrics required of eviCore; monthly
  - eviCore issues log review report; tracks issues/resolution; monthly
  - Complaint summary; turnaround time for response to member complaints; monthly
  - Provider appointment survey; measures waiting times for emergency/urgent/routine care, office contacted, number completed, providers surveyed, and number of compliant providers; monthly
- KEPRO reports:
  Since this is a proposed new subcontractor, we do not have any established report history with them. However, anticipated reports will include provider complaints, claims, FWA, payments, metrics, and others that will be determined once this subcontractor has been onboarded and their contract requirements are reviewed. We will contractually require them to meet all State reporting obligations and timeframes. Suggested reports include the following:
  - A monthly report to the health plan and the Department concerning underserved areas of the state where KEPRO believes additional SNS providers should be permitted to enroll to address gaps
  - A monthly training report (on all training and orientation activity including primary care providers and other providers)
  - Monthly utilization management process reports or as deemed appropriate
  - Monthly Bureau for Children and Families (BCF) provider verification report
  - File transfers and loads with BCF for the SNS referral and rollback files report as needed
  - Data reporting, including UM information, retrospective review samples, and ad hoc data requests
  - Monthly provider performance reports

- An annual attestation showing that KEPRO has established the appropriate interface(s) and testing and meets all Department-specific interface requirements, including, but not limited to, the Families and Children Tracking System (FACTS)

Using Reports/Data from Each Subcontractor

Aetna has a well-established Quality Assurance and Performance Improvement (QAPI) program to direct organization-wide initiatives for continuously improving the health and well-being our members. 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 and knowledge of the processes, procedures, and ability to assess areas for improvement. Committee members review recommendations, make suggestions, monitor status of corrective actions, and assist in prioritizing resources within the organization to achieve the Department's goals. Committees that use reporting and data to monitor and improve member satisfaction, access, continuity of 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; and works to make sure the QAPI plan is integrated throughout the organization and among departments, delegated organizations, and network providers/practitioners.
- **Delegation Committee:** Chaired by the director of quality management with cross-functional representation; advises and 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 members, practitioners, or providers.
- **Service Improvement Committee:** Chaired by the director of operations with cross-functional representation; advises and makes recommendations to the QMOC and/or Aetna management about customer, member, 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 members or providers.
- **Member Advisory Committee:** Chaired by the manager of the Member Services department with cross-functional representation and member representatives; provides feedback to Aetna regarding strategies for improving member care and services, including health education and other member materials.

Frequency of Contact and Status Calls with each Subcontractor During Go-live and Ongoing

During go-live, we touch base with our vendors at a minimum of once a day, starting as soon as we receive the first 834 file and then at go-live. For example, there are up to four touchpoints a day for the first five days (this includes holidays and weekends) and if issues identified are resolved (if any). Then we decrease contact to once a day for approximately seven days and then twice a week and then once a week for about 30 to 60 days post go-live. However, we will continue to maintain (frequent) daily contact throughout our relationship with our vision subcontractor. We do not decrease our touchpoints unless leadership agrees there are no identified issues and or concerns. We also have key-point people that the Implementation team can call; and if the subcontractor finds an issue, they can call us. After go-live, our health plan COO has monthly calls with each subcontractor until they are meeting metrics. Once the subcontractor is meeting their required metrics, the calls are quarterly. Our ongoing contact with our subcontractors will be at least quarterly on a formal basis; however, we have an open-door policy and excellent relationships with our subcontractors. For example, our Provider Relations staff often contact SKYGEN Dental once a week or more often depending on ongoing activities.

Plan for a Subcontractor that Does Not fulfill the Contractor or Service Obligations

Whenever we identify a potential deficiency, we work with the subcontractor to ensure compliance to the contract and their service obligations. This includes working directly with the subcontractor on customer service techniques, assisting providers, and fulfilling contract service requirements. In addition to poor audit results, increases in member complaints, indications that downstream providers are not being paid, alerts from the Department that can trigger heightened financial monitoring and oversight activities, and news reports about a subcontractor's financial instability can also trigger quality improvement flags. If issues of noncompliance or emerging risks are identified, we will take immediate action to correct the problem. Determined by the nature of the problem, remediation 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 monthly at our DOC meetings. On a quarterly basis, subcontractors report metrics, claims turnaround time, and accuracy. Reports are provided to our various quality management committees, including the Service Improvement Committee and JOC. Whenever issues are identified, the subcontractor follows our CAP processes. The DOC, Compliance department, and JOC then review financial results. If the CAP is not successful and the subcontractor's financial stability remains poor, or if we continue to receive complaints, we may terminate the contract based upon contractual provisions.

Contingency Plan in the Event of Contract Termination

Our processes ensure all business functions, including a subcontractor contingency plan, are in place to protect our members, the Department, and the health plan. In the event a subcontractor must terminate a contract agreement or is terminated by us, we will follow the path outlined in their subcontractor agreement. For example, our dental provider agreement requires the subcontractor to give at least written notice 60 days prior to termination. This allows us time to research and vet a new subcontractor, maintain care standards without disruption, and help ensure continuity of care through secure transfer of member records, and other pertinent member information. Our vendor liaison would work to inform the Department, members, and both the terming subcontractor and the new subcontractor, to create a seamless transition to a new subcontractor.

Affiliated and Non-affiliated Subcontractors

VSP Vision Care, our vision provider; SKYGEN, our dental provider; eviCore, our support subcontractor for high-end radiology and pain management; and KEPRO, our proposed SNS subcontractor, are the only subcontractors we will use for this contract, and none of them are affiliated with Aetna. VSP Vision Care, SKYGEN, and KEPRO report into our operations function, and eviCore reports into our medical management function within our organizational chart. We confirm that we will provide the Department with a final subcontractor organizational chart upon contract notification.

2. Use of Department Staff

Describe the required staffing of business and technical resources the Department should provide to support the Vendor. Specifically, the Vendor should address the following:

- The nature and extent of Department support required, in terms of staff roles and percentage of time available
- Assistance from Department staff and the experience and qualification levels of required staffing for both implementation and operations phases

The Department may not be able or willing to provide the additional support the Vendor lists in this part of its proposal. Therefore, the Vendor should indicate whether its request for additional support is a requirement for its performance. If any part of the list is a requirement, the Department may reject the Vendor's proposal, if the Department is unwilling or unable to meet the requirements.

Aetna respectfully suggests that the Department consider creating two positions to facilitate support of its goal of improving health and social outcomes for members receiving benefits under the Specialized Managed Care for Children and Youth project.

First, we recommend a permanent, dedicated liaison position to oversee the business and program and/or technical resources to support other engaged State agencies, the managed care organization (MCO), and the administrative services organization. While not a requirement for our performance related to this new contract, this position would bridge the target population's transition into the contract. The state liaison should have experience navigating within the Department as well as experience with foster and adoption services. Functions for the dedicated liaison position should include the following:

- Sharing and leveraging the best practices the Department already has in place
- Streamlining internal State processes to reduce any redundancy
- Supporting the selected MCO as new laws are passed that affect these populations and the program
- Improving communication among MCO staff, stakeholders, and other State agencies through participation in proposed governance roundtables
- Reducing fragmentation of services and enhancing continuity of care
- Encouraging meaningful and complete transition of electronic health records for the selected MCO, the Department, and providers as well as encouraging other information technology (IT) supports to improve data sharing
- Supporting the implementation process by engaging in regular updates with the MCO and answering questions for the Implementation team, which will aid in a smooth transition for members into the MCO environment

Additionally, a dedicated IT project manager during the implementation phase through a month after go-live would also be advantageous to the project. Although not required for Aetna to fulfill contract terms, this position would help create a supportive environment for successful program growth. After the implementation phase, this position's involvement would be minimized to weekly and then monthly checkpoints. The IT project manager should be experienced in testing/implementing secure data transfer and working with external entities. Functions for the IT project manager should include the following:

- Acting as a highly visible liaison for IT workgroups
- Overseeing the State's role in creating secure data interfaces for the initial testing, transferring, and sharing of data
- Overseeing the State's role in creating and testing secure data interfaces for the routine exchange of data

- Participating in IT planning sessions
- Acting as a catalyst to help ensure all parties meet deliverables

3. Key Staff and Resumes

Key staff consist of the Vendor's senior leadership for the Specialized Managed Care for Children and Youth 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 Specialized Managed Care for Children and Youth 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:

- Contract Liaison/Medicaid Administrator
- Chief Financial Officer
- Medical Director
- Behavioral Health Medical Director
- Medical Management Director
- Care Management Director
- Social Services Director
- SNS Liaison
- Quality Director
- Program Integrity Lead
- Network Development Director
- Provider Relations Director
- Information Technology Director
- Member Services Director
- Claims Payment Director
- Community Engagement Director
- Dental Director

- Medicaid Member Advocate

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 12 and embed resumes of all proposed key staff to this section of the proposal. Each resume should demonstrate experience relevant to the position proposed. If applicable, 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.
- 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.

We are West Virginians dedicated to solving the issues surrounding many of our children and youth. Through this new contract, we will fulfill our mission to provide services, benefits, and supports to help lift these vulnerable individuals to a better, more promising future. This project will be headed by our seasoned key staff and senior leadership, who together offer more than 300 years of combined health care experience in areas such as adult and child trauma treatment, substance use, trauma-informed care, high-risk youth, social work, and behavioral health. 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 West Virginia's most vulnerable citizens. We are fully equipped with the local knowledge and expertise to improve the health and social outcomes for our children and youth and their families.

Each key staff resume illustrates the education, knowledge, and expertise that will enhance our Specialized Managed Care for Children and Youth project. Support staff for this contract will be hired upon contract award and the education, experience, and licensure will fulfill all State requirements. Support staff job descriptions are addressed as part of our staffing response in **Attachment C, Question 1**. Resumes are presented in an embedded format in the following **Table 12**, which was provided by the State and includes educational information, experience, licensure, and relevant project information. Resumes have also been provided at the end of this section for ease of review.

Table 12: 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, currently serves as the chief executive officer (CEO) of and is responsible for	**Yes**

Name	Proposed Role	Experience in Proposed Role	Currently Employed by the Vendor?
Attachment C_Question 3, Resur		delivering on all state contractual requirements. 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 with the National Committee for Quality Assurance 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. In his role as CEO, Mr. White will oversee the contract liaison/Medicaid administrator for this new contract and will be responsible for the overall delivery of the project during all phases of the contract. 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.	
To Be Hired Upon Contract Award	Contract Liaison/Medicaid Administrator	We are committed to having the best resource in each role so that we can effectively meet the Department's goals. The person filling this role will be highly qualified, with the experience and	**No**

Name	Proposed Role	Experience in Proposed Role	Currently Employed by the Vendor?
		expertise to lead our contract serving children and families. They will be 100% dedicated to the new contract and will fulfill all the Department's requirements, including the following: • Attending meetings, legislative committee meetings, and hearings in person as well as establishing and maintaining a positive client relationship and meeting with Department staff or such other person(s) as designated by the Department on a regular basis to provide oral and written status reports and other information as required • Providing timely and informed responses to operational and administrative inquiries that arise • Making contractual, operational, and financial decisions, including claims payment and provider relations/contracting Responding to issues involving information systems and reporting, appeals, quality improvement, member services, service management, pharmacy management, medical management, care coordination, and issues related to the health, safety, and welfare of members, as well as helping to ensure that members have 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 member	
Tina Bailes Attachment C_Question 3, Resur	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. She previously served as the deputy	**Yes**

Name	Proposed Role	Experience in Proposed Role	Currently Employed by the Vendor?
		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 members served through the program, as well as the financing structure for access to needed services, and provider participation to ensure services are delivered.	
Donald Gibbon, DO Attachment C_Question 3, Resur	Medical Director	Dr. Donald Gibbon, Doctor of Osteopathy (DO), is an experienced executive who has practiced medicine for 20 years. He has 6 years of managed Medicaid experience, 6 years serving as a medical director, and 5 years serving West Virginians. His expertise includes leadership roles in the emergency occupational and urgent care medicine fields, adult and child trauma treatment, and substance use/trauma arenas. From routine complaints to physical abuse, sexual abuse, suicidal ideation and attempts, trauma, and other behavioral issues, Dr. Gibbon has examined and treated children of all ages.	**Yes**
Kimi King, BSN Attachment C_Question 3, Resur	Medical Management Director	Kimi King is a sixth-generation West Virginian who is also 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 Virginia. Her expertise includes nursing, clinical management, accreditation preparation, and strategic insights in the medical management arena.	**Yes**

Name	Proposed Role	Experience in Proposed Role	Currently Employed by the Vendor?
Johna Easter, RN, CCM Attachment C_Question 3, Resur	Care Management Director	Johna Easter, registered nurse and certified case manager (RN, CCM), is an experienced care management executive who is a native West Virginian. 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.	**Yes**
Frank Angotti III, MD Attachment C_Question 3, Resur	Behavioral Health Medical Director	Dr. Frank Angotti, a native West Virginian and experienced psychiatrist and behavioral health management professional. He has 10 years of health care industry experience, 5 years of experience serving the Medicaid population in West Virginia, and 3 years of managed Medicaid health plan experience. His expertise includes leadership roles in the child and adolescent psychiatry, behavioral clinic health, and substance use/trauma arenas.	**Yes**
Margaret Heasley Attachment C_Question 3, Resur	Social Services Director	Margaret Heasley is a longtime West Virginian and an experienced therapeutic and clinical professional. She has 28 years of health care industry experience and 19 years of experience supporting child welfare programs. Her expertise includes child and adolescent behavioral health and evidence-based practices and interventions. Ms. Heasley is well-versed on the health and well-being of children who have experienced trauma, particularly early childhood trauma. She worked for the Kanawha County School District for 14 years as the attendance director, where she dealt with children	**Yes**

Name	Proposed Role	Experience in Proposed Role	Currently Employed by the Vendor?
		experiencing a variety of life-changing issues.	
Louann Petts Attachment C_Question 3, Resur	SNS Liaison	Louann Petts is a native of West Virginia and is an experienced therapeutic and clinical leader in the state. Ms. Petts has 20 years of health care industry experience and 4 years of managed Medicaid experience. Her expertise includes child and adolescent behavioral health and evidence-based practices and interventions. She has been instrumental in the implementation of a trauma-informed pilot project and is the designated trauma champion for the health plan.	**Yes**
Elaina Wickas, RN, BSN Attachment C_Question 3, Resur	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 Virginia. Her expertise includes managed care quality improvement, managing large-scale teams and projects, regulatory and accreditation compliance, and audit oversight.	**Yes**
Greg Carpenter Attachment C_Question 3, Resur	Chief Operating Officer	Greg Carpenter, a native West Virginian, is an experienced executive who has 12 years of health care industry experience and 5 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, Greg is responsible for overall direction and day-to-day operations of the entire plan. Prior to joining Aetna, Greg served as West Virginia Director of Medicare	**Yes**

Name	Proposed Role	Experience in Proposed Role	Currently Employed by the Vendor?
		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. Greg serves at Cross Baptist Church and has ministered to children who have experienced trauma and those in foster care. He 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	
Kelley Mitchell Attachment C_Question 3, Resur	Member Services Director	Kelley Mitchell, a native West Virginian, is an experienced member service and professional communication executive who has 19 years of health care industry experience and 3 years of managed Medicaid experience managing a member services call center in West Virginia. Her expertise includes customer service resolution, call center operations, claims adjustment and resolution, and process improvement. She was responsible for developing a proactive service model for high-volume providers. These providers serve all populations, including the vulnerable children and youth population. In her free time, Ms. Mitchell is a pastor's wife who works with low-income youth. These youth often have one parent who is incarcerated or involved in substance use. Their church provides these children with the opportunity to attend church camp at no cost each summer and has taken them to events and provided food and clothing.	**Yes**

Name	Proposed Role	Experience in Proposed Role	Currently Employed by the Vendor?
April Ballengee Attachment C_Question 3, Resur	Claims Payment Director	April Ballengee is a native West Virginian and a claims subject matter expert. She has 18 years of health care industry experience and 3 years of managed Medicaid experience in West Virginia. Her expertise includes claims projects and reviews, trend analysis, provider risk management, and customer service. She is especially qualified for this project because she experienced homelessness in high school herself, which led her to train in trauma-informed care.	**Yes**
Dorsen McConnaughy Attachment C_Question 3, Resur	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.	**Yes**
Sarah White Attachment C_Question 3, Resur	Provider Relations Director	Sarah White is an experienced provider relations executive who is a native West Virginian. 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.	**Yes**
Alva "Fuzzy" Page III, JD Attachment C_Question 3, Resur	Program Integrity Lead	Alva "Fuzzy" Page 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 in the areas	**Yes**

Name	Proposed Role	Experience in Proposed Role	Currently Employed by the Vendor?
		of program integrity and fraud prevention in West Virginia. His expertise includes experience in Medicaid matters in federal and circuit courts, as well as strategic and tactical planning.	
Brad Liston Attachment C_Question 3, Resur	Information Technology Director	Brad Liston is a 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 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. His professional focus is on Medicaid and health care, financial and medical reporting, data integrity and transformation, and data security.	**No**
Jim Smallridge, RN Attachment C_Question 3, Resur	Community Engagement Director	Jim Smallridge is an experienced community engagement professional. He has 26 years of health care industry experience and 7 years of managed Medicaid experience. His expertise includes hands-on nursing, adolescent behavioral health, emergency medicine, and long-term care.	**Yes**
Diane Paletta, DDS Attachment C_Question 3, Resur	Dental Director	Dr. Diane Paletta 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	**Yes**

Name	Proposed Role	Experience in Proposed Role	Currently Employed by the Vendor?
		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.	
Virginia White Attachment C_Question 3, Resur	Medicaid Member Advocate	Virginia White, a native West Virginian, is an experienced case management and counseling professional who has six years of health care industry experience and six years of managed Medicaid experience. Her expertise includes case management, trauma-informed care, and Mental Health First Aid. Prior to joining Aetna, Ms. White served as a family support specialist for the West Virginia Department of Health and Human Resources, where she was responsible for completing intakes to ensure members received appropriate benefits. She was also a case manager/support counselor at Prestera and served children, including those in foster care. Her entire health care work experience has been spent working with low-income and foster care populations and treating them with cultural sensitivity.	**Yes**

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 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 with the National Committee for Quality Assurance, the only West Virginia managed care organization currently scored at that level. During his 13 years of Medicaid experience and his 24 years of health care industry experience, Todd 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 in particular is the nation's first neonatal abstinence syndrome facility, Lily's Place. Todd has been employed by the health plan for over 22 years. Prior to his experience working at the health plans, Todd 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

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 market for West Virginia Medicaid from 16 counties to all 55 counties in the State

Todd White

- 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

Licensures and Certifications

Six Sigma Certification, Yellow Belt (2019)

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, Tina 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, Tina 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, and 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

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

Tina Bailes

- 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

Licensures and Certifications

Certified Public Accountant

Donald Gibbon, DO
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 relates to the people of West Virginia. The health of the most vulnerable people in West Virginia is important to him due to his valuable work dealing with foster and abused children. Dr. Gibbon 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 has examined and treated children of all ages. His expertise includes leadership roles in the emergency, occupational, and urgent care medicine fields, adult and child trauma treatment, and substance use/trauma 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 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. Additionally, he provides direction and oversight to the medical directors for the plan. Prior to joining Aetna, he served as a medical director for Coventry Health Care. He is licensed to practice medicine in West Virginia and Pennsylvania. He earned his Doctor of Osteopathy from the Kirksville College of Osteopathic Medicine in Kirksville, Missouri, and a Bachelor of Science in Biology from Mercy Hurst College in Erie, Pennsylvania.

Experience

Aetna Better Health of West Virginia 2015 – Current
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 (QAPI) Committee
- Provides oversight of care to children and adults in their crisis levels of care
- Leads Aetna's Medicaid plans in their strategy against opioid abuse and serves on the Opioid/Substance Use Disorder Program Development team
- Leads Aetna's Medicaid plans in their strategy to improve influenza vaccination rates
- Served as a trainer for Aetna medical directors nationwide
- Served as the featured physician in Aetna's Utilization Management Rounds training video

Donald Gibbon, DO

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
- Identifies opportunities to implement best practice approaches and introduce innovations to better improve outcomes

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 the 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% in the country
- Treated patients in emergent and trauma situations

Education

- Doctor of Osteopathy, Kirksville College of Osteopathic Medicine, Kirksville, Missouri
- Bachelor of Science in Biology, Mercyhurst College, Erie, Pennsylvania

Licensures and Certifications

- Medical License, West Virginia Board of Medicine (License #2974)
- Medical License, Pennsylvania Board of Licensure (License #OS-008237L)
- 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

Kimi King
Medical Management Director

Kimi King is a sixth-generation West Virginian who is also an experienced clincial services executive. Kimi 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, Kimi is responsible all areas of medical management for the Medicaid health plan. Prior to joining Aetna, Kimi 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, Kimi 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 taskforces 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, and utilization management
- 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

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

Kimi King

- 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 (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 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 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, Johna is responsible for overseeing the day-to-day operations of staff members, reporting, planning, and developing new care coordination programs. Prior to joining Aetna, Johna served as the director of care management for HealthSmart Care Management Solutions, where she was responsible for supervising a staff of nurses and performing precertification and case management services and reporting. She also served as a care manager and 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, Johna 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 SNS, 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

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

Johna Easter, RN, CCM

- 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 Med-Surg-Tele 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 (License #[redacted]
- Certification for Case Management (License [redacted]

Frank Angotti, MD

Behavioral Health Medical Director

Frank Angotti, MD, is a native West Virginian who is an experienced psychiatrist and behavioral health management professional with 10 years of health care industry experience and 6 years of managed Medicaid experience. His expertise includes leadership roles in the 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 behavioral health needs under the Medicaid system and within the State of West Virginia. In his role as a behavioral health medical director for Aetna, Dr. Angotti leads and supports the Behavioral Health staff, works with upper management to develop the strategic direction of the department, and oversees the utilization management of behavioral health, 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 (MD) 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 behavioral health 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

Cherry Hospital in Goldsboro, NC 2012 – 2013
Inpatient Child Psychiatrist

- Responsible for evaluation and treatment of children with complex behavioral health needs, working within a multidisciplinary team
- Provided longer term and subacute services for those who were difficult to find placement

Frank Angotti, MD

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

- Medical License, West Virginia Board of Medicine ([redacted])
- Medical License, Kentucky Board of Licensure [redacted]
- Medical License, North Carolina Medical Board (2009-00086)
- 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

Margaret Heasley

Social Services Director

Margaret Heasley is a long-time West Virginian and an experienced therapeutic and clinical professional. She has 28 years of health care industry experience and 19 years of experience supporting child welfare programs. Her expertise includes child and adolescent behavioral health and evidence-based practices and interventions. Margaret is well-versed on the health and well-being of children that have experienced trauma, particularly early childhood trauma. She worked for the Kanawha County School District for 14 years as the attendance director where she dealt with children experiencing a variety of life-changing issues. Margaret will start with Aetna Better Health of West Virginia on August 12, 2019; in her role as the social services director for Aetna Better Health of West Virginia, Margaret will serve as an expert in MDT efforts and as the Child Protective Services (CPS) coordinator. Prior to joining Aetna, Margaret served as a clinical therapist for Highland Hospital on the long-term residential unit working with children from six to seventeen. Her educational background includes a Master of Social Work from West Virginia University and a Bachelor of Social Work from West Virginia State University. Margaret is a licensed independent clinical social worker and Board-Certified Diplomate (BCD). She was awarded the NASW Social Worker of the Year for 2017.

Experience

Aetna Better Health of West Virginia 2019 – Current
Social Services Director

- Performs oversight of activities relating to social services referrals, connections, and services
- Serves as Aetna's subject matter expert related to MDT and CPS
- Serves as a resource to caseworkers throughout the MDT process to facilitate appropriate and effective treatment options
- Oversees and collaborates with the SNS liaison
- Ensures organizational awareness and connectivity to social services and CPS resources for the population

Highland Hospital 2014 – 2019
Clinical Therapist

- Served as the clinical therapist on the long-term residential unit working with children ages six through seventeen
- Consulted with unit leadership regarding the psychological health issues of children and recommended plans of action to address identified issues

Kanawha County School District 2000 – 2014
Attendance Director

- Managed the attendance system for the entire school district
- Counseled children and parents concerning attendance issues and barriers
- Served as a therapist/counselor for children dealing with traumatic situations such as physical, mental, and sexual abuse, abandonment, and foster care situations

Thomas Memorial Hospital 1999 – 2000
Clinical Therapist

Provided therapy to geriatric and substance abuse patients at the Beacon outpatient program

CAMC Health System 1991 – 1999
Nephrology Social Worker

Margaret Heasley

- Worked with end stage renal patients
- Conducted assessments and counseling sessions
- Wrote grants to garner funding for the programs for the patients
- Made referrals to community resources

Education

- Master of Social Work from West Virginia University
- Bachelor of Social Work from West Virginia State University

Licensures and Certifications

Licensed Independent Clinical Social Worker (License [redacted])

Louann Petts

SNS Liaison

Louann Petts is a native of West Virginia and an experienced therapeutic and clinical leader in the State. She has 20 years of health care industry experience and 4 years of managed Medicaid experience. Her expertise includes child and adolescent behavioral health and evidence-based practices and interventions. Louann is well-versed on the health and well-being of individuals who have experienced trauma, particularly early childhood trauma. She has been instrumental in the implementation of a Trauma-Informed Pilot Project and is the designated trauma champion for the health plan. Louann serves on several councils and coalitions across the State that focus on addressing trauma, foster care, and the opioid drug crisis. In her role as the SNS liaison for Aetna Better Health of West Virginia, Louann coordinates all socially necessary services for the plan. Prior to joining Aetna, Louann served as the Wing Director of Psychological Health for the West Virginia Air National Guard. Her educational background includes a Master of Arts in Psychology from West Virginia Graduate College in South Charleston, West Virginia, and a Bachelor of Arts in Rehabilitation Counseling from Marshall University in Huntington, West Virginia. Louann is also a licensed psychologist and licensed professional counselor.

Experience

Aetna Better Health of West Virginia 2015 – Current

SNS Liaison

- Monitors the utilization of SNS and ensures access to SNS
- Collaborates and interfaces with BCF and all SNS providers to facilitate member access to care and positive health and social outcomes to maintain safety, permanency, and well-being
- Supports the administration of retrospective reviews of SNS providers
- Ensures that behavioral health benefits are efficiently managed and focused on integrating member care and clinical care coordination
- Develops, implements, and monitors programs and quality initiatives to address the needs of members
- Serves as the designated plan lead for the annual Behavioral Health Member Satisfaction Survey as required by the National Committee for Quality Assurance
- Represents the plan and collaborates with state agencies, key stakeholders, community organizations, and advocacy groups as well as the plan's behavioral health and chief medical directors in meeting member needs
- Actively participates on the plan's Quality Improvement Committee, Quality Management/Utilization Management Committee, Policy and Procedure Committee, Service Improvement Committee, Compliance Committee, Behavioral Health Practitioner Workgroup, and HEDIS Workgroup

West Virginia Air National Guard 2013 – 2015

Wing Director of Psychological Health

- Managed the psychological health program for Air National Guard members, including onsite clinical assessments, consultation, referral facilitation, and case management services
- Consulted with wing and unit leadership regarding the psychological health issues of service members and recommended plans of action to address identified issues
- Served as designated leader in crisis and critical response situations
- Developed briefings and educated wing personnel on a variety of topics including signs and symptoms of substance misuse, post-traumatic stress disorder, traumatic brain injury, suicide prevention, and protocol for duty to warn/duty to protect

Louann Petts

- Provided evidence-based psychological education programs equipping service members with coping and problem-solving skills to manage life stressors

Energy Corporation of America 2011 – 2013
Neurofeedback Specialist

Managed and administered a neurofeedback training program that taught elementary students self-regulation skills to improve classroom behavior. These were students who were diagnosed with attention deficit hyperactivity disorder, anxiety and depression, and/or had experienced trauma.

Diamond Consulting Corporation 2010 – 2011
Employment Assistance Specialist

- Managed contracts for employee assistance programs at private and public businesses
- Provided direct client services including clinical evaluations, crisis intervention, and referrals to mental health/substance abuse inpatient/outpatient programs
- Employed evidence-based therapy for individuals, couples, and families
- Consulted with management of contract companies regarding employer/employee concerns
- Developed employee/supervisory training programs

Psycon, PLLC 2008 – 2010
Program Specialist

- Conducted comprehensive psychological evaluations for individuals applying for West Virginia Division of Rehabilitation Services
- Composed detailed evaluation reports including recommendations for treatment, as well as classroom and workplace accommodations
- Provided individual therapy services to Division clients

Education

- Master of Arts in Psychology, West Virginia Graduate College, South Charleston, West Virginia
- Bachelor of Arts in Rehabilitation Counseling, Marshall University, Huntington, West Virginia

Licensures and Certifications

- Licensed Psychologist, West Virginia Board of Examiners of Psychologists ([redacted])
- Licensed Professional Counselor, West Virginia Board of Examiners in Counseling ([redacted]
- Board-certified in Neurofeedback (Inactive)
- Member, West Virginia Behavioral Health Planning Council
- Co-chair Education Committee, WV ACEs Coalition
- Certified Instructor, Adolescent Mental Health First Aid (2019)
- Certified Instructor, Adult Mental Health First Aid (2019)
- Certified Instructor, Connections Matter

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, Elaina 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, Elaina 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. Her 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

- Oversees all the quality management processes and initiatives, QAPI program, and Healthcare Effectiveness Data and Information Set operations
- Manages a staff of 8 employees
- Responsible for compliance with the state Medicaid contract, including annual External Quality Review Organization audits
- 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 line of business
- 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 one or more quality indicators
- Engages in activities related to APMs 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
- Responsible for NCQA accreditation readiness for Aetna Corporate NCQA Survey annual submissions
- 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

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

Elaina Wickas, RN, BSN

- Managed ongoing survey readiness preparation for renewal surveys in Pennsylvania and West Virginia as well as 'new' survey preparation for PPO 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 URAC requirements
- Managed the credentialing and utilization management delegates as well as HIPAA-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

Licensures and Certifications

Registered Nursing License, West Virginia (License [redacted])

Gregory Alan Carpenter

Chief Operating Officer

Greg Carpenter is a native West Virginian and is an experienced executive that has twelve years of health care industry experience and five 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, Greg is responsible for overall direction and day-to-day operations of the entire plan. Prior to joining Aetna, Greg 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. Greg serves at Cross Baptist Church and has ministered to children who have experienced trauma and those in foster care. He 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
Chief Operating Officer

- 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% increase in Medicare membership (MAPD and Medicare Supplement)
- Nurtured relationships with brokers, sales managers, regulators, advocates, and community leaders

Independent Agency 2007 – Present
Medicare Sales Executive

- Developed a state-wide reputation for being a Medicare and Social Security expert
- Delivered over $200,000 in Medicare sales revenue (employer group and individual sales)

Coventry Health Care of West Virginia, Inc. 2007 – 2008
Medicare Sales Manager

- 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

Education

- Master of Arts in Theology from Liberty Baptist Theological Seminary and Graduate School, Cum Laude, Lynchburg, Virginia

Gregory Carpenter

- Bachelor of Arts in Business Administration from West Virginia State University, Institute, West Virginia

Licensures and Certifications

West Virginia Life and Health Insurance License ([redacted])

Kelley Mitchell

Member Services Director

Kelley Mitchell is a native West Virginian who grew up in Charleston. She is an experienced member service and professional communication executive who has 19 years of health care industry experience and 3 years of managed Medicaid experience in West Virginia. Her expertise includes customer service resolution, call center operations, claims adjustment and resolution, and process improvement. In her role as the member services director for Aetna Better Health of West Virginia, Kelley is responsible for overseeing the day-to-day operations of the member services operation, monitoring calls, educating staff, and ensuring all metrics are met and/or exceeded. Prior to joining Aetna, Kelley served as a Customer Service Supervisor III for CareFirst BlueCross BlueShield, where she was responsible for developing a proactive service model for high-volume providers. In her free time, Kelley is a pastor's wife and along with helping to run the church, she works with low-income youth who many times have one parent who is incarcerated or involved in substance use. Their church provides these children with the opportunity to attend church camp at no cost each summer, taking them to other events and providing food, clothing, and school supplies. Kelley's educational background includes coursework in psychology and business administration at Marshall University in Huntington, West Virginia. She is currently pursuing a Bachelor of Science in Business Administration from Western Governors University with an anticipated graduation date in 2022.

Experience

Aetna Better Health of West Virginia 2016 – Current

Member Services Director

- Oversees day-to-day operations of Member Services department to ensure that members obtain their covered benefits and services
- Interfaces with members, Child Protective Services workers, foster care parents, and providers to handle questions and complaints
- Ensures that the Member Services phone line meets the minimum performance requirements
- Oversees the enrollment and onboarding activities of members
- Monitors and reports call center metrics
- Hires and manages personnel and creates performance assessments
- Directs a team of 5 supervisors, 2 quality analysts, and 65 customer service representatives
- Creates and updates policies and procedures
- Creates the first-call resolution focus and immediate resolution of member inquiries
- Participates in Aetna expansion preparation and review of member-facing materials
- Represents Aetna at member-facing town halls and forums

CareFirst BlueCross BlueShield 2002 – 2016

Customer Service Supervisor III

- Developed a proactive service model for high-volume/high-profile providers
- Created workflows and department guidelines
- Active in multiple committees, workgroups, and projects
- Represented the company at national and regional Blue Card meetings and seminars
- Monitored and reported call center metrics
- Hired and managed personnel and created performance assessments
- Directed a team of 15-25 customer service representatives
- Created and updated workflows

Kelley Mitchell

- Assisted in the development of the Blue Card University training program
- Represented BlueCross BlueShield during regular onsite meetings with high-profile providers

Education

- Completed five semesters of coursework towards a bachelor's degree in Business Administration and Psychology, Marshall University, Huntington, West Virginia
- Pursuing a Bachelor of Science, Business Administration, Western Governors University; anticipated graduation date in 2022

Licensures and Certifications

- Professional, Academy for Healthcare Management
- Professional Health Insurance Advanced Studies

April Ballengee

Claims Payment Director

April Ballengee is a native West Virginian who was raised in the Elk River and Pinch areas. She is a claims subject matter expert with 18 years of health care industry experience and 3 years of managed Medicaid experience in West Virginia. Her expertise includes claims projects and reviews, trend analysis, provider risk management, and customer service. She is particularly invested in this project because she experienced life as a homeless student in high school herself. This led her to train in trauma-informed care. In her role as claims payment director for Aetna, April is responsible for overseeing the payment of provider claims, leading departmental projects, and coordinating across a matrix of departments to meet member and provider needs. Prior to joining Aetna, April served as a network relations manager for CareFirst BlueCross BlueShield, where she managed risk to providers and maintained positive provider relationships. She is currently pursuing a bachelor's degree in business management from Western Governors University and has reached the Yellow Belt level of the Six Sigma Certification program.

Experience

Aetna Better Health of West Virginia 2016 – Current

Claims Payment Director/Manager, Service Operations

- Serves as a subject matter expert (SME) in claims projects and reviews, system updates and capabilities, and submitting, tracking, and auditing system-wide developments
- Ensures timely and accurate payment of provider claims for physical and behavioral health services
- Monitors claims processing activities for all health care services
- Oversees the reprocessing of claims due to rate changes or claims resubmissions
- Oversees the submission and data integrity of encounter claims
- Manages and develops staff
- Coordinates with other internal departments including, but not limited to, Shared Services, Systematics, and Provider Relations
- Completed trauma-informed care training and serves as a SME
- Serves as an accreditation SME with the Aetna Medicaid organization line of business
- Leads projects, creates project timelines, identifies key milestones and additional resources, and tracks the progress/status until completion
- Develops procedures for the Department
- Solicits and evaluates internal and external customer feedback to enhance continuous quality improvement

CareFirst BlueCross BlueShield 2001 – 2016

Network Relations Manager

- Established and maintained provider risk management and positive relationships with larger, high-profile hospital systems to ensure that their needs are proactively met
- Created, implemented, and streamlined several new processes and systems in negotiation with facilities to increase provider satisfaction
- Analyzed trends proactively to curb provider dissatisfaction
- Recognized as a customer service SME
- Recognized as a SME for all levels of claim functionality including claims adjustments
- Scheduled and hosted onsite meetings and conference calls with providers

April Ballengee

- Served on multiples committees such as the Associate Satisfaction Committee and the Division and Department Recognition Committees

Quality Analyst II, Large Group

- Completed daily, weekly, monthly, quarterly, and yearly audits in a variety of platforms to analyze program effectiveness within the standardized metrics
- Audited EFDE claims as well as system claims to ensure accurate processing
- Monitored and audited high-dollar adjustments
- Tracked and audited performance group claims to safeguard against company penalty payments for inaccurate processing and timeliness
- Audited customer service phone calls and correspondence for accurate responses, proactive steps taken to identify the issues, and how the resolution was handled

United Airlines Mileage Plus 1999 – 2001

Quality Assurance Analyst II

- Assisted internal customers with questions concerning system issues as well as flight availability
- Assisted external customers with frustrations concerning fees, flight availability, and general complaints
- Monitored customer service representatives for quality assurance and discussed opportunities with them

Education

Pursuing a bachelor's degree in Business Management, Western Governors University; anticipated graduation date of May 2021

Licensures and Certifications

Six Sigma Certification: Yellow Belt (2017) and White Belt (2016)

Dorsen McConnaughy

Network Development Director

Dorsen McConnaughy is an experienced network development executive who has lived in West Virginia for almost 30 years. Dorsen 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. In his role as the network development director for Aetna Better Health of West Virginia, Dorsen is responsible for overseeing the network development and contracting activities for physical and behavioral health services. Prior to joining Aetna, Dorsen 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 sufficient provider contracts for physical and behavioral health 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 the managed care organization's provider network as per contractual requirements
- Facilitates physical health and behavioral health provider contracting activities, including creative payment arrangements and APMs
- Oversees physical and behavioral health contracting documents and addenda
- Supports the oversight of physical health and behavioral health provider credentialing activities
- Reports to the Department on access to care and network development needs for SNS providers

Aetna Better Health of West Virginia 2005 – Current
Senior Network Contractor

- Negotiated ongoing contracts with hospitals, ancillaries, and physician groups for development of provider network for commercial HMO/PPO, Medicare, and Medicaid products
- Negotiated out of network single case agreements for member access with non-contracted providers
- Addressed providers' concerns regarding reimbursement issues

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

Dorsen McConnaughy

- 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

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. Sarah 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, Sarah 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. Sarah also served as a senior provider relations representative for Coventry Health Care of West Virginia, Inc before it became part of Aetna; during that time, she 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 foster children 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

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

Sarah White

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/DC 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

Licensures and Certifications

Six Sigma Certification, Yellow Belt (2017)

Alva "Fuzzy" Page III, Esq.

Program Integrity Lead

Alva "Fuzzy" Page III, Esq. is an executive with extensive health care law experience and success in the areas of government affairs and compliance. Alva is a West Virginia native who was raised in Kanawha County. Alva 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. In his role as program integrity lead for Aetna Better Health of West Virginia, he 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. Alva 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
Program Integrity Lead/Senior Compliance Lead

- 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
- 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 a Special Investigations Unit 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

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, Synder, 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 utilize 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

West Virginia Bar (License [redacted])

Brad Liston

Information Technology Director

As a native West Virginian and subject matter expert in information systems, Brad 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, Brad 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. Brad'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
- 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

Brad Liston

- Supports corporate data managers in testing and validation during system upgrades and migration
- 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 5 bureaus/agencies
- Responsible for daily monitoring, management, and backup
- Performed user support and management
- Performed monthly/quarterly updates/patching
- Diagnosed O/S, database, and application errors and provided corrective action
- Installed, configured, deployed, and upgraded databases
- Provided analysis of Medicaid data to internal/external offices
- 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, and Oracle Enterprise Manager, Windows, UNIX, and Linux O/S

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
- Assisted the Bureau technicians with desktop computer installation, maintenance, and support

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

Jim Smallridge, RN

Community Engagement Director

Jim Smallridge was born and raised in the Charleston, West Virginia area and is an experienced community engagement professional. He has 26 years of health care industry experience and 7 years of managed Medicaid experience. His expertise includes hands-on nursing, adolescent behavioral health, emergency medicine, and long-term care. He has forged several relationships in the West Virginia community as it relates to improving public health and available programs for those in need. Jim has been a frequent speaker and conference presenter on numerous topics related to health care in West Virginia and serves on several boards and community wellness coalitions across the State. In his role as a community engagement director for Aetna Better Health of West Virginia, Jim leads all outreach innovations and activities for the plan. Prior to joining Aetna, Jim served as the director of clinical education for the Golden Living Center. His educational background includes an Associate of Science in Nursing from Excelsior College in Albany, New York. He is currently pursuing a Bachelor of Science in Health Information Management from Western Governors University with an anticipated graduation date in 2020. Jim is also a licensed registered nurse for the State of West Virginia.

Experience

Aetna Better Health of West Virginia 2012 – Current

Community Engagement Director

- Develops and maintains Medicaid marketing policies and procedures in adherence to state and federal regulations
- Develops and submits all marketing materials to the Department
- Develops a written marketing plan for the health plan
- Ensures prohibited marketing activities do not occur, as stated in the contract
- Engages with the community and provides educational and informational materials at outreach events, in accordance with marketing activity guidelines
- Oversee all marketing and outreach to the membership
- Develops a focused outreach program to best connect with our target population based on various criteria
- Directs all marketing efforts of the plan including development, promotions, and press relations
- Collaborates with departments within the organization to market various issues
- Chairs and participates on committees within the plan, the community, and nationally

Quality Improvement Coordinator

- Worked independently and as part of a team during the collection, tabulation, and reporting of quality and regulatory measures
- Served as the onsite lead for issues related to the National Committee on Quality Assurance
- Administered member surveys on quality of life and continuity of care
- Collected data related to provider credentialing and worked in a variety of positions during the annual audits

Golden Living Center 2011 – 2011

Director of Clinical Education

- Supervised all associates' education and training for a 108-bed, long-term care facility
- Researched, wrote, and presented training on a variety of subjects
- Performed all pre-employment background and drug screenings, as well as orientation
- Responsible for infection prevention within the facility

Jim Smallridge, RN

- Monitored the use of antibiotics on all facility residents
- Oversaw the employee influenza vaccine program
- Co-chaired the facility's Safety Committee and Injured Workers' Return to Work program

AARP Foundation 2008 – 2011
Program Specialist

- Directed the AARP Foundation's Money Management Program (MMP) and Benefits QuickLINK (BQL) program throughout the State of West Virginia
- Worked with coordinators within the local service agencies to develop their individual programs
- Coordinated the statewide effort to expand MMP and train the volunteer workforce
- Served as the interim national coordinator for MMP during the last two quarters of 2009, at which time the program saw a significant increase in volunteer recruitment over the previous two quarters
- Major contributor to a two-year grant awarded by the National Council on Aging for the development of a multi-county Benefits Enrollment Center
- Developed and gave presentations around the state to promote and make the public aware of all foundation programs
- Led the organization's statewide efforts in the "Drive to End Hunger" program
- Expanded upon existing relationships with agencies, organizations, and companies
- Made numerous television and radio appearances on behalf of the organization to promote programs and events

Education

- Pursuing a Bachelor of Science in Health Information Management, Western Governors University; anticipated graduation in 2020
- Associate of Science in Nursing, Excelsior College, Albany, NY

Licensures and Certifications

- Registered Nursing License, West Virginia Board of Nursing ([redacted])
- Certificate in Practical Nursing, Tennessee Technology Center, Morristown, TN, 1993

Diane Paletta, DDS

Dental Director

Diane Paletta, DDS, 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 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, American Dental Association, West Virginia Dental Association, West Virginia Academy of General Dentistry, West Virginia Board of Dentistry, and the West Virginia Rural Health Development Council.

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
- Utilizes resources available from SKYGEN Utilization Management staff to maintain current knowledge and understanding of dental coverage services requiring her review

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

Diane Paletta, DDS

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

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

Virginia White

Medicaid Member Advocate

Virginia White grew up in West Virginia and is an experienced case management and counseling professional with six years of health care industry experience and six years of managed Medicaid experience. Her expertise includes case management, trauma-informed care, and Mental Health First Aid. In her role as the Medicaid member advocate for Aetna Better Health of West Virginia, Virginia is responsible for interacting with the vulnerable children and youth population and ensuring that all members are referred and connected to appropriate resources. Prior to joining Aetna, Virginia served as a family support specialist for the West Virginia Department of Health and Human Resources, where she was responsible for completing intakes to ensure members received appropriate benefits. She was also a case manager/support counselor at Prestera and served children, including those in foster care. Virginia's entire health care work experience has been spent working with low-income and foster care populations and treating them with cultural sensitivity. Her educational background includes a bachelor's degree in psychology from West Virginia State University and an associate degree in psychology from Axia College of Phoenix. Virginia also earned a Medical Office Admissions Assistant Certificate from Garnet Career Center.

Experience

Aetna Better Health of West Virginia 2017 – Current

Medicaid Member Advocate/Case Management Coordinator

- Responsible for interacting with the population and ensures that members are referred and connected to appropriate resources
- Collaborates with care management director, care coordinators, and the SNS liaison
- Provides member support related to enrollment, access, and continuity of care issues
- Supports members throughout any grievances or appeal activities
- Assists members in obtaining materials in alternative formats, as applicable
- Supports and addresses needs of children and youth in foster care
- Interacts with members in a culturally sensitive manner
- Serves as an advocate for members by creating a bridge between them, community programs, and social services

Case Management Associate

- Served as a liaison between the member and providers by obtaining appointments and reviewing QNXT, PPM, and other programs to ensure the member is receiving all health care benefits, services, and durable medical equipment
- Functioned as a point of contact for state liaisons
- Operated multiple systems/programs at once
- Assisted nurses and social workers with coordination of care for members
- Communicated effectively with members, providers, and stakeholders
- Responsible for meeting minutes, referrals, mailings, and outreach

West Virginia Department of Health and Human Resources 2016 – 2017

Family Support Specialist

- Conducted visits to the homes of recipients and their families
- Ensured that recipients received the appropriate benefits and updated their information
- Performed crisis management and prevention
- Planned and conducted therapeutic activities

Virginia White

REM – The Mentor Network 2016 – 2016
Service Coordinator
- Performed case management functions
- Managed the Medicaid budget for the department
- Coordinated services with members, providers, and others that were necessary for the member
- Performed home visits and site visits

Charleston Treatment Center 2014 – 2016
Substance Abuse Counselor/Case Manager
- Performed case management functions
- Performed support and counseling functions for clients with substance abuse issues
- Coordinated services with members, providers, and others that were necessary for the member
- Performed home visits and site visits

Prestera 2013 – 2014
Case Manager/Supportive Counselor
- Performed case management functions
- Conducted the Medicaid billing for the company
- Performed support and counseling functions for clients, including children in foster care
- Coordinated services with members, providers, and school staff
- Performed home visits and site visits

MRC Global 2009 – 2011
Freight Payables Analyst, Team Leader, and Inventory Accounting Analyst
- Performed freight payables analysis for the company
- Conducted the claims billing for the company
- Processed refunds
- Performed inventory analysis

Education
- Bachelor's degree in Psychology, West Virginia State University
- Associate degree in Psychology, Axia College of Phoenix

Licensures and Certifications
Certification as a Medical Office Admissions Assistant, Garnet Career School, 2005

REQUEST FOR PROPOSAL

Department of Health and Human Resources,
RFP CRFP 0511 BMS 1900000001

ATTACHMENT D: 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 may 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 may 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 G: 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. When appropriate, Vendors must provide narrative responses in the area below. The Vendor's narrative response for Attachment D should not exceed 50 pages.

See the attached Microsoft Excel® file titled, "***D_ Mandatory_Requirements.***"

Coventry Health Care of West Virginia, Inc. dba Aetna Better Health of West Virginia (Aetna)[1] will meet the following mandatory requirements found in **Attachment D** in serving members within the West Virginia Specialized Managed Care for Children and Youth project.

Compliance with Applicable Requirements

MR001	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.

Aetna will meet and comply with all applicable requirements outlined in this procurement, as well as the SPA and any modifications pursuant to changes to State policy, State or federal laws and regulations, waiver amendments, or State Plan amendments for members in foster care or who are receiving adoption assistance. As an incumbent Medicaid plan, we have already implemented and are in compliance with many of the requirements in the SPA through our existing Mountain Health Trust Medicaid contract for state fiscal year 2020. We continually monitor policy, regulatory, and legislative changes to maintain compliance with applicable requirements and engage with Department staff on a continual basis to collaborate and update on any needed changes. We will also meet and comply with all requirements related to the upcoming Children with Serious Emotional Disorders Waiver (CSEDW) once approved.

Acceptance of the Rate Established by the State

MR002	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.

[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.

Aetna will accept the rate established by the State on a per member per month (PMPM) basis for managed care physical health (PH) and behavioral health (BH) services, and we understand the normal rate setting process that will occur for each subsequent year of the contract.

Meeting All Operational Requirements as Agreed Upon

MR003	The Vendor must have all requirements operational, as agreed upon with the Department, by January 1, 2020.

Aetna will meet all operational requirements as agreed upon with the Department by January 1, 2020. Implementing a new program can present challenges and requires a methodical and proven approach to addressing potential barriers and setbacks. Therefore, we develop a comprehensive work plan that incorporates the project requirements to address all activities, work streams, and variables as part of our approach to a successful implementation. This work plan is developed through a project management governance structure aligning all implementation elements and project staff from award date to kickoff and beyond. We use a multi-tiered approach to make sure through transparency, integration, timely decision-making, and action execution we deliver all implementation requirements from project initiation to operational performance. This approach makes certain we meet all operational requirements for a contract start date of January 1, 2020.

W.Va. Code §9-5-27 Requirements

MR004	The Vendor must comply with W.Va. Code §9-5-27 requirements, including, but not limited to, reporting; establishing a voluntary advisory group of foster, adoptive, and kinship parents; and maintaining a primary workplace in the State where at least 80% of the full-time equivalent positions are located.

Aetna will comply with W.Va. Code §9-5-27 requirements, including, but not limited to, reporting; establishing a voluntary advisory group of foster, adoptive, and kinship parents; and maintaining a primary workplace in the State where at least 80 percent of the full-time equivalent positions are located. We will develop the program on a statewide, fully integrated, and risk-based basis integrating Medicaid-reimbursed eligible services with aligned incentives to make certain the appropriate care is delivered in the most appropriate place and time.

Reporting

Aetna will meet all monthly, quarterly, and annual reporting requirements identified in **Attachment D**. Specifically, we will provide an annual report to the Department that will include the following:

- Number of claims submitted, approved, denied, and appealed
- Resolution of appealed claims
- Average time of an appeal
- Average length of stay in a child residential care center, and health outcomes

In collaboration with the Bureau for Medical Services (BMS), we will complete and submit the initial report no later than July 1, 2021 and provide the Legislative Oversight Commission on Health and Human Resources Accountability and the Foster Care Ombudsman with a final report by July 1, 2023.

Advisory Group

Aetna will establish a voluntary advisory group for foster, adoptive, and kinship parents to engage and address program needs. Establishing this advisory group will be a key component of Aetna's overall effort to comply with all requirements of West Virginia Code §9-5-27 in the transition to a capitated Medicaid program for a child classified as a foster child, and a child placed in foster care under Title IV-E of the Social Security Act who is living in the state by January 1, 2020. We will also comply with all State reporting requirements as stipulated within West Virginia Code §9-5-27.

The voluntary advisory group will serve an important role in providing stakeholder feedback. The advisory group will meet every quarter for the first year following the effective date of the changes made to this section during the 2019 Regular Session of the Legislature and every six months thereafter. The advisory group will discuss issues they are encountering with Aetna and recommend solutions. We will report on the recommendations of the advisory group and address how and why procedures have or have not changed based on those recommendations. This report shall be submitted to the secretary and the Legislative Oversight Commission on Health and Human Resources Accountability.

We will leverage experience gained through the Aetna Medicaid organization's work in other states related to child and youth welfare programs in establishing advisory groups that include foster, adoptive, and kinship parents. In addition, we will establish Child and Family Advisory Partnership (CFAP) Community Forums to connect foster, adoptive, kinship, and group home caregivers to what is happening in the local behavioral health community and offer an opportunity to interact directly with providers. Attendees will be encouraged to share ideas on how to improve the delivery of care to members, their families, and supports.

We will conduct at least 12 focus groups throughout the year with youth, families, and foster parents that reside in the community and utilize socially necessary services (SNS). The focus groups will provide an opportunity to give the Department feedback on where services are being most impactful, our coordinated effort to integrate physical, behavioral and SNS services, and how we will adjust and make programmatic changes to improve the overall health of the program. The focus groups will target, but not be limited to, the following six areas:

- Access
- Service delivery
- Gaps in support systems
- Engagement with system staff
- Cultural competency
- Consumer knowledge of services and supports

Eighty Percent Staffing Requirement

As an active Medicaid managed care organization since 1996[2], exceeding the 80 percent full time equivalent threshold for over 23 years, Aetna will continue to maintain a primary workplace in the state where at least 80 percent of the full-time equivalent positions are located. We are West Virginians looking forward to serving the Mountain State for the Children and Youth project.

Adherence to Case Management Decisions

MR005	The Vendor must adhere to the case management decisions of the Department caseworker, multidisciplinary team (MDT), or court, but must document and provide all recommendations for case management, as appropriate.

We will meet the requirement to adhere to all case management decisions of the Department caseworker, MDT, or court and will document and provide all recommendations for case management, as appropriate. On a routine and ongoing basis, we will continue to collaborate with Department caseworkers, the judicial system, and other stakeholders involved with our Children and Youth project members. Through our efficient and effective case management process, we make certain all decisions,

[2] Our history dating back to 1996 began with Coventry Health Care of West Virginia, Inc., formerly known as Carelink Health Plans, Inc., which 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.

recommendations and relevant information is documented and integrated both into the Medicaid plan of care and the case management documents of the State, courts, and/or families, as appropriate. We will also document and provide all recommendations for case management, as appropriate, fulfilling our commitment that we will coordinate with Department caseworkers and incorporate their case plan recommendations into our integrated care plan when we work with the inter-disciplinary team (IDT) to create it. Through the IDT, we collaborate with the member's case worker, the Department, Child Protective Services (CPS), Aetna Care Coordination team, PH, BH, and SNS providers, child's guardian, kinship, adoptive, or foster parents (if appropriate), court system, and others. Further, we understand many children and youth have been exposed to Adverse Childhood Experiences (ACEs), resulting in early toxic stress and trauma. We believe coordination of care through intensive, trauma-informed, and specialized care coordination is necessary to help address complex needs including toxic stress and trauma within the project population. We have in place a justice system of care administrator to assist with communication and coordination with judicial systems, making certain that the MDT and the member's circle of support are engaged throughout the case management process.

Requirements for Qualified Residential Treatment Program Placements

MR006	The Vendor must comply with requirements for qualified residential treatment program (3.2.1QRTP) placements as described in the Service Provider Agreement (SPA).

We will meet and comply with requirements for qualified residential treatment program (3.2.1 QRTP) placements as described in the SPA. To address ACEs and childhood trauma experienced by our members, we are committed to providing our trauma-informed treatment model and the 30-day assessment requirement. We will also comply with accreditation requirements and clinical staffing expectations.

In addition, we will work with the QRTPs to support safe family contact while youth are in their programs and actively participate in transition planning (upon admission) for members who are placed in their programs. We will work to continuously support members to live in the most integrated and least restrictive setting as possible. We will work with QRTPs to assign a care manager to each child who participates in treatment team meetings, making certain that the facility has completed necessary evaluations. The care manager will collaborate with facility staff, the CPS worker, courts, family/guardians, and others with the goal of discharge to a safe placement making certain that all community services and needs are in place prior to discharge. We will also work with parents/guardians to make sure they have the necessary resources and supports. Collaboratively with stakeholders, including QRTPs, we will develop compliance and outcome measures that will largely focus on efforts by the QRTP to contribute in supportive ways to practices that support Aetna's overall person-centered approach to children/youth and family related to connectedness and well-being.

We will make certain that an independent assessment of each child and youth placed in a QRTP is completed within 30 days after placement in the QRTP. For each placement we will ensure a qualified individual assesses a child to determine the appropriateness of the placement in a QRTP within 30 days after the placement is made for purposes of approving the case plan and the case system review procedure in compliance with section 475A(c) of the Social Security Act.

We believe that quality assessments are essential to assure timely placement in the appropriate level of care and will undertake discharge and transition planning from the beginning of care. We will also comply with the standards and regulations of children and youth being placed in a QRTP as defined by the Family First Prevention Services Act federal and state legislation.

Physical Health and Behavioral Health Provider Network

MR007	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 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. We will maintain provider networks in geographically accessible locations and in sufficient numbers to make all covered services available to the populations served in a timely manner. We will ensure access to all services included in the managed care organization (MCO) benefits package, even where a standard for the specialty type has not been defined.

As defined by the SPA, for all adult and pediatric populations served, Aetna will contract with a sufficient number of active pediatricians to meet the standard of one primary care provider (PCP) for every 250 members per county as specified in the SPA. We will actively recruit and maintain a robust network including pediatric and youth-focused behavioral health and pediatric specialists to effectively serve children and youth members. For children who have aged out of foster and adoption assistance eligibility, we will also recruit and maintain obstetricians/gynecologists (OB/GYNs) participation to adequately serve those individuals as well.

In addition, we will adhere to the Medical Provider Network Time and Travel Distance requirements for each specialty group as outlined in the SPA on pages K-2 through K-4.

Accreditation by the National Committee for Quality Assurance

MR008	The Vendor must be accredited by the National Committee for Quality Assurance (NCQA).

Aetna has achieved a Commendable rating effective October 18, 2016 from the NCQA. **Aetna was the first to achieve and is the only West Virginia Medicaid MCO to currently hold a Commendable rating from NCQA.**

The NCQA evaluates how well a health plan manages all parts of its delivery system—physicians, hospitals, other providers, and administrative services to continuously improve the quality of care and services provided to its members. A Commendable rating for Aetna signifies that our excellent service and clinical quality meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement.

Requested Supporting Documentation

MR009	The Vendor must provide all requested supporting documentation upon notification of award, or a later date as specified by the Department, according to the requirements described in Appendix 4: List of Requested Documents.

We will meet and provide all requested supporting documentation upon notification of award, or a later date as specified by the Department, according to the requirements described in **Appendix 4: List of Requested Documents**. Through the Aetna Medicaid organization's years of experience implementing managed care programs across the country, including in West Virginia, we understand implementing a new program takes time and requires an intense focus on ensuring member access and quality care. Aetna will engage with the Department, providers, and community stakeholders continuously to form collaborative relationships that foster readiness for our programs and processes through our dedicated Children and Youth program implementation team. We will partner with the Department upon contract award to participate in a continual Department-led readiness review process.

Aetna will provide supporting documentation—if requested, including, but not limited to, the following list outlined from **Appendix 4**—upon notification of award:

- Vendor and subcontractor organizational charts
- Hiring plan
- Certificate of Authority from the Office of the Insurance Commissioner and a copy of all materials submitted to the West Virginia insurance commissioner
- Vendor ownership and control disclosures
- Standard provider contracts and disclosure forms for PCPs and specialists (including dentists, behavioral health providers, and hospitals)
- A copy of the contract if any aspect of claims processing, such as data entry, is contracted out
- Fraud and abuse compliance plan
- Employee false claims training
- Advance directive policies and procedures, including procedures for informing members of their right to make advance directives, providing physicians and members with appropriate forms of guidance, and ensuring that advance directives are maintained in members' medical records
- Vendor/other benefit manager grievance and appeals policies and procedures
- Physical health and behavioral health provider recruitment plan
- Vendor/other benefit manager credentialing policies and procedures
- Sample explanation of benefits (EOB) forms
- Member/Provider Services department toll-free contact phone numbers
- Phone call transfer protocols and decisions trees
- Disenrollment policies
- Policy on prohibitions of inappropriate physician incentives
- Vendor policies on reimbursement for crisis stabilization services
- Medical prior authorization policies, procedures, and flowcharts
- Sample clinically appropriate treatment plan (care plan) that addresses the coordination of primary, specialty, ancillary, community, and social support and carved-out services for members identified as having special health care needs
- Quality improvement plan that includes plans to evaluate how effectively the plan is delivering quality and accessible services that address the needs of members with special health care needs, and identifies areas of improvement for members with special health care needs
- Medicaid and commercial Healthcare Effectiveness Data and Information Set (HEDIS) reports from the past two years
- Policies and procedures for authorizing SNS
- A copy of the plan's health risk assessment form or protocol, whether to be performed by the plan or a subcontractor

Evidence of Efforts to Contract

MR010	The Vendor must provide evidence of efforts to contract with all currently enrolled providers under the Department's fee-for-service (FFS) Medicaid program.

We currently and will continue to meet the requirement to provide evidence of efforts to contract with all enrolled providers under the Department's FFS Medicaid program. In addition, upon receipt of the annual list of all licensed WV providers from the State, we compare the list against the providers in our network. We review this list for any providers that we can encourage to enroll as a Medicaid provider with the State, so we can then contract them. We will also seek to contract with all state SNS providers and understand that they may not be licensed.

Credentialing and Re-credentialing

MR011	The Vendor must credential and re-credential new physical health and behavioral health providers in accordance with federal and State requirements, as defined by the Department.

Aetna will meet the requirement to credential and re-credential new physical health and behavioral health providers in accordance with federal and State requirements, as defined by the Department. As part of our ongoing quality improvement processes, Aetna's Credentialing Performance Committee solicits feedback on our credentialing and re-credentialing processes on an ongoing basis. They review provider complaints, feedback, and trending analyses as available to make recommendations on revising and improving our policies, procedures, systems, and processes. We will also continue to receive practitioner advice with respect to criteria for credentialing and re-credentialing of individual health care professionals.

Credentialing

Individual providers who are members of a contracting group, such as an independent association or medical group, are credentialed individually. We understand this information will be provided by the Department for Aetna to make quality determinations through our Credentialing Performance Committee.

We will adhere to specific credentialing requirements found in **Model Service Provider Agreement Section 3.1.6** related to PCPs, and OB/GYNs as the process must include a visit to the provider's office, documenting a structured review of the site and medical recordkeeping practices to ensure conformance with the MCO standards. Related to BH providers, we will adhere to requirements found in **Section 2.1.6.3** to verify the following:

- Verify that comprehensive behavioral health centers or licensed behavioral health centers hold a valid license through the West Virginia Office of Health Facility Licensure and Certification;
- Verify that an independent psychologist or an independent practicing licensed social worker holds current license with their professional boards
- Verify that a physician is approved to provide Suboxone® treatment by the Department. A licensed MCO physician who intends to provide Suboxone treatment must meet established requirements.

For individual practitioners, we consider the information provided through the Department's completed credentialing and verified information packet. Our credentialing process uses intelligent process automation to improve the efficiency with which we collect and enter accreditation data into our provider data staging tool. This creates greater accuracy and makes certain that credentialing information is updated in a timely fashion. Our credentialing automation system processes over 200 providers per day (compared to 170 per week manually) and eliminates defects for credentialing application submissions to Aetna's credentialing verification organization. Intelligent automation delivers process standardization and optimization to increase throughput, completeness, and quality.
We will continue to comply with West Virginia C.S.R. §114-53-6 and 42 CFR 455, Subpart B and at a minimum include a statement by the applicant regarding the following:

- Any physical or mental health problems that may affect current ability to provide health care
- Any history of chemical dependency/substance use disorder
- History of loss of license
- Felony convictions as required by West Virginia 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, Aetna will verify the following:

- The identity and the exclusion status of the 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 Drug Enforcement Administration (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 that 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

Aetna's review also determines that practitioners have office hours and wait times that meet Aetna and West Virginia contract standards, or the medical director or designee approves exceptions as needed to allow for appropriate network configuration.

Re-credentialing

The process for re-credentialing will follow the same process and policy as previously described for initial credentialing. Aetna's standard process is to re-credential every three years. In between formal credentialing cycles, Aetna monitors the following as part of our ongoing quality review:

- **For individual practitioners:** State board sanctions; loss of license; Office of Personnel Management/Office of Inspector General (OPM/OIG) exclusion reports; Medicare opt-out; member complaints that are tracked and monitored through our Provider Relations department's monitoring; Aetna's grievance and appeals process, as well as received through our quality processes; and internally identified potential quality-of-care concerns tracked through Aetna's extensive monitoring and quality management tools and processes
- **For non-individual providers:** OPM/OIG exclusion reports and potential quality-of-care concerns identified through Aetna's extensive monitoring and quality management tools and processes.

As part of our ongoing quality improvement processes, Aetna's Credentialing Performance Committee solicits feedback on our credentialing and re-credentialing processes on an ongoing basis. They review provider grievances, complaints, feedback, and trending analyses as available to make recommendations on revising and improving our policies, procedures, systems, and processes.

Early and Periodic Screening, Diagnosis, and Treatment

MR012	The Vendor must ensure compliance with Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program requirements for applicable members, as outlined in the Service Provider Agreement (SPA).

Aetna will comply with EPSDT program requirements for applicable members, as outlined in the SPA. In providing EPSDT HealthCheck services to West Virginia Medicaid children since 1996,[3] Aetna makes certain children and adolescents receive eligible EPSDT services including comprehensive preventive, dental, behavioral health, and developmental and specialty services for a healthier West Virginia. We believe early detection, screening, and interventions are essential to identifying developmental, physical, and behavioral issues. We recognize that PCPs are central to the identification of possible developmental delays in young children as part of the EPSDT program. We offer families a choice of providers who conduct ongoing developmental surveillance in accordance with medical necessity criteria specific to EPSDT.

To make sure all eligible members have access to HealthCheck services, we will provide a combination of written and oral methods designed to effectively inform all EPSDT-eligible individuals, their families, and their foster care parents and CPS worker, if applicable, about the EPSDT program. We will also continue to provide appointment reminders, follow-ups, and outreach to EPSDT-eligible members.

Aetna care managers educate members 21 years and under on EPSDT during outreach calls. If a gap of care is identified through our documentation system, we will address on the call with the member or guardian. All services for EPSDT are covered by the health plan. If it is a service not currently covered by Aetna that is considered EPSDT, an exception will be made, and service will be covered for payment. Periodic screenings and immunizations are covered without a prior authorization.

Aetna is committed to working with providers to make sure all Medicaid-eligible members under the age of 21 receive EPSDT services and their parents, caregivers, and providers use resources effectively. Aetna will routinely monitor for gaps in care within our FamilyConnect system. Through FamilyConnect, care coordinators will monitor member records for receipt of appropriate required screenings. Aetna provides EPSDT coverage that aligns with guidelines outlined in the SPA including providing an initial health assessment and comprehensive exam within 30 calendar days of placement in foster care. We will also provide a follow-up visit within 90 calendar days of placement in foster care. Once the child is enrolled with Aetna, we will be responsible for working with the assigned CPS worker to make sure these important health assessments, exams, and follow-up visits are performed timely.

Post-stabilization Care

MR013	The Vendor must comply with post-stabilization care per applicable federal and State requirements, as defined by the Department.

Aetna will meet and comply with post-stabilization care per applicable federal and State requirements, as defined by the Department to maintain, improve, or resolve the member's stabilized condition in compliance with 42CFR 438.114 and 42 CFR 422.113(c). Aetna's post-stabilization care promotes efficient and timely coordination of appropriate care of a managed care member after the member's condition has been determined to be stable. Our efforts include discharge planning and arrangement of continuing care services to perpetuate continued improvement and engagement with the interdisciplinary team to ensure the best quality member outcomes via the next, most appropriate level of care. We will make timely and reasonable payment on behalf of our members for services obtained from a provider or supplier whether that provider or supplier contracts with Aetna to provide covered services. Post-stabilization care services are covered services pre-approved by Aetna. Aetna will approve services within one hour after services for post-stabilization care are requested.

[3] Please refer to Footnote 2.

24-hour Access to a Provider or Service in Emergency Situations

MR014	The Vendor must provide 24-hour access to a provider or service in emergency situations.

We will provide 24/7/365 access for medical, BH, dental, and crisis stabilization services. We will provide 24-hour behavioral health and nurse education lines with daytime live responders and 24/7/365 resources. Aetna will meet the requirement to provide 24-hour access to a provider or service in emergency situations through the following providers:

- National Youth Advocate Program: http://www.nyap.org/west-virginia/4576181134
- Genesis Youth Crisis Center (includes Alta Vista and Ridgeline): http://genesiswv.org/about-us/
- Children's Home Society of West Virginia, including the Davis Child Shelter (http://www.childhswv.org/). The David Child Shelter has a large network with 12 service locations that provide statewide services and is available on a 24/7/365 basis.

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. In addition, we provide specific education on after-hours resources including urgent care services. Member advocates will assist members in navigating the health care system. It is our goal that each Children and Youth project member will be associated with a medical home where after-hour services are arranged. Our medical home model delivers primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective to every child and adolescent. Medical homes address preventive, acute, and chronic care from birth through transition to adulthood and aid facilitation of our integrated care coordination with an interdisciplinary team of members and families, PCPs, specialists and subspecialists, hospitals and health care facilities, public health, and the community.

Full Range of Specialty and Facility Service Providers

MR015	The Vendor must, based on Department provider access to care requirements, ensure access to the full range of specialty and facility service providers for members in applicable populations with complex needs.

Aetna will comply with Department provider access to care requirements and make certain access to the full range of specialty and facility service providers for members in applicable populations with complex needs. Our strong community relationships, integrated network analysis and recruitment processes, and high-touch model of network management assist us in providing a network sufficient to meet the needs of West Virginia members. Through our network management strategies and processes, we continue to provide timely access to culturally competent primary and specialty care services necessary to promote the Department's goals. Our provider network, which meets the Department's expectations and requirements, includes all provider types for the highest quality of care, including the following:

- PCPs
- Pediatricians
- Behavioral health providers
- Specialists
- Ancillary providers
- Community mental health centers
- Hospitals
- Federally qualified health centers (FQHCs)
- Qualified residential treatment providers (QRTPs)
- Rural health clinics (RHCs)
- OB/GYNs
- Pharmacies

Ensuring Individuals in Applicable Populations Receive Primary Care Services

MR016	The Vendor must ensure that individuals in applicable populations who have specialists as primary care providers (PCPs) are receiving primary care services on an ongoing basis.

Aetna will make certain that individuals in applicable populations who have specialists as PCPs are receiving primary care services on an ongoing basis helping to ensure quality, effective care. Access to care by pediatric and youth care physicians is particularly important, we believe, and essential to counteracting trauma, helping to create resiliency, and improving the health of our children and youth members. **We currently have 100 percent of members with access to a PCP within the time and distance standards.** We have 96 percent coverage across West Virginia. Additionally, 88 percent of our PCP network has open and accessible panels for new members. In addition, **Aetna has contracts with over 11,177 providers, which includes over 1,312 PCPs, 4,346 specialty physicians, 578 behavioral health specialists, and 77 physical health hospitals including adjacent border states.**

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. As an additional precaution, we review quarterly analysis and trending of member grievances to identify potential availability or accessibility issues, perform root-cause analysis, and develop corrective action plans, if necessary. We understand we can designate physicians outside the specialties of general or family practice and pediatricians as PCPs for specific individuals including persons with disabilities. This will help provide access to the care needed for the children and youth populations within this project whose underlying health conditions are best managed by specialists. As an example of our process, we have members who have designated an OB/GYN as their PCP. In those instances, our Provider Relations team flags the system for the specialists to be designated as the PCP. This approach will continue to be allowed for members designating specialists as their PCP.

Monitoring PCP Panels for Compliance

MR017	The Vendor must monitor primary care provider (PCP) panels for compliance with the Bureau for Medical Services (BMS) limit of Medicaid members assigned per PCP, for applicable populations.

Aetna will monitor PCP panels for compliance with the BMS limit of Medicaid 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.

Aetna acts upon every PCP assignment by analyzing the potential PCP's panel to make sure 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.

Aetna actively participates in an external independent review performed by the Department-BMS. The health plan provides BMS with access to site, information, documentation and data.

Aetna and our subcontractor(s) will make 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 External Quality Review Organization (EQRO), HEDIS, encounter data validation, and other related activities.

We will submit a corrective action plan, 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. We will obtain advance written approval from BMS before releasing or sharing data, correspondence and/or improvements related to the internal quality management program with any other external entity.

Network Standards Documentation and Geographic Mapping Reports

MR018	The Vendor must submit network standards documentation and geographic mapping reports in accordance with the reporting instructions in the Service Provider Agreement (SPA).

Aetna currently meets and will continue to comply with the requirement to submit network standards documentation and geographic mapping reports in accord with the reporting instructions within the SPA. On an annual basis we currently provide network standards documentation to the Department including geographic mapping reports in accord with our current contract reporting instructions demonstrating that our network meets physical, behavioral, and SNS needs. We will follow this same process in accord with the project contract requirements and specifications. Through this documentation and geographic mapping process, we may identify opportunities to enhance our existing network.

To assure effective access to SNS services, Aetna will collect a monthly progress report from the provider, or delegated vendor as described in their contract for each family served by the 10th day of each month. We will also continuously monitor the utilization of SNS and provide monthly reports highlighting geographic areas in which there is a high utilization of services required with low provider enrollment. This monitoring encompasses analysis of provider capacity by routinely reviewing provider reports to assure members are effectively accessing SNS provider services.

Through trauma-informed care training and our educational programs, we make certain our providers have knowledge and experience identifying child abuse and neglect as they are serving the Children and Youth population.

Screening Processes

MR019	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.

Aetna meets and has established screening processes (per applicable federal and State requirements, as defined by the Department) designed to make certain we do not subcontract with entities 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. Aetna will not hire any individual or contract with any entity that has been debarred, suspended, or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities.

Our screening process includes routine review of the Office of the Inspector General debarred, excluded, and suspended provider databases and lists to ensure we do not enter into and contract relationships with entities or individuals who are debarred, suspended or otherwise excluded from participating in federal or State health care programs.

Aetna executes subcontracts only when it adds value for our members. We use well-qualified, experienced subcontractors to provide services in support of the project—subcontractors with unique expertise and proven records of accomplishment relative to improving outcomes for our members by providing appropriate, coordinated care and services in a financially responsible manner. Aetna will not

utilize the services of any entity that has been debarred, suspended, or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities. Subcontractor oversight is integrated into the health plan organizational structure with clear lines of responsibility and oversight to ensure a streamlined experience for members, providers, and the Department.

All our proposed subcontractors demonstrate sustained quality performance serving members in a seamless manner. Aetna performs ongoing monitoring of subcontractor performance. We meet with subcontractors on a weekly, monthly, or quarterly basis, depending on the subcontractor, and perform a comprehensive review annually in which we 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. Aetna provides the Department with a copy of the annual review and any corrective action plans developed as a result.

Records Retention Process

MR020	The Vendor must establish and maintain a records retention process in accordance with applicable federal and State requirements, as defined by the Department.

Aetna will establish and maintain a records retention process in accordance with applicable federal and State requirements, as defined by the Department. We understand records must be retained for at least 10 years from the date of expiration or until any ongoing audits have been settled, if longer. If any litigation, claim, negotiation, audit, or other action involving the records has been started before the expiration of the 10-year period, the records must be retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular 10-year period, whichever is later. Aetna agrees to and will require our subcontractors to retain the source records for data reports for a minimum of 10 years and will have written policies and procedures for storing this information.

Contractually, our currently participating West Virginia practitioners agree to maintain medical records in a current, detailed, organized, and comprehensive manner in accordance with customary medical practice, applicable laws, and accreditation standards. Our records retention policies make certain we maintain effective control of important records including the following:

- Making sure records are stored in a safe, secure, and accessible manner
- Retaining records in a manner that permits efficient and cost-effective retrieval
- Reducing storage costs by preventing the unnecessary buildup of records that should be destroyed
- Providing for the systematic disposal of inactive and/or obsolete records
- Reducing the risk of using superseded or outdated records

Quality Assessment and Performance Improvement Program

MR021	The Vendor must implement and maintain a quality assessment and performance improvement program, as defined by the Department.

Aetna will implement and maintain a Quality Assessment and Performance Improvement (QAPI) program as defined by the Department. We monitor outcomes of all our quality improvement plans through our QAPI program. Each project has a plan to identify goals, project tasks, defined roles and responsibilities, and outline budget and necessary resources needed. The quality management and provider relations staff work together to monitor network practitioner and provider performance, including SNS providers. Quality management staff assists provider relations staff in developing measurable objectives across all populations including foster care and children with special health care needs to evaluate provider performance, analyzing data collected in the monitoring process, and preparation of information for the Quality Management Oversight Committee (QMOC). Our QAPI program has a comprehensive set of policies and procedures to manage the delegation of responsibility for any

delegated program function. We understand all processes required for effective oversight of subcontractor performance, and we are successful at conducting these activities as part of our daily business. We have extensive experience with subcontractor oversight, with selecting subcontractors, and with ongoing monitoring of subcontractor performance.

QAPI monitoring activities will be expanded to include measurement of the quality and performance of services delivered by SNS providers with careful attention not to overburden their care delivery for Children and Youth members. Our goal is to collaborate with the SNS providers to provide timely, comprehensive, and quality services to these vulnerable members. Delegation oversight activities for SNS providers are formally monitored as a component of the QAPI program. 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] Committee, Delegation Subcommittee, National Vendor Delegate Oversight Committee) for review and approval and then to the QMOC. Our QMOC is chaired by our chief executive officer. The committee provides executive oversight of the QAPI program and makes recommendations to the board of directors about quality management and performance improvement activities.

Public Meetings and Other Events

MR022	The Vendor must participate in public meetings and other events at the request of the Department.

Aetna will participate in public meetings and other events at the request of the Department. During our implementation of this contract we will make sure to engage community members through participation in public meetings and other events to engage their voices, choices, and preferences. All key stakeholder feedback is considered, thus modeling the program design in full collaboration at the governance and leadership levels. Aetna finds this approach to be most effective as it demonstrates a congruent adherence to principles and standards at all levels of leadership, management, and direct care. Engaging with stakeholders early is our key to a successful implementation. Each implementation is unique, as is each program, community, and state. Our existing community collaborations feature initiatives across West Virginia encouraging health education and actions to address the medical and non-medical drivers of the members' health needs. As an example, we will conduct Child and Family Advisory Partnership (CFAP) Community Forums to create collaborative connections among foster, adoptive, kinship, and group home caregivers. We believe these community connections will strengthen the local behavioral health community and offer an opportunity to interact directly with providers.

Meeting Monthly during First Year of Implementation

MR023	The Vendor must meet with the Department and industry-specific provider councils on a monthly basis during the first year of implementation, as requested by the Department.

Aetna will meet with the Department and industry-specific provider councils on a monthly basis during the first year of implementation, as requested by the Department. We will build key stakeholder relationships with the Department through monthly meetings on a collaborative basis during the first year of implementation to understand service gaps and needs. We will outreach and collaborate with the following agencies, including those that have policy and decision-making oversight for children and youth services on a monthly basis for the planning and delivery of West Virginia child and family services under this contract:

- Bureau for Behavioral Health and Health Facilities (BBHHF)
- BCF
- BMS
- Bureau for Public Health (BPH)
- Department of Education

- Hospitals
- Office of the Courts and Juvenile Justice
- Universities

Specifically, our collaboration with the BBHHF and its 13 comprehensive community behavioral health centers, of which 5 of these have regional youth centers, will foster and maximize community-level efforts and engagement.

We will make certain we also engage agency stakeholders throughout West Virginia to successfully implement the Specialized Managed Care for Children and Youth contract to meet all service needs, including community-based supports. These efforts will also serve to meet the State's goal of improving communication and training among stakeholders and increase engagement of supports for children and youth within the project.

Aetna's community engagement director will be responsible for relationship management, including stakeholder education, knowledge of State systems, and assessment of community training needs and outcomes. The community engagement director will engage collaborative entities across West Virginia and identify necessary competencies and associated training needs for the new model of care and address identified gaps in training, incorporating provider identified training needs.

We will outreach and collaborate with the following provider industry stakeholders and associations that are involved in services for individuals served on a monthly basis during the first year of contract implementation:

- West Virginia Primary Care Association
- School Based Health Assembly
- Behavioral Health Provider Association
- Healthy Kids Coalition
- West Virginia Childcare Association

These councils will assist us in engaging provider organizations with expertise in services for children, youth, and families. These organizations are involved in providing on-the-ground services to members. This collaboration and coordination will include outreach, education, and training to remove barriers to care coordination and improved service for children and youth members involved in foster care, child protection, adoption assistance, and juvenile justice.

Meeting Quarterly after the First Year of Implementation

MR024	The Vendor must meet with the Department and industry-specific provider councils on a quarterly basis after the first year of implementation, as requested by the Department.

Aetna will meet with the Department and industry-specific provider councils on a quarterly basis after the first year of implementation, as requested by the Department. We will engage agency stakeholders throughout West Virginia to successfully implement the Specialized Managed Care for Children and Youth contract to meet all service needs, including community-based supports.

Aetna will continue to engage the following entities after the first year of the contract and any additional agencies or groups we identify for collaboration during the first year of the contract:

- BBHHF
- Bureau of Children and Families
- Bureau of Medical Services
- BPH
- Department of Education
- Hospitals

- Office of the Courts and Juvenile Justice
- Universities

By engaging stakeholders throughout the state, we will gain insights on unique needs in differing regions and address them with customized solutions within our implementation and operations. Our interaction with community stakeholders and agency collaborators will build on the needs and gap analysis gained in the first year of implementation to develop an adaptable strategic plan built on family and stakeholder engagement with a framework for success. Through the strategic planning process, we will learn of new entities to engage and collaborate with, and we will continually engage members and their families for their input and insights into program operations, needs, and future collaborations.

We will also engage industry-specific provider councils including the following on a quarterly basis after the first year of contract implementation:

- West Virginia Primary Care Association
- School Based Health Assembly
- Behavioral Health Provider Association
- Healthy Kids Coalition
- West Virginia Childcare Association

Aetna will continue to engage the listed provider industry councils and groups after the first year of the contract and any additional agencies or groups we identified for collaboration during the first year of the contract.

These councils will assist us in engaging providers with expertise in providing services and supports for children and youth impacted by trauma and adverse childhood events, and experience in serving West Virginia children and youth involved in foster care, child protection, adoption assistance, and juvenile justice.

External Quality Reviews

MR025	The Vendor must participate in external quality reviews in alignment with federal and State requirements, as defined by the Department.

Aetna will participate in external quality reviews in alignment with federal and State requirements, as defined by the Department. We maintain a highly effective compliance program including facilitating external quality reviews (EQR). Our director of quality improvement works closely with the compliance officer in facilitating external quality reviews and both serve as critical resources to all operational areas assuring alignment with both federal and State requirements. We will continue to collaborate with the Department regarding initiatives aimed at assessing and improving program performance. We will comply with Department requirements for regular reporting to the State and an annual EQR consisting of an onsite systems performance review of quality outcomes, timeliness of, and access to services covered in the Children and Youth contract. Quality assessments through external reviews are vital to making certain children and youth receive quality, effective services. Therefore, we will continue to make every effort to comply with EQRs that will be implemented by any organization contracted by the Department. This may include participating in the design of the external review, collecting medical records and other data, and/or making data available to the EQRO. Aetna and our subcontractor(s) will make 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.

Oral Presentations

MR026	The Vendor must participate in the oral presentations to be scheduled during the proposal scoring period. Proposed key staff must be present for orals, in lieu of corporate or sales personnel being the primary participants.

We will participate in the oral presentations to be scheduled during the proposal scoring period. Our proposed key staff will be present for orals, in lieu of corporate or sales personnel being the primary participants. We will carefully consider and include in our oral presentation individuals who are knowledgeable about the State's requirements and the Children and Youth project population.

Providing All Requested Information

MR027	The Vendor must provide all requested information prior to and participate in a readiness review, which will be defined by the Department, prior to implementation.

Aetna will provide all requested information prior to and participate in a readiness review, which will be defined by the Department, prior to implementation. Aetna, across all our Medicaid plans, has passed 16 consecutive readiness reviews on the strength of our proven implementation process illustrating our diligence and consistency in meeting state documentation and process needs leading to successful implementation of services for our members. We will partner with the Department upon contract award to participate in a continual Department-led readiness review process that will include, as necessary, the following:

- Review and approval of all our policies and procedures and member materials
- Demonstration of our systems
- Value-added services
- Thorough review of our health plan's understanding of the contractual requirements
- Onsite reviews, desktop reviews, policy reviews, system demonstrations, staff interviews, and self-audit evaluations
- Pre-delegation audit and readiness of vendors

Aetna Honored for Information Technology Excellence

- Aetna Inc. won the ISE® West Project of the Year Award for the Aetna Entitlements, Identity & Risk System (AEIRS) in 2018.
- We were awarded Project of the Year in 2017 by T.E.N., a technology and information security executive networking and relationship-marketing firm, for managing security differently across 14 affiliates.
- Global security staff was honored as the 2017 ISE® Central People's Choice Award for exemplifying information security leadership as voted on by peers across the industry.

Current and Future Security Policies and Procedures

MR028	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 link: http://www.wvdhhr.org/mis/policies.asp https://technology.wv.gov/security/Pages/policies-issued-by-the-cto.aspx

We will comply with all current and future security policies and procedures of the Department and the West Virginia Office of Technology (WVOT) found at the provided linked websites. In addition, Aetna exceeds industry standards with robust information security policies, procedures, and standards based on the information we need to protect, as well as who uses the information and laws/regulations that apply to Aetna and its industry. Aetna supports customer assessments of our security program and standards and stays current with technological advances to determine if our specific expectations are adequately addressed. Access to a copy of Aetna's policies, control standards, and procedures is available upon State request.

Compatibility with Versions and Standards

MR029	The Vendor must ensure compatibility with the most current West Virginia Office of Technology (WVOT) supported versions and standards.

Aetna ensures our compatibility with the most current WVOT-supported versions and standards. At Aetna, protecting member data—keeping all information safe and secure—is of utmost importance. Each member is treated as an individual, thoughtful consumer; they are not just statistics or data figures to us. As such, we push our global cybersecurity program beyond what is standard for our industry. We improve security while making it more convenient for each individual and we continue to invest in practices, processes, and controls to stay a step ahead of an ever-evolving issue. We commit to provide access to best practice health care for Children and Youth project members while diligently protecting their privacy. On a weekly and monthly basis Aetna successfully transfers files to and from the Department. 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 children's dental and vision benefits
- 834 enrollment file (monthly)
- 820 and 835 payment files (monthly)
- Encounter files will be submitted consistent with the 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)

Our Information Technology department has created the Blue Box file in a monthly report format for proprietary encounter file for the State. On a weekly basis we send to Maximus, the State's enrollment broker, a provider file to make sure members receive up-to-date provider information ensuring accurate member selection of PCPs.

In addition, we receive the following files helping to make sure providers are accredited to State guidelines:

- **Prov 12:** complete provider listing of all accredited West Virginia providers (monthly)
- **Prov 98:** provides newly created, termed, and pay-hold providers on a weekly basis

These reports help Aetna ensure proper claims administration payment and provider credentialing. We also receive daily pharmacy files that allow us to provide member care and medical management integrated into our physical and behavioral health care focused on the needs of children and youth.

HIPAA Compliance

MR030	The Vendor must provide a 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.

Aetna will provide a plan for how we will maintain full HIPAA compliance, and maintain this compliance, throughout the life of the contract at no additional cost to the Department.

We currently and will continue to comply with HIPAA requirements to ensure privacy of protected health information. Every employee is required to complete annual training on these requirements. We will update our Medicaid compliance plan annually and submit it to the Department prior to October 1, 2019. Business-specific privacy training is monitored by the business area manager in conjunction with the privacy manager. In addition, we make certain that each staff member completes annual Business

Conduct and Integrity training through monitoring by the hiring manager, business compliance officer (BCO) and corporate compliance. We make certain that records are confidential and when released to members or other providers, all HIPAA standards are met, including obtaining the appropriate signatures for their release. This is particularly needed in our effort to coordinate care for the Children and Youth population. The plan includes the following operational element details and discussion illustrating how we ensure compliance with Department requirements throughout the life of the contract:

- Written policies, procedures, and standards of conduct, including privacy policies concerning securing member's protected health information and individuals' right to request restrictions and confidential communications
- Description of compliance officer, Compliance Committee and high-level oversight duties and responsibilities
- Description of effective training and education procedures
- Description of communication processes
- Description of well-publicized disciplinary standards
- Description of effective system for routine monitoring and identification of compliance risks
- Procedures and system for prompt response to compliance issues

Confidentiality/Privacy

MR031	The Vendor must comply with applicable State and federal law regarding confidentiality/privacy, including, but not limited to, the confidentiality requirements of §1160 and §1902(a)(7) of the Social Security Act; the information safeguarding requirements of Title 42, Part 431 (Safeguarding Information on Applicants and Beneficiaries), Subpart F (42 CFR 431 F); and Title 45, Parts 160 (General Administrative Requirements), 162 (Federal Information Security Management Act [FISMA]), and 164 (Security and Privacy), to the extent they apply.

Aetna will comply with applicable State and federal law regarding confidentiality/privacy, including, but not limited to, the following:

- The confidentiality requirements of §1160 and §1902(a)(7) of the Social Security Act;
- The information safeguarding requirements of title 42, Part 431 (Safeguarding Information on Applicants and Beneficiaries), Subpart F (42 CFR 431 F); and Title 45, Parts 160 (General Administrative Requirements], 162 (Federal Information Security Management Act [FISMA]), and 164 (Security and Privacy)

Each Aetna employee completes an annual training entitled Privacy Training for Aetna Colleagues, which provides training on protecting the confidential information of our members, colleagues, and the company as a high priority at CVS Health. This course reviews the important policies regarding handling, protecting, and safeguarding confidential information including those listed legal requirements.

Incorporating Requirements Mandated

MR032	The Vendor must agree to incorporate all requirements mandated through federal and State regulations and legislation, which will include, but not be limited to, new reporting requirements.

Aetna agrees to meet and incorporate all requirements mandated by federal and State regulations and legislation, which will include, but not be limited to, new reporting requirements, including those identified in **Attachment D** and the SPA, including the following:

- Quality reporting
- Provider reporting
- Financial reporting
- Federal reporting
- Any new reporting requirements for the Children and Youth contract
- Other State-required reporting including those required related to advisory councils

We have developed Aetna Policy and Procedure document-1300.10, which addresses State reporting requirements pertaining to all ad hoc and contractually mandated regulatory reporting and establishes guidelines for regulatory reporting in accord with State regulatory specifications. Aetna's Business Information Management's Reporting Management team is responsible for monitoring plan data to confirm that data conforms to specified formats and reporting requirements. They also confirm that third-party reporting services are held accountable for complete, accurate, and timely data reporting that meets Department requirements. The Reporting Management team is also responsible for maintaining a current list of regulatory report requirements on the data hub to assure we meet any new reporting requirements as they are implemented.

Compliant Support Services

MR033	The Vendor must provide compliance support services to include, but not be limited to, providing up-to-date, accurate, and thorough documentation and reporting for regulatory and State compliance auditing.

Aetna will provide compliance support services to include, but not be limited to, providing up-to-date, accurate, and thorough documentation and reporting for regulatory and State compliance auditing. Aetna has protected the integrity of our operations for the past 23 years[4] and will continue to do so in assuring overall operational compliance with federal, State, and contractual requirements. Aetna does this by having monthly Policy and Procedure Committee meetings; quarterly Compliance Committee meetings; Service Improvement Committee meetings; QM/UM Committee meetings; and quarterly QMOC meetings. In addition, Aetna has developed 'Reach Team' meetings with the various areas (e.g., Medical Management, Care Management, Provider Relations, and Compliance departments) of the health plan to make sure Aetna meets all federal, State, and contractual requirements. By having these committees and the Reach Team meetings, Aetna can respond with up-to-date, accurate, and thorough documentation to all audits in an efficient manner.

Aetna actively participates in an external independent review performed by the Department- BMS. Aetna provides BMS with access to site, information, documentation, and data.

Aetna and their subcontractor(s) will make 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.

Compliance with Section 508 of the Rehabilitation Act of 1973

MR034	The Vendor must ensure that all applications inclusive of internet, intranet, and extranet applications associated with this contract are compliant with Section 508 of the Rehabilitation Act of 1973, as amended by 29 United States Code (USC) §794d, and 36 Code of Federal Regulation (CFR) 1194.21 and 36 CFR 1194.22.

Aetna will ensure that all applications inclusive of internet, intranet, and extranet applications associated with this contract are compliant with the following requirements:

- Section 508 of the Rehabilitation Act of 1973, as amended by 29 United States Code (USC) §794d, related to ensuring accessibility of internet, intranet, and extranet applications for people with disabilities
- 36 Code of Federal Regulation (CFR) 1194.21, related to reducing barriers to electronic resources such as the internet, intranet, and extranet for those with disabilities

[4] Please refer to Footnote 2.

- 36 CFR 1194.22 related to complying with accessibility standards to electronic communications for members

We perform regular internal accessibility compliance audits of our applications to ensure we remain compliant with these requirements. We take seriously maintaining accessibility of communications to our members with disabilities regarding electronic communications and resources. In serving Medicaid membership since 1996, we have experience in providing resources to individuals with physical, intellectual, behavioral, visual, and hearing-oriented disabilities and work diligently to ensure equal access.

Data Retention and/or Accessibility

MR035	The Vendor must ensure that data entered, maintained, or generated to meet the requirements of this Request for Proposal (RFP) are retained and/or accessible according to the federal requirements in 45 Code of Federal Regulations (CFR) Part 75 and/or applicable State and/or federal requirements.

Aetna will ensure that data entered, maintained, or generated to meet the requirements of this RFP are retained and/or accessible according to the federal requirements in 45 Code of Federal Regulations (CFR) Part 75 and/or applicable State and/or federal requirements. We understand the importance of the retention, maintenance, and accessibility of data related to federal and State contract awards and funding to assure effective and efficient use of finite, public Medicaid funding sources.

Approval for All Key Staff Hired and All Personnel Assigned

MR036	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.

Aetna will 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 will be replaced only with persons of equal or greater experience and qualifications. For each position staffed within this project, we will seek to hire individuals with child and welfare program expertise and understanding to optimally serve Children and Youth project members. As the project matures, we will collaborate with the State to enhance and advance the positions to continually and fully support the project populations and advance service to the Children and Youth population. 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

MR037	The Vendor must employ Key Staff 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 30 calendar days of the contract award.

Aetna will employ key staff 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 Aetna key staff members will enter the project within 30 calendar days of the contract award, creating an effective and efficient transition and continuity of services. We will make certain each key staff member has thorough knowledge and expertise in serving the children and youth population in leveraging our proven implementation processes for a seamless transition of services.

Minimum of 10 Business Days' Notice

MR038	The Vendor must provide the Department a minimum of ten (10) business days' notice for staffing changes.

Aetna will provide a minimum of 10 business days' notice to the Department of any staffing changes. We believe in strong inter-staff relationships to build cohesive processes fostering a proactive work environment and relationship with the Department. A key component of maintaining continuity of services is thorough succession planning in anticipation of potential staffing changes and creating cross-functional capability whenever possible. To assure continuity of services we identify potential interim replacements, when applicable, to maintain continuity of program administration and personnel management in concert with our philosophy of a trauma-informed system of care.

Replacement of Key Staff within 30 Business Days

MR039	The Vendor must replace key staff within 30 business days after the position is vacant, unless a longer period is approved by the Department.

Aetna will replace key staff within 30 business days after a position is vacant, unless the Department approves a longer period. We will strive to have positions open for as short a timeframe as possible and identify quickly interim replacements to assume essential functions during the hiring and replacement process. These interim assignments will be filled by experienced professionals with applicable knowledge and skills to assume the position duties effectively and without service disruption.

Ensuring Operations are Efficient, Professional, Legal, and Secure

MR040	The Department has an interest in ensuring that its operations are carried out in an efficient, professional, legal, and secure manner. The Vendor must remove any staff involved in the project, if the Department determines that any such staff has interfered or may interfere with the Department's interests identified above.

Aetna understands the Department has an interest in ensuring that its operations are carried out in an efficient, professional, legal, and secure manner. We will remove any staff involved in the project, if the Department determines that any such staff has interfered or may interfere with the Department's interests. We will continue to collaborate with the Department's interests in carrying out operations in an efficient, professional, legal, and secure manner. These efforts will be made to protect the State's investment and service to our members and help to assure their best possible outcomes.

Financial, Legal, Ethical, and All Other Forms of Responsibility

MR041	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 Vendor on the project.

Aetna will accept 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. Subcontractors bring added value to our members while we assure all processes remain and are fiscally responsible to the State. To create compliance with subcontractors, we have a system of subcontractor monitoring to bring extensive oversight to assist in selecting subcontractors and continuing to successfully monitor and oversee 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. Aetna undertakes subcontracts only when it adds value for our members. We use well-qualified, experienced subcontractors to provide services in support of the project—subcontractors with unique expertise and proven records of accomplishment relative to improving outcomes for our members by providing appropriate, coordinated care and services in a financially responsible manner.

Accessing, Editing, or Sharing Personal Information

MR042	The Vendor must have controls in place to ensure that unauthorized staff and other users do not have the capability to access, edit, or share personal information data. Personal information data includes, but is not limited to, Protected Health Information (PHI), Personally Identifiable Information (PII), Federal Tax Information (FTI), and Social Security Administration (SSA) data (including, but not limited to, family, friends, and acquaintance information).

Aetna will have controls in place to ensure that unauthorized staff and other users do not have the capability to access, edit, or share personal information data. We understand personal information data includes, but is not limited to, PHI, PII, FTI, and SSA data (including, but not limited to, family, friends, and acquaintance information). We fully protect member privacy and data within our systems. Annually, every employee is required to complete compliance training on the stated requirements. Our entire organization, including Medical Management, Member Services, Quality Management, Provider Relations, and if applicable, Care Management, and Utilization Management departments are responsible for implementing the oversight process and maintaining monitoring activities, including monitoring the delegate's provisions to safeguard members' PHI, as applicable.

We have the proper controls in place to ensure that unauthorized staff and other users do not have the capability to access, edit, or share personal information data. Aetna takes a risk-based approach to information security management. Asset criticality and data classification determine level of protection and quarterly risk assessments. This is derived from daily threat and vulnerability reviews. Our approach allows us to keep abreast of key risks and threats and to focus on managing the top key risks. Aetna's resulting security control environment lays the foundation for data protection, and Aetna's innovative solutions result in a level of protection typically found only within the financial industry and other highly regulated environments.

Some of the most directly relevant components of the Aetna security program include the following:

- Social Security number reduction/protection program
- Encryption of data in motion and at rest
- Application and web security controls
- Data security controls
  - Layered encryption strategy
  - Secure hardware disposal
  - Data loss prevention systems
- Physical security controls
  - Secure access management (pre-registration, identity authorization, business need validation); physical security monitoring (closed-circuit television cameras, 24/7/365 security guard, etc.)
  - Access controls (card readers, anti-pass-back, tailgate detection, etc.)
- Enhanced security monitoring controls
  - Database access security monitoring
  - Centralized Security Information and Event Management with 24/7/365 monitoring
  - Host and network intrusion detection and prevention systems
- Software lifecycle security hardening controls
- Access management
  - Centralized role-based access
  - Privileged account management
  - Privileged user monitoring
- Email security
  - Email encryption
  - Email/Domain Name System security standards

  - Inbound/Outbound email: malicious code controls, proof point email gateway
- Third party/Vendor governance

Vendor Employee Confidentiality Statement

MR043	The Vendor must ensure that all project staff have completed a Department Office of Management Systems (OMIS) Vendor Employee Confidentiality Statement (VECS) before beginning work on the project.

Aetna will ensure that all project staff has completed a Department OMIS Vendor Employee Confidentiality Statement before beginning work on the project. We are committed to operational integrity in collaborating with the Department and will ensure that all project staff has completed an OMIS Vendor Employee Confidentiality Statement prior to beginning work on the project. Assuring the integrity of the State's management systems from breaches of confidentiality is core to our maintaining confidential member PHI.

Federal Executive Order 11246

MR044	The Vendor must comply with Federal Executive Order 11246 related to Equal Employment Opportunity, the Clean Air Act, and the Clean Water Act.

Aetna will comply with the requirements of Executive Order 11246 related to Equal Employment Opportunity, the Clean Air Act, and the Clean Water Act. We provide assurance that we do not discriminate in employment decisions based on race, color, religion, sex, sexual orientation, gender identity, or national origin. Aetna undertakes various recruiting efforts to develop and ensure we maintain a diverse workforce creating career opportunities for people without discrimination, such as that based upon race, religion, color, national origin, age, sex, or disability, minority, and ethnic groups. We will hold regional and/or virtual job fairs with screening sessions to evaluate potential candidates and will develop a regional marketing effort to recruit staff. We will collaborate with recruiting agencies and job-training organizations and focus on recruiting diverse individuals through these local relationships. We believe that solving for the challenges of an increasingly complex health care environment requires the creativity and insights that only an inclusive, diverse workplace can deliver.
Aetna also complies with environmental regulations within the Clean Air Act and Clean Water Act, respectively, assuring the communities and members we serve that we are a responsible, environmentally friendly corporate partner.

Drug-free Workplace

MR045	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 will provide a drug-free workplace for employees and all applicable agents, including, but not limited to, subcontractors. We will comply with requirements to make certain all agents do not engage in the unlawful manufacture, distribution, dispensation, possession, abuse, or use of alcohol or a controlled substance during the performance of the contract. Employees 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.

If an employee is convicted or pleads no contest to a drug-related crime occurring in the workplace, they are required to tell their manager within five days of the conviction or plea. If employees need help with alcohol- or drug-related problems, the Aetna Resources for Living program is available to provide the following services:

- Assessment

- Counseling
- Referral resources

The following conduct is prohibited while working or on company premises including buildings, parking lots, or other properties used by the company:

- Engaging in the unlawful or inappropriate manufacture, distribution, dispensation, possession, use, transfer, solicitation, purchase, or sale of alcoholic beverages, controlled substances, and/or illegal or prescribed drugs
- Reporting to or remaining at work under the influence of alcohol or controlled substances, except when prescribed by a physician and use does not negatively affect an individual's ability to perform their job
- Unauthorized use or possession of alcohol, drugs, or any controlled substance, except when prescribed by a physician
- Testing positive for controlled substances except for legally prescribed medications
- Refusing to undergo drug and/or alcohol testing

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. All personnel are screened as part of the pre-employment hiring process. 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. Aetna provides a drug-free workplace for employees and all applicable agents, including, but not limited to, subcontractors.

HIPAA Compliance Officer

MR046	The Vendor must designate one named individual in its proposal as the Vendor Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance officer.

Aetna designates Alva "Fuzzy" Page III, Esq. as our HIPAA compliance officer. Mr. Page 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. In his role as program integrity lead for Aetna, Mr. Page 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 Written Approval by the Department

MR047	The Vendor must not publish or copyright any data using the Department's name without prior written approval by the Department for every instance. In this context, "data" shall mean all results, technical information and materials developed and/or obtained in the performance of the services hereunder, including but not limited to: all reports, surveys, plans, charts, recordings (video and/or sound), pictures, drawings, analyses, graphic representations, computer programs and printouts, notes and memoranda, and documents whether finished or unfinished, which result from or are prepared in connection with the services performed hereunder. Except with respect to any commercial software, the Department will be and remain the owner of all data provided to the Department by the Vendor or its agents, subcontractors, or representatives pursuant to the contract other than the Vendor's internal administrative procedure records.

Aetna will comply with State requirements to not publish or copyright any data using the Department's name without prior written approval by the Department for every instance. We understand the importance of protecting State-owned data and the definitions of data provided by the Department as we make certain to secure and protect data where appropriate in accord with all State requirements.

Expenses Required to Access Department Systems

MR048	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 will comply and be responsible for all expenses required to obtain and maintain access to Department systems. We understand these expenses include, but are not limited to, hardware, software, network infrastructure, and any licensing costs. Aetna has successfully managed and integrated with West Virginia Medicaid information technology systems throughout our 23-year history of serving the State through the Mountain Health Trust contract.

Results of Third-party Audits

MR049	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 will comply and 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 has achieved a Commendable rating from NCQA. NCQA evaluates how well a health plan manages all parts of its delivery system—physicians, hospitals, other providers, and administrative services to continuously improve the quality of care and services provided to its members. A Commendable rating for Aetna signifies that our excellent service and clinical quality meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement.

Aetna performs comprehensive penetration testing and vulnerability scanning, and we are happy to share numerous software security attestations such as security scorecard reports, penetration test reports and BSIMM assessments. Other assessments available include the following: HIPAA, SIG, NIST 800-53, payment card industry, security control assessment, and cyber security framework. Aetna can provide all assessments indicated upon State request.

In addition to providing our current third-party independent assessments, a copy of Aetna's policies, control standards and procedures are available upon member request. If additional information is needed, the Department can attend an Aetna onsite day event for further information on Aetna's security and technology programs, data center tours, and evidence reviews to satisfy yearly assessments.

Authorization to Access Records

MR050	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 will comply in providing authorization from a parent, affiliate, or subsidiary organization for the State to have access to its records if such a relationship exists that impacts our performance under the Children and Youth contract. We currently have policies and procedures in place to respond to requests by the State. In addition, we routinely respond to requests from BMS for certain documents and we respond timely to those requests. In the event the State determines that our relationship with a parent or affiliate impacts our performance under the contract, we will provide the State with applicable records.

Instructions for Completion of Attachment D - Mandatory Requirements

1. The Vendor must note compliance with each mandatory requirement listed in the ***Vendor's Disposition*** column of *Tab 3 - Mandatory Req Responses*, using only the values that appear in the drop-down list.
2. *Vendor's Disposition* values are outlined below:
    1. "Will Meet": Vendor agrees to the mandatory requirement.
    2. "Will Not Meet": Vendor declines to meet the mandatory requirement.
3. All mandatory requirements must contain one of the values identified above. Any mandatory requirement without a ***Vendor's Disposition*** response value will be considered to be "Will Not Meet."
4. If appropriate, the Vendor must provide the ***Attachment***, ***Section***, and ***Page Number(s)*** where their detailed narrative response for each mandatory requirement resides, providing the Department with a crosswalk, and ensuring that each mandatory requirement is addressed. Be advised that the ***Attachment*** column has been pre-populated with the location that the Department anticipates the narrative response to reside; however, it is up to the Vendor to update that column accordingly, should the Vendor respond to a mandatory requirement in a different location.

Tabs in this spreadsheet	
1. Worksheet Instructions	Instructions for completion of this RFP supplement.
2. Worksheet Information	This tab including information about the contents of this workbook.
3. Mandatory Req Responses	Contains the mandatory requirements and all related data.
4. Code Values	Contains coded values for use in the mandatory requirements tab, and explanations as appropriate.

Columns on the Mandatory Req Responses Tab			
Section	**Column(s)**	**Description**	**Corresponding Code Values**
Mandatory Requirements	*Req ID #*	The unique ID of the mandatory requirement.	N/A
	Requirement Text	The text of the mandatory requirement.	N/A
	Type	How the mandatory requirement is categorized.	N/A
Vendor Response	*Vendor's Disposition*	Vendor is expected to indicate its compliance with the mandatory requirement using one of the supplied values.	Vendor Response - Disposition
	Attachment	Vendor is expected to provide a reference to the appropriate RFP attachment where more detailed information about the mandatory requirement can be found. The expected attachment is identified for Vendor convenience.	Response Templates
	Section and Page Reference	Vendor is expected to provide a reference to the appropriate section and page number within the specified attachment where more detailed information about the mandatory requirement can be found.	N/A

Mandatory Requirements			Vendor Response			
Req ID #	Requirement Text	Type	Vendor's Disposition	Attachment	Section	Page #
MR001	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.	Federal and State Requirements	Will Meet	Attachment D - Mandatory Requirements	Compliance with Appli	365
MR002	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.	Capitation Rate	Will Meet	Attachment D - Mandatory Requirements	Acceptance of the Rat	365
MR003	The Vendor must have all requirements operational, as agreed upon with the Department, by January 1, 2020.	Implementation	Will Meet	Attachment D - Mandatory Requirements	Meeting All Operation	366
MR004	The Vendor must comply with W.Va. Code §9-5-27 requirements, including, but not limited to, reporting; establishing a voluntary advisory group of foster, adoptive, and kinship parents; and maintaining a primary workplace in the State where at least 80% of the full-time equivalent positions are located.	Federal and State Requirements	Will Meet	Attachment D - Mandatory Requirements	W.Va. Code §9-5-27 Re	366
MR005	The Vendor must adhere to the case management decisions of the Department caseworker, multidisciplinary team (MDT), or court, but must document and provide all recommendations for case management, as appropriate.	Care Coordination	Will Meet	Attachment D - Mandatory Requirements	Adherence to Case Ma	367
MR006	The Vendor must comply with requirements for qualified residential treatment program (QRTP) placements as described in the Service Provider Agreement (SPA).	Federal and State Requirements	Will Meet	Attachment D - Mandatory Requirements	Requirements for Qual	368
MR007	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.	Network Standards	Will Meet	Attachment D - Mandatory Requirements	Physical Health and Be	369
MR008	The Vendor must be accredited by the National Committee for Quality Assurance (NCQA).	Accreditation	Will Meet	Attachment D - Mandatory Requirements	Accreditation by the N	369
MR009	The Vendor must provide all requested supporting documentation upon notification of award, or a later date as specified by the Department, according to the requirements described in Appendix 5: List of Requested Documents.	Readiness Review	Will Meet	Attachment D - Mandatory Requirements	Requested Supporting	369
MR010	The Vendor must provide evidence of efforts to contract with all currently enrolled providers under the Department's fee-for-service (FFS) Medicaid program.	Network Standards	Will Meet	Attachment D - Mandatory Requirements	Evidence of Efforts to	370
MR011	The Vendor must credential and re-credential new physical health and behavioral health providers in accordance with federal and State requirements, as defined by the Department.	Federal and State Requirements	Will Meet	Attachment D - Mandatory Requirements	Credentialing and Re-c	371
MR012	The Vendor must ensure compliance with Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program requirements for applicable members, as outlined in the Service Provider Agreement (SPA).	Federal and State Requirements	Will Meet	Attachment D - Mandatory Requirements	Early and Periodic Scre	372
MR013	The Vendor must comply with post-stabilization care per applicable federal and State requirements, as defined by the Department.	Federal and State Requirements	Will Meet	Attachment D - Mandatory Requirements	Post-stabilization Care	373

Mandatory Requirements			Vendor Response			
Req ID #	Requirement Text	Type	Vendor's Disposition	Attachment	Section	Page #
MR014	The Vendor must provide 24-hour access to a provider or service in emergency situations.	Access to Care	Will Meet	Attachment D - Mandatory Requirements	24-hour Access to a Pr	374
MR015	The Vendor must, based on Department provider access to care requirements, ensure access to the full range of specialty and facility service providers for members in applicable populations with complex needs.	Access to Care	Will Meet	Attachment D - Mandatory Requirements	Full Range of Specialty	374
MR016	The Vendor must ensure that individuals in applicable populations who have specialists as primary care providers (PCPs) are receiving primary care services on an ongoing basis.	Benefit Administration	Will Meet	Attachment D - Mandatory Requirements	Ensuring Individuals in	375
MR017	The Vendor must monitor primary care provider (PCP) panels for compliance with the Bureau for Medical Services (BMS) limit of Medicaid members assigned per PCP, for applicable populations.	Federal and State Requirements	Will Meet	Attachment D - Mandatory Requirements	Monitoring PCP Panels	375
MR018	The Vendor must submit network standards documentation and geographic mapping reports in accordance with the reporting instructions in the Service Provider Agreement (SPA).	Network Standards	Will Meet	Attachment D - Mandatory Requirements	Network Standards Do	376
MR019	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.	Federal and State Requirements	Will Meet	Attachment D - Mandatory Requirements	Screening Processes	376
MR020	The Vendor must establish and maintain a records retention process in accordance with applicable federal and State requirements, as defined by the Department.	Data Retention and Accessibility	Will Meet	Attachment D - Mandatory Requirements	Records Retention Pro	377
MR021	The Vendor must implement and maintain a quality assessment and performance improvement program, as defined by the Department.	Quality	Will Meet	Attachment D - Mandatory Requirements	Quality Assessment an	377
MR022	The Vendor must participate in public meetings and other events at the request of the Department.	Stakeholder Engagement	Will Meet	Attachment D - Mandatory Requirements	Public Meetings and O	378
MR023	The Vendor must meet with the Department and industry-specific provider councils on a monthly basis during the first year of implementation, as requested by the Department.	Stakeholder Engagement	Will Meet	Attachment D - Mandatory Requirements	Meeting Monthly duri	378
MR024	The Vendor must meet with the Department and industry-specific provider councils on a quarterly basis after the first year of implementation, as requested by the Department.	Stakeholder Engagement	Will Meet	Attachment D - Mandatory Requirements	Meeting Quarterly afte	379
MR025	The Vendor must participate in external quality reviews in alignment with federal and State requirements, as defined by the Department.	External Quality Reviews	Will Meet	Attachment D - Mandatory Requirements	External Quality Revie	380
MR026	The Vendor must participate in the oral presentations to be scheduled during the proposal scoring period. Proposed key staff must be present for orals, in lieu of corporate or sales personnel being the primary participants.	Orals	Will Meet	Attachment D - Mandatory Requirements	Oral Presentations	381

Mandatory Requirements			Vendor Response			
Req ID #	Requirement Text	Type	Vendor's Disposition	Attachment	Section	Page #
MR027	The Vendor must provide all requested information prior to and participate in a readiness review, which will be defined by the Department, prior to implementation.	Readiness Review	Will Meet	Attachment D - Mandatory Requirements	Providing All Requeste	381
MR028	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 link: http://www.wvdhhr.org/mis/policies.asp https://technology.wv.gov/security/Pages/policies-issued-by-the-cto.aspx	Security	Will Meet	Attachment D - Mandatory Requirements	Current and Future Se	381
MR029	The Vendor must ensure compatibility with the most current West Virginia Office of Technology (WVOT) supported versions and standards.	Compatibility	Will Meet	Attachment D - Mandatory Requirements	Compatibility with Ver	382
MR030	The Vendor must provide a 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.	Security	Will Meet	Attachment D - Mandatory Requirements	HIPAA Compliance	382
MR031	The Vendor must comply with applicable State and federal law regarding confidentiality/privacy, including, but not limited to, the confidentiality requirements of §1160 and §1902(a)(7) of the Social Security Act; the information safeguarding requirements of Title 42, Part 431 (Safeguarding Information on Applicants and Beneficiaries), Subpart F (42 CFR 431 F); and Title 45, Parts 160 (General Administrative Requirements), 162 (Federal Information Security Management Act [FISMA]), and 164 (Security and Privacy), to the extent they apply.	Security	Will Meet	Attachment D - Mandatory Requirements	Confidentiality/Privacy	383
MR032	The Vendor must agree to incorporate all requirements mandated through federal and State regulations and legislation, which will include, but not be limited to, new reporting requirements.	Federal and State Requirements	Will Meet	Attachment D - Mandatory Requirements	Incorporating Requirer	383
MR033	The Vendor must provide compliance support services to include, but not be limited to, providing up-to-date, accurate, and thorough documentation and reporting for regulatory and State compliance auditing.	Audit Compliance	Will Meet	Attachment D - Mandatory Requirements	Compliant Support Ser	384
MR034	The Vendor must ensure that all applications inclusive of internet, intranet, and extranet applications associated with this contract are compliant with Section 508 of the Rehabilitation Act of 1973, as amended by 29 United States Code (USC) §794d, and 36 Code of Federal Regulation (CFR) 1194.21 and 36 CFR 1194.22.	Federal and State Requirements	Will Meet	Attachment D - Mandatory Requirements	Compliance with Secti	384
MR035	The Vendor must ensure that data entered, maintained, or generated to meet the requirements of this Request for Proposal (RFP) are retained and/or accessible according to the federal requirements in 45 Code of Federal Regulations (CFR) Part 75 and/or applicable State and/or federal requirements.	Data Retention and Accessibility	Will Meet	Attachment D - Mandatory Requirements	Data Retention and/or	385

Vendor's Responses to Mandatory Requirements

Mandatory Requirements			Vendor Response			
Req ID #	Requirement Text	Type	Vendor's Disposition	Attachment	Section	Page #
MR036	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.	Staffing	Will Meet	Attachment D - Mandatory Requirements	Approval for All Key St	385
MR037	The Vendor must employ Key Staff 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 30 calendar days of the contract award.	Staffing	Will Meet	Attachment D - Mandatory Requirements	Key Staff Assigned to t	385
MR038	The Vendor must provide the Department a minimum of ten (10) business days' notice for staffing changes.	Staffing	Will Meet	Attachment D - Mandatory Requirements	Minimum of 10 Busine	385
MR039	The Vendor must replace key staff within 30 business days after the position is vacant, unless a longer period is approved by the Department.	Staffing	Will Meet	Attachment D - Mandatory Requirements	Replacement of Key St	386
MR040	The Department has an interest in ensuring that its operations are carried out in an efficient, professional, legal, and secure manner. The Vendor must remove any staff involved in the project, if the Department determines that any such staff has interfered or may interfere with the Department's interests identified above.	Staffing	Will Meet	Attachment D - Mandatory Requirements	Ensuring Operations a	386
MR041	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 Vendor on the project.	Staffing	Will Meet	Attachment D - Mandatory Requirements	Financial, Legal, Ethica	386
MR042	The Vendor must have controls in place to ensure that unauthorized staff and other users do not have the capability to access, edit, or share personal information data. Personal information data includes, but is not limited to, Protected Health Information (PHI), Personally Identifiable Information (PII), Federal Tax Information (FTI), and Social Security Administration (SSA) data (including, but not limited to, family, friends, and acquaintance information).	Security	Will Meet	Attachment D - Mandatory Requirements	Accessing, Editing, or S	387
MR043	The Vendor must ensure that all project staff have completed a Department Office of Management Systems (OMIS) Vendor Employee Confidentiality Statement (VECS) before beginning work on the project.	Security	Will Meet	Attachment D - Mandatory Requirements	Vendor Employee Con	388
MR044	The Vendor must comply with Federal Executive Order 11246 related to Equal Employment Opportunity, the Clean Air Act, and the Clean Water Act.	Federal and State Requirements	Will Meet	Attachment D - Mandatory Requirements	Federal Executive Ord	388
MR045	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.	Federal and State Requirements	Will Meet	Attachment D - Mandatory Requirements	Drug-Free Workplace	388

Mandatory Requirements			Vendor Response			
Req ID #	Requirement Text	Type	Vendor's Disposition	Attachment	Section	Page #
MR046	The Vendor must designate one named individual in its proposal as the Vendor Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance officer.	Security	Will Meet	Attachment D - Mandatory Requirements	HIPAA Compliance Off	389
MR047	The Vendor must not publish or copyright any data using the Department's name without prior written approval by the Department for every instance. In this context, "data" shall mean all results, technical information and materials developed and/or obtained in the performance of the services hereunder, including but not limited to: all reports, surveys, plans, charts, recordings (video and/or sound), pictures, drawings, analyses, graphic representations, computer programs and printouts, notes and memoranda, and documents whether finished or unfinished, which result from or are prepared in connection with the services performed hereunder. Except with respect to any commercial software, the Department will be and remain the owner of all data provided to the Department by the Vendor or its agents, subcontractors, or representatives pursuant to the contract other than the Vendor's internal administrative procedure records.	Publication and Copyright of State Data	Will Meet	Attachment D - Mandatory Requirements	Prior Written Approval	389
MR048	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.	Cost of Maintaining Access to State Systems	Will Meet	Attachment D - Mandatory Requirements	Expenses Required to A	390
MR049	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.	Audit Compliance	Will Meet	Attachment D - Mandatory Requirements	Results of Third-Party A	390
MR050	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.	CMS RFP Checklist	Will Meet	Attachment D - Mandatory Requirements	Authorization to Acces	390

Aetna Better Health® of West Virginia

Vendors should not edit this worksheet.

Vendor Response - Disposition	
Vendor's Disposition	**Description**
Will Meet	Mandatory requirement will be met by the Vendor.
Will Not Meet	Mandatory requirement will not be met by the Vendor.

Response Templates	
Response Template	**Description**
Attachment A	Cost Proposal
Attachment B	Vendor Qualifications and Experience
Attachment C	Project Organization and Staffing
Attachment D	Mandatory Requirements
Attachment E	Detailed Specifications Approach
Attachment F	Sample Case Scenario
Attachment G	Terms and Conditions Response Template

1. BENEFIT ADMINISTRATION

The Vendor should refer to the relevant specifications located in ***Appendix 1: Detailed Specifications*** (based on the categorization within Column E: Subject Matter Area) and pertinent narrative in ***Section 4: Project Specifications*** in this RFP, and then describe its approach to Benefit Administration below. The Vendor's narrative response should not exceed 100 pages.

Coventry Health Care of West Virginia, Inc. dba Aetna Better Health of West Virginia (Aetna)[1] knows West Virginia through its long significant history dating to 1996[2] when Medicaid managed care began in the state. It has been an honor and privilege to serve the State of West Virginia for over 23 years. Aetna is looking forward to partnering with the State and all stakeholders to assist with the transformation of the system of care and services provided to the child welfare population. The Aetna Medicaid organization has proudly served child welfare members since 1995, and individual staff at all levels of the organization have the deep expertise and commitment necessary to serve the vulnerable populations included in this response through the full scope of work. Our programs and systems are guided by a team of child welfare experts who understand the resources needed and strategies to work collaboratively with the Department to support stability, build on members' and families' capabilities, and help them achieve their life goals. We are steadfast in our mission to support West Virginia as a national leader engaging in a systemwide transformation using a preventive-focused approach to support children and youth.

Our approach to supporting West Virginia children and youth involved in the child welfare system is based on our experience as a Mountain Health Trust plan and our understanding of the needs of West Virginia's children and families. This local knowledge is further supported by the Aetna Medicaid organization's comprehensive experience serving children and youth involved in the child welfare system in nine states (Arizona[3], Kansas, Kentucky, Louisiana, Maryland, Michigan, New Jersey, Pennsylvania, and Virginia).

Our wraparound evidence-based solutions and flexible approach to integrated care management provide unique opportunities for improved health outcomes that meet and exceed the expectations of the Bureau of Medical Services and the Department. Specifically, to provide high-quality care for children and youth involved in the child welfare system, we will use the **nationally award-winning Collaborative Family Engagement as a framework and methodology to strengthening and sustaining a partnership with the Bureau of Child and Families (BCF) staff and leadership**. This will be a unique approach to build a collaborative effort to stand a health system and child protection system shoulder-to-shoulder in supporting and strengthening the safety of children and the well-being of families. The methodologies address the challenges of collaboration between public child welfare internal cultures and external community-based partners.

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[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.

[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 was 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.

[3] Aetna's experience in Arizona is through its administration of Mercy Care, an unaffiliated health plan.

Our approach delivers enhanced coordination of care and access to services, including physical health, behavioral health, dental care, and socially necessary services (SNS). We simplify processes to reduce administrative burden on providers and reduce fragmentation for members and families, offering seamless continuity of care. We accomplish this through improved communication and training among stakeholders and the development and utilization of meaningful information technology (IT) solutions.

In our approach, West Virginia's children and families will receive high-quality, person-centered, trauma informed care (TIC) delivered at home, in schools, and throughout their communities. This model supports West Virginia's goals to reduce the number of children entering the foster system and prevent unnecessary or prolonged out-of-home placements for children. We adopt a family-centered approach to care that provides necessary and coordinated services to all members of the family. Aetna sees this as a starting point, not an outcome by itself. To reduce unnecessary or prolonged out-of-home placements, the best evidence available today supports families and kinship care as the place for children to develop if they cannot be safely with a parent. Aetna views the role of child welfare as additive and specialized, adhering to a value of foster parents as supports to families, not substitutes for parents.

We understand the key populations, disparities, health indicators, areas of need for population health improvement, and key regional differences. Aetna's population health analytics allow us to identify and impact the specific regional disparities in health outcomes facing West Virginians. **Figure 1.1-1** demonstrates regional variation in West Virginia for the same key indicators.

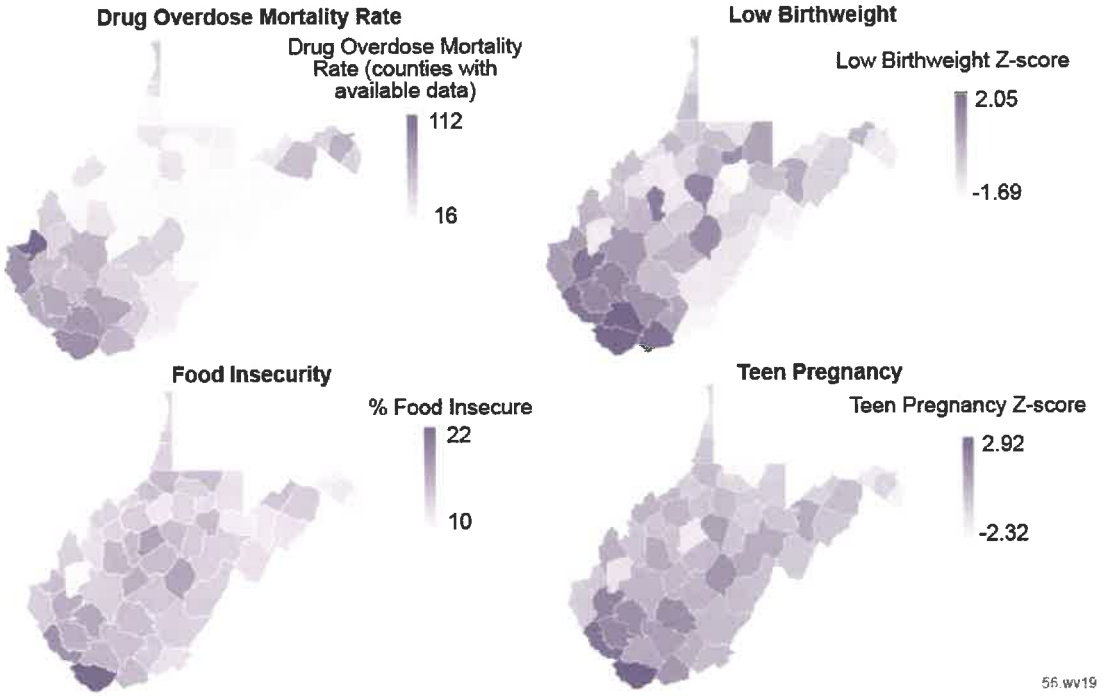

Figure 1.1-1: Regional Variation in Health Outcomes in West Virginia[4]
Aetna's uses population health management data analytics to identify and impact the specific regional disparities in health outcomes facing West Virginians.

Some important disparities in health outcomes in West Virginia are as follows:

[4] County Health Rankings and Roadmaps, "West Virginia," accessed July 1, 2019; https://www.countyhealthrankings.org/sites/default/files/state/downloads/CHR2019_WV.pdf

- **Teen birth rate**: In Monongalia County the teen birth rate is 11.5 per 1,000 females aged 15-19, while it is 73.6 per 1000 in McDowell County
- **Low birthweight**: Barbour has the lowest rate of infants born with low birthweight at 7.0 percent, while the rate is the highest in Mercer County at 12.1 percent
- **Drug overdose deaths**: Drug overdose deaths are the least common in Marion County, 15.9 per 100,000 people, and as high as 111.5 per 100,000 in Cabell County
- **Food insecurity**: In Jefferson and Putnam counties, 9.7 percent of residents face food insecurity, while 22.4 percent of McDowell Country residents have trouble acquiring enough food to eat

Regional Approach to Opioids in West Virginia

In Cabell, Mercer, and Raleigh counties, Aetna care managers are onsite at several medication-assisted treatment (MAT) facilities to meet members face-to-face when they come in for treatment. Our care managers are currently embedded in MAT practices in the central, southern, and western regions of the state.

Throughout this response we will demonstrate how Aetna understands the complexity of the child welfare system and how we are prepared to administer benefits to children, youth, and families statewide as well as support communities to implement sustainable solutions. For example:

Combatting the opioid crisis in West Virginia: Aetna acknowledges the impact of opioid use disorder (OUD) on the population of children and youth in child welfare in West Virginia. **Under the leadership of Dr. Don Gibbon, the chief medical officer/medical director of our Medicaid plan in West Virginia,** Aetna's national Medicaid organization has developed a multifaceted, national strategy for combating the complex issue of inappropriate use of opioids. The approach focuses on prevention, intervention, and support for our members. For example, Aetna encourages the use of screening, brief intervention, and treatment (SBIRT), a service appropriate for both parents and youth members at high risk, among all providers as a first-line approach to prevention and early intervention for those members with substance misuse, as well as those at risk for developing addictive disorders. We have implemented this strategy in West Virginia, and the 15 other states where we operate Medicaid plans. We bring our national expertise to our partnerships with local, state, and federal governments, as well as local stakeholder groups, such as first responders and public health agencies. Aetna emphasizes care coordination and continuity of care by reducing barriers to substance use disorder (SUD) treatment, MAT, support programs, and non-pharmaceutical alternatives through our extensive provider network, use of telemedicine, remote patient monitoring, and our comprehensive Medicaid and value-added benefits package. (See the **Promoting Prenatal Care** section for details on our neonatal abstinence syndrome [NAS] program.) We have created our Opioid dashboard, which uses pharmacy and medical claims data to trend key metrics to help us combat inappropriate use of opioids. For example, data from our Opioid dashboard demonstrate that between January 2017 and March 2019 Aetna has achieved impressive results in addressing the opioid use crisis in West Virginia:

- Rate of treatment with non-opioid procedures for members with chronic pain increased by 47.9 percent
- Rate of opioid prescription in members with a prior overdose decreased by 67.9 percent
- Rate of 7+ day opioid prescription after an acute procedure decreased by 65.9 percent

Addressing food insecurity: Aetna's food strategy aims to address food insecurity statewide through multiple modes of intervention. **Figure 1.1-2** shows a recent sponsorship to the Facing Hunger Food Bank, a local food bank that serves people facing food insecurity throughout much of Appalachia, including McDowell County. Aetna sponsors food bank distribution events throughout the state to support all West Virginians in need of food. In addition, Aetna assisted in the purchase of a box truck to deliver food to local food pantries and mobile food pantries. Aetna supports community organizations with grants.

Initiatives to combat premature birth and low birthweight: Aetna combats low birthweight and premature birth through the following actions:

- **High-risk pregnancy outreach and Makena administration**: We conduct educational outreach calls to high-risk pregnant members and text messaging to members identified as pregnant but who have not received prenatal services within recommended timeframes. In addition, Aetna supports the administration of Makena, a progesterone medicine to prevent preterm birth. Care coordinators determine if Makena is appropriate and reinforce with members the benefit of the injection and explain potential side effects. The care coordinator arranges transportation, as needed, for obstetrics and gynecology (OB/GYN) appointments and injections. Aetna attempts to conduct postpartum depression screening for all pregnant members after delivery.
- **Prenatal tobacco cessation:** Aetna care coordinators encourage pregnant members who smoke to participate in the State's Cessation Program and assist them with quitting through the West Virginia Tobacco Quitline and the Tobacco-Free Pregnancy Initiative. This initiative educates pregnant members, as well as members of child-bearing age, about the dangers of using tobacco. In addition, we transfer any pregnant member who indicates she smokes when completing the health risk assessment to care management associates for education on smoking cessation through Krames member education materials. Aetna receives a list of our enrolled members accessing the Quitline and outreaches and enrolls them into care management if they are not already participating.
- **Neonatal abstinence syndrome program:** In West Virginia, Aetna's nationally recognized, innovative, state-leading NAS program includes care coordinators embedded in High Risk OB practices that offer MAT for SUD. Our care coordinators meet with the mothers, enroll them in care coordination, and follow the mother throughout her pregnancy and concurrent treatment for SUD. **We have supported 1,475 mothers and babies in our NAS program since it began in 2015**. A detailed description and outcomes are in the **Promoting Prenatal Care** section.

Figure 1.1-2: Supporting Local Food Banks
Aetna supports food banks throughout West Virginia to combat food insecurity.

"My case manager was kind, non-judgmental, and an actual person who cared about me."
—Alexandra Miller
NAS program participant

Care Coordination

BA007	The Vendor should support the Department caseworker in the development of the member individualized service plan (ISP).	The Vendor should describe the procedures and protocols for how will meet this specification.
BA013	The Vendor should work with caregivers and families to help track appointments members are scheduled for and may miss without further reminders or assistance	The Vendor should describe how it will work with caregivers and families to meet this specification.
BA014	The Vendor should assist in rescheduling appointments and removing potential obstacles to care, including, but not limited to, transportation.	1) The Vendor should describe how it will work with caregivers and families to meet this specification. 2) The Vendor should give an example of an obstacle of care and how the Vendor would work to remove it. The Vendor may use transportation as this example but is not required to do so.

Effective wraparound philosophy of care coordination is critical to the success of children, youth, and families. Aetna coordinates a comprehensive array of services across life domains that address physical, emotional,

social, and educational needs, guided by an individualized, integrated service plan. We use tools, like the University of Missouri–Kansas City Institute for Human Development's Charting the LifeCourse™[5] framework, to facilitate person-centered decision-making, problem-solving, and planning when working with our members. Aetna's use of the LifeCourse™ model combines a focus on health equity and social determinants with an understanding of how biology and environment impact members' voice and choice. Health develops over a lifetime and care coordination places the member and /or guardian in the center of the Care Connection team guiding the care plan. Aetna focuses on the needs of the children and youth rather than the needs of the service system. West Virginia children and youth and their families should be empowered to have their own views on what is best for them and their own priorities in life. Aetna has learned we must be flexible to meet the needs of members and to make our system suit them. Youth, when able to, are an equal partner in the planning of care and know that their opinions are always important and are respected. Not all members served in the child welfare system, such as very young children, are able to meaningfully participate in care planning and Aetna emphasizes a family-centered approach to assessment and individualized service plan (ISP) development in these instances. Aetna recognizes the needs of an infant or very young child are different than those of an older child. We make every attempt to achieve the goal that all children/youths' connection to safe people from their family can be maintained and their connections to their communities are not completely gone. We support new mothers with SUD through our NAS program. We currently support our members in obtaining SUD services, and when possible reunification with their children. The Care Management (CM) team also works closely with such groups as Birth to Three and Right from the Start to ensure the needs of the young children are met. Traumatic histories and mental health conditions make this communication of goals and priorities at times challenging but critical.

In our approach to serving children and youth involved in the child welfare system, Aetna care coordinators ask them what they want using appropriate communication methods to actively encourage them to participate in their own care and to be real partners in the decisions made. Aetna makes sure to get the information needed to help them and their supports make decisions about their care and treatment. Services are provided locally, holistically, in an integrated fashion, and in accordance with the unique needs and potentials of each youth and are guided by person-centered care planning.

Aetna's person-centered, holistic approach to care coordination for children and youth served in the child welfare system in West Virginia is based on our integrated care management (ICM) model. Each member in care management (which will include all members served in this contract) has a locally-based care coordinator as a single point of contact and is supported by an interdisciplinary care team (ICT) comprised of the members, their family members of choice, and others following approval including their desired providers (e.g., primary care provider [PCP], specialists, non-traditional providers, and pharmacists, etc.), representatives from community-based organizations (CBOs), social service organizations (SSOs), faith-based organizations, and Aetna peer support specialists (PSSs) and community-based community health workers (CHWs). The ICT members develop trusting relationships with members to provide personalized support and collaborate with Aetna's regionally based Care Connection teams, comprised of care coordination staff who live and work in their assigned regions. Aetna's CCT program is regional and localized with a composition of members to meet the needs and gaps of the communities they work in. CCT members provide face-to-face resources and have established productive working relationships with the Department, Bureau for Children and Families (BCF), Child Protective Services (CPS), Juvenile Services, the Bureau for Medical Services (BMS), and Bureau of Behavioral Health (BBH). CCT members

Within five months of its initial implementation, Aetna's regional Care Connection team approach led to an increase in post-discharge follow-up **by 87% and a decrease in readmissions by 14%** due to enhanced member outreach guidelines.

[5] "LifeCourse Principles," Charting the LifeCourse™; http://www.lifecoursetools.com/principles/: accessed February 2018

have also built relationships with providers and community service agencies, which supports smooth implementation of individual care plans. Integration and community-based care are the keys to the success of the CCT.

Aetna also uses a comprehensive system of care model that not only looks at the members but the system within which the member must reside. Health literacy and health accessibility are both key.

System of Care Model

Aetna recognizes that to achieve optimal health outcomes and reduce costs, members, their assigned Department caseworkers, and their parents (including kinship care, and foster and adoptive parents) must understand how to access their covered health care benefits. With multiple moves and relocations, continuity in medications and health care access is critical. Aetna has implemented a team of local team of system of care (SOC) staff that includes an adult, child, recovery and resiliency and a justice system of care administrator primarily focused on improving the member experience by reducing barriers to care. The SOC model focuses on factors that negatively impact health and addresses them through a comprehensive array of supports and services, including community-based organizations.

System of care model application to West Virginia Specialized Child and Youth welfare program: To address the vital needs of West Virginia Children and Youth and implement the SOC model, Aetna will hire SOC staff, in addition to the mandatory positions of the **Model Service Provider Agreement**, experienced in child welfare and health care systems with a deep understanding of integrated, whole-person care and the impact of trauma. SOC staff must have excellent relationship management skills and attend case rounds for complex members and work with care coordinators to solve for systemic barriers. For our children and youth involved in the child welfare system, the SOC team helps resolve challenges and barriers and works with communities to identify sustainable solutions to assure care coordination. SOC administrators also play a key role in building organizational capacity to support the needs of all West Virginia members. The implementation of these SOC roles demonstrates our enhanced commitment to improving the service delivery system, in partnership with other stakeholders, to provide seamless coordination. Aetna will hire SOC individuals in the roles described in **Table 1.1-1:**

As of July 31, 2019, 85% of Aetna's member-facing staff have been trained in trauma-informed care, with the goal of having 100% trained by October 1, 2019.

Table 1.1-1: Aetna's System of Care Positions for West Virginia's Specialized Managed Care Program

System of Care Team	Supporting Children and Youth Enrolled in West Virginia's Specialized Managed Care
Child System of Care Administrator	• Builds collaboration with agencies through Help and Hope West Virginia, West Virginia ACES Coalition, and drug courts, and Helping Everyone/Each Other Reach Out (HERO) workshops. (HERO workshops are a peer-to-peer initiative shown to shorten the time to relate and leads to a relationship of understanding of the shared lived experience. They help foster care children identify independent solutions to the challenges they and their families face.) • Builds programs to target negative trends, analyze population data, and increase family-centered care, prevention, and early intervention • Collaborates with the network development director to provide a multidisciplinary and comprehensive service array for the needs of children and youth including identification of trauma treatment providers and foster and adoption competent therapists • Interfaces with socially necessary services (SNS) liaison to facilitate member access to care to maintain safety, permanency, and well-being

System of Care Team	Supporting Children and Youth Enrolled in West Virginia's Specialized Managed Care
Adult System of Care Administrator **(Transitional age/member-focused, e.g., 18-21 years old)**	• Collaborates with the Bureau for Public Health to increase the number of families enrolled in the West Virginia Home Visitation Program • Identifies system gaps and works to collaborate with health plan staff and community stakeholders to mitigate gaps • Collaborates with medical management on transition of care for members like aging out preparation and needs • Works with medical management to mitigate gaps in crisis service delivery including solutions to emergency room (ER) holds, reduction in out-of-state placements, and difficult-to-place members • Coordinates system approach to members needing emergency services for interpersonal violence, unaccompanied minors, and related support services
Recovery and Resiliency Administrator	• Builds supportive programs, interventions, and education related to resiliency, member advocacy, person-centered care, foster family and biological family support, recovery maintenance, etc. • Collaborates with the network development director to coordinate the peer support network and other non-traditional providers to serve children and youth • Advocates for service environments that are supportive, welcoming, and recovery-oriented by working with providers to implement TIC service delivery approaches and other initiatives • Collaborates with all health plan staff, children and youth, families, and stakeholders to help to ensure all members have advocacy support • Promotes the hope and person-centered language for recovery within the health plan • Provides update to the Member Advisory Committee based on monthly focus groups
Justice System of Care Administrator	• Coordinates with judicial system for family needs and judicial involvement, including legal aid, permanency, and treatment courts • Collaborates with child-serving systems including the Child Advocacy Centers, Court Appointed Special Advocates, and West Virginia Child Abuse Network to promote community integration and coordinated systems serving the member and their families • Develop partnerships with community providers trained in TIC to recognize the impact of trauma on justice-involved populations • Identify and support West Virginia members at risk for/or are incarcerated and collaborate with care managers to devise solutions to support West Virginia's complex population • Oversees the design and implementation of the integrated delivery programs [behavioral health (BH), physical Health (PH), and social determinants of health (SDOH)] to ensure the needs of West Virginia adults and their families in the justice system are met

Aetna's regionally based approach in West Virginia includes SOC staff within the CCTs. Our CCTs have been in place for two years and are specialized to regions in the state, such as the eastern panhandle and the Appalachian coalfields of the southern area of West Virginia. The CCTs include care coordinators, utilization management (UM) nurses, and behavioral health and SUD specialists. Members and families with care needs are discussed daily within our CCTs and include local medical directors along with our leadership team. We have strategically hired staff that reside in each of our designated regions, are aware of the local resources and providers in the area and continue to develop relationships with key community-based resources. The SOC staff support our members, providers, and the broader community by creating a seamless health care experience. For example, if a CCT that serves the eastern panhandle identifies access to a PCP is limited or identifies a barrier to access (e.g., a senior pediatrician retires from primary care) our child SOC administrator works to develop sites for telehealth or assist families with transportation to the nearest pediatrician until a new local provider is identified. The CCTs work with providers and stakeholder within their regions. They are experts in identifying the social determinants of health (SDOH) in their region and knowing available community resources.

Aetna's West Virginia CCTs have not only improved member outcomes, but have also led to improvement for our employees:

- Employee surveys indicate a 10% increase in employee satisfaction
- Care management efficiency measures indicate a 27% increase in productivity

Figure 1.1-3 shows our extensive co-location in West Virginia. Each site listed has a care coordinator onsite one to four times per week to interact with Aetna members face-to-face. This fosters the establishment of a relationship with the member and provider, so a collaborative team approach is maintained. This allows members' needs to be addressed and assessed in real time, increasing access and improving health care literacy and the member experience by bringing health care home.

"Laura White, CM, is an embedded Case Manager in our office 2-3 days weekly. She is able to assist with patients in our office who have complex needs and social situations. Laura has been a team player in care coordination for our Aetna members ensuring they have their basic resources met. She has also been able to assist with billing issues for our office staff. Our office has opened a new practice in Logan, in which we have asked that Laura take an active role in being onsite at that location as well."

—Dr. Ammar Shammaa, Woman Care Clinic, Charleston, WV

[BA007] Supporting the Development of the Individualized Service Plan

Specializing in serving children and youth involved in the child welfare system requires a coordinated system, an understanding of available resources, and the ability to access care. All these capabilities are necessary so each child has a single, integrated, individualized service plan. Members of Aetna's Care Management team and KEPRO's (our vendor authorizing and reviewing SNS) team will work with the Department caseworker in identifying services available for a full continuum of medical, behavioral, and SNS support based upon the identified needs of the child.

Aetna begins its relationship with members (and their families, foster families, and Department caseworkers) who are either newly involved in the child welfare system or who are already involved but are newly enrolled with Aetna, **by our rapid response process based on wraparound standards of care for youth in crisis.** From the first contact with the caseworker, regardless of the methods by which the member enters the child welfare system, the Aetna care coordinator works to achieve alignment as critical partners in the safety, well-being, and permanency needs of the member. Alignment between State staff and the Aetna care coordinator is critical to support the member's needs for safe family relationships, access to normative experiences, and continuity of health, mental health, and dental services.

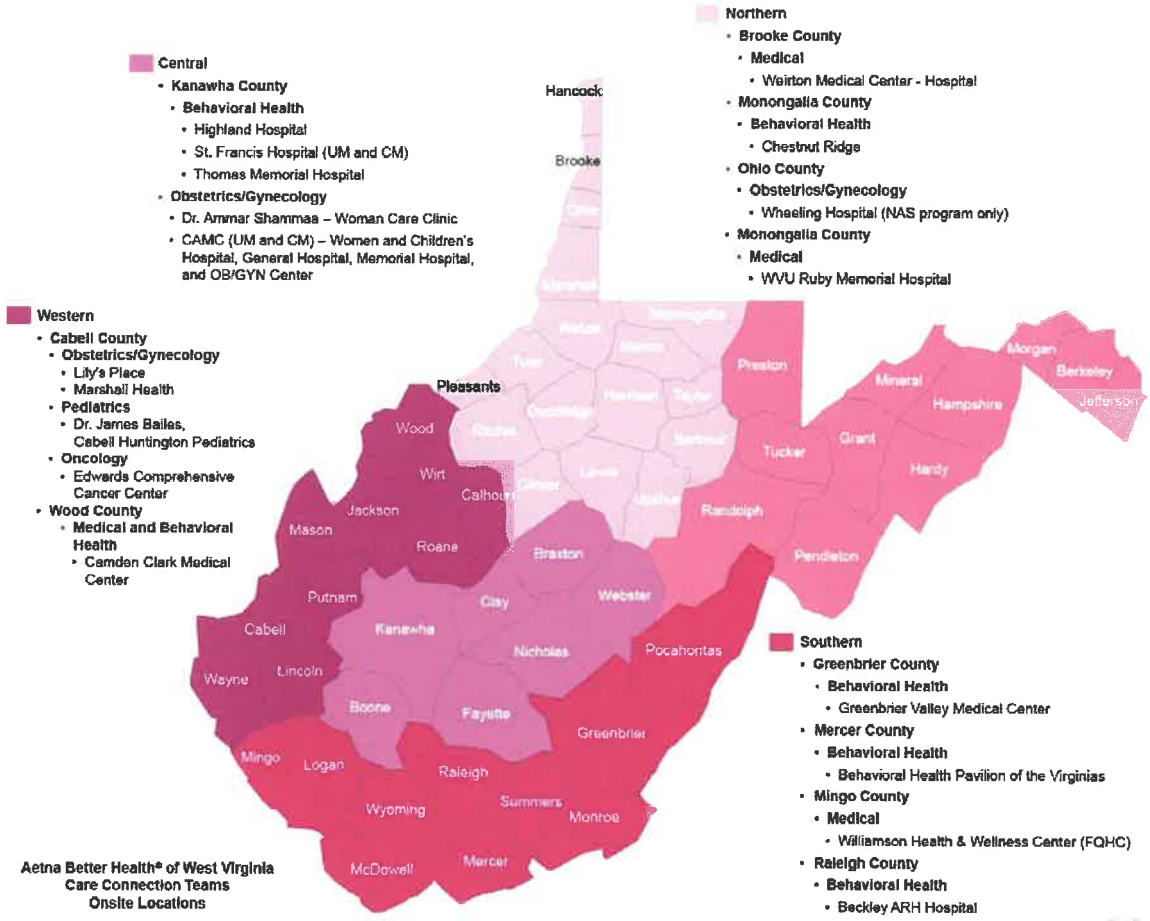

Figure 1.1-3: CCT Co-location with Local Providers

Aetna's CCTs are co-located with local providers, providing timely and easy access to care for members across the state.

Aetna will work collaboratively with the State agencies and where appropriate the juvenile courts to develop processes for timely referral and enrollment with the health plan. Where it is safe and geographically possible, Aetna proposes a shared response to children and families at imminent risk of removal and family separation. The added support and practices available through Aetna may significantly reduce the frequency of removal or result in increasing the opportunity to engage kinship support for children rather than placement in foster or residential care. This focus, as an early intervention and primary and secondary prevention, is complimentary to the State's intention to implement the Family First Prevention Services Act.

Aetna care coordinators use a variety of assessment tools and interview techniques to tailor their response to the age and development of members, from infants to young adults. Very young children are dependent on the responsiveness of their caregivers. The level of support caregivers receive is crucial to their ability to meet the developmental and affection needs of children in their care. Care coordinators serving children in this age group focus on support with parents (kin and foster parents) on careful coordination of access to services and supports, which best support the care of the child. Aetna facilitates a clear consensus plan for a good life and childhood from the perspective of the caring adults in a young child's life. Strategies and support must be adjusted as youth grow older. As children reach school age, Aetna care coordinators increase their time with the member themselves to raise their opportunity to voice needs and preferences for their health and

wellness as well as for care they may benefit from. Care coordinators recognize the need to bring the voice of youth together with their caregivers, family, and caseworkers to promote cohesion and safety within the young person's network of support. Adolescents who are nearing, or are in, transition to adulthood should be the leaders and architects of their own life and plans. Aetna care coordinators utilize Charting the LifeCourse Tools for individual members as a critical approach to life course planning and support development. Aetna engages youth in this age group in our HERO workshops where cohorts of older youth have the added opportunity of forming a peer community of support to assist them in their active efforts toward transition to adulthood (see **Figure 1.1-4** for a picture of a recent workshop).

Figure 1.1-4: Aetna Hero Workshop
Aetna hosts HERO workshops in West Virginia to give children and youth in foster care the opportunity to connect with peers.

Aetna care coordinators convene the ICT to empower the member and their circle of support to claim the opportunity for a good life, good health, and a bright future, through the development of the ISP. Aetna care coordinators partner with Department caseworkers through in-person participation in the Department's multidisciplinary team (MDT) and telephonic and email contact as needed to address a member/family's needs and facilitate an interdisciplinary, whole-person approach partnering with the member, PCP, specialty care, SNS, and BH providers, representatives from CBOs/SSOs, caregivers, foster/adoptive and biological family members, and Aetna's ICT when requested by the member or family. They also collaborate with utilization reviewers, pharmacy, and other stakeholders to make sure all appropriate information is incorporated into the plan.

The assigned care coordinator's goal is to avoid duplication and/or disruption of existing relationships with services and providers and to work collaboratively to develop an ISP for the member that carefully aligns services. The individualized, whole-person plan may include specific interventions or tasks for the Department caseworker and Aetna care coordinator that facilitate the member achieving their plan and self-management goals, such as completing referrals, assisting the member with access to a provider or a community resource, or following up to verify the member received the care or services needed. The team identifies caregivers who may need further reminders of appointments or assistance in scheduling or getting children to their health care visits. Aetna's goal is to include peer support specialists and CHWs on all CCTs. CHWs can serve to both remind caregivers of appointments and assist with scheduling and rescheduling appointments.

Aetna understands the first introduction to CPS (e.g., a child's first involvement with the justice system, the loss of a parent to incarceration, etc.) is a high-risk situation that requires immediate access to services. As a result, we have developed a front-end process that allows for a quick and clinically appropriate rapid assessment, utilizing crisis response teams discussed in the crisis section of this question. **All children and youth engaged in the child welfare system in West Virginia will have an Aetna care coordinator who will be the convener and single point of contact for the care coordination team in the community in which the member lives.** Once stable and back in their community, children and youth will undergo a screening and assessment process, conducted by specialized Aetna care coordination staff with training in wraparound and experience working with the child and youth in the child welfare system. The screening tools allow Aetna to appropriately stratify members into the appropriate level of care management (e.g., the population health level, supportive care management, or intensive care management) which will drive the person-centered care planning process and timelines (please refer to **Table 1.1-2** for the clinical and SDOH criteria for each care management tier). Those youth identified with high complexity will undergo a more in-

depth clinical assessment process. This is key in the development of a single care plan that stays with the child/youth as the primary source of truth. This single source of truth is housed in Aetna's **FamilyConnect system**.

Table 1.1-2: Clinical Criteria for Care Management Levels

Level	Clinical and/or SDOH criteria
Population Health Care Coordination (Tier 1)	• 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) to the extent appropriate for their age • Member showing improvement who moved from Tier 2 to Tier 1
Supportive Care Management (Tier 2)	• Moderate acuity, not at risk of crisis • Individuals in the system with juvenile justice involvement • 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
Intensive Care Management (Tier 3)	• 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 behavioral health inpatient admissions • Pregnant members with a history of substance use or who are currently using substances • Pregnant members current or historical high-risk pregnancy • Infants with neonatal abstinence syndrome • Children and young adults with abuse and/or trauma histories with significant social determinant of health needs or with other complex diagnoses • Individuals in the Coordinated Re-Entry Program or incarcerated members • Children with serious emotional disturbances • Individuals with HIV/AIDS, cancer, chronic renal failure, and other chronic complex conditions • Individuals transitioning from a Psychiatric Residential Treatment Facility (PRTF)

FamilyConnect: To support continuity of care, the Aetna care coordinator uses **Aetna FamilyConnect**, the shared, electronic health record (EHR) to be implemented in collaboration with the Department, West Virginia Health Information Network (WHVIN), PreManage via Collective Medical Technologies (CMT), and providers. FamilyConnect serves as the single source of truth for children and youth in child welfare. Aetna understands the fragmented nature of the current child welfare environment in terms of clinical, social, and programmatic documentation and is prepared to address this significant gap as specified in the wraparound approach, which strives for one child-one plan. Aetna has designed an information management system for the purpose of integrating all components of the delivery of care to members. The system has the capability to securely store and transmit information, interface with subcontractors (e.g., SKYGEN for dental care) and other relevant systems, including Families and Children Tracking System (FACTS), and reports data in a format specified by the Department. The Aetna Medicaid organization has years of experience with health level 7 (HL7) transaction format and will be fast healthcare interoperability resources (FHIR)-compliant as directed by the Centers for Medicare & Medicaid Services (CMS). The data systems will be integrated so the West Virginia member's data can be compiled in one central source. The member's complete health history, or health passport, will be housed within the FamilyConnect system as well as hardcopy for the foster parents to assist in continuity of care.

All information is only shared with the signed consent of the West Virginia member or their guardian. We have protocols in place for adding or removing permissions to access FamilyConnect for parents, guardians, and foster parents as placements change for children and youth. This proprietary integrated digital system serves as a records repository with access for all key players involved in the care of children and youth in the

child welfare system, including the members of the CCT, educators, representatives from community-based organizations and social services organizations, and staff at State agencies. This supports our person-centered model of care in which one care plan is developed that incorporates service and support needs identified by each stakeholder, such as the member's Individualized Education Program, terms of probation, and social determinant needs. This approach contributes to defragmentation of the health care delivery system for children, youth, and young adults enrolled and reduces both provider and member and family burden to make the health care system navigable for parents and children.

[BA013] Tracking Appointments and Providing Reminders for Members are Families
Each member's primary care coordinator inputs upcoming appointments in the FamilyConnect system to track them. The care coordinator also sets a task reminder, especially for parents/guardians who may need reminders of appointments. The primary care coordinator who is part of the members' ICT and is supported by the regional CCT will serve to remind caregivers of appointments and assist with scheduling and rescheduling appointments.

Aetna care managers will encourage members and their caregivers or family to keep scheduled appointments by sending an email/text message to the member and/or caregiver or family member one week prior to their scheduled appointment. This message would include the date and time of the appointment and the phone number for a contact person if the client misses their appointment or may arrive late

Care coordinators make calls to members depending on the needs of members/families and the goals of the care plans to improve attendance at scheduled appointments and reduce missed appointments. In addition, Aetna member services representatives have access to gaps in care (GIC) information in the electronic care management system and provide reminders to members and their families to schedule needed appointments when a GIC is identified in their record.

Aetna care coordinators also make contact with members and their families post-hospitalization (including a hospitalization for a BH concern) to make sure they receive appropriate follow-up care. The care coordinator will work with the members existing providers, through the ICT, to identify any immediate gaps in care as well as needs identified but not yet addressed. If for any reason the member cannot continue with the established care provider, the care coordinator will assist in properly transferring records and make sure the new provider addresses all identified needs. The care coordinator updates the care plan, located in FamilyConnect, and the primary Aetna care coordinator takes over from the transition of care team.

Upon implementation, Aetna will expand this program and enhance each CCT to further identify families who would benefit from a phone call and arrange for the primary care coordinator to create a reminder task for the family in FamilyConnect.

In addition, Aetna care coordinators are **currently co-located in 20 physical and behavioral health provider locations across the state** (a number that far surpasses other managed care organizations [MCOs]) and provide reminders related to follow-up appointments for children and families.

Missing appointments can be monitored more frequently, and Aetna is committed to working with the Department on further health information exchange (HIE) integration to provide more timely notification of missed appointments.

Text messaging solutions: Aetna's texting campaigns provide members notifications for physical, dental, and routine screenings (including family planning) and are based on member age, gender, and eligibility. We will send these messages to members, their caregivers or families for whom a date of their last physical exam is either not 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 receiving mobile phones if the member/family does not have a phone to receive messages. Members or their caregivers can choose not to receive text messages at any time.

Specifically, Aetna uses text messaging to support campaigns to encourage families of children receiving Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services to access dental care, well child visits, and to complete lead screenings. Our educational text-messaging program consists of the Lifeline smartphone (foster care families receive a phone for each child placed in their care) and targeted messages to remind members to get tests and screenings done. It sends routine reminders to members to support their health goals related to weight management, diabetes, substance use, prenatal and postpartum care, well-child visits, and flu shots. Many of these text campaigns serve as virtual health coaches that allow members to interact and be educated on their specific conditions. Some of the unique monthly broadcast messages we have sent to members include reminders on keeping contact information current with the local Bureau for Children and Families office or even ER diversion and the importance of seeking their PCP first. Messages are delivered to members in either English or Spanish, depending on their preference. Aetna care coordinators make sure that as children change placement, the new foster/adoptive family can access a Lifeline phone to promote continuity of care.

[BA014] Rescheduling Appointments and Removing Potential Obstacles to Care

Aetna care coordinators proactively identify potential obstacles to care during the initial assessment and care planning process and establish strategies to minimize potential missed appointments as early as possible (e.g., addressing issues related to transportation, access to a reliable phone, etc.). When an Aetna care coordinator or member services representative becomes aware that a member or their family member missed an appointment, they assist with rescheduling, as necessary. In addition, members determined to have socially or medically complex needs (e.g., multiple chronic conditions, SDOH barriers, gaps in care, health disparities, etc.), receive a comprehensive evaluation through our ICM program and are supported at an appropriate intensity based upon identified needs and defined criteria. The care coordinator works with the member and family to identify SDOH barriers that may create obstacles to care. The care coordinator offers to assist with scheduling appointments and resolves any barriers to getting to the appointment, such as transportation. Specifically, to assist children and youth to reach needed appointments, we offer:

- Non-Emergency Medical Transportation through coordination with LogistiCare, the State's vendor
- Coordination with SNS providers to provide needed services that address member's/family's obstacles to receiving care
- Text messaging reminders to encourage members/families to access covered benefits and to call Aetna for assistance through care management. As of July 2019, 67,519 Aetna members are engaged through our text messaging (SMS-based) health services. About 70 percent of Aetna's West Virginia members have a valid mobile phone number and of those, 93 percent have been reached with text messaging programs. Aetna has launched four population health programs: txt4health (adult prevention), text4kids (pediatric prevention), text4baby (maternal and infant health), and care4life (diabetes management). Additionally, Aetna has launched targeted campaigns, including: Benefits & Resources; Diabetes Gap in Care; Opioid Prevention; Well Child Visits; Flu Shot Reminders, and monthly ad-hoc messages
- Outreach by Aetna care management staff to conduct screenings for social resource needs
- Coordination with community-based CHWs to link members to non-Medicaid services, such as those offered through CBOs, SSOs, and faith-based organizations

Example of removing an obstacle to care: Heidi (not her real name), a 28-year-old female, was 17 weeks pregnant and receiving high-risk services from her obstetrician due to issues with substance use. Heidi's obstetrician reached out to Aetna to request Heidi be connected with care management services. Upon the request, Heidi was connected with a care manager who quickly assessed that Heidi was in need of transportation services to ensure she would be able to attend all her scheduled obstetrician appointments along with remaining successful in her local MAT programming. The Aetna care manager coordinated with a

local transportation provider so Heidi's address and contact information were correct and make sure regularly scheduled transportation was in place. Through the care manager's coordination of care efforts, Heidi was able to attend all her scheduled appointments. The Aetna care manager's support also enabled Heidi to develop confidence in her ability to contact a vendor to schedule her own transportation for her future appointments.

Socially Necessary Services

BA001	The Vendor should establish and implement authorization criteria for socially necessary services (SNS).	The Vendor should provide proposed authorization criteria for these services.
BA002	The Vendor should establish and implement a process for providers to request authorization for socially necessary services (SNS).	The Vendor should describe the provider authorization request process for these services.
BA003	The Vendor should establish and implement a process to review authorization requests for socially necessary services (SNS)	The Vendor should describe the authorization request review process for these services.
BA004	The Vendor should apply utilization management guidelines to retroactively review socially necessary services (SNS).	The Vendor should describe its process to retroactively review socially necessary services (SNS).
BA005	The Vendor should coordinate socially necessary services (SNS) for the member and/or their family.	The Vendor should describe in detail the process to coordinate these services for the member and/or their family.
BA006	The Vendor should verify the most appropriate provider of socially necessary services (SNS) Is used to meet the member's needs.	The Vendor should describe both the verification process and how the Vendor proposes to define "most appropriate" for the purposes of verification.
BA008	The Vendor should use family service plan (FSP) and individualized service plan (ISP) information, as applicable from the Department caseworker, to authorize socially necessary services (SNS).	The Vendor should describe the procedures and protocols for using the family service plan (FSP) and individualized service plan (ISP) to authorize socially necessary services (SNS).
BA055	The Vendor should notify providers and/or members regarding expiration of existing medical, pharmacy, and socially necessary services (SNS) authorizations.	The Vendor should describe how it will meet this specification.

Aetna understands the importance of establishing permanency and well-being for children in the child welfare system and providing early intervention family services to prevent removal of children from the home through the provision of SNS to provide the opportunity to prepare members with independent living skills as they age out of the child welfare system and age in to a positive life trajectory. These types of services are based on an evidence-based Wraparound model of care for foster youth and families. They are designed to maintain or establish safety, permanency, and well-being for children and families in the child welfare population. Aetna's model for serving children and youth in the child welfare system includes a social services director and a SNS liaison, who collaborates and interfaces with the BCF and all SNS providers to facilitate member access to care and positive health and social outcomes in a seamless way. Aetna care coordinators facilitate the adoption of a single care plan through use of the FamilyConnect platform system through which data from multiple sources is integrated to create a single record for the member. Data integration is key to continuity of care for physical health, behavioral health, and socially necessary services.

Children and families involved with SNS interventions have multiple and complex needs across several life areas often with histories of Adverse Childhood Experiences (ACEs). Aetna will team with the Department workers to coordinate the least restrictive, most integrated services to reduce the number of children entering the child welfare system, avert institutional placement, improve independent living skills, and reduce barriers during care transitions. SNS are key to interrupt (and bring to an end to) a cycle of acute psychiatric hospital admissions or residential placements.

Because 26.1 percent of children and youth aged 0-17 in West Virginia have experienced two or more ACEs, which is 20.2 percent higher than the national average,[6] we augment our preventive approach by collaborating with CBOs and SNS providers before risk and danger commences by implementing and adapting solutions to meet family needs through informal and formal supports. A- risk youth are identified with our proprietary risk stratification model and will receive referral to SNS (details on this approach is in the **Special Health Care Needs** section). We believe SNS help to prevent child welfare placements in the first place by addressing unmet social needs, as well as preparing transitioning youth and families for independence and life in the community.

[BA001] Authorization Criteria for Socially Necessary Services

Aetna will utilize the services of KEPRO, which has been providing services to the Department since 2000, to conduct authorization of SNS using the existing **Appendix 9 SNS UM Guide** as the criteria for authorizing SNS. Aetna's goal is to limit negative impacts on vulnerable children and youth involved in the West Virginia child welfare system by reducing the number of changes to the system.

We look forward to working with KEPRO and the Department to refine these authorization criteria and develop an integrated model as appropriate based on the implementation of the Family First Prevention Services Act, feedback mechanisms Aetna has in place (including focus groups) with members, families, and foster parents; providers; stakeholders; and the Department as well as our continued analysis of our UM program and member outcomes. As the implementation of the Family First Prevention Services Act progresses in West Virginia, services will be added, deleted and/or refined to meet BCF requirements. We will work with the department as new services and authorization criteria are established and implemented to reflect the updated services.

We will use our established Member Advisory Committee to conduct SNS-specific focus groups at least 12 times per year to gather feedback from youth, families, and foster parents who use SNS. Focus groups inform, educate, and identify opportunities to improve member, family, and provider care coordination and health outcomes.

Aetna has significant experience collaborating with an administrative services organization to bring high-quality, non-medical services to our members.

For example, in Ohio we contract with local Area Agencies on Aging (AAA) to perform care management and authorization of waiver services for members. The AAAs develop care plans and work closely with the Aetna care management team, use our electronic care management system, and serve as a single point of contact for members.

Aetna also uses a vendor in several of our long-term care markets to provider pre-employment services including: enrolling Medicaid members and their Personal Care Assistant (PCA), who is the member's employee; processing PCA timesheets; deducting, filing, and paying state and federal income and employment taxes and other withholdings; paying PCAs; providing customer service through a call center; providing training on Fiscal/Employer Agent enrollment and payroll processing procedures to member and Designated Entities responsible for supporting the member in managing their PCA, and providing an electronic visit verification system compliant with the 21st Century Cures Act for personal care services.

[BA002] Provider Requests for Authorization of Socially Necessary Services

KEPRO will process referrals for SNS submitted by a BCF caseworker through the State's FACTS system within 24 hours. The process will remain the same at this time for providers to request authorizations for socially necessary services, although Aetna will assure an integrated approach. It

[6] America's Health Rankings, "Trend: Adverse Childhood Experiences, West Virginia, United States," (2018); Accessed July 16, 2019: https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/ACEs/state/WV

begins when the Department worker enters a SNS in the service plan contained in FACTS, selects a provider, and prints a referral letter. The referral letter is then sent to the identified agency by the Department worker. The Department provides all the SNS referrals generated that business day in the agreed upon file layout and transfers it to the Department's secure site. KEPRO retrieves the file, validates the data, loads into their UM system, and makes certain fields are un-modifiable by providers and UM vendor staff. Service providers log onto the SNS UM system to enter remaining data elements and submit their requests.

KEPRO utilizes a tiered system for the purpose of authorizing services delivered to BCF members. All data is submitted electronically. Increasing levels of data are required as the complexity of a case increases. Information received is automatically entered into the SNS UM system, which compares the member data to UM criteria. KEPRO promptly makes a confirmation of authorization available to providers for those requests that meet the criteria via the secure KEPRO website.

KEPRO's UM application process follows CMS security regulations and will comply with Health Insurance Portability and Accountability Act (HIPAA) regulations. Aetna will establish a fully compliant, secure file exchange and system access capability with KEPRO for all two-way data and application access requirements. We utilize industry-standard Secure File Transfer Protocol (SFTP) servers to handle inbound and outbound file exchanges and employ a rigorous combination of automated and manual processes to validate successful exchange of files. Our file monitoring software will alert us automatically in the event of a failure anywhere in the end to end process, and if a failure occurs our production support team is immediately engaged to research and resolve the issue. We also have a full audit trail for all inbound and outbound files and data processed retained in a separate audit database retrievable for audit and compliance purposes.

Aetna will collaborate with KEPRO to maintain the current system of SNS authorization and implement an oversight committee through our Quality Management department to assess under- and over- utilization, unnecessary high costs of care, etc. Aetna and KEPRO understand there will be many changes members will experience with a transition from fee-for-service to managed care and keeping access to SNS services stable is critical.

[BA003] Reviewing Authorization Requests for Socially Necessary Services

Aetna will incorporate an SNS authorization specialist with our prior authorization staff specifically to integrate with KEPRO staff to provide continuity of care by utilizing the process to review authorizations currently established and familiar to SNS recipients, providers, and BCF staff. The SNS authorization specialist will have relevant educational background (e.g., a Bachelor of Social Work) and/or work history serving children and youth in child welfare or receiving adoption assistance. The SNS authorization specialist will receive all current UM training, with an emphasis on topics including: State SNS UM criteria, safety, needs assessments, trauma-informed care, Mental Health First Aid (MHFA), as well as supplemental training on the needs of foster care children and children receiving adoption assistance.

Aetna will ensure continuity of care by utilizing the process to review authorization requests that is currently established and familiar to individuals receiving SNS, providers, and BCF staff. KEPRO utilizes a tiered system for the purpose of authorizing services delivered to BCF members. All data is submitted electronically. As the complexity of the case increases, escalating levels of data are required:

- Tier One involves a minimal set of data elements
- At Tier Two, the number of data elements increases. This tier is utilized for more complex case scenarios that warrant further review.
- Tier Three is reserved for transitional living services

Information received is automatically entered into the KEPROS's UM system, which compares the member data to UM criteria. KEPRO promptly makes a confirmation of authorization available to providers for those requests that meet the criteria via the secure KEPRO web portal.

For each eligible member for whom the provider has submitted an authorization request, if the UM criteria are met, there is an initial amount of each service automatically authorized for a particular level of care.

When criteria are not met, the authorization request is automatically flagged by the system and deemed pending or pended for the KEPRO care manager to review with the requesting provider or the Department worker. Providers are notified of pended requests via the secure KEPRO web portal. If a member needs service beyond the initial authorization, providers obtain re-authorization for continuing services through the use of the submission of data at the appropriate Tier based on the defined UM Guidelines for the service. The authorization/pending process for re-authorization requests functions the same manner as for initial authorization requests. After the review process, one of the following outcomes will occur: authorization, review, closure, or an alternative service is recommended. The service requests are not authorized if the member is ineligible for all or specific requested services, maximum allowable number of authorizations has been exhausted, and/or the service is being used inappropriately.

If the Department worker wishes to appeal the decision, the SNS specialist and the KEPRO reviewer will analyze the case and data available to determine if there is justification for granting the request. If justification is not found, the request(s) will be denied. Internal reviewers for policy related denials are master's level licensed social workers, counselors, or psychologists who are not conflicted and have no prior knowledge of the case being reconsidered. The program director reviews denials when they exceed the number of reauthorizations available. If the Department worker desires a second-level appeal, the case is forwarded to the appropriate Department region Review Committee, which consists of the regional program manager or designee, customer service manager (CSM), the social services supervisor, Department worker supervisor, and Department worker. KEPRO then implements the decision of the Department Review Committee. KEPRO posts all responses on our secure website for providers to access and places all the authorizations on the Department's secure site to be loaded into FACTS. KEPRO then retrieves the next day's referral file and any Department-initiated rollbacks and the cycle begins again. All KEPRO services will receive Aetna subcontractor oversight, audit, and reporting requirements.

[BA004] Utilization Management Guidelines to Retroactively Review Socially Necessary Services

We believe in the value of SNS and consider all referrals on an individual, member- and caregiver-centric approach so our members' needs are met. KEPRO will administer retrospective reviews of SNS services in two ways in accordance with the requirements established in **Section 12.4 of the Model Purchase of Service Provider Agreement**. First, UM guidelines will be used to retroactively review SNS service requests. Second, after the prior authorization, KEPRO will implement a retroactive review of provider documentation practices and UM processes. KEPRO will review service invoices presented by the provider and utilize a random sample of authorizations. The provider's credentialing information will also be evaluated while on-site for the retrospective review. Each SNS provider will be reviewed within three years of the term of the BCF agreement with the provider. Additional reviews may be warranted based on:

- **The scores from the past review period being under 80 percent**: Providers must score at least 80 percent during their retrospective review for each service reviewed. Providers failing to meet 80 percent will be placed on a probation period for each respective service failing to meet that threshold. The KEPRO reviewer will provide a written notice that the probation period is in effect. At the end of the probation period, KEPRO will conduct another assessment. If the provider continues to score less than 80 percent for that service, KEPRO will recommend to BCF the service be closed for that provider and the provider should no longer be eligible for referrals for that service. If the provider scores a zero on any safety related service during any review, the service will be automatically closed for the provider.

- **Special requests from the Bureau of Children and Families:** Providers with 10 or more unduplicated members authorized for SNS will receive an onsite review. Providers with less than 10 unduplicated members will receive a desk audit. Consultations with SNS providers will be scheduled at least four to six weeks in advance by the designated trainer/consultant (TC). If the provider cannot be immediately reached by phone, the TC will leave a message for the provider to return a call to the TC's cell phone. If the call is not returned the same day, the TC will attempt to contact the provider daily for three business days. If no return call is received within three business days, the TC will email the provider with three possible dates for review. During the phone call to schedule the consultation, the TC outlines the consultation process and its purpose. The list of case records for potential review will be provided by fax or e-mail (per provider preference) three days prior to the review to allow time to pull the requested records. The TC maintains confidentiality according to HIPAA guidelines. If questions arise, providers will be given the opportunity to provide an explanation or to locate missing or misfiled information. KEPRO meets with providers at the conclusion of the on-site review.

  The most important findings of the review, assessed strengths, and areas of improvement for the provider are discussed. The TC addresses any provider questions brought up during the entrance meeting or during the review process. A consultation report, which presents results and recommendations for improvement, is distributed electronically to the provider and BCF. If any individual service scores less than 80 percent, BCF is notified to take appropriate action, the provider must receive training/technical assistance, and the service is reviewed again in six months. BCF then determines whether the provider remains open or if they will be allowed to continue providing the identified services. The program will continue to support compliance with State and federal requirements for child welfare services throughout changes in federal and state regulations/policy.

[BA005] Coordinating Socially Necessary Services for the Member and/or Their Family

Every member in our West Virginia Specialized Managed Care for Children and Youth plan will have an assigned care coordinator with experience serving children and youth in the child welfare system who serves as their single point of contact and is a member of both their Aetna ICT and BCF MDT. Aetna has identified and will implement the following best practices to support the coordination of person-centered SNS proactively to our members and their families:

- Aetna will employ specialized CCT staff with expertise serving the population of children and youth involved in the child welfare system and provide them with additional training related to SNS (e.g., the types of services available and how they support children and youth.) We also train CCT staff in the principles of person-centered planning, TIC, MHFA, LifeCourse tools, and other Aetna trainings available through the Relias Learning Management System, such as training on the West Virginia Child and Adolescent Needs and Strengths (WV-CANS). KEPRO will provide staff training on Chapter 49 definitions of abuse/neglect, and BCF policy and procedures.
- Our regionally based Care Connection team model links members to care coordinators with skills matched to members' needs (e.g., nurses support members with primarily medical needs, while behavioral health specialists supports members with primarily mental health or SUD concerns) and local expertise and lived experience in the community where members reside.

Our individualized, person-centered model of support integrates SNS with physical health and behavioral health services, and other Medicaid (e.g., durable medical equipment) and non-Medicaid services and supports (e.g., community-based supports to address unmet social resource needs, such as transportation and nutrition) to promote and support health and community tenure for the populations we serve. **Through our integrated care model, Aetna care coordinators conduct routine face-to-face care coordination activities to assist members and their families to engage in the SNS outlined in the ISP.** Service plans, inclusive of SNS, are shared with members and their ICT with appropriate consent. Care coordinators work

with members and their ICT regularly and through the reassessment process to monitor SNS delivery, satisfaction with SNS, and address any concerns, gaps in SNS, or other contingencies affecting the delivery of SNS (e.g., creating crisis plans).

Supporting our members to avoid unnecessary disruption to their SNS, their environments, and their living situations is of paramount importance. Our processes will maintain the efficient, continuous, and non-duplicative provision of SNS for all members who receive them. General strategies performed across settings will include the following:

- Proactive member outreach through routine ISP meetings, UM, member education, and reassessment to identify members at risk of SNS disruptions
- Facilitation of strong SNS provider relationships to support routine communication and integration of up-to-date, external, clinical, and community-based care plans within their Aetna service plan
- Utilization of technology platforms that encourage SNS provider/health plan communication, such as Aetna's FamilyConnect
- Dissemination of user-friendly member and caregiver education tools by the member's assigned care coordinator, member advocates, and the SNS liaison to encourage reporting of gaps in service and how to access the 24-hour Health Information line (Nurse Line) and the Behavioral Health Crisis Services hotline and available community-based crisis supports to respond to urgent needs
- Follow-up by care coordinators either co-located in a facility or through telephonic contact no less than **three** days following transition from an inpatient setting back to a community setting to make sure SNS resume timely

Aetna will conduct at least 12 focus groups each contract year with youth, families, and foster parents that reside in the community and utilize SNS as an opportunity to provide the Department with feedback on ways to improve the SNS program in terms of: access; service delivery; gaps in support systems; engagement with system staff; cultural competency; and member knowledge of services and supports. In addition, Aetna will collaborate with BCF on the questions to be used in the focus groups to ensure the most useful information is being collected. Aetna will collect monthly progress reports from SNS providers for each family served by the 10th day of each month. In addition, Aetna will coordinate with the Department caseworker and BCF to determine if this deliverable has been met so the Department may issue payment.

[BA006] Verifying Use of the Most Appropriate Provider of Socially Necessary Services

BCF manages provider enrollment at the state level and the DHHR caseworker chooses the provider. The Aetna CCT team, that includes KEPRO, will review authorization requests for SNS and provide support to BCF staff. Aetna will notify the Department if any problems are found with a provider either in their UM practices or retrospective reviews. The Department will also be notified of geographic issues surrounding certain members' situations and if there is a more appropriate service or provider available for consideration by the child/youth's MDT.

To provide a seamless level of service to all members, recommendations for ZNS made by a care coordinator, the SNS liaison, or other providers (e.g., the PCP, specialists, pharmacist, etc.) for SNS will be provided to BCF for consideration for authorization. Aetna will pay for court ordered medical and behavioral health services, including children's residential treatment services, and will recommend the most appropriate treatment options, alternative services, and assist with the identification of a provider that best suits the child's needs.

Our contracting process includes processes to verify the qualifications of providers. SNS providers are credentialed following the same process Aetna uses for other non-traditional providers.

Our Provider Services department will administer retrospective reviews of contracted SNS providers within three years of the term of the contract agreement. Providers who do not meet established thresholds for each SNS provided will be subject to contract remedies, such as probation, re-review, and removal of specific SNS from their contract. Aetna will report findings of retrospective reviews to the Department as requested.

Aetna will report monthly to the Department on underserved areas of West Virginia where additional SNS providers should be permitted to enroll to address a gap in care and make sure members and families have access to the most appropriate provider of SNS possible.

[BA008] Using a Family Service Plan and Individualized Service Plan

KEPRO SNS authorization specialists will review the family service plan (FSP) and individualized service plan (ISP) completed by the Department caseworker when authorizing requested SNS. Aetna houses the FSP and ISP in FamilyConnect and in our electronic care management system. The SNS requested for authorization should be included in the FSP and/or ISP. Aetna care management staff will collaborate with the Department caseworker if a requested SNS is not recommended in the FSP or ISP to make certain the most appropriate services are authorized. The members' primary care coordinator reviews the FSP and the ISP with the BCF case worker and with family and member, as appropriate. The care coordinator assures all data is reported into FamilyConnect and in the members' integrated care plan.

In the event the Department caseworker has not yet made an ISP or FSP available to Aetna, our care coordinators will reach out to ask for a Department MDT to be scheduled to establish a plan for completing and sharing the required documents.

[BA055] Notifications Regarding Expiration of Existing Authorizations

Aetna's electronic care management system, aligned with our authorization system, tracks all authorization expiration dates, and will include tracking for SNS. Care management staff and SNS authorization specialists will automatically be alerted when an authorization is going to expire within 30 days. The SNS authorization specialist will generate a notice to the member's assigned care coordinator if an authorization is about to expire. The care coordinator will contact the member/family by telephone, or arrange a face-to-face contact, to explain the expiration and discuss potential continued need and potential reauthorization. KEPRO staff also inform the provider concerned and Department caseworker (via fax or email) informing them of the expiration date of the authorization. The provider will be informed to submit a new authorization request if services are to continue beyond the expiration date of the current authorization. UM staff or an SNS authorization specialist will collaborate with care coordinators and the Department caseworker as needed to determine if additional authorization is warranted.

EPSDT

BA009	The Vendor should establish medical necessity guidelines specific to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for applicable populations.	The Vendor should demonstrate its understanding of medical necessity guidelines specific to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, according to the Vendor's experience and the policies, procedures, and requirements outlined in the Service Provider Agreement (SPA).
BA010	The Vendor should establish processes specific to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services in all geographic areas, for applicable populations	1) The Vendor should specify activities that will be performed for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and responsible staff/departments. 2) The Vendor should demonstrate its understanding of American Academy of Pediatrics (AAP) EPSDT standards, including, but not limited to, timeframes for a child placed within foster care to receive the initial health assessment and comprehensive EPSDT exam. 3) The Vendor should demonstrate its understanding of the Department Foster Care Child Welfare Policy and the HealthCheck

		program, including, but not limited to, evaluation timeframes and periodicity schedules. 4) The Vendor should detail how its plan will be accomplished in all geographic areas.
BA011	The Vendor should develop and distribute materials to inform members, parents, and providers about the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, for applicable populations.	1) The Vendor should explain what materials it will develop to inform members, parents, and providers about the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. 2) The Vendor should explain how it will emphasize EPSDT services to children receiving primary care from a specialist.
BA012	The Vendor should use reports to monitor Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services	The Vendor should describe reports, and other tools if applicable, that will be used to monitor Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services.

Aetna's network provides comprehensive and preventive health care services to all eligible members. These services include routine screenings, developmental screenings, and social/mental/physical health screenings and do not require prior authorization (PA). **Table 1.1-3** provides some key Healthcare Effectiveness and Data Information Set (HEDIS) measures for child and adolescent wellness and preventive care.

Table 1.1-3: Aetna Key HEDIS Measures for Preventive Care and Wellness Visits in West Virginia

HEDIS Measure	HEDIS 2018	HEDIS 2017	HEDIS 2016	HEDIS 2015	Quality Compass 50th Percentile Met/Not Met
Adolescent Well Care	58.39%	55.90%	39.86%	50.47%	Met
Adolescent Immunization (Combo 1)	86.62%	85.14%	83.90%	84.27%	Met
Childhood Immunizations (Combo 10)	36.50%	24.53%	33.73%	27.36%	Met
Well Child 3-6 Years	75.91%	71.93%	72.13%	77.81%	Met

[BA009] Medical Necessity Guidelines for Early and Periodic Screening, Diagnosis, and Treatment Services

Aetna understands that 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, behavioral health, developmental, and specialty services. Members are entitled to as many doctor visits, hours, and amount of any services as are medically necessary for their individual conditions if authorized under EPSDT. Some EPSDT services may require prior authorization and the HealthCheck program are consistently reviewed utilizing evidence-based guidelines to determine medical necessity. Aetna's guidelines cover the entire continuum of care and include specific considerations for children and adolescents, as appropriate.

Aetna also maintains a medical management 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 request outlines benefits not covered.
- The nurse will collect all necessary information and provide it to the medical director.
- The medical director will use 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 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, therapeutic activity chairs, lead abatement, standers, 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
- The item or service is approved or denied.
- We fax or mail the decision information to the requesting member and provider.
- We document in the electronic claims management system the name of the person requesting guidelines, contact information for the requestor, date request received, date information given, method of delivery of information, and guidelines name and number provided.

Accessing Needed Food for an Infant through the HealthCheck Program

Aetna serves a 2-year old member who was born at 24 weeks and lived for the first 8 months of his life in the neonatal intensive care unit (NICU). Due to developmental delays and kidney and lung issues, he is qualified for the Children with Special Health Care Needs (CSHCN) program, but his specific food needs (real food blends of egg, apple and oats) could not be addressed via the CSHCN program. Collaborating with the representative at the CSHCN program, the Aetna care coordinator determined that she could submit a request of coverage for the member's needed food through the HealthCheck program due to the fact he has tried other formulas in that past that he could tolerate. Since getting access to his needed nutrition through the HealthCheck program, the member has also begun to get therapy with a Birth to Three provider and is doing well at this time. He continues to receive services through the CSHCN program as well. His specialized nutritional needs have been covered. An Aetna care coordinator has completed face-to-face visits with providers, the member, and his family to assist with educational needs and coordination of resources. The member and his family continue to work with the Aetna care coordinator to assist with scheduling of dental and medical appointments, as he has many special needs.

[BA010] Processes Specific to EPSDT Services

Aetna is committed to working with providers to make sure all Medicaid-eligible members under the age of 21 receive EPSDT services through the HealthCheck program according to the **Department Foster Care Child Welfare Policy**, and their parents, caregivers, and providers use resources effectively. Staff from our Utilization Management, Care Management, Quality Management, Provider Relations, and Member Services departments are all instrumental in the implementation of our EPSDT policy that outlines our approach to meeting West Virginia's requirements for making EPSDT services available and accessible, including the requirement that initial EPSDT screenings occur within 30 days of placement in foster care, with a follow-up appointment within 90 days. Aetna is leveraging our extensive experience implementing and maintaining EPSDT programs in other states to ensure children and adolescents receive comprehensive preventive, dental, behavioral health, and developmental and specialty services for a healthier West Virginia.

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 access to services is a critical component of our integrated managed approach to whole-person care. Aetna will provide 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)
- Behavioral health screening
- Health education (including anticipatory guidance)
- Interperiodic 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 empower and train all staff to help members address their barriers to care and educate members on the availability and importance of the HealthCheck program and EPSDT services. We recognize that PCPs trained to work with this specialized population are central to the identification of possible developmental delays in young children as part of the HealthCheck program. If a member entering the foster care system chooses to stay with an established PCP or patient-centered medical home (PCMH), we will help ensure continuity of care by initiating a single-case agreement (SCA). We will also outreach to that PCP or PCMH to begin the process of bring them into our network of providers.

Aetna collaborates with the only freestanding children's hospital in the state to provide face-to-face visits for children and youth to address gaps in care such as well child visits and immunizations. The concurrent review staff that perform these visits offer assistance with resources addressing barriers to care such as transportation and provide referrals to the care management department.

Aetna understands the challenge with meeting all the health care needs of our members and has a specific strategy to assist members and families in completing EPSDT. For members there are covered benefits in local pharmacies including immunizations, urgent care visits, follow-up urgent care visits and assistance with transportation and scheduling. The central care plan specifically addresses the importance of prevention.

Aetna has been training the entire Medicaid organization to understand and implement trauma informed principles. Working with families, Aetna's care managers spend time with members to understand their challenges and identify appropriate providers to meet each member's specific needs. Aetna is collaborating with the National Council on Behavioral Health, a nationally recognized leader on TIC organizations. Together we are bringing a provider collaborative to West Virginia to support local communities with trauma-informed training and resources.

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 to the availability of a comprehensive suite of benefits. In this benefit list, the availability of well-child and preventive health visits is stressed. We also offer incentives through a gift card for completion of EPSDT visits. Through our collaborative efforts and education activities with PCPs, parents, caregivers, and others, we promote timely completion of EPSDT services.

[BA011] Materials to Inform Members, Parents, and Providers about EPSDT Services

Members and parents: Aetna maximizes the opportunity to enhance member and parent education about the HealthCheck program and EPSDT services and requirements with every interaction. We will routinely work with Department caseworkers, parents (including kinship care, foster, and adoptive parents) to arrange

for an EPSDT screening within 30 days of enrollment. Care coordinators also educate them on the periodicity schedule. We explain the EPSDT guidelines to parents and caregivers in plain language, paying particular attention to the guidelines that are 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 treatment available under the HealthCheck program.

Aetna will utilize the innovative outreach and engagement approach in which community based CHWs (employed at our contracted West Virginia federally qualified health centers [FQHCs]) and peer support specialists serve as part of the ICT. They are supported by Aetna's System of Care team (e.g., the child OC administrator, adults SOC administrator, and the recovery and resiliency administrator), the SNS liaison, and the member advocate. CHWs work with school nurses or with school health advisory committees and parent-teacher associations to provide information for families (including kinship care, foster, and adoptive families) and Department caseworkers regarding EPSDT and the benefits of prevention for children and youth.

Educating Johnny's Parent about Nutrition Related to a Member's Health Condition

Johnny (not his real name), a 14-year old Aetna member, suffered a fall while playing which resulted in anal abscess. Because of pain associated with bowel movements, he was not eating much food and began vomiting and having diarrhea as well. Johnny lost 30 pounds, which ultimately led to his hospitalization. An Aetna care coordinator who is co-located at a West Virginia hospital was contacted by the hospital discharge planner to assist with coordination of care for Johnny. Aetna's care coordination nurse was able to visit Johnny on the pediatric unit while he was still hospitalized to provide education to him and his parents about nutrition and discharge planning. The care coordinator established a program for Johnny to increase his access to supplemental nutrition and he was enrolled in the CSHCN program. Johnny now follows a diet of six to seven Ensure drinks and eats one small meal per day. The family has reported that his abscess has been healing well. In addition, the Aetna care coordinator was able to send Johnny's mother resources for coupons for Ensure to help with the expense of buying them until he heals completely can eat a normal regular diet. Johnny is gaining weight back and thriving.

CHWs use a variety of modalities to contact members. These include direct phone calls, mailings, automated calls, and face-to-face engagement activities. Some CHWs are embedded part-time in primary care practices to provide supports, including but not limited to providing member lists, assisting with calling, and scheduling appointments.

In addition to Aetna's member-facing efforts surrounding EPSDT outreach, we promote comprehensive awareness and education for parents and caregivers of children and youth involved in the child welfare system. The Aetna care coordinator will utilize our current education, outreach, and engagement processes to educate parents, guardians, foster parents, and members of the member's circle of support. We provide new members/families with welcome contacts, information on a medical home, resource information (e.g., Medicaid dental list, eye care provider list, and transportation assistance), and having the parents or primary caregiver identify the top health concerns they have about their children.

Aetna will augment prevention efforts through preventive screening reminders and additional education and training throughout the year. We will coordinate with Department caseworkers to identify these opportunities, which are not limited to simply alerting parents, caregivers, or members to gaps in care. They help members, parents, and caregivers understand the importance and potential health impacts of timely and complete screenings. These efforts include 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 (including kinship care, foster, or adoptive parents), caregivers, and members with phone numbers that support text messaging about the importance of well visits, and use text4baby to send reminders about upcoming appointments, lead screening, and more.

Providers: Aetna will support a robust provider education process. This includes information about the West Virginia EPSDT periodicity schedule and educating providers on 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, which include: 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, 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.

[BA012] Reports to Monitor EPSDT

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. Aetna will submit to DHHR a report sooner than 45 calendar days after the end of each quarter to identify our performance regarding EPSDT outreach/enabling services, screening and referral rates, well-care child visit rates, dental visits, and immunization rates. Regular monitoring helps us to identify strategies that are working very well and provides insights into areas where we may be able to overcome our members' barriers to care.

Aetna CCTs 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 with delinquent screenings; and conducting outreach to parents/caregivers of members ages 0-20 with delinquent well-visit exams/screenings on the importance of well-visit exams, screenings, and following EPSDT schedules. EPSDT requirements and related HEDIS measures are tracked and the data is utilized to generate reports and to identify any early deficiencies. Some tools used include care alerts (which identifies high- and medium-risk members who are delinquent), priority lists, quarterly measures and feedback EPSDT Profile, tracking phone calls conducted (automated and direct), and face-to-face contacts. The pediatric measures are shared with the network and practices quarterly for quality improvement purposes. The EPSDT Profile for each provider or practice is generated and includes items such as well-visit rates and well-visit components.

Aetna utilizes the data and reporting to identify areas for continuous quality improvement. Aetna examines the data collected; we analyze the entire history, looking for gaps in performance and for measures with positive outcomes. We look for member, provider, and geographic differences, and search for any data issues that may be affecting performance. Data elements included in EPSDT oversight and compliance reviews include timely EPSDT screenings completed; timely completion of services members are referred to as part of EPSDT; authorizations for EPSDT services in UM; turnaround time reporting for key services related to EPSDT exams; claims audits to test claim edits and rules; and identification of members who may need EPSDT screening or who have no record of completed services. For providers who show a low compliance rate, the Quality Management team will obtain and review a sample of records for additional investigation. This assessment of outcomes becomes a part of the quality plan and both the Utilization Management and Quality Management team review outcomes with the providers and Care Management team. We also encourage providers to perform well visits in tandem with acute visits to record preventive

services through coding. We emphasize that providers can either address EPSDT requirements while the member is in the office, or schedule additional follow-up for an EPSDT visit.

Utilization Management

BA015	The Vendor should develop and review utilization management guidelines for physical health and behavioral health services.	The Vendor should describe its process to develop and revise physical health and behavioral health services utilization management guidelines.
BA016	The Vendor should apply utilization management guidelines to authorize payments or services for physical and behavioral health.	The Vendor should provide proposed physical and behavioral health utilization management guidelines that reflect an understanding of this contract's population, services, and stakeholders.
BA017	The Vendor should apply utilization management guidelines to retroactively review payments or services for physical and behavioral health.	The Vendor should describe its process to retroactively review payments or services for physical and behavioral health.
BA018	The Vendor should help expedite the submission and return of service authorization data from providers.	The Vendor should describe its process to help expedite the submission and return of service authorization data.
BA035	The Vendor should establish utilization management processes for members, including, but not limited to, the following:	The Vendor should describe how its utilization management processes support members, both for the processes listed and any other processes the Vendor identifies as supporting members.
BA036	Medical necessity review	See the parent specification.
BA037	Social necessity review	See the parent specification.
BA038	Approvals	See the parent specification.
BA039	Denials	See the parent specification.
BA042	The Vendor should modify its standard utilization management protocols when reviewing referral and treatment requests for members with special healthcare needs, including, but not limited to, the following:	The Vendor should: 1) Identify factors that may require modification of its standard utilization management protocols. 2) Give at least one example of each factor and describe how the standard protocols would be changed as a result.
BA043	Standing referrals	See the parent specification.
BA044	Expedited utilization review processes	See the parent specification.
BA045	The Vendor should establish condition-specific protocols or standards that will be used to manage members with special healthcare needs.	The Vendor should describe how it will meet this specification.
BA046	The Vendor should update and share condition-specific protocols or standards with primary and specialty care providers.	The Vendor should describe how it will meet this specification.
BA047	The Vendor should establish, implement, and update guidelines for the services or types of services that require prior authorization (PA) by the Vendor.	The Vendor should list the services or types of services that require prior authorization by the Vendor.
BA048	The Vendor should establish, implement, and update guidelines for the services or types of services that can be approved by the member's primary care provider (PCP) for physical and behavioral health services.	The Vendor should list the services or types of services that can be approved by the member's primary care provider (PCP).
BA049	The Vendor should establish, implement, and update guidelines for the services or types of services to which the member can self-refer.	The Vendor should list the services or types of services to which the member can self-refer.
BA050	The Vendor should establish and implement a required length of time for providers to request prior authorizations (PAs) for services.	1) The Vendor should provide its proposed required length of time for providers to request prior authorizations (PAs) for services. 2) If this varies by service or circumstance, the Vendor should provide the applicable length of time for each service/situation.
BA051	The Vendor should establish and implement levels of authority for prior authorizations (PAs).	The Vendor should provide its proposed levels of authority for prior authorizations (PAs).

BA052	The Vendor should provide prior authorization (PA) approval/denial letters to members, providers, and caseworkers, as appropriate.	1) The Vendor should explain which elements would be included in prior authorization (PA) approval/denial letters to members, providers, and caseworkers, and how the Vendor would define "as appropriate." 2) The Vendor should provide sample letter(s).
BA053	The Vendor should develop and use clinical guidelines for prior authorizations (PAs) for physical and behavioral health services.	1) The Vendor should provide proposed clinical guidelines for physical and behavioral health services. 2) The Vendor should describe how it develops and uses guidelines. 3) The Vendor should provide a specific example that follows a prior authorization (PA) through the process.
BA071	The Vendor should perform ongoing monitoring of emergency room (ER) usage.	The Vendor should separately describe ongoing monitoring of emergency room (ER) usage.
BA072	The Vendor should apply the "prudent layperson" standard for all emergency room (ER) visits.	The Vendor should explain: 1) Application of the "prudent layperson" standard for all emergency room (ER) visits. 2) If it would not require prior authorization (PA) for screening and stabilization of members.

Aetna's unique local experience, including our regional Care Connection team approach which incorporates UM staff, bolstered by our national child welfare model, demonstrates our ability to improve the lives of children and youth in West Virginia members' and their families'. We also understand the importance of recognizing the unique needs of our members involved in the foster care system and will arrange and authorize services for this population with an understanding that their unique needs may, at times, necessitate a personalized approach. Our UM program philosophy is to deliver high-quality, whole-person care for our members. It is designed to identify, evaluate, manage, and improve clinical care and services provided to our members. In addition to managing utilization of services, the focus of UM is to promote delivery of high-quality and cost-effective care to our members. The program goals and objectives consider individual member characteristics; unmet health care and social needs; and demographics while encompassing cultural humility into practices throughout its network of practitioners and providers. The scope of our UM program spans all clinical aspects of health: PH including preventive, diagnostic, oral health, and treatment services in inpatient, outpatient, and homebased treatment settings; BH; and the full set of factors that impact health.

[BA015] Guidelines for Physical and Behavioral Health

Aetna regularly reviews its process to develop and revise physical health and behavioral health service UM guidelines. Aetna reviews UM criteria by reviewing utilization, approvals and denials, and provider performance. During implementation, Aetna will assess all services provided to assure full parity as well as review of provider specific approvals and denials to identify opportunities to streamline services for members and processes for providers by reducing the number of procedures requiring PA. Because Aetna has the single source of truth in the ISP, the centralized data with FamilyConnect and the care management point of contact this fully integrated model will help the member and their families understand their health care benefit and reduce administrative burden to providers. Members can also access their ISP on the internet with secure passwords and can update demographic and health information.

Aetna uses nationally recognized evidence-based criteria to develop and review UM guidelines, which we apply based on the needs of individual members and characteristics of the local delivery system to align with the Department's clinical coverage policies. Our UM clinical criteria policies and procedures define eligible criteria sources and the process for adoption, review, and approval of clinical criteria. We review clinical criteria sets for adoption per award, and then review and update them 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 a pharmacist, in developing, adopting, and reviewing criteria. Aetna ensures that the 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. 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 visit with providers, and the provider manual. 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.

Formal medical committees and ad hoc workgroups advise and guide the development and adoption of guidelines. Aetna develops clinical criteria policies using peer-reviewed medical literature, 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 reviews clinical criteria policies annually or more frequently based on knowledge of relevant new medical literature, guidelines, and regulatory action notices. Aetna's Clinical Policy Council Committee and external practicing clinicians with expertise in providing the types of services in the clinical criteria policies conduct a comprehensive review process of both new and revised policies.

Helping a Member with Special Health Care Needs Access Portable Oxygen

Thomas (not his real name), a teenager, has multiple medical concerns including cerebral palsy, seizure disorder, and a tracheotomy. He was in need of portable oxygen tanks as he was going on a vacation with his family, which required them to take a flight. Thomas' father contacted Aetna's care management program and Thomas was connected to a care manager. The care manager made contact with Thomas and his father to develop an understanding of the family's needs and their request for portable oxygen tanks and a portable concentrator for their trip. The care manager contacted Aetna's medical director who assisted with approving Thomas's request to make sure that his medical needs were met. In collaboration with Aetna's prior authorization department, Thomas's request was expedited to avoid any complication in care. Thomas and his family were able to go on their trip and have a memorable experience together.

[BA053] Clinical Guidelines for Prior Authorizations

Proposed clinical guidelines: Aetna uses the following criteria for physical health, behavioral health, and medical pharmaceuticals, consulted in the order listed; as applicable:

- Criteria required by the Department or federal regulatory agencies
- ASAM (American Society of Addiction Medicine) criteria for any requested service when a SUD diagnosis is present
- MCG for physical and behavioral health, and medical pharmaceutical criteria
- LOCUS (Level of Care Utilization System)—BH services for adults
- CASII (Child and Adolescent Service Intensity Instrument) BH services for children and adolescents
- Aetna Clinical Policy Bulletins (CPBs)
- Aetna Clinical Policy Council Review

Aetna will coordinate with KEPRO to submit proposed socially necessary services criteria not specifically addressed in the listed criteria for approval by the Department of Health and Human Resources.

Aetna is experienced in complying with the Mental Health Parity and Addiction Equity Act of 2008 and 42 C.F.R. 438 Subpart K in West Virginia and the additional 15 states where we provide Medicaid managed care services. Through our initiation of activities to comply with these acts in 2008, we have conducted review of clinical authorization guidelines for physical and behavioral health. As a result, our processes and systems are in place to fully comply with the act. The treatment limitations we apply to mental health and SUD benefits

are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by Aetna. Additionally, there are no separate treatment limitations applicable to mental health or substance use disorder benefits. Aetna provider agreements require provider compliance with the Mental Health Parity and Addiction Equity Act.

Development and use of clinical guidelines: Aetna adopts evidence-based clinical practice guidelines from nationally recognized sources. These guidelines are adopted to promote consistent application of evidence-based treatment methodologies, facilitate improvement of health care, and reduce unnecessary variations in care.

Aetna receives a request by phone, fax, or provider portal for a service. 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. If the needed clinical information is not present, it will be requested at the initial contact with the requestor. All requests are prioritized based on the urgency of the request. 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, taking into account the individual needs of the member and allowing for consultation with requesting practitioners/providers when appropriate. Once it has been determined that a clinical review is needed, the nurse clinician reviews the request for the individual's needs. This could include 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 the following:
  - Availability of services in the area to support the member
  - Practitioner/facility ability to provide all recommended services

The next step is determining if the request meets the appropriate medical necessity criteria. The nurse reviewer then notifies the requesting provider of the determination and notifies the member's assigned care manager, as appropriate.

Certain medical services, while being medically necessary, 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.

Prior authorization process—specific example: The Prior Authorization team received a request for an admission to an out-of-network facility for a short-term medical admission with adolescent medicine to provide comprehensive medical treatment for medical stabilization and psychological evaluation. The nurse reviewer reviewed the clinical information provided which detailed information about a 19-year-old female with a history of a 50-pound weight loss over the last year, psychogenic dysphagia, anorexia nervosa, anxiety, and depression. Despite outpatient treatment, the member had been unable to eat or drink and was dependent

on a feeding tube. The member had also had a recent hospitalization for a possible blockage of her feeding tube and pain with swallowing. The member's mother stated she had been unable to flush the feeding tube. The member was tearful and stated she is unhappy with her body habitus. The mother had been trying to get her daughter into an eating disorder clinic without success. The Aetna care coordinator collaborated with the Network Management department to find an appropriate out-of-network residential facility. The member's admission to an out-of-network facility was approved based on the individualized needs of this member and a care management referral was completed for follow-up.

[BA016] Guidelines to Authorize Payments or Services

Clinical UM staff use nationally recognized, evidence-based guidelines, described previously, to drive consistency in decision-making and authorize payments and services for physical and behavioral health. Guidelines represent best practices, reflect national standards, support SNS determinations, and are applied based on the needs of individual members.

We train service authorization staff members who make physical and behavioral service authorization determinations to use the criteria consistently. The policy of using established decision criteria promotes consistency of reviews. Aetna does quarterly audits on all staff performing clinical reviews and addresses any gaps in knowledge, as needed. We also perform inter-rater reliability on all criteria utilized upon hire and yearly for all members of the clinical UM team. The criteria are consistently applied and referenced for consultations with requesting providers when appropriate.

Prior authorization enables us to monitor utilization of defined services and non-emergent procedures and hospitalizations before the member receives the service. For services requiring prior authorization, we confirm services are the following:

- Requested for eligible members and included in the covered benefits
- Provided at an appropriate level of care or place of service based on individual circumstances
- Determined to be appropriate, timely, and cost-effective
- Coordinated as necessary with care management and communicated to applicable operations areas or to the external contractor per contractual requirement
- Documented to facilitate timely reimbursement and accurate reporting

Aetna rewards appropriate utilization using value-based purchasing arrangements with providers. To address high ER utilization, we use Pay-for-Quality and PCMH models that incentivize providers when their ambulatory ER rate per 1,000 members is above the HEDIS 75th percentile or meets another predetermined target.

[BA017] Guidelines to Retroactively Review Payments or Services

Reimbursement for services may be determined retrospectively (e.g., we receive notification of a hospitalization after the member's discharge or for members who receive retroactive Medicaid eligibility). We base our retrospective reviews solely on the medical information available to the attending physician or ordering provider at the time the member received health care services. We review retrospective determinations utilizing the same criteria as concurrent determinations for the same service. We communicate retrospective review decisions to the requesting practitioner/provider and the member, if applicable, within 30 calendar days of receipt of the request.

[BA018] Expediting the Submission and Return of Service Authorization Data

Aetna encourages providers to use our provider portal to access a complete member profile for each of their members, including member demographic information, plans of service, and other critical member information. Providers are also able to determine member eligibility, review PA requirements and status, and access HEDIS gaps in care reporting.

The provider portal includes requirements for PA and how to request a copy of medical necessity criteria, in addition, how to access to the Provider PA Tool. This application allows providers to verify that a service is a covered benefit and to determine whether it requires PA. We educate providers to provide all necessary clinical information to facilitate rapid authorization for the right services. Aetna clinical policy bulletins and pharmacy guidelines are also available through the provider portal.

Aetna's dedicated UM staff are available seven days per week to accept urgent authorization requests from our providers. If inbound calls are received on weekends or holidays, our after-hours team responds to providers with urgent requests. We employ a dedicated PA team that includes specialists who can process requests for high-risk pregnancies, NICU, customized durable medical equipment, and behavioral health services. When the provider gives adequate clinical information, we respond to an urgent preservice request within 48 hours.

[BA035 – BA039] Processes for Medical and Social Necessity Review, Approvals, and Denials

Medical necessity review: To support medical necessity determinations, Aetna uses nationally recognized, evidence-based criteria applied based on the needs of individual members and characteristics of the local delivery system. Our medical management clinical criteria policies and procedures define eligible criteria sources and the process for adoption, review, and approval of clinical criteria. Criteria sets are reviewed annually for appropriateness to the need of the West Virginia population of children and youth involved in child welfare and updated as applicable when national or community-based clinical practice guidelines are updated. The annual review process involves appropriate physical health and behavioral health medical directors, pharmacists, and practitioners in developing, adopting, or reviewing criteria. We advise members and providers that criteria are available upon request, free of charge, in the Notice of Action (NOA), and the provider manual. **[BA036]**

We train service authorization staff members who make medical necessity determinations to use the criteria consistently. The policy of using established decision criteria promotes consistency of reviews. The criteria are consistently applied and referenced for consultations with requesting providers/practitioners when appropriate. Our medical management clinical criteria policies and procedures define eligible criteria sources and the process for adoption, review, and approval of clinical criteria.

Provider services and UM staff are available to answer questions and provide guidance on the use of clinical guidelines and UM requirements. We are transparent and forthcoming regarding our use and description of guidelines. Aetna proactively educates our members and our provider community about the basis for use and the content of the guidelines. Targeted education will be provided to care coordinators on guidelines for SNS to facilitate the authorization of the most appropriate provider, scope, and duration of the requested service based on the individual member needs. In our experience, this step helps to remove any access to care issues involved in the required administrative processes.

Aetna communicates changes and updates to clinical practice guidelines, MCG, Aetna clinical policy bulletins, and PA requirements through provider forums, fax blasts, provider letters, and regular and ad hoc meetings by network account management. They are also reviewed and approved by the QM/UM Committee in which providers participate.

Social necessity review: SNS will be reviewed by KEPRO according to the West Virginia requirements and guidelines. Each case will be reviewed according to the individual request by specially trained staff on social services. We will establish audit reports to identify opportunities to reduce administrative burden. BCF manages provider enrollment at the state level and the DHHR caseworker chooses the provider. The Aetna SNS team, that includes KEPRO, will review SNS requests and provide support to bureau staff. Aetna will notify the Department if any problems are found with a provider either in their UM practices or retrospective reviews. The Department will also be notified of geographic issues surrounding certain members' situations

and if there is a more appropriate service or provider available for consideration by the child/youth's MDT. **[BA037]**

Approvals: Aetna makes prior authorization decisions and notifies practitioners and/or providers and members as applicable in a timely manner in accordance with Aetna policies and procedures. Where regulatory and accreditation standards differ, Aetna uses the strictest or shortest timeframe to assure compliance with all requirements and in the best interest of the member. Aetna follows NCQA or State-required timelines (based on which is most stringent) for our decision and notification. Our written UM policies and procedures are in accordance with 42 CFR § 438 Subpart F, 1915(c) Waivers or State policy. **[BA038]**

Denials: Aetna provides the primary practitioner/provider(s) and member with electronic/written notification of any decision to in whole or part deny, reduce, suspend or terminate a service authorization request, or to limit or authorize a service in an amount, duration or scope that is less than requested. The notification includes information on how to obtain criteria used to make the decision as well as member appeal rights and provider appeal rights.

Aetna has processes to provide the member's PCP with electronic/written notification of adverse benefit determinations to facilitate care coordination, to assure the PH and BH needs of members are identified, and that services are facilitated and coordinated with all service providers, individual members, and their family, if appropriate, and authorized by the member or their guardian.

Only the medical director may determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested. We notify practitioners/providers in the denial letter (i.e., NOA) that they may request a peer-to-peer consultation to discuss denied authorizations with the medical director reviewer by calling Aetna. Prior to written notification for urgent requests, Aetna elects to provide verbal notification at which time we notify the practitioner/provider of the opportunity for the peer-to-peer consultation. If a peer-to-peer conversation or review of additional information does not result in an approval, or if the practitioner/provider elects not to request a peer-to-peer consultation, the denial letter informs the practitioner/provider and member of the right to initiate an appeal and the procedure to do so.

Our Notice of Action 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 and is thoroughly completed in easily understandable language, and includes all required information detailed in 42 CFR 431.210. **[BA039]**

[BA042 – BA044] Modifying Protocols for Members with Special Healthcare Needs

Aetna modifies its standard UM protocols when reviewing referral and treatment requests for members with special healthcare needs. **[BA042]** Factors that may require modification include, but are not limited to, the following:

- Benefit limits:
  - Lifetime benefit: e.g., for members in need of orthopedic braces due to scoliosis or spina bifida, exceptions to lifetime benefit limits can be made to allow 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
- Time limit exceptions: e.g., for members in the course of ongoing treatment, Aetna makes exceptions to time limits on benefits during the transition phase to make sure members' 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

- EPSDT: e.g., any service requested under EPSDT that is not otherwise covered as a Medicaid benefit can be covered if 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 their nutritional needs are met

Standing referrals: Aetna members who require specialized care over a prolonged period for a life-threatening, degenerative, or disabling condition may be allowed a standing referral to a specialist or specialty care treatment centers with expertise in treating the condition or disease. This includes conditions involving a complicated treatment regimen requiring ongoing monitoring of the member's adherence to the regimen and BH services for members with a history of trauma or ACEs. **[BA043]**

The determination and notifications must be made within the time frames 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 all pertinent clinical information is not present to determine medical necessity, the utilization 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.

Aetna care coordinators will research a member's authorization history to avoid the following:

- Duplicating services the member is already receiving
- Authorizing services that are not in the member's benefit plan or treatment plan
- Duplicating authorizations already documented in the system

Expedited utilization review processes: Behavioral health and medical services for the treatment of an emergency condition are permitted to be delivered in or out-of-network without obtaining prior authorization. Aetna requires coverage of emergency services in the following situations:

- To screen and stabilize the member without prior approval, where a medical practitioner deems that emergency services are required
- When an attending physician determines that 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 covered person to severe pain that cannot be adequately managed without the health care service or treatment being requested
- For service or treatment of a substance use disorder or co-occurring mental health disorder within a partial hospitalization program or crisis stabilization unit needed to keep a covered person from requiring inpatient services **[BA044]**

Expediting Review for Pharmacy Authorization

Stephanie (not her real name), a 20-year-old female, suffered from a large wound infection which required the need for intravenous (IV) antibiotics. These IV medications were prescribed by Stephanie's PCP due to Stephanie's inability to tolerate oral antibiotics due to issues with adverse physical reactions. Upon submission of the member's medication PA, the PCP received a PA denial from the State's pharmacy vendor due to missing information on the PA request. Stephanie told her PCP about the denial and they contacted the Aetna care manager for assistance. In order to expedite the approval and to support Stephanie's needs, an Aetna care coordinator contacted the member to obtain additional information and then contacted Aetna's pharmacy director regarding Stephanie's needs. The pharmacy director and Stephanie's PCP coordinated their efforts which led to submission of the missing PA information to West Virginia's pharmacy PA vendor. The PA was approved within hours and Stephanie was able to obtain her medications which prevented any potential hospitalization to address Stephanie's treatment needs.

[BA045] Condition-specific Protocols or Standards for Members with Special Healthcare Needs

Aetna provides specialized medical care for children who have or might have a chronic, disabling medical condition(s). On a monthly basis, Aetna care coordinators outreach members who have special health care needs. Aetna care coordinators will inform them of Aetna's specialty care program which provides care management and access to specialty services through a system of outreach specialty clinics, thus enabling children with special health care needs to receive a member/family-centered medical home approach to comprehensive, coordinated services and supports. Referral to care management services is completed for formulation of care plans.

Members identified with special healthcare needs will be referred to specified providers who have been deemed to have the necessary training in meeting the member's unique needs.

Eligibility is based on the following factors:

- Must be a U.S. citizen
- The child must be under 21 years of age
- The child must reside within West Virginia
- The child must have an eligible medical diagnosis

Medical conditions that are eligible include, but are not limited to, the following:

- Conditions which involve bones, joints, or muscles
- Heart conditions
- Epilepsy and other convulsive conditions
- Neurological conditions such as cerebral palsy and spina bifida
- NAS
- 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
- Hearing loss, including hearing aid placement, and related services
- Other chronic conditions, such as: cystic fibrosis, and sickle cell anemia

[BA046] Updating and Sharing Condition-specific Standards/Protocols with Providers

Aetna care coordinators ensure the use of appropriate health care professionals in assessing those conditions, identifying medical procedures to address and/or monitor the conditions, and developing treatment plans appropriate for those members determined to need a course of treatment or regular care monitoring for special healthcare needs. Treatment plans must specify an adequate number of direct access visits to specialists to accommodate implementation of the treatment plan. Aetna will make all efforts to make sure a person-centered treatment plan is developed in collaboration with the member's PCP, with participation from the member and the member's care coordinator and in consultation with any specialists caring for the member; and must meet applicable quality assurance and utilization standards. These treatment plans must be reviewed and revised upon reassessment of functional need, at least every 12 months, when the member's circumstances or needs change significantly, or at the request of the member.[7]

[BA047] Guidelines for the Services that Require Prior Authorization

Decisions to require PA for certain services depend on utilization data that identifies services that are likely to be over-utilized or to trigger the need for collaboration and communication as appropriate for the coordination of the members' care. Aetna's interdisciplinary teams include care management and quality management

[7] State of West Virginia Department of Health and Human Resources Purchase of Service Provider Agreement: Article 5.6, Section 3

staff. Concurrent review may provide feedback to support changes in our PA list. Our PA requirements are communicated to practitioners and providers in the provider manual, on the plan website available to the network, through provider forums, and provider contracts. They are also available to network practitioners and providers upon request.

Our annual UM program evaluation process includes reassessment of program structure, scope, processes, and sources used to determine benefit coverage and medical necessity. Aetna Medicaid has instituted a rigorous process for continuous reevaluation of services requiring authorization on a code by code basis. **As of 2019, we have committed to review the prior authorization status of every CPT/HCPCS code on an annual basis**. The aim of this process is to reduce wherever possible barriers to member care and administrative burden on providers.

Once it is finalized, Aetna care coordinators, as well as providers and members, can access the PA service grid within the member and /or provider web portal. Providers are updated on any changes via fax.

[BA048] Guidelines for the Services that can be Approved by the Member's PCP

Aetna has established guidelines that allow PCPs to approve any service, or type of service, that does not require PA. Aetna refers providers to its Participating Provider Prior Authorization Requirement Search Tool (Pro PAT) which allows them to determine if PA is required for specific services. Providers can search up to six Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes at a time. Aetna periodically updates it PA guidelines through Aetna's UM Steering Committee, which makes recommendations to support improved/standardized UM processes and according to change in West Virginia approved codes and standards.

The director of clinical health services is responsible for preparing a written annual UM program description and UM annual evaluation of the UM program and submitting it for review and approval to the QM/UM Committee and Quality Management Oversight Committee (QMOC), which includes the CMO and behavioral health medical director. Assessment of completed and ongoing activities and evaluation of data trends over time identify opportunities for changes to the UM program for the coming year. The program description and work plan developed for the subsequent year incorporate recommended changes based on reassessment and goals not achieved.

The annual evaluation process includes reassessment of program structure, scope, processes, and sources used to determine benefit coverage and medical necessity. Aetna Medicaid completes a comprehensive, code-by-code reevaluation of our PA requirements annually. During our most recent review, we removed more than 500 codes from the PA list. We anticipate removing an additional 400 to 500 codes this year, lessening the administrative burden for our providers. We also recently removed the PA requirement for a home health evaluation to facilitate increased access and timeliness of care. At implementation, we will review additional potential changes in the authorization process for this specialized population. Some changes to services under consideration include allowing for adjustments to annual caps on psychological testing or other screening, evaluation, and diagnostic tests and an increased number of allowed units for behavioral health therapies.

[BA049] Guidelines for the Services to which the Member Can Self-refer

Aetna members can directly access covered services from any Aetna provider without referral from their PCP (as described in the member handbook), including the following:

- Primary care dental and oral surgery services and evaluations
- Family planning

- Maternity care, and access to a women's health specialist (e.g., gynecologist, certified nurse midwife) within our network for women's routine and preventive health care services, in addition to direct access to a PCP for routine services, if the PCP is not a women's health specialist
- Immunizations for members 19 and over at pharmacy or health department
- Sexually transmitted disease screening, evaluation, and treatment are available from the PCP or public health departments
- Tuberculosis screening, evaluation, and treatment
- Testing for HIV, HIV-related conditions, and other communicable diseases
- Direct access to a specialist is not restricted

Our ISPs specify an adequate number of direct access visits to specialists to accommodate implementation of the treatment plan.

[BA050] Required Length of Time for Providers to Request Prior Authorizations

Aetna does require PA for elective hospital admissions and some outpatient services. Contacting our UM department prior to scheduling elective services may minimize any scheduling, network access, benefit availability, and/or medical necessity issues during the pre-authorization process. At a minimum, the request for services must be made –three business days prior to the date of service to promote a timely determination. All late notifications of elective admissions or outpatient services are subject to denial based on lack of timely notification.

[BA051] Levels of Authority for Prior Authorizations

Our UM program functions under the direction of the West Virginia-licensed CMO, who is involved in the implementation, supervision, oversight, and evaluation of the program. Our UM department comprises licensed and non-licensed health care professionals, including physicians, registered nurses, licensed practical/vocational nurses, independently licensed behavioral health professionals, and support associates qualified to function within the UM program within the defined scope of their job descriptions.

Aetna's UM staff has expertise in physical and behavioral health services, as well as experience and training working with adults and children with disabilities and children with special health care needs. Our UM staff will receive training to combine clinical skills with service techniques to support our UM processes. These include PA, concurrent review, and retrospective review of services. Our expert licensed clinicians review and approve medically necessary services under the supervision of medical directors. When a clinician is not able to approve or has a question, they engage Aetna medical directors for assistance.

Aetna's staff participate in learning and performance activities on a regular basis and at least annually. **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.**

[BA052] Prior Authorization Approval/Denial Letters

Aetna makes PA decisions and notifies practitioners and/or providers and members, as appropriate, in a timely manner in accordance with Aetna policies and procedures. Where regulatory and accreditation standards differ, Aetna uses the strictest or shortest timeframe to assure compliance with all requirements and in the best interest of the member. Aetna provides the primary practitioner/provider(s) and member with electronic/written notification of any decision to in whole or part deny, reduce, suspend or terminate a service authorization request, or to limit or authorize a service in an amount, duration or scope that is less than requested. The notification includes information on how to obtain criteria used to make the decision as well as member appeal rights and provider appeal rights.

The member's PCP is also provided electronic/written notification of adverse benefit determinations to facilitate care coordination; to assure the PH and BH needs of members are identified; and services are facilitated and coordinated with all service providers, individual members and their family, if appropriate, and authorized by the member.

Only licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease may determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested. We notify practitioners/providers in the denial letter (i.e., NOA) that they may request a peer-to-peer consultation to discuss denied authorizations with the medical director reviewer by calling Aetna. Prior to written notification, Aetna elects to provide verbal notification, for urgent requests, at which time we notify the practitioner/provider of the opportunity for the peer-to-peer consultation. If a peer-to-peer conversation or review of additional information does not result in an approval, or if the practitioner/provider elects not to request a peer-to-peer consultation, the denial letter informs the practitioner/provider and member of the right to initiate an appeal and the procedure to do so.

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 hotline assists members and their families to discuss any questions about care determinations, NOAs, and appeal processes. Aetna will comply with all noticing requirements and timeframes in the Contract.

Aetna has separate member and provider letters for each of the following types of PA categories: non-covered services, out-of-network requests, and medical necessity reviews. An example of a complete letter is provided as **Appendix F**.

[BA071] Ongoing Monitoring of Emergency Room Usage

Aetna uses admission, discharge, and transfer (ADT) feeds and an extensive suite of UM dashboards and reports with near real-time data to monitor appropriate utilization of ER services and cost efficiencies.

Admission, discharge, and transfer feeds: We currently receive ADT feeds from PreManage via Collective Medical Technologies and the West Virginia Health Information Network. Aetna receives the ADT data on our population health platform and is working with providers to discuss value-based contracting based this near real-time data. Promoting the integration of data at the state level will be a significant advantage for the population of children and youth involved in child welfare as they tend to experience many care transitions and are served through many care systems.

Demographic distribution for ER utilization dashboard: This dashboard, as depicted in **Figure 1.1-5** allows users to review ER utilization data through a demographic and health equity lens. 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 divert members to those services when possible. This provides for a region specific, targeted approach to ER diversion. We use our own care coordinators and engage local, community based CHWs, and the facilities with high ER utilization to participate in discharge planning and educate members about these other services available in their local community in lieu of the ER. Additionally, we monitor care management metrics regularly and use data from the ER utilization dashboard to deploy care coordinators for member outreach during or immediately following an ER visit.

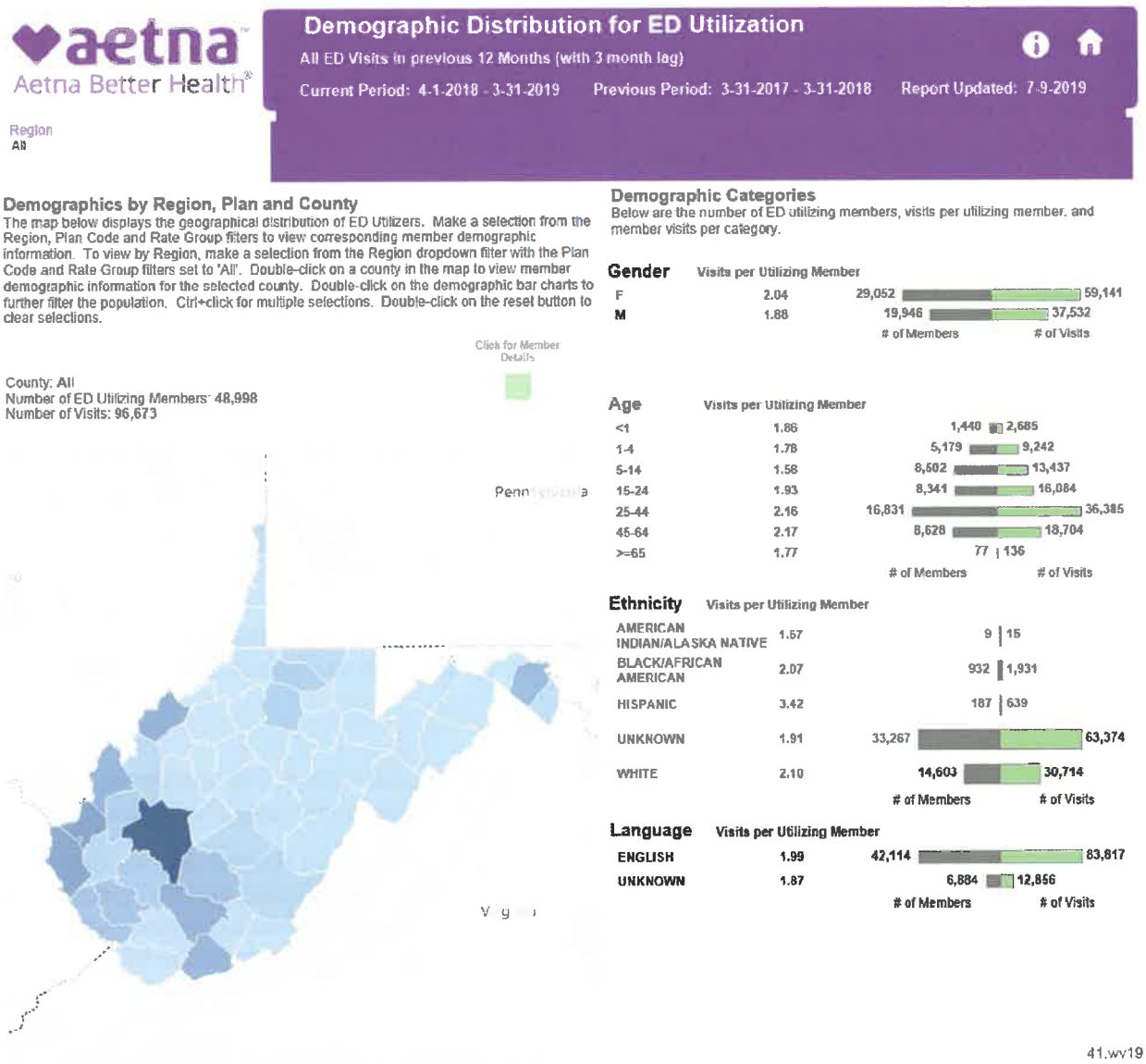

Figure 1.1-5: Demographic Distribution for Emergency Services Utilization Dashboard
Aetna uses emergency services utilization data from this dashboard to identify possible demographic-related disparities for a region-specific, targeted approach to ER diversion.

- **CHWs and peer support specialist services:** Aetna's community-based CHWs and PSSs coordinate with community-based organizations to refer members to appropriate services to resolve social needs that can worsen health or increase avoidable ER visits.

Health Information line: Aetna members have 24/7/365 access to our Health Information line (Nurse Line) and Behavioral Health Crisis Services hotline. Through these resources, members receive recommendations, in the language of their preference, on their health care issues. Nurses who staff the Health Information line instruct members on self-care options, refer them to their PCPs for follow-up, or recommend a visit to urgent care, helping to prevent avoidable ER visits.

Telemedicine: As part of our comprehensive network offering, we support members in their homes and communities by offering telemedicine services through our existing network in place with Anytime Pediatrics, contracted FQHCs, and community mental health centers throughout the state. Additionally, we collaborate with West Virginia University Medicine Children's Hospital to offer a web-based solution, enabling members to access outpatient services from the convenience of their community. We also contract with Marshall University to provide access to board-certified maternal-fetal medicine specialists for women experiencing high-risk pregnancies via telemedicine. Aetna looks forward to further developing its telemedicine program within State guidelines and to partnering with the Department to develop solutions that meet the needs of children and youth in the child welfare system.

West Virginia University Children's Hospital Telemedicine

Aetna collaborates with WVU Medicine Children's Hospital to increase access to specialty services for children and families in the Eastern Panhandle through a telemedicine clinic in Martinsburg. The clinic, which is located at Tuscarora Primary Care, provides telemedicine appointments with pediatric specialists in cardiology, endocrinology, gastroenterology, infectious diseases, nephrology, neurology, neurosurgery, orthopedics, pulmonology, and urology.

Population health management platform: Aetna makes ADT information from PreManage via CMT and WVHIN available to providers through our electronic population health management platform.

In addition, Aetna addresses high ER utilization alternative payment models (APMs). Our pay-for-quality and PCMH APM contracts allow providers to earn specified payments when their ambulatory ER rate per 1,000 members is above the HEDIS 75th percentile or meets another predetermined target.

[BA072] Standards for Emergency Room Visits

Aetna never requires PA for emergency care. We follow the prudent layperson standard; our payments are based on the member's symptoms, not on the final diagnosis. Aetna provides ER and post-stabilization services across 16 states in which we currently operate Medicaid programs. Additionally, we adhere to the following guidelines regarding ER services:

- Aetna does not limit what constitutes an emergency medical condition based on lists of diagnoses or symptoms. Furthermore, our emergency and post-stabilization services do not require PA.
- We will pay for the member's emergency screening and treatment for all claims received within 10 calendar days of presentation for emergency services, regardless of network participation status.
- Aetna also pays for follow-up screening and treatment services necessary to diagnose or stabilize the member as needed to treat the member appropriately.

We will not apply restrictions on follow-up services beyond covered services limitations based on State Medicaid requirements. Aetna considers the emergency provider responsible for determining appropriate treatment. When a member's provider or designated covering provider is not available, an Aetna plan physician will assume care until the provider is available. In this situation, Aetna will reimburse a non-participating provider. Our UM staff and health services director/manager collaborate with the treating provider to prior authorize or coordinate services needed for transition and follow-up.

Aetna's written and detailed UM policies and procures for emergency services and post-stabilization adhere to 42 CFR § 438.114(e) and 42 CFR § 422.113(c). They are reviewed annually and revised more frequently should changes be necessary based on State or federal language.

Transitions and Continuity of Care

BA054	The Vendor should honor medical, behavioral health, pharmacy, and socially necessary services (SNS)	The Vendor should describe how it will meet this specification.

	authorization approvals from previous coverage during the transition period.	
BA056	The Vendor should authorize out-of-network services, including, but not limited to, the following:	The Vendor should describe how it will meet these specifications.
BA057	Emergency situations	See the parent specification.
BA058	Non-emergency situations, including, but not limited to, both medically necessary and non-medically necessary services	See the parent specification.
BA059	The Vendor should grant members a standing referral to a specialist provider according to guidelines that the Vendor develops and the Department approves, including, but not limited to, the duration and/or number of visits usually granted or maximally allowed.	1) The Vendor should describe the circumstances under which a member might be granted a standing referral to a specialist provider. 2) The Vendor should propose durations and/or number of visits usually granted or maximally allowed.
BA060	The Vendor should develop and implement physical health and behavioral health guidelines for the extent to which a specialist may:	The Vendor should provide proposed guidelines.
BA061	Admit patients for inpatient care	See the parent specification.
BA062	Choose the hospital for admission	See the parent specification.
BA063	Determine that the patient must remain hospitalized	See the parent specification.
BA064	Schedule or provide ancillary services, such as laboratory testing	See the parent specification.
BA065	Refer patients to sub-specialists or other providers	See the parent specification.
BA066	The Vendor should refer members to out-of-network providers using guidelines that the Vendor develops and the Department approves.	The Vendor should describe circumstances in which members might be referred to out-of-network providers.
BA067	The Vendor should establish and Implement a process through which members and/or providers can request out-of-network referrals.	The Vendor should describe the process for members and/or providers to request out-of-network referrals.
BA068	The Vendor should ensure that information from non-network providers is shared with the member's primary care provider (PCP.)	The Vendor should explain the procedures for ensuring that information from non-network providers is shared with the member's primary care provider (PCP).
BA069	The Vendor should review and process medical referrals according to guidelines that the Vendor develops and the Department approves.	The Vendor should: 1) Provide proposed timeframes for reviewing and processing medical referrals. 2) Describe the average duration of medical referrals.
BA070	The Vendor should develop and implement guidelines under which a member may continue an existing relationship with an out-of-network provider (or provider that leaves the Vendor's network) if it is considered to be in the best medical interest of the member, as determined by the member's primary care provider (PCP) and/or the Medical Director.	The Vendor should: 1) Describe the circumstances and process under which a member may continue an existing relationship with an out-of-network provider (or provider that leaves the managed care organization's [MCO's] network) if it is considered to be in the best medical interest of the member. 2) Specify how long it will allow members to see out-of-network providers that refuse to contract with the health plan for ongoing courses of treatment past the first 90 days.
BA073	The Vendor should transition the member from an out-of-network provider to an appropriate in-network provider if the member is currently seeing a provider that does not participate in the network.	The Vendor should: 1) Describe the process by which the Vendor will work to meet these specifications. 2) Explain how the Vendor would propose to define an "appropriate" in-network provider.

BA074	The Vendor should assist in transferring necessary clinical information to the foster care member's new in-network physical health or behavioral health provider.	The Vendor should describe how it will meet this specification.

All transitions can be traumatic, and we are committed to making sure each transition is supported thoughtfully and appropriately. We will work with the Department and other MCOs leading up to the transition of children and youth served under the Department to obtain necessary medical records, prior authorizations, medication lists, and any additional pertinent details we can use to discern members with immediate need. Ideally, we would have this information far enough in advance of implementation to identify immediate needs and gaps in care. The timeliness of obtaining these records, as documented in our Transition of Care policy, is essential to minimizing disruption in services in a population that requires our unwavering commitment, collaboration, and compassion.

To assist members to maintain eligibility and help ensure continuity of care, our care coordinators follow our Coordination/Transition of Care policy, which includes the following:

- Contact members with pending disenrollment every two weeks to remind them to respond to the Department
- Inform them of their potential disenrollment date
- Respect prior authorizations from the member's prior plan for 90 days for acute care services and 6 months for skilled nursing services
- Attempt to bring members' pre-existing non-network providers into our network
- Link the member's historical record to the new record in the electronic care management system
- Assist members who have lost eligibility to file an appeal and continue services during the appeal process
- Work to identify local community-based organizations such as Wayne County Community Services in Huntington to provide services when the member loses eligibility and share the extant plan with the member's permission

We also ensure continuity of care through our innovative, integrated, electronic population health management platform—linked to health information exchange connectivity—which fully supports the health level 7 international (HL7) format for time-sensitive events like ADT. This provides our care coordinators a 360-degree view of the member across the care continuum.

The role of the Care Connection team during transition: A specialized CCT, comprised of interdisciplinary staff who are experienced serving children, youth, and young adults similar to the population served through the Department, will outreach the member's care coordination and transition specialist at the previous MCO. We ensure that our care coordinators understand the impact of previous trauma in the West Virginia foster care and adoption assistance population and the importance of creating an environment of safety that does not cause re-traumatization. With this in mind, at each step, the CCT involves the member and/or their representative, providers, and the member's ICT in the transition process to ensure the member feels supported and heard throughout the change. During the initial conversation, the care coordinator obtains information about existing services and the member's ongoing support needs and any current concerns. Our transition coordination staff works to develop a comprehensive transition plan, with a systematic guide outlining how transition continues the members' existing services. The care coordinator will review 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 former MCO. **Aetna has contracts with over 11,177 providers, including more than 1,312 primary care providers, 4,346 specialty physicians, 578 behavioral health specialists, and all FQHCs and RHCs across the state**, making it likely that a West Virginia member will not need to change providers if they are enrolled with Aetna. If the member is required to change providers, the care coordinator will assist in navigating the member to a provider within in their community that will meet their needs. The goal is to keep members with their current providers. However,

Aetna understands that there are times when a change may be necessary due to relocation or community change. The CCT, based on the member's needs, can offer appropriate providers available to the member. Aetna's goal is that when there will be an insurance transition, it will be seamless and almost imperceptible to the member and their caregivers.

[BA054] Honoring Authorization Approvals from Previous Coverage during Transitions

Aetna maintains the continuity and the quality of members' care and services as they enroll in Aetna plan during the transition period. Aetna's standard Medicaid transition of care procedures include honoring existing medical and behavioral health authorizations for 90 days, or until the current treatment is completed (e.g., supporting a pregnant mother through the delivery of her child, a member in treatment for cancer, etc.) in the interest of maintaining previously established therapeutic relationships. By subcontracting with the current ASO for SNS, Aetna will provide additional assurance that continuing coverage of SNS authorizations will be seamless.

When a member transitions to Aetna, they are indicated by their rate code or are flagged in FamilyConnect. This allows staff from the Utilization Management department to identify their current authorized services that should continue to be authorized during the transition period to support continuity of care. In addition, the Claims Processing department uses rate code information to assure that claims received during the transition period are paid timely and correctly without an Aetna prior authorization via our electronic claims management system.

In addition, Aetna supports member transitions from previous coverage by providing access or ensuring access to covered medications consistent with State requirements by making available or ensuring availability of two fills of a medication up to a 34-day total transition supply within 90 days from date 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 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, antineoplastics, and behavioral health medications by providing or acquiring 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.

[BA056 – BA058] Authorizing Out-of-Network Services

When it is necessary to meet a member's unique, whole person needs, Aetna allows out-of-network services for emergency situations and non-emergency situations. [**BA056]**

Emergency situations: Aetna educates our members that **emergency care is available 24/7/365, at the nearest facility available, regardless of the emergency room's provider participation status**. Medicaid members visit the ER more often than non-Medicaid members do because they often have higher rates of chronic disease and more co-occurring physical and behavioral health disorders. In addition, these members have barriers stemming from social determinants of health. 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. **[BA057]**

Non-emergency situations: Prior authorization 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 network providers. The initial step in reviewing a service request is the same for both in- 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 be non-medically necessary, it goes to a medical director for further review. No denials are made by non-physician UM staff. Second, 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. 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 care management staff will work with the provider and member to access an in-network provider for delivery of care. Out-of-network providers are invited to join the network, and single-case agreements, if necessary, are initiated for an out-of-network provider. **[BA058]**

[BA059] Standing Referrals to a Specialist Provider

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 limits to the duration or number of visits. We encourage all members to discuss specialty care with their PCP, who can coordinate needed services. Services must be obtained from an in-network Aetna practitioner or provider. There are exceptions to this, however; emergency, family planning, federally qualified and rural health center services do not require prior authorization for in-network or out-of-network practitioners or providers. Members may access these services from a qualified practitioner or provider enrolled with the State of West Virginia Medicaid program. We do not require PA for in-network specialty services.

[BA060 – BA065] Guidelines for Specialists

Aetna established the following guidelines for specialists: **[BA060]**

Admitting patients for inpatient care: Medical services for the treatment of an emergency condition are permitted to be delivered in or out of network without obtaining prior authorization. Aetna requires coverage of emergency services in the following situations:

- To screen and stabilize the member without prior approval, where a prudent layperson, acting reasonably, would have believed that an emergency condition existed
- If an authorized representative, acting for the organization, authorized the provision of emergency services
- To provide post-stabilization care services for the member **[BA061]**

Choosing the hospital for admission: Aetna contracts with The Joint Commission and Medicare-approved facilities that offer a full spectrum of covered services available to our West Virginia members. During Aetna's hospital contracting processes and credentialing activities, hospital specialties and capabilities are captured. GeoAccess is evaluated so that access-to-care requirements are met. For the convenience of our members and provider network, physical health and behavioral health facilities included in our network are listed in the provider directory, through a searchable link on our West Virginia website, or by contacting our customer services department. In the rare situation that an in-network facility is not able to meet a member's specialty health or care needs, a single-case agreement will be developed for a non-network facility that can meet the member's needs. **[BA062]**

Determining that the member must remain hospitalized: Aetna minimizes the burden to specialists by providing links to our evidence-based UM guidelines on our provider website and through our provider portal.[8] This transparency enables the treating provider at the facility to review and follow the guidelines to support best practice medically necessary care. Aetna's UM team consistently follows these guidelines, obtaining clinical and medical information from the facility's utilization and discharge planning teams to review care. Our UM team refers cases to Aetna's medical directors that do not appear to meet guidelines. As appropriate, the Aetna medical directors discuss cases with the member's treating provider or specialist. This step serves to allow our medical directors to consider all relevant factors impacting medical necessity for continued hospitalization. Additionally, Aetna's medical directors are available during business house to educate any requesting provider on use of evidence-based guidelines. Aetna uses the following criteria for physical health, behavioral health, and medical pharmaceuticals, consulted in the order listed below; as applicable:

- Criteria required by the West Virginia regulatory agencies
- ASAM Criteria for any requested service when a SUD diagnosis is present
- MCG for physical and behavioral health, and medical pharmaceutical criteria
- LOCUS— BH services for adults
- CASII BH services for children and adolescents
- Aetna CPBs
- Aetna Clinical Policy Council Review **[BA063]**

Scheduling or providing ancillary services, such as laboratory testing: Network providers may schedule the member for ancillary care with other network providers, including network laboratory testing providers. For the convenience of our members and provider network, Aetna's network ancillary service providers are listed in our provider directory, through a searchable link on our West Virginia website, or by contacting our customer services department. Additionally, upon request, our customer service department assists providers to schedule ancillary service appointments for Aetna's members. **[BA064]**

Referring members to subspecialists or other providers: When members have health care conditions and needs that cannot be managed adequately by a specialist, Aetna facilitates direct referrals to a sub-specialist by the member's specialist or PCP. Our subspecialists are listed in the provider directory and via a searchable link on the Aetna website. When access to a sub-specialist 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. **[BA065]**

[BA066] Guidelines for Out-of-network Referrals

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. We will provide any necessary information for the member to be able to arrange the service. The member will not incur any additional cost for seeking these services from an out-of-network practitioner or provider.

Aetna will work with the provider to attempt to bring them into the network. We establish a single case agreement for the current services provided to our member and assure continuity of care to the member and family. If the provider declines to contract with Aetna, the Provider Relations team begins to identify opportunities to fill the possible service gap via recruitment, telemedicine options, or identifying a vendor. Aetna supports the family in transportation and room and board for out-of-network services that are out of state or that a member cannot access without additional support.

[8] https://www.aetnabetterhealth.com/westvirginia/providers/guidelines

For medically necessary admissions that result 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 documents its out-of-network services in policy, which Aetna will provide to the Department for approval. We will comply with the Department's determination when out-of-network treatment is warranted.

[BA067] Process for Out-of-network Referrals

Aetna covers out-of-network services for emergency services, family planning services, or services we have prior authorized. We educate members to contact member services or their PCP to discuss a referral to an out-of-network provider. The ordering provider must submit a service authorization request from Aetna for approval of out-of-network services. If we approve the request to see an out-of-network provider, Aetna covers the services. We inform members they can appeal if we do not approve a service authorization request. We describe the process to request out-of-network services in our provider manual and member handbook.

Assisting a Rural Member to Continue in Equine Therapy

Josh (not his real name), a 9-year-old boy, struggled with Generalized Anxiety Disorder which was related to constant worry about his mother's health. Josh's mother suffered from a brain tumor and Josh has witnessed his mother experience seizures on multiple occasions. The anxiety that Josh experienced led to issues with school attendance as he did not want to leave his mother home alone as he constantly worried about her safety. In order to assist Josh with managing his anxiety, Josh was enrolled in animal assisted therapy at a local equine therapy provider and was reacting positively to his treatment. The provider was identified as being out-of-network with Aetna. The Aetna prior authorization nurse reached out to the Aetna medical director regarding the enrollee's need for continue treatment with his out of network provider. This request led to an approval for a benefit exception which allowed Josh to continue with his much-needed equine therapy and prevented Josh from experiencing any further distress. Following this service approval, the Aetna prior authorization nurse continued to collaborate with Josh's therapist who soon became an in network equine therapist with Aetna.

[BA068] Sharing Information from Non-network Providers with the Member's PCP

Sharing information across multiple system agencies, placements, and providers is of prime importance to provide care for children and youth involved in the child welfare system. Aetna's regional CCTs foster information sharing as they have developed strong relationships with providers of all types across West Virginia. Care coordinators share information regarding non-network provider claims and services with the member's PCP. Our network PCPs are also invited to use our electronic population health management platform, which collects and displays data on their utilization, including with non-network providers. Aetna's regional Provider Relations team works with providers to establish single-case agreements and then to recruit the SCA provider into the Aetna network.

[BA069] Reviewing and Processing Medical Referrals According to Guidelines

Aetna's written policies, procedures, and workflows, which will be submitted to the Department for evaluation and approval during the designated implementation period prior to the start of our contract, outline the criteria and methods we will use to review and process medical referrals.

The average duration of medical referrals varies based on the type of service requested and the UM guidelines Aetna uses. For example, the average referral for a home health is approved for between 5-7 days, while the average referral for therapeutic services (e.g., physical therapy) is for two weeks.

Aetna follows NCQA or West Virginia-required timelines (based on which is most stringent) for our decision and notification. 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 1.1-4**:

Table 1.1-4: Authorization Request Types and Decision/Notification Timeframes

Request Type	Decision/Notification Timeframe
Medical pharmaceuticals urgent concurrent request	24 hours from receipt of request
Urgent pre-service request (including medical pharmaceuticals)	2 calendar days from the receipt of the request
Concurrent review request	3 calendar days from the receipt of the request
Non-urgent pre-service request (including medical pharmaceuticals)	7 calendar days from the receipt of the request
Post-service request	30 calendar days from the receipt of request

[BA070] Guidelines for Continuing an Existing Relationship with an Out-of-network Provider

Although prior authorization is required for out-of-network providers, we grant accommodations during transitions of care to allow new members and their families to maintain established relationships with providers who may be out-of-network for 90 days, or longer in special circumstances as we work to establish in-network options that adequately meet the member's ongoing needs. For example, if a child is in the course of cancer treatment or has an established relationship with an important provider and the permanency plan expects the child to return to the home, Aetna would grant an extension to complete their course of therapy and to avoid a disruption in care. Aetna establishes SCAs with out-of-network specialists in West Virginia or outside the state when medically necessary specialty care is not available within our network.

[BA073] Transitioning the Members from an Out-of-network to an In-network Provider

Aetna adheres to our continuity of care policy for members new to Aetna. If a member has an established relationship with an out-of-network provider, Aetna will allow continued medically appropriate services for 90 days or longer from the provider until an alternative in-network provider can be found or until the provider enrolls in the network. Aetna establishes single case agreements to facilitate continued access to out-of-network providers, as appropriate.

Aetna would consider an out-of-network provider to be appropriate based on the type of provider, the maximum travel time from the member's home, appointment availability, and waiting time standards established by the Department for this contract, so as not to disrupt the member's care.

[BA074] Transferring Clinical Information to the Member's New Provider

Aetna recognizes the importance of transferring clinical information to the child welfare member's new in-network physical health or behavioral health provider. Therefore, when a new member enrolls with Aetna, we begin by understanding where they have been and what has worked in the past. As such, we coordinate with their previous managed care organization or providers to acquire their assessments and care plans. We review claims data to understand members' health history, including their diagnoses and prescriptions. Aetna uses our electronic population health management platform to support the transfer of this information electronically to the new in-network providers. Aetna understands that there may be challenges related to accessing comprehensive and historical data for our foster care youth, and therefore may have to gather sources from multiple sources such as prior placements and information from the youth's circle of support and birth family.

Fraud and Abuse

BA040	The Vendor should operate utilization management monitoring activities, in conjunction with fraud and abuse detection activities.	The Vendor should describe how it will meet this specification.
BA041	The Vendor should prevent and detect fraud and abuse related to pharmacy services.	The Vendor should describe how it will meet this specification, if the Department chooses to carve in pharmacy services at a later date.

Aetna is a national leader in health care and pharmacy fraud, waste, and abuse (FWA) prevention and detection.

[BA040] Fraud and Abuse Detection Activities

Aetna uses a variety of techniques, analysis, 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, in addition to inappropriate and undocumented charges. Cases of potential fraud, waste, and/or abuse are referred to the Special Investigations Unit (SIU) department for review and disposition.

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 ongoing reviews suggest to the SIU investigators which specialties/providers/codes to review for outlier behavior which is indicative of FWA.

In addition, on a quarterly basis, the SIU analytics group runs a minimum of 19 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 home- and community-based health care, durable medical equipment, and physical therapy are at high risk for fraudulent behavior and are among 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 in order to better analyze trends and schemes identified through various sources. SIU investigators review the data mining report and take appropriate action.

Aetna's SIU data mining is enhanced by Healthcare Fraud Shield (HCFS), a platform that comes equipped with 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 fraud, waste, and abuse behaviors and assigns them a risk score. Aetna's SIU use the HCFS application screens to visualize all fraud, waste, and/or abuse leads and provider billing activity as well as download the past 12 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, among others key fraud, waste and abuse 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 the results, anticipates even greater increased fraud, waste, and abuse savings, recoveries, and prevented losses.

[BA041] Prevention and Detection of Fraud and Abuse Related to Pharmacy Services

Aetna staff within each department plays a vital role in our compliance efforts, including promoting program integrity and monitoring for FWA. Armed with the knowledge they gain through compliance and FWA training, Aetna team members in every department know they play a key role in promoting program integrity and monitoring for FWA; they know their FWA responsibilities in the context of their roles within the health plan. Their expertise within their disciplines, along with provider and member referrals, complement the automated pre- and post-payment edits, audits, and analytics performed by the Compliance and SIU teams. For example, reports by our Medical Management team highlight unusual patterns that indicate potential FWA. The directors of pharmacy, clinical health services, and the SIU all play a role in detecting polypharmacy and overprescribing issues. Our Provider Relations and Quality Management teams are trained to identify FWA indicators during routine office visits. The Member Services department tracks and documents member complaints and analyzes results that may suggest FWA issues or emerging fraud trends. Claims are routinely sampled and requested through the members for validation that the services were rendered. Additionally, Aetna Credentialing department validates provider credentials and evaluates provider information from a variety of sources, including federal and state licensing, quality, and exclusions databases.

Aetna Dental Super-Prescriber Program

As part of its commitment to combatting the opioid epidemic in West Virginia, Aetna has developed and instituted a Dental Super-Prescriber program which aims to reduce the average days' supply of opioids prescribed by dental providers in the state. Aetna is implementing initiatives to educate on and encourage non-opioid alternatives for treatment of pain after dental surgery. We have sent 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. The letters were co-branded with SKYGEN, our dental subcontractor. Aetna has also encouraged SKYGEN to reinforce the message with their contracted dental providers. During the period of January to June 2019, as compared to July 2017 to June 2018, there was an 82% reduction in dental providers giving prescriptions with 4 or more days' supply of opioids (from 34 to 6 providers).

The Aetna pharmacy team conducts activities, including routine audits, to prevent and detect FWA through the review of pharmacy claims (made available from the state of West Virginia or processed by our Pharmacy benefit manager (PBM), CaremarkPCS. The Aetna Pharmacy team runs monthly and quarterly reports such as: Top Member with over $5000 in prescription spend, Top Pharmacy by cost and prescription utilization, and Top Prescribers by pharmacy cost and prescription volume to identify members, pharmacies, and prescribers of concern and shares that information with appropriate Care Management, Medical Management, Utilization and Quality Management, and Compliance team members to take next steps. When the pharmacy benefit is carved in, the pharmacy team will expand its review of claims activity beyond that described previously to also looking for signs of drug diversion by reviewing prescription claim reject reports that identify concerning patterns of prescription activity such as multiple early refill attempts, and high dose or high quantity rejects within drug categories of concern for youth populations such as stimulants and other central nervous system active medications. Reject report review will look for concerning patterns amongst members, prescribers, and pharmacy providers.

Additionally, members of concern are identified in our Member Safety Program focused on Polypharmacy, and our Member Restriction Program, which is managed by Aetna's Care Management department and medical director in collaboration with the pharmacy director:

- In the **Polypharmacy program**, the CMO/medical director and pharmacy director, in collaboration with care management, complete a clinical pharmacy review of all members during the member's initial evaluation and care planning process. The intent of this review is to identify members with several prescribed medications in the same or similar drug class along with more than two prescribing

practitioners to determine potential safety and drug interaction/risks. Members identified with safety concerns are outreached by care management for a medication review, identification of intervention, and communication with prescribing practitioners on identified prescribed medication concerns. The members identified with safety concerns are reviewed at least semi-annually thereafter. Findings are discussed by the health plan care team and follow up initiated as indicated. If indicated, the Aetna care manager will reach out to a member's state social worker to share appropriate information and collaborate on the best approach to supporting our members and families.

- In the **Pharmacy Supportive Care Management program**, monthly reports are used to monitor pharmacy and utilization data to identify potential abuse, misuse, or fraud. Medication use reports identify members that fill opioid prescriptions from more than 10 prescribers in 90 days as well as members with possible doctor shopping demonstrated by filling any 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** (our Member Restriction program) edits such as presence of opioid abuse disorder/medication-assisted therapy to create a member ranking report based on total number of edits triggered by a member. This ranking report is reviewed by the Aetna Committee to determine next steps within the program. If restriction is recommended by committee a recommendation/referral is made to the state if the pharmacy benefit is 'carved out' and if the pharmacy benefit is 'carved in' the committee will take appropriate next steps as defined by Aetna **Supportive Managed Care Program (SMCP) 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 healthcare needs, and coordinate care with the member's PCP 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/pharmacy. The restriction will be in effect for a period of up to one year or longer depending on the state specific contract.

When pharmacy benefit services are 'carved in' the Aetna Pharmacy team works collaboratively with our PBM, CaremarkPCS, who manages the pharmacy network and conducts claims review, pharmacy audit and investigations to prevent, detect and take action on fraud and abuse demonstrated by pharmacies, members, and prescribers. CaremarkPCS performs outpatient drug claim quality assurance activities for all pharmacies in the network. Our PBM has a Medicaid Quality Assurance team that performs rejected claims review using targeting logic built to validate accurate clinical adjudication based upon the benefit structure and monitors each network pharmacy on all claims submitted via our online claims processing system. The team monitors claims to ensure appropriate fees and payment are adjudicated per contract terms and these results are provided to Aetna. Rejected claim reviews are performed using targeting logic built to validate accurate clinical adjudication based upon the benefit structure coded. If an issue is detected, the Medicaid Quality Assurance team escalates the issue to the appropriate internal party to ensure expedient remediation. Desktop audits occur daily, and onsite audits occur as needed, to detect fraud, waste and abuse at the pharmacy, prescriber and member levels. We monitor each network pharmacy on all claims submitted via our online point of service (POS) claims processing system.

Edits are also used at the POS and confirm pharmacy compliance with program parameters even before prescriptions are dispensed. A report is produced daily to check claims for inconsistencies in quantity, days' supply, etc., with the vast majority of these inconsistencies resulting from keying errors during the claim submission process. When errors are detected, an outreach is completed to the submitting network pharmacy to have them reverse the claim and submit a corrected claim with the appropriate data.

In addition, 100 percent the PBM's network pharmacies are subject to audit desk reviews based on utilization and cost data pulled from reports of high-dollar claims. A report is produced daily to check these claims for inconsistencies in quantity, days' supply, etc. To identify pharmacies for audit, an automated statistical review referred to as the Pharmacy Exceptional Activity Report (PEAR) is used. This computer analysis, conducted each quarter, reviews the statistics of every pharmacy that has submitted more than $1,000 in claims in a single quarter. The PEAR helps identify pharmacies with unusual or improper claim activities that might indicate noncompliance with the provider agreement or plan guidelines; identified network pharmacies will be scheduled for an on-site audit to review prescription documentation to assure integrity of the claims submitted and processed for payment. The PBM routinely completes a minimum of three percent on-site audits of the total number of network pharmacies.

To identify potential cases of overutilization or fraud, Aetna uses Caremark PCS' Retrospective Safety and Monitoring program that employs staff pharmacists to review and intervene on claims that are system generated daily, monthly, and quarterly based on CaremarkPCS' proprietary algorithms and software. This is to help to identify, correct, and/or deter potential cases of overutilization, misuse, and fraudulent claims at the member level for high-abuse drugs. The Safety and Monitoring Program targets high risk drug classes such as opioids, benzodiazepines, muscle relaxants, stimulants, and other controlled substances (i.e., testosterone) and inappropriate use and misuse related indicators such as polypharmacy, provider shopping, and high-total controlled substance claims volume. The intervention criteria include but is not limited to the number of targeted drug prescribers and pharmacies, total drug claim number, and cost, number of concurrent drugs and providers, excessive utilization as well as the total number of Metropolitan Statistical Area (MSA) codes within a defined timeframe. Our 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. On a quarterly basis, clinical pharmacists evaluate controlled substance claims and any available supporting medical data to identify potential medication misuse and inappropriate claims for appropriate intervention. During subsequent quarters, pharmacists conduct follow-up activities utilizing physician responses and current claim activity. Situations identified as being potentially inappropriate are referred to our pharmacy director, a care manager, the Aetna's SMCP team, or Aetna's SIU team.

Family Planning and Pregnancy Related Services

BA075	The Vendor should inform members of their choices in Family Planning services, for applicable populations.	The Vendor should describe how it will meet this specification.
BA076	The Vendor should facilitate timely payment for Family Planning services for In-network and out-of-network providers, for applicable populations.	The Vendor should describe how it will meet this specification.
BA077	The Vendor should identify pregnant women at enrollment and on an ongoing basis.	The Vendor should describe the mechanisms it will employ to identify pregnant women, both at enrollment and on an ongoing basis.
BA078	The Vendor should promote "early and often" prenatal care for women who are identified as being pregnant, for applicable populations.	The Vendor should describe how it will meet this specification.

Aetna makes sure members have information and access to family planning services and prenatal care. We work to assure timely payment for these services and early and ongoing identification of pregnant members. We recognize the psychosocial issues surrounding pregnancies in this population and will help ensure we identify the need for any additional support as well as close coordination with BCF staff involved in these members' treatment team.

[BA075] Informing members of their Choices in Family Planning Services

We provide members with direct access to women's health specialists for routine and preventive health care services within our network, in addition to the member's designated PCP. Our members are also provided the opportunity to choose a qualified family planning provider outside our expansive network of providers. We also ensure there are enough trauma informed family planning providers to provide timely, culturally sensitive access to covered services. Examples of these providers include but are not limited to, local health departments and health system-affiliated family planning clinics and programs. Our care coordinators provide education on various birth control options in a culturally sensitivity manner including information regarding the Long-Acting Reversible Contraception program. Aetna has also worked closely with providers and facilities to offer Long-Acting Reversible Contraception at the time of delivery. Additionally, the Aetna website contains a Women's Health section describing well-woman checkup as well as pregnancy, and family planning information. Finally, all information related to members' access to family planning services is available to members in the member handbook.

[BA076] Timely Payment for Family Planning Service

Aetna does not require PA for family planning services accessed through providers either in or out-of-network. Our claims system processes family planning related services with limited edits to facilitate timely payment.

[BA077] Identifying Pregnant Women at Enrollment and on an Ongoing Basis

Aetna includes a question during the initial and comprehensive assessment processes on whether members are pregnant as an initial step towards identifying pregnant women upon enrollment with the plan. When care coordinators identify that a woman is pregnant, her ISP is updated to include pregnancy-related goals, as needed. In addition, Aetna care coordinators check the maternity notification system on a weekly basis to track all prenatal risk screening instruments and submissions. We analyze the pharmacy utilization data report to also identify pregnant members and initiate the coordination of care for the enrollee. Outreach is completed by phone to Aetna members who have been identified as being pregnant and members will be connected to resources for prenatal care.

Identifying and Supporting a Member with SUD

Jennie (not her real name), 25 years old at the time, was working to manage numerous health challenges including substance use disorder. She was pregnant with her first daughter and became concerned about how her substance abuse disorder may impact her child. Jennie was working with the West Virginia high-risk pregnancy program, and upon testing positive for multiple drugs, they referred her case to Aetna care management. A care manager who specializes in working with pregnant members who are facing challenges in addressing their substance use disorder outreached Jennie to get her involved in treatment that met her personalized needs. After exploring all options with her care manager Jennie chose to enroll in inpatient treatment, and subsequently in outpatient care. With the care manager's support, Jennie remained in her recommended programs and engaged with her assigned care team. Thirty days later, Jennie's daughter was born without any complications. The partnership between Jennie and her care manager not only resulted in a healthy baby, but she has remained in recovery for three years and is now a medical assistant with plans to pursue a career in nursing.

Providers who submit a Pregnancy Risk Screening Instrument (PRSI) form for Aetna members are eligible to receive a $20 incentive payment for qualified forms. This incentive allows early notification of pregnant members and assists in the early identification of high-risk pregnancies. Our care management staff is then able to enroll the members earlier and provide education and interventions to encourage healthy pregnancies.

Aetna care managers get a referral from concurrent review nurse on any pregnant member that has a hospitalization that does not include a delivery. We also have an onsite concurrent review nurse onsite at Charleston Area Medical Center (CAMC) Women and Children's Hospital that meets with members, stresses the importance of prenatal care, addresses gaps in care and any barriers to care such as transportation.

Aetna care coordinators receive the following reports every Monday: prenatal and postpartum outreach reports are received from the plan analyst, and the deliveries reports are received from Medicaid Application Support. The Aetna care coordinator formats the prenatal and delivery reports for member mailings. The formatted reports are emailed to the Aetna print procurement contact for processing vendor member prenatal and postpartum mailing packets. In addition to the reports being utilized for member mailings the reports are saved to the Care Management department shared drive for member prenatal and postpartum outreach.

Focus on teen pregnancy: Teens in child welfare systems are at higher risk of teen pregnancy and birth than other groups. For example, young women living in foster care are more than twice as likely to become pregnant than those not in foster care.[9] Aetna provides care to teens that 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 such as the Regional Youth Service Centers for behavioral health needs, residential, or other long-term housing.

> "Our partnership with Aetna is built on a shared commitment to trauma-informed care and made possible by their unique approach with us as a provider. Our experience with Aetna has been more relational than contractual—there is a sense of mutuality, as we work with a coherent vision of delivering effective, evidence-based services to produce the best outcomes possible for the people we serve. The language of our trauma treatment framework is a common language in our conversations; in fact, we have agreed to provide training on trauma-informed care throughout Aetna's organization."
>
> **—Kathy F. Szafran, MA, LPC**
> **President and CEO, Crittenton Services, Inc.**

Aetna collaborates with Crittenton Services, the only residential program in the state for pregnant teens or teen girls who are parenting. Crittenton leads West Virginia in providing trauma-informed care 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.

[BA078] Promoting Prenatal Care

Aetna promotes health and wellness through the use of preventive and routine care and services and provides information to encourage members to learn how to enjoy a healthy pregnancy and deliver a

[9] Boonstra, Heather, "Teen Pregnancy Among Young Women In Foster Care: A Primer," (2011), Guttmacher Policy Review 14(2) 8-19; Accessed July 30, 2019: http://citeseerx.ist.psu.edu/viewdoc/download;jsessionid=0CB7B343438D16E3D591B994D5749265?doi=10.1.1.295.1666&rep=rep1&type=pdf

healthy baby. Once we have identified a pregnant member, we encourage early and often prenatal care by scheduling an initial prenatal care visit within 14 calendar days of the date on which the member is found to be pregnant. In addition, all pregnant members receive a prenatal welcome packet, **including a copy of Aetna's *Healthy you, healthy baby: A guide for moms and families*, which provides information on our Healthy Pregnancies, Healthy Babies Program** (see **Figure 1.1-6**).

Figure 1.1-6: Aetna's Healthy You Healthy Baby Guide
Aetna provides comprehensive educational materials to pregnant members to encourage prenatal care.

Healthy you, healthy baby also provides all member-facing staff telephone numbers (e.g., member services, care management, etc.), and detailed information on prenatal care, including topics such as nutrition, exercise, sleep, and safe sex. It includes information on tobacco cessation, stress management, oral care, the consequences of high-risk behaviors, alcohol and drug treatment resources, childbirth classes, and planning for postpartum doctor visits. The welcome packet also includes the following educational materials: Getting Ready for Baby; High-risk Pregnancy; Safe Sleep; Prenatal Care; Depression after Having a Baby; Staying Smoke-free; Your Baby's Development; and What to Do if Your Child Has a Cold.

Upon implementation, Aetna will customize these member education materials for girls involved in the child welfare system who will likely have unique issues, which could include little or no family support, uncertainty about their future, concerns about removal of the child due to not having a stable living situation, the

possibility of the pregnancy being related to the abuse, and the impact of trauma on the experience of pregnancy and motherhood.

Aetna's Care Management and Provider Relations teams are collaborating to develop notification processes for missed appointments and to better understand the root cause. Our integrated data resource, FamilyConnect, can be viewed by providers, with permission from a member's guardian, and can serve as a notification site for missed appointments. The CCT can track and identify members who have a pattern of missing prenatal visits and will work with care coordinators who are assigned, in near real time to resolve barriers to care. Our regional CCTs stay in close communication with their community providers and participate in multidisciplinary case rounds to review members with a pattern of missed visits as well.

In addition to outreach to schedule an initial prenatal care visit and our outreach and educational materials, Aetna leads the following initiatives that promote prenatal care:

Aetna-sponsored baby showers: Care coordinators work with the Member Outreach department to invite members, families, and circles of support to regional Aetna sponsored baby showers, organized by local community-based organizations, where low-income mothers-to-be and new mothers receive baby supplies, education about the importance of prenatal care, and meet other pregnant members in her area. Our standard prize for participating mothers-to-be is a portable bassinet/playpen, which can be used to promote safe sleep for newborns. These fun and supportive baby showers offer members an opportunity to celebrate their pregnancy and develop friendships.

Supporting Moms and Babies

Aetna's Care Connection team offers a lactation specialist for support and education on breast feeding. In addition, all Aetna care management staff have received training on the Safe Sleep program to prepare them to educate members on the importance of using safe sleep practices with their newborns. Aetna was the first MCO to partner with TEAM for West Virginia's Our Babies: Safe & Sound campaign. 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.

Outbound text messaging, mailing, and social media: Our educational text-messaging program consists of the Lifeline smartphone and targeted messages to remind members to get tests and screenings done. Through the text4baby program, the first free mobile health service in the country, routine reminders are sent to members to support health goals related to prenatal and postpartum care, well-child visits, flu shots, weight management, diabetes, and substance use. Many of these text campaigns serve as virtual health coaches and allow members to interact and be educated on their specific conditions. We currently mail newsletters to our members and post them to our website, and soon we will use texting to distribute our newsletter and notify members about important events like open enrollment. We already use social media ads to educate our members on preventive measures, such as lead screenings.

West Virginia Healthy Start/Helping Appalachian Parents and Infants (HAPI): Aetna care coordinators work closely with Right from the Start and the HAPI program. Pregnant members are referred to Right from the Start and those who are eligible are educated on the HAPI program. HAPI services are targeted to improve maternal well-being during pregnancy, prenatal care, postpartum, and during the interconceptional period. In addition to these services, HAPI also offers services to fathers/male partners of HAPI clients. HAPI strives to offer services, education, 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 on parenting and fathering skills.

Maternity Matters Program: This preventive health program for pregnant members and new mothers includes incentive to reduce premature births and to support healthy prenatal and postnatal behaviors. The funds earned are provided through a single reloadable Maternity Matters card and are available to use toward maternity and baby supplies, such as wipes, nursing supplies, diapers, formula, bottles, and pack-n-plays/cribettes. Members can earn a $25 incentive for completing their initial prenatal visit.

Supporting mother and babies affected by NAS: Research demonstrates that, "youth in foster care have much higher rates of adolescent pregnancy and childbearing than their peers."[10] In West Virginia we support pregnant members at risk of delivering babies with NAS by co-locating a nurse care coordinator at Lily's Place, the first NAS center in the United States. Aetna was the first MCO to contract with Lily's Place in West Virginia. The care coordinator meets with the mothers face-to-face, enroll them in care management, and follow them throughout pregnancy and concurrent treatment for substance use disorder. Following birth, the baby is enrolled in care management and followed through the first year. The program has shown success in keeping the mom engaged in prenatal care as well as engaged in substance use disorder treatment. Most importantly, most babies are remaining with their birth mother. Aetna uses incentives to encourage participation in its NAS initiative: mother receive a portable bassinette/play pen or baby wrap carrier for enrolling in the program and an education toy for completing it. Outcomes include:

Supporting Stephanie with SUD and Social Resource Needs

Stephanie (not her real name), a 28-year-old female, recently gave birth to her first child. While in the hospital, Stephanie communicated struggles with prenatal care, drug use, and issues with food, clothing, and transportation. While in the hospital, Stephanie was connected with Aetna's care management program. Stephanie began working with an assigned care manager who assessed Stephanie's needs and goals. Upon discharge from the hospital, the care manager connected with Stephanie by phone and in person and assisted Stephanie with obtaining Supplemental Nutrition Assistance Program services through the West Virginia Works program to ensure that her needs for food and clothing were met. The Aetna care manager also connected Stephanie with a local medical home and set Stephanie up with regular transportation to her follow up obstetrician and pediatrician appointments. Stephanie also communicated her need for treatment for substance use issues. With the assistance of her care manager she was connected with a local MAT provider to help manage her SUD needs. Over time, Stephanie has become more confident in her ability to advocate for services. With the support of her care manager, Stephanie now coordinates her own transportation and continues to attend all scheduled appointments to maintain her health and the health of her child.

- For 2018, 59 percent of moms stayed in engaged in opioid treatment and/or counseling during pregnancy and through first year after delivery. By the second quarter of 2019 this increased to 88 percent
- For 2018, 82 percent of babies remained with birth mom and were not removed from the home and/or placed in foster care. But the second quarter of 2019 this increased to this increased to 91 percent

Identifying Special Health Care Needs

BA079	The Vendor should identify individuals with complex or serious medical conditions on an ongoing basis, for applicable populations.	Vendor should describe how it will meet this specification.
BA080	The Vendor should use Information systems to identify members with special needs.	The Vendor should describe how it will meet this specification.
BA081	The Vendor should use information systems to isolate data specific to eligibility category or diagnosis.	The Vendor should describe how it will meet this specification.

[10] Dworsky, Amy, and DeCoursey, Jan, "Pregnant and Parenting Foster Youth: Their Needs, Their Experiences," (2009), Chicago: Chapin Hall at the University of Chicago; Accessed July 24, 2019: https://www.chapinhall.org/wp-content/uploads/Pregnant_Foster_Youth_final_081109.pdf

Nationally, the Aetna Medicaid organization has over 30 years of experience delivering successful solutions to complex problems for Medicaid populations, including Members with Special Health Care Needs (MSHCN), with heritage in Medicaid managed care innovation dating to 1986.

Aetna believes in a prevention and early intervention approach wherever possible, and we use many data sources to identify and assess members, and to assign them to a level of care coordination that meets their needs (e.g., complex care management, management of chronic conditions, or wellness and prevention). This enhanced use of our technology increases our service efficiency and effectiveness to our members.

The Aetna team uses many data sources to identify and track MSHCN, on an ongoing basis and to assign them to a level of care management that meets their needs (e.g., complex care management, management of chronic conditions, or wellness and prevention) and in accordance with their choices for the level of care they request **[BA079]:**

- **Pharmacy usage data file and enrollment file analysis**: Aetna analyzes our enrollment file and the pharmacy usage data file to identify MSHCN and to prioritize outreaching to them for assessment. Our care coordinators also use the enrollment file to gather data that may indicate the appropriate care management level based on historically identified care management levels, current service authorizations, and active ISPs.
- **Enrollment manager**: The enrollment manager is an application that loads/processes/generates enrollment data automatically end-to-end (i.e., member data received via the 834-eligibility file, coordination of benefits/third-party liability records, and enrollment load reports for verification of data load). This data contributes to identification of MSHCN and can inform care coordinators about member diagnoses and participation in West Virginia child welfare programs. **[BA080, BA081]**
- **Screening and assessment process**: Aetna uses our initial screening and assessment process to identify MSHCNs who are new members from whom Aetna does not have historical data and who are not indicated on the enrollment file. We screen members with special health care needs within 30 calendar days of the date of identification. In addition, Aetna's behavioral health providers conduct an assessment for eligibility based on level of care needed within three business days of referral by provider or a care coordinator, based on the member's unique needs.
- **Analysis of Aetna data**: Our care coordinators conduct stratification for all members to identify those members at highest risk. We use integrated information management tools, including data from our proprietary Consolidated Outreach and Risk Evaluation (CORE™) predictive modeling platform (for members with prior utilization) and our electronic population health management platform, to identify indicators of member needs and care management level needs based on members' medical history. Aetna's Care Management team reviews claim-specific information to identify capitated services; diagnosis and condition; physical, behavioral health, and social risk needs; use of durable medical equipment; medical supply needs, etc., all of which may indicate the member has a priority condition or is in a priority population. **[BA080, BA081]**
- **Conducting assessments**: Based on health risk assessment (HRA) findings, we may conduct a member needs assessment and additional condition-specific assessments to evaluate PH and BH, therapies, functional, or DME needs. We conduct additional assessments customized to a variety of populations, including age- and gender specific preventive screening questions and assessments specific to disease or priority populations. For example, children with special health care needs also receive specialized assessments, including the Survey for the Well-Being of Young Children. Additional assessments informing care planning include the UNCOPE and PHQ-9, as well as assessments of anxiety, pain, and weight management.
- **Referrals:** Members may be referred for assessment to determine if they have special health care needs by their PCP, other providers, community-based organizations, or their caregiver or circle of support; members may also self-refer.

- **Real-time coordination of care**: Aetna's UM care teams track inpatient census daily. Our care coordinators receive automatic notifications for inpatient admission alerts. We also identify members with multiple inpatient admissions or ER visits within a rolling 12- month period. A case synopsis is created for members who have been in the hospital for 10 days or more and that have multiple comorbidities, and for those with high inpatient and ER utilization. Weekly, a multidisciplinary group of medical directors, the chief medical officer (CMO), physical health and behavioral health care team members, and representatives from UM, care management, and discharge planning convene to discuss these members. Decisions are made as a group on the best approach to take with these members (e.g., whether care management outreach would be beneficial, what potential BH needs can be addressed, and potential discharge planning needs, such as home modifications and durable medical equipment needs). **[BA080, BA081]**
- **Rising risk model for risk stratification:** Our rising risk model will identify children and youth at risk for crisis episodes. This practice allows the shared Children, Youth, and Family teams to convene at an earlier point with new children, youth, and young adults involved in the West Virginia child welfare system in need of increased support and services to avert potential traumatic events, including being placed out of their home. Aetna's rising risk model uses 28 different measures to stratify and score members age 17 and under based on a multitude of measures including specific behavioral health disorders, opioid use, physical/sexual/psychological abuse, self-harm claims, co-morbidities, risk stratification score, engaged in care management, PCP assignment, frequency of changing PCP over the course of a year, total medical spend, emergency room utilization, pregnancy, justice system involvement, sexually transmitted disease diagnoses, household opioid use, household self-harm claims, and household physical, sexual, or psychological abuse. Using this method, we will rapidly identify members and who are at elevated risk that may need additional resources from the health plan. In addition to identification of specific members, we will use demographic and geographic information to focus resources on areas of rising risk concentration. As part of our population health strategy, our goal is to early identify members with special health care needs, which include members served through the West Virginia child welfare system, and direct services to communities with members with early and less complex illnesses prior to them appearing as higher risk and higher spend. **[BA080, BA081]**
- **Predictive modeling for opioid use disorder** Aetna is exploring advanced analytics approaches to identify the members at high risk of opioid use disorder (OUD). Data sources include the following: eligibility data, medical claims data, pharmacy claim data, approved diagnosis codes, procedure codes, and drug codes. Using this data, a multivariate logistic regression model was developed to assess the likelihood of a member developing OUD using person-level data. The final model includes the following variables: age (e.g., 0-18 years, 19-29 years, etc.), rate group, ethnicity, chronic pain, alcohol abuse, tobacco abuse, first opioid prescription lasting more than seven days, opioid days' supply, and unnecessary ER visits. All factors have been demonstrated to be statistically significant. The model accuracy of prediction is 89 percent and high-risk members with OUD are flagged by a selected cutoff value, so that our pharmacy and Care Connection teams can limit harm of use and collaborate regarding outreach strategies to the member. **[BA080, BA081]**

Aetna has written policies and procedures for enrolling newborn children of members retroactively effective to the time of birth. These procedures include transfer of newborn information to the Department and establish processes for completing enrollment within 30 calendar days of the date of birth. Aetna will provide all covered services to the newborn child during this time. Aetna will inform the Department caseworker of the birth of an infant to a child in foster care within one business day of learning of the birth.

Crisis Services

BA082	Vendor should ensure timely access to crisis stabilization services.	1) The Vendor should indicate if crisis stabilization services are subject to medical necessity review criteria. If so, the Vendor should describe how it will ensure timely access to these services and state what it considers as timely access to such services. 2) The Vendor should address an approach to these services when they are provided out of network.

Aetna will have an established provider network to support members contacting the BH Services line throughout West Virginia, making sure that key contracts are in place to manage services across the BH crisis services system of care. This system includes mobile crisis, facility-based crisis, inpatient services, ER services, State facility services, and other providers. Aetna has contracts with most hospitals in the State and several of the other crisis providers, including mobile crisis. Aetna will continuously monitor, develop, and support BH crisis resources and providers. In addition, Aetna will have a recovery and resiliency administrator on our system of care team who will work with all SUD stakeholders to integrate and collaborate on both a system and member level, including crisis services. PA is not required for emergency or crisis services.

[BA082] Timely Access to Crisis Stabilization Services

In West Virginia, Aetna's internal, 24/7/365 toll-free BH Crisis Services hotline will be fully and seamlessly integrated into our overall service array. It will provide members immediate access to crisis stabilization services as well as link them to the appropriate level of services in the highest quality, least restrictive setting compatible with member safety and clinical efficacy. The BH Crisis Services hotline provides members immediate access to qualified BH services professionals to assess, triage, and address specific BH emergencies and link them to the appropriate level of services in the highest-quality, least restrictive manner possible.

Our comprehensive approach to managing BH crisis calls 24/7/365 with qualified crisis clinicians supports our commitment to meet member and family needs on an immediate basis. Staffed with independently licensed BH professionals trained in supporting the needs of children and youth involved in the child welfare system and their families, the BH Services line connects members or parents who may also call immediately to the crisis response system and can patch directly to 911 emergency services. The crisis line does not allow for busy signals, does not have an automated response, does not shift calls during high-volume times, and does not allow maximum call duration limits.

Hours of operation: Aetna does and will continue to offer members throughout West Virginia a dedicated, toll-free Crisis Services hotline 24/7/365. The BH Crisis Services hotline will include routine assistance with benefits and referrals, as well as BH crisis and emergency services. We will handle crisis, urgent, and routine requests from members or their legally authorized representative and remain on every call if necessary, to address all the caller's needs.

Staffing: Our BH clinicians are licensed, experienced, and trained to serve the needs of our members. The following are the minimum required clinical credentials for the BH Services line staff:

- Master's degree in social work, psychology, counseling, or related BH field, or a nursing degree from an accredited school
- An unencumbered license to practice
- At least three years of experience working in a BH setting
- Knowledge and experience working with diverse populations prevalent in the service areas

Training: BH Crisis Services hotline staff receives initial training during onboarding with Aetna. Additionally, they receive BH-specific training and must demonstrate an understanding of the initial training and then receive on-the-job training including shadowing and mentoring facilitated by experienced management, supervisory, or other senior BH staff. BH-specific training covers the following topics:

- Mental Health First Aid for all staff—our staff are certified in this evidence-based training
- Trauma-informed care
- Aetna crisis policy and effective crisis call management, administering suicide risk assessments, and screening and triaging calls to determine level of care needs including processes for immediate crisis intervention and/or emergency response for members at risk of harm to themselves or others
- Community-based resources including mobile crisis teams and face-to-face emergency services
- Mock scenarios of crisis calls and actual crisis calls presented during case rounds
- Appropriate identification, management, and reporting of quality of care/service concerns; complaints; or potential abuse, neglect, or exploitation

BH crisis calls: A live BH Crisis Services hotline staff member answers BH crisis calls immediately—we never answer BH crisis calls through an automated call system. The BH Crisis Services hotline staff begin to stabilize the crisis by assessing, screening, and triaging through telephonic crisis intervention to make sure the member is safe. This staff coordinates the most appropriate level of care needed, including hospital-based ER services, mobile crisis unit services, face-to-face stabilization services, or other care.

Our system supports seamless warm transfer of calls to 911 for emergency response, staying on the line with the caller until emergency response arrives, and supports conference calling for consults with the medical director or others regarding complex clinical situations. Our BH Crisis Services hotline staff is trained to warm transfer callers to the local suicide hotline or other crisis response systems as needed. After hours, weekends, and holidays, calls are routed to Aetna's call center. The call center is staffed 24/7/365 with BH clinicians and access to psychiatrists.

BH Crisis Services hotline staff work in collaboration with the interdisciplinary care team to coordinate management of the crisis and make sure follow-up occurs after crisis resolution. Care coordinators see a crisis note and follow up with members following a BH crisis intervention within 24 hours to address their current needs.

Consistently exceeding performance measures: Aetna consistently exceeds performance requirements for our current BH Crisis Services hotline. Since 2015, we have answered 100 percent of calls by the fourth ring and no calls receive a busy signal with an average call abandonment rate of 2.4 percent, much lower than the standard of 7 percent or less. We will continue to monitor our performance against the performance requirements for quality assurance purposes and to provide BH Crisis Services hotline reports as indicated, demonstrating consistently exceeded Department standards in all service areas. We monitor call performance requirements monthly through our QMOC. If performance requirements are not met, corrective actions are implemented, which may include staff education and live call monitoring by supervisory staff.

Culturally competent BH Crisis Services hotline: Aetna's recruiting and hiring practices include strategies to hire personnel that represent similar cultural considerations to our members. We certify bilingual staff as bilingually competent through third-party competency testing prior to taking calls in another language. We employ BH Crisis Services hotline staff who are certified bilingual in Spanish. Our BH Crisis Services hotline staff are also supported by Voiance for 24/7/365 real-time interpretation of more than 200 languages.

Children's Mobile Crisis teams: Aetna contracts with FMRS Health Systems, which serves Raleigh County, and United Summit (serving 13 counties) for Children's Mobile Crisis team services. We are committed to exhausting every opportunity to expand these relationships, or developing collaborations with similar agencies, statewide. The Children's Mobile Crisis teams provide the following services:

- Conduct risk assessments, provide crisis interventions and connect the individual to ongoing behavioral health services or other community resources/supports
- Provide crisis services of triage, assessment and immediate stabilization of acute symptoms of mental illness, substance use, and emotional distress

- Make reasonable efforts to stabilize acute psychiatric or behavioral symptoms, evaluate treatment needs, and develop plans to meet the individual's needs
- When clinically indicated, shall assist and transport the individual to a more appropriate facility for further care
- Provide two-person mobile teams—with at least behavioral health technician (BHT) level crisis workers
- Engage peer and family support services as preferred and identified by the member and Department caseworker

Following a mobile crisis intervention, Aetna will work with FMRS and United Summit to coordinate necessary outpatient services with the child's guardian to provide the following services:

- Assist the individual to utilize community and family/support systems with the intent of preventing the reoccurrence of similar events in the future
- Assess the immediate crisis and facilitate resolution and de-escalation
- Engage the individual to identify follow up services and assist the individual to access these services that are necessary to manage and/or prevent further BH crisis experiences

In addition, we are contracted with 12 of the 13 comprehensive community behavioral healthcare providers established under State authority. FMRS and United Summit, who offer children's mobile crisis units, are two of the comprehensive community behavioral healthcare providers. Providers offer telehealth, crisis intervention services and a toll-free crisis line that is operational 24/7/365. We are anticipating with Family First Prevention Services Act implementation in October 2019, we will see expansion of mobile crisis units.

We educate members on the following resources:

- 844-HELP-4WV, which offers a 24/7/365 chat, text, or call service that provides immediate help for an individual who is struggling with an addiction or mental health issue. This service is staffed with peers who live and work in the state.
- 800-273-8255- Suicide Prevention Lifeline: operates 24/7/365. This service is staffed by clinicians who live and work in the state.

Collaborating with FMRS to Increase School-based Behavioral Health Services

Recognizing the need to expand behavioral health services for children, Aetna approached FMRS, a Regional Behavioral Health Facility, which currently serves four schools in Raleigh County. School based behavioral health services can increase access, especially for those with transportation difficulties or in rural settings in which getting to a clinic setting consistently is difficult. FMRS provides a service coordinator in all four schools, who is responsible for assessment, care management, crisis response and supportive counseling. FMRS also provides a therapist one to two days per week in each school who conducts intensive individual and/or family therapy. All school-based therapists are trained in evidence-based, trauma informed therapy models including Trauma-Focused Cognitive-Behavioral Therapy and Parent Child Interactional Therapy. FMRS has also provided in kind, Teacher Child Interaction Training in the schools to support teachers who are dealing with increased numbers of children who have been exposed to trauma. With the success in Raleigh County Schools, FMRS was approached by Fayette County Schools to replicate many of our initiatives in their schools. Aetna provided the startup costs equipment costs for this expansion as well as the startup expenses for hiring new staff. This expansion began in Spring 2019, at Fayette Elementary. We look forward to continuing to work with FMRS to expand these services.

Aetna will work with all stakeholders to explore new models that will support people before, during, and after a crisis occurs including building capacity around positive behavioral support, creating short term respite, and taking a prevention first approach. We also recognize that this population may encounter a higher rate of crisis episodes and will proactively address these issues through the individualized care planning process, and crisis planning. The CCT may also include crisis stabilization services on the care plan for members who

are identified as high risk for having a crisis episode. By developing ongoing relationships, leveraging new and preventive Family First Prevention Services Act services and by 'thinking outside the box' West Virginia will be a national leader in disrupting the crisis cycle at all levels of the system.

Collaboration between PCPs and Behavioral Health Providers

BA088	The Vendor should ensure that primary care providers (PCPs) maintain information shared by behavioral health providers as to the outcome of behavioral health screenings and evaluations, including, but not limited to, in a patient's medical record.	Vendor should describe the process for how it will meet this specification.
BA089	The Vendor should inform primary care providers (PCPs) about changes in a member's behavioral health, including, but not limited to:	The Vendor should: 1) Describe how it will meet this specification. 2) Explain how it proposes to define what constitutes a change in behavioral health status.
BA090	Hospitalization	See the parent specification.
BA091	Emergency room (ER) usage	See the parent specification.
BA092	Change of medication	See the parent specification.
BA093	The Vendor should assist members in accessing additional services as a result of change in behavioral health status, including, but not limited to, the care coordinator's assistance in making appointments for members.	The Vendor should describe how it will meet this specification.

Aetna's system of care is fully integrated, and we emphasize collaboration between PCPs and behavioral health providers for all members.

[BA088] Ensuring that PCPs Maintain Information Shared by Behavioral Health Providers

Behavioral health conditions, such as depression, anxiety, psychosomatic disorders, and substance use are frequently seen and diagnosed at a PCP's office during a routine appointment. While some PCPs manage the member's BH condition, time constraints and lack of knowledge can limit the member's care. Ideally, the member will be referred to a BH specialist. Aetna educates PCPs on the importance of making referrals to a BH specialist and care coordinators assist with referrals when necessary. We also collaborate with West Virginia University to allow PCPs to consult with psychiatrists for children's mental health care. Our provider relations representatives are also available to provide education and information on the importance of care coordination between physical and behavioral health providers. Care coordinators invite PCPs and BH providers to participate in the member's integrated care teams and share care plans with them with member consent. Care plans address PH and BH needs as well as SDOH. Collaboration between PH and BH providers has been shown to increase adherence to medications and prevent progression or worsening of the member's current condition. Numerous factors prevent clear communication between these providers including federal and West Virginia laws, incompatibilities between electronic medical records, and lack of knowledge regarding the importance of this communication among provider groups. West Virginia requires that explicit written permission be given from the member prior to the PCP and BH provider sharing records (although no parental consent is needed for children ages 12 to 17 who seek treatment for SUD). Using our integrated model, Aetna care coordinators monitor signed consent forms for all required parties (including kinship care, foster, and adoptive parents) and outreaches to families to get signed consent when forms have not been completed. We protect all Protected Health Information per federal regulations. Aetna acts, as necessary, to improve continuity and coordination of care across the health care network based on routine assessments.

Continuity and coordination of care activities between medical and BH care 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 members with coexisting medical and BH disorders
- Implementation of primary or secondary preventive BH programs
- Assessment of needs of members with severe and persistent mental illness

Collaboration for Early Intervention for Substance Use Disorder

In Greenbrier and Ohio counties, Aetna is in collaboration with Drug Free Moms and Babies Project to initiate a program with CPS to provide early intervention to mothers and babies affected by substance use disorder. This program is active with Greenbrier Valley Physicians in the southern region, and Wheeling Hospital in the northern region of West Virginia. This early intervention program is designed to help prevent children from entering the child welfare system by providing the birth mother support and assistance with locating necessary treatment programs.

We educate PCPs about how to screen and refer for BH services and educate BH providers to refer members to their PCP as indicated for known or suspected and untreated PH concerns. For example, SBIRT is an early intervention approach that targets individuals with non-dependent substance use to provide effective strategies, like motivational interviewing, for intervention prior to the need for more extensive or specialized treatment. This approach differs from the primary focus of specialized treatment of individuals with more severe substance use or those who meet the criteria for diagnosis of a SUD. Aetna informs providers how they can access SBIRT training and encourages the use of this evidence-based service. Additionally, we educate providers about a toolkit for PCPs on SBIRT, focused on its application for opioid use disorder.

[BA089 — BA092] Informing Primary Care Providers about Changes in a Member's Behavioral Health

As an NCQA-accredited MCO, we analyze collaboration of our PCPs and BH providers annually **[BA089]**. Aetna recognizes that opportunities exist within the plan to improve coordination of care overall. As our Provider Services team spends more time in the field during 2019, the goal is to provide education and encouragement in coordination of care and improve provider satisfaction. Sharing of information across the plan, especially feedback from the Provider Services teams to our care coordinators and Network Operations teams, will also help keep these areas top of mind when speaking to members and providers. Members or their parents/guardians, through awareness of the importance of using their PCP as their medical home, can request that their BH providers communicate their care back to their PCP. Providers can also speak to the importance of this coordination of care during appointments when they make referrals. Achieving these small tasks has great potential to positively impact our coordination of care results between PCPs and BH clinicians.

The care coordinator is the primary point of contact for our members in foster care or receiving adoption assistance. Our care management model utilizes an ICT approach, which fully integrates PH and BH, along with SNS, to address the holistic needs of the member. Through the ICT, when members who are enrolled in care management (which would be all members of the population served under this contract) have a change in their behavioral health status (e.g., a BH hospitalization, ER usage related to BH, or a change in medication) the care coordinator informs the member's PCP **[BA090 – BA092].** All members of the ICT, including the PCP, are cross-trained, attend integrated clinical rounds together, and can respond to any concern or issue. Members, their representatives, and providers can also call the member services hotline to request to speak to someone from the Care Management department and can utilize the 24-hour Health Information line (Nurse Line) (. Our care coordinators can determine if the member is experiencing a

behavioral health or medical crisis and facilitate appropriate care (e.g., immediate emergency care, urgent appointment within 48 hours, or care for a non-life-threatening behavioral health emergency within six hours).

To support coordination of care, the Aetna care coordinator uses Aetna FamilyConnect, the shared EHR implemented in collaboration with Department, West Virginia Health Information Network, and providers which serve as the single, source of truth for children involved with child welfare. Aetna understands the fragmented nature of current foster environments in terms of clinical, social and programmatic documentation, and is prepared to address this significant gap. Aetna has designed an information management system for the purpose of integrating all components of the delivery of care to the West Virginia child welfare members. The system has the capability to securely store and transmit information, interface with subcontractors and other relevant systems, including the West Virginia Health Information Network, the Department's Medicaid Management Information System (MMIS), and report data in a format specified by the Department. Aetna Medicaid has years of experience with HL7 transaction format and will be FHIR-compliant as directed by CMS. The data systems will be integrated so that the member's data can be compiled in one central source. The Medical Passport will be housed within the FamilyConnect system as well as hardcopy for the foster parents to assist in continuity of care.

All information is only shared with the consent of the member or their guardian. This proprietary integrated digital system serves as a records repository with access for all key players involved the care of a child or youth involved in West Virginia's child welfare system, including the members of the ICT, educators, representatives from community-based organizations and social services organizations, and staff at State agencies. This supports our person-centered model of care in which one care plan is developed that incorporates service and support needs identified by each stakeholder, such as the member's Individualized Education Program, terms of probation, and social determinant needs. This approach contributes to defragmentation of the health care delivery system for children, youth, and young adults enrolled in West Virginia's child welfare system and reduces both provider and member and family burden to make the health care system navigable for parents and children.

This system is currently used in a similar capacity today at Aetna and will be expanded to meet the needs of all stakeholders. This care coordination platform is web accessible today for providers and will be expanded to grant appropriate data and document visibility for foster kids, their peer and care circles, clinical staff, biological parents, kin, and other guardians. The platform, designed for children and youth in the child welfare system, will facilitate the rapid inclusion of disparate documentation, included paper reports, enrollment lists, school transcripts, foster parent notes, training media, case notes, and any other support documentation related to the child.

[BA093] Accessing Additional Services as a Result of Change in Behavioral Health

We annually assess members for any new health care or social needs, but conduct reassessment more often as indicated by a change in condition or as deemed appropriate by the Department. In collaboration with the BCF caseworker, our CCT care planning process will include an ongoing assessment of the safety of the member's living environment; we will also work closely with BCF to help ensure the member is place in the least restrictive environment to meet their unique needs. The care plan is reviewed and revised on a specific follow-up schedule based on the member's ICM program level. It is also updated whenever there is a change in condition, status, or placement or other changes that warrant an update such as loss of employment, housing, etc. All initial and subsequent care planning activities are tracked on the written care plan and in the care management business application system.

Annual comprehensive reassessments include all components of the member's initial assessment. During each reassessment, member stratification is reviewed and potentially adjusted. Regularly scheduled contact and use of the interval assessment provides feedback, allowing care managers to evaluate members' progress toward their person-centered goals, and determine if the current care plan is meeting the member's

needs or if needs have changed. The interval assessment may indicate a need for a care plan update or comprehensive reassessment, and/or identify a significant change in condition. Additionally, members may experience a change in condition that may require a different care setting or level of care. Care coordinators are notified when a member is admitted to an acute or subacute care facility to begin collaborating with the member, concurrent review nurse, facility discharge planner, and ICT to identify the root cause of admission and develop a discharge plan.

The care coordinator identifies appropriate providers for the services identified in the care plan based on the re-assessment due to the change in condition and helps schedule appointments as needed. Providers are selected by the member/family based upon their preferences and cultural considerations.

Pharmacy

BA083	The Vendor should manage pharmacy benefits, ensure contractual and regulatory compliance, and coordinate services.	The Vendor should provide a general description of how it would meet this specification, if pharmacy benefits are carved in at a future date.
BA084	The Vendor should develop and implement prescription limits, Including, but not limited to, limitations on brand name and generic prescriptions.	1) The Vendor should describe how it would meet this specification, if pharmacy benefits are carved in at a future date. 2) If applicable, the Vendor should provide the policies and procedures for how limits would be managed and how cases of medical necessity would be handled.
BA085	The Vendor should identity and manage polypharmacy utilization.	The Vendor should provide a general description of the strategies it would use to meet this specification, if pharmacy benefits are carved in at a future date.
BA086	The Vendor should monitor potential abuse or inappropriate utilization of controlled prescription medications.	The Vendor should provide a general description of the strategies it would use to meet this specification, if pharmacy benefits are carved in at a future date.
BA087	The Vendor should manage members with a history of prescription drug abuse, including. but not limited to, lock-in.	1) The Vendor should provide a general description of the strategies it would use to meet this specification, if pharmacy benefits are carved in at a future date. 2) The Vendor should describe any data that would be needed from the Department to facilitate this transition.

Aetna understands and will comply with standards under section 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 the West Virginia Bureau of Medical Services (BMS) including the submission of all required pharmacy benefit and pharmacy services documents to BMS for review and approval before implementation as appropriate.

Our approach to pharmacy management is an integrated, collaborative, and strategic model built on over 30 years of experience in developing, implementing, and managing pharmacy programs that meet the needs of the diverse populations we serve. Aetna's **dedicated, West Virginia-based licensed pharmacy director, chief medical officer, and care teams** coordinate interdisciplinary access to pharmacy benefits in partnership with our members' physical and behavioral health providers to improve our members' health.

The Aetna pharmacy team understands the complex needs of our child and at-risk youth members and their guardians and families and have worked to create and establish member-centric pharmacy services and programs integrated with our Care Management and Health Services teams to help our members and the State of West Virginia meet the Safe at Home West Virginia and health and wellness goals. To improve member health and quality of care during complex transitions and lifelong events, we use a systematic, ongoing process to review the prescribing, dispensing, and use of medications that preserves member timely access to clinically appropriate medications. Our experience has shown there are challenges in appropriately managing behavioral health conditions, SUD, obesity and medication misuse. We are committed to work collaboratively with the West Virginia Child Welfare program to address these and other ongoing issues that impact member health.

[BA083] Pharmacy Benefit Management

Aetna provides comprehensive, integrated, and collaborative pharmacy benefits and services for foster children and at-risk youth consistent with federal and individual State requirements in nine states where the Aetna Medicaid organization serves Medicaid members. Our Medicaid pharmacy services which include, but are not limited to: providing access to covered medications through a credentialed pharmacy provider network; supporting real time pharmacy claims adjudication, pharmacy help desk and pharmacy prior authorization services that ensure members have access to covered medications seven days a week; monitoring and coordinating appropriate use of medications, including high risk medications in our youth populations; and, supporting all State and federal requirements for reporting the provision of federally reimbursable medications products. Aetna has and can provide pharmacy benefits and services consistent with the West Virginia Department of Health and Human Resources Bureau for Medical Services (BMS) Provider Manual Chapter 518, Pharmacy Services, the Omnibus Budget Reconciliation Act of 1990, all 42 CFR § 438 Subpart F, 1915(c) Waivers, and section 1927(d)(5) of the SSA.

Aetna's **dedicated, West Virginia-based licensed pharmacy director and chief medical officer** oversee all pharmacy operations in compliance with the requirements. Since April 2013, we have collaborated with the West Virginia BMS to administer pharmacy benefits, services, and programs as either a 'carve-in' or 'carve-out' program; since July 1, 2017 we have provided services via a 'carve-out' model. As part of our ongoing collaboration, Aetna's West Virginia Pharmacy Director, Mark DeMary, R.Ph., a lifelong West Virginia resident, has been active in several key committees and program development, such as the Supportive Managed Care Program Committee. Mark was privileged to collaborate with the State, other Medicaid MCOs, and West Virginia Public Employee Insurance Association (PEIA) to help develop The Safe and Effective Management of Pain Initiative. We look forward to providing **our local presence backed by national experience** to continue this collaboration with BMS and other state departments in developing and implementing innovative and creative solutions.

To improve member health and quality of care as well as align with all regulatory and contractual obligations, Aetna uses a systematic, member-specific approach that starts with a comprehensive review of the member's medication history, social circumstances, provider network, and medication use behaviors. This review is ongoing to achieve continuity and identify potential gaps, barriers, and inappropriate use as early as possible. In our West Virginia Medicaid plan, our pharmacy director and clinical pharmacists work with medical providers and pharmacists, in coordination with our care coordinators, to ensure our foster children always have access to needed medications and pharmacy services especially during care transitions and placements, while continually monitoring for indications of inappropriate use of psychotropic and other high risk medications for children and youth in involved in the child welfare system. Our pharmacy director uses weekly, monthly, and quarterly reports to monitor drug trends and identify changes in utilization with special focus on over-utilization or under-utilization. Our pharmacy director participates in weekly clinical rounds with our care managers, medical directors and other health services staff to address specific member cases and ensure appropriate utilization of psychotropic medications in our children and other high risk member populations, and coordinate access and use of necessary medical, social, and laboratory services required to achieve the desired health outcomes.

Relationship with CaremarkPCS: Since 2012, Aetna has utilized CaremarkPCS Health, L.L.C. (CaremarkPCS) as our PBM to support our provision of the pharmacy benefit. Our PBM delivers a best-in-class pharmacy claims adjudication and payment system as well as pharmacy network and specialty pharmacy services to our Medicaid members and providers. Our URAC-accredited PBM has been **serving the Medicaid population since 1988,** and currently supports 33 managed Medicaid health plans and more than 22 million covered members in 32 states. CaremarkPCS is NCQA-accredited in Case Management and Disease Management in specific specialty medical conditions; all these high quality, member-centered care models can be leveraged in supporting our West Virginia Medicaid members and providers when needed.

Currently, Aetna has membership of more than 137,700 which includes over 61,000 members under 21 years of age. Aetna retains control of decision-making elements critical to providing services that reflect our deep understanding of the specific needs of West Virginia Medicaid child and youth members. **Table 1.1-5** outlines the roles and responsibilities between Aetna's West Virginia pharmacy director, our national Medicaid pharmacy management, and CaremarkPCS.

Table 1.1-5 Carve-in Pharmacy Service Roles and Responsibilities

Aetna Pharmacy Director	Aetna National Medicaid Pharmacy Management	Caremark PCS
• Liaison with the State • Formulary management • DUR program management • Member and provider education • PBM delegation oversight • Retail/specialty program and pharmacy network oversight • Member and provider complaints • Encounter management • Regulatory reporting • Interdisciplinary case rounds • Quality management	• Formulary and utilization management programs • New drug review and analysis • DUR program management • PBM delegation oversight • Specialty pharmacy program development and maintenance • Medication managements programs • Pharmacy trend and reporting • Pharmacy management policies and procedures	• Code and test pharmacy benefits • Prescription drug claim adjudication • Prospective, concurrent, and retrospective DUR edit implementation and reporting • Clinical pharmacy programs • Retail/specialty pharmacy network development, maintenance, and audit • Pharmacy help desk • Encounters reporting and reconciliation • Regulatory reporting • Client web-based tools

Aetna Oversight of CaremarkPCS: Aetna will be accountable for the oversight of all program requirements and the functions delegated to CaremarkPCS. The pharmacy director will confirm that all delegated pharmacy services are in compliance with contractual and regulatory requirements.

As part of our Quality Management Committee structure, we utilize a Joint Oversight Committee chaired by the West Virginia pharmacy director. JOC membership will consist of the CMO, compliance officer, and representation from all areas of the health plan including operations, medical management, care management, and quality management. The committee meets with the PBM on a quarterly basis to assess and evaluate key performance metrics, including, but not limited to the following: cost performance and trends, prospective and retrospective DUR programs, specialty drug utilization, pharmacy network and pharmacy help desk, encounter submission acceptance and clinical pharmacy programs outcomes.

Ensuring access to medication consistent with the West Virginia Medicaid pharmacy benefit: Aetna works collaboratively with our PBM to enhance our member and provider experiences and optimize member health outcomes by ensuring access to appropriate medications and providing innovative solutions to members, prescribers, and pharmacies. We work diligently to ensure our pharmacy benefit functions consistently with the West Virginia BMS pharmacy benefit requirements and the needs of our members and providers. Pharmacy benefit systems and services provided are developed and implemented under the direction of the Aetna pharmacy director, CMO, and Aetna Medicaid pharmacy management **[BA083]**.

Aetna ensures adherence to the preferred drug list (PDL) in numerous ways. Our website links our providers and members to tools that assist with the identification of PDL-preferred products and to augment access to covered medications Our PDL can be downloaded electronically or linked via other electronic applications, such as electronic medical records (EMR), and mobile devices including smart phones. Aetna publishes the PDL for our members, providers, and the public on our website in multiple formats, including: a printable PDF document, an online search tool, and an electronic machine-readable file formatted as specified in 42 C.F.R. 438.10. The PDL documents which are updated at least quarterly display medications' PDL status (preferred,

non-preferred), an indication if PA is required, applicable UM tools such as quality limits, step therapy, and information necessary to initiate a request for PA, or access to a non-preferred medication.

Member communication is an essential part of our PDL management program. We notify our members of approved formulary changes through member newsletters, our website, and individual letter notifications at least 30 days prior to change. When we remove medications from the PDL, we send letters to members who are receiving those medications to inform them of formulary status change, and to contact their prescriber for a replacement prescription or PA.

Pharmacy benefit claims administration: Aetna collaborates with our PBM to deliver state-of-the-art pharmacy claims adjudication and payment system to serve our Medicaid members and providers. Our point of service pharmacy claims processing system provides average response time of one second or less for all processed transactions calculated over a 12-month period. To ensure compliance with the West Virginia State PDL and pharmacy benefit requirements, Aetna's pharmacy team in collaboration with our PBM monitors claims processing activities daily. Our claims processing system is configured to support the rules governing benefit design which includes but is not limited to pricing which is configured consistent with the West Virginia State Medicaid contract, network coverage, 340B claims processing requirements, PDL coverage and edits, prospective DUR, or other benefit edits. Edits are used at the POS and confirm the pharmacy and the submitted claims' compliance with the Aetna and BMS' program parameters even before prescriptions are dispensed **[BA083]**.

Our PBM monitors a daily report which checks claims for benefit and PDL inconsistencies in quantity, days' supply, dispensing fee, etc. When pharmacy submission errors are detected, an outreach is completed to the submitting pharmacy to have them submit a corrected claim with the appropriate data. When errors are found in claims processing suggesting specific parameters (e.g., PDL status, reimbursement, etc.) are not functioning consistent with the required benefit immediate action is taken to identify, resolve, and remediate the issue(s) of concern.

Pharmacy help desk and access to medications: Aetna in collaboration with CaremarkPCS makes pharmacy help desk services available to our pharmacy and medical providers to ensure access to information on covered pharmacy products and services. Aetna provides via our PBM the operations of a toll-free pharmacy help desk 24/7/365 for access by our pharmacy providers **[BA083]**.

Educating Susie's Family on Appropriate Use of Medications

Susie (not the real name) is a 12-year-old member who was recently discharged from an inpatient stay due to reports of suicidal ideation and use of sharp objects to cut on her wrists. Within days of discharge, our clinical pharmacist spoke with Susie's aunt about the medications given to Susie. Susie's aunt states she is doing much better after discharge and that Susie has returned to school and is taking her medications (citalopram daily at night-time and hydroxyzine twice a day, as needed) as prescribed by her doctor. Susie and her aunt had a follow-up appointment with therapist to review Susie's treatment plan. The clinical pharmacist discussed the importance of medication adherence to prevent worsening of depression and anxiety with Susie's aunt and encouraged Susie and her aunt to stay positive while waiting for improvement in symptoms which can often take several weeks. Pharmacist also discussed that hydroxyzine for anxiety may cause sedation, so taking 30-60 minutes before bedtime may help with her insomnia. Susie's aunt stated she understood and appreciated the information and did not have any further questions. At the end of the call, the pharmacist verified with Susie and her aunt the contact information for Susie's Aetna care manager and encouraged her aunt to reach out to Aetna to gain access to resources available for her and her niece. Additionally, the pharmacist documented the discussion in our electronic care management system and shared information with Susie's care manager and integrated care team.

Collaboration is key to the success of our pharmacy. CaremarkPCS help desk includes a Retail Customer Care team that works with and supports the network pharmacies participating in our national network by troubleshooting point of service online claim transmissions. Retail customer care representatives have access to retail pharmacy electronic transactions, allowing them to assist with eligibility concerns, rejected claim resolution, and clarification of adjudicated claims. The retail customer care representatives also provide triage support on inquiries regarding pharmacy payment, network enrollment, and other general contract support, providing the retail pharmacist with a single point of contact.

Pharmacists can dial our toll-free number to select options from the retail services interactive voice response (IVR) menu for assistance or have the option to speak to a pharmacy help desk representative if they have additional questions or if the IVR is unable to provide the answer or direction needed to adjudicate the claim.

The Aetna pharmacy director working collaboratively with our PBM account manager creates help desk tools that define rules to ensure clarity of help desk staff instructional documents to assist with access to medications and to prevent member and pharmacy provider miscommunication issues. Help desk supervisory staff conduct audits of calls; the results of these audits are tracked and reported to call CaremarkPCS account management and Aetna staff. If an issue is identified that requires resolution, the CaremarkPCS and Aetna teams will collaborate towards a resolution. Actions and outcomes of audit activities and issue resolution are discussed at quarterly JOC and Delegated Oversight Committee meetings to fully integrate identified solutions. Additionally, the Aetna pharmacy team monitors the CaremarkPCS help desk through review of statistical reports, telephone calls, or onsite visits and maintains a pharmacy help desk quality assurance program. The CaremarkPCS pharmacy help desk system monitors and reports all required call management metrics to ensure we meet the West Virginia State Medicaid performance standards as measured by monthly averages and ensure first call resolution.

Our PBM's help desk for pharmacy services is adequately staffed to ensure accurate and timely responses as defined by service warranties and consistent performance metrics are met. The help desk operates phone lines 24/7/365 and is staffed to accommodate first-call resolution performance. All calls received are acted upon at time of inquiry and no calls are blocked or refused.

Pharmacy help desk statistics and audit activities are reviewed and discussed during quarterly JOC meetings between Aetna and our PBM. The meetings are attended by the West Virginia pharmacy director, Medicaid executive pharmacy director, chief executive officer, CMO, vice president medical affairs, and member services lead as well as our PBM's strategic account executive, strategic account director, clinical advisor, analytic consultant, and specialty account executive. This information is also shared with the Delegated Oversight Committee and action is taken if concerning patterns are identified.

Pharmacy PA operations: Our **local West Virginia-based pharmacy director** provides oversight to the pharmacy PA function, administered by our Medicaid Pharmacy Prior Authorization Call Center. Our national Medicaid team of 62 certified pharmacy technicians and 22 licensed clinical pharmacists collaborate with the West Virginia chief medical officer/medical director to complete timely reviews and determination of PA requests **[BA083]**.

Our pharmacy PA program complies with the requirements of section 1927(d)(5) of the SSA and with Department requirements. Our PA system will be configured to utilize Aetna Medicaid PA clinical criteria and/or State-defined PA clinical criteria. Our program ensures there is no undue disruption of a member's access to care; prevents penalization of the provider or member for PA requests or approvals; and incorporates the following requirements:

- Our clinical PA review criteria are evidence-based, and follow best clinical practice standards, and/or other national standards and are approved by our P&T Committee.

- Our coverage criteria are readily available to our providers and members on our website as well as through electronic tools such as ePA.
- Reviewers utilize medical and pharmacy claims information and supporting documents available within our medical claims and pharmacy systems as well as information provided by the prescriber to determine compliance with the clinical coverage criteria guideline prior to rendering a decision on each case
- Pharmacy PA requests are reviewed by certified pharmacy technicians, licensed pharmacists, and/or Aetna medical directors. All Pharmacy PA request denial decisions are made by West Virginia licensed physicians.
- A physician peer review is available upon a physician's request for any denial decision. Additionally, providers may appeal authorization denials on members' behalf.
- PA determinations are made and communicated to the requesting provider within 24 hours from the initial request including weekends in compliance with the provisions of OBRA 1990 mandate, Section 1927 of the Social Security Act, and other federal regulations.
- All PA activities and decisions are documented in our online pharmacy care management system. Aetna care management and appropriate clinical staff have access to the case information within the PA system.

To support real-time processing of prescriptions within minutes of an approval of the PA request, the system loads the authorization into the claims adjudication system. The system tracks the status of the clinical review in real time at any point in the process to ensure a decision is rendered within 24 hours. Once the approval is loaded it is available to Aetna staff via the People Safe program utilized by our staff to answer provider and member questions. In 2018, across our Medicaid plans, Aetna processed 217,536 requests for prior authorization, with 97.86 percent of requests reviewed within 24 calendar hours. And, in 2019 between January and June, Aetna Medicaid processed 105,820 requests for prior authorization, with 98.93 percent of requests reviewed within 24 calendar hours.

To reduce administrative burden and improve the member's experience, Aetna offers two automated PA review programs (**SMART PA and ePA**) which allow medications to process at the point of sale after meeting specific Aetna or if required State PA criteria **[BA083]**. Both automated programs make approved PAs available immediately at the local pharmacy. Aetna's pharmacy system allows specific prescriptions to process without requiring the provider to submit for a PA. In 2017, 7,324 prescriptions were processed utilizing SmartPAs and 142,829 in 2018. Specific examples Smart PA edits created by Aetna's Clinical Guideline team that can be implemented by our Medicaid plans include, but are not limited to, the following: Naltrexone concurrent use with opioids and Morphine Milligram Equivalent (MME) dose edit for opioids except buprenorphine product; and MME edit exemption if diagnosis of burn or sickle cell crisis. Our pharmacy director works with the state to determine which edits are appropriate for implementation and creates additional SmartPA edits meeting the requirements of the PDL covered drugs' PA criteria.

ePA allows prescribers to **submit an electronic PA (ePA) request decreasing the provider's administrative burden immediately.** Using the ePA tool, providers transmit PA requests electronically, thus eliminating the need for handwritten PA fax forms and/or phone calls. Pharmacy PA requests are submitted via a secure web portal using Surescripts, an information technology company that supports e-prescriptions, and CoverMyMeds, a software company that automates the PA process.

Within the ePA system the provider can view the criteria for coverage and provide member-specific responses to criteria questions and member medical and prescription information that support the use of the medication requested. Final determinations for the PA request are either approved (after meeting clinical criteria) or require further review from a pharmacist and/or medical director.

Additionally, the tool enables providers to check approval and denial statuses after submission. By utilizing the ePA tool, providers should see a decrease in their administrative burden **while supporting continued compliance with the PDL and clinical criteria**

Our provider satisfaction survey of the top 20 providers for our Medicaid plans utilizing ePA revealed that 97 percent of responses noted that ePA saved the practice time, provided a faster response and decision, and continued use of the service was planned. As of June 2019, Aetna Medicaid health plans average pharmacy e-PA rate was 44.6 percent demonstrating provider acceptance of this time efficient process.

Aetna's business hours of operation for our pharmacy PA call center are 8 a.m. to 6 p.m., Eastern Time, Monday through Friday. We provide a toll-free call center number where a provider can receive an immediate PA decision, including approvals or denials. In addition, we provide two additional methods of PA submission, electronic and fax, which are supported 24/7/365. Aetna's licensed pharmacists will consult on complex cases with the West Virginia-based medical directors before making a final determination or recommendation. The pharmacist or the medical director may contact the prescriber to discuss the case and will consult with a board-certified provider from an appropriate specialty area when needed, such as a psychiatrist, to assist in determining medical necessity.

Upon making a pharmacy authorization decision, Aetna notifies the prescribing provider and member within 24 hours if a request is made via phone, requested by fax, electronically, or mail. If the prescribing practitioner is unavailable to provide a request for authorization, the member will receive a 72-hour emergency supply of a prescribed drug at no cost to member subject to either PA or clinical edits. Aetna's pharmacy network includes retail and mail order pharmacies that will deliver medication to our enrolled children's' homes; some of our retail pharmacies will deliver medications to members the same day as the prescription is filled. **Upon comparison of The West Virginia State Pharmacy Roster file, 736 of the 755 (97.5 percent) pharmacies are currently active on both West Virginia Roster file and Caremark National networks, including 174 pharmacies that deliver for free.** Aetna members have appeal and grievance opportunities and member services as well as pharmacy services are trained to assist members if their medication request is denied.

The pharmacy director and the Pharmacy PA Operations Management team manage metrics and performance by trending volume, types of requests, and authorization determination percentages through daily and monthly reports. The data is used to continually identify opportunities for quality and process improvement and/or make recommendations to the State related to PA requirements and criteria. Aetna issues an inter-rater reliability exam quarterly to pharmacy technicians, pharmacists, and medical directors. The exam is used to confirm and/or identify areas for education on the appropriate application of the PA criteria. We also audit all denials on a daily and monthly basis to guarantee compliance with the NCQA denial notification standards.

[BA084] Developing and Implementing Prescription Limits

Aetna has experience in managing a multitude of pharmacy benefit scenarios, including implementing prescription limits, state Medicaid PDLs, and clinical PA criteria. Aetna provides pharmacy programs and services across 13 states including Arizona, Kentucky, New Jersey, Texas, and Virginia, and Michigan and has implemented **custom, common core, and state-run PDLs.**

BMS requires MCO to implement State PDL: Aetna will collaborate with BMS to implement and manage the PDL, including PA, quantity level limits, and step therapy requirements as defined by the State. We are experienced at seamlessly coordinating benefits. Our local West Virginia pharmacy director is responsible for all point of sale edits and management of the coding instructions to our PBM as well as testing and validation

of the PDL, and utilization management edits in alignment with the BMS requirements. This is the current practice for the general Medicaid population and supports foster children currently in West Virginia. Through our existing weekly file exchange processes with the State program, Aetna determines if changes and updates to the PDL are required and completes in accordance with BMS requirements. To drive alignment, we provide regular updates to our Aetna Pharmacy PA Call Center and Member Services teams on PDL, and/or clinical PA criteria edits. Aetna sends CaremarkPCS, our PBM, the State's weekly PDL file. On a weekly basis, a file comparison is performed between the existing and the new file and changes are loaded into production. To keep our members and prescribing practitioners up to date of the BMS -approved PDL drug coverage, **Aetna provides a direct link to the BMS website through our health plan website** for access to the most current information on drug coverage. The formulary is available to members and providers through a mobile app. We provide notifications to members and in provider newsletters to check our website for updates. Members can also contact member services for assistance with looking up drug coverage or having a paper version printed and mailed to their home. Members and providers have access to any updates to formulary, medication limits, and PA through a member or provider portal.

Aetna establishes the PDL: Today, Aetna's Pharmacy team maintains **custom and common core PDLs** that are fully compliant with the Social Security Act, the Code of Federal Regulations, and the State Medicaid contracts that guides access to covered outpatient medications. The PDL we utilize for the West Virginia Child and Youth program will be compliant with the West Virginia State Medicaid contract and will ensure clinically appropriate access to medications commonly used by this population which includes but is not limited to medications for asthma, dermatological conditions, attention-deficit/hyperactivity disorder (ADHD), and other behavioral health conditions. We have a comprehensive, evidence-based clinical process to continuously review and select drugs in all appropriate therapeutic classes and subcategories in the development and ongoing maintenance of our formulary and PDLs. This process includes the evaluation and selection of drugs, brand and generic, for inclusion based on safety, efficacy, and cost protocols according to documented, proven, clinical evidence, as well as a review of the most complex and chronic diseases and member-specific needs based on current utilization and disease conditions. Our PDL excludes only medication categories required to be excluded under Section 1927(d) of the SSA as amended including drugs of manufacturers that do not participate in the federal rebate program are excluded from coverage without exception. **[BA084]**.

For each medication on the PDL, the committees take into account the medication's clinical efficacy and safety as demonstrated by scientific evidence documented in American Hospital Formulary System, United States Pharmacopoeia Dispensing Information, Micromedex DRUGDEX®, and National Comprehensive Cancer Network, as well as peer-reviewed medical literature, pharmacoeconomic studies, outcomes research, and standards of practice including treatment protocols and evidence-based practice guidelines such as Institute for Clinical Systems Improvement.

When the PDL prefers generic equivalents, Aetna provides a brand name formulary exception process for prescribers to pursue when brand name products are required for members due to medical necessity. The PDL formulary exception process is clearly documented within member and providers materials; forms and criteria are available on our website. Providers can submit requests for non-PDL medications as well as requests for drug limit exceptions (e.g. quantity limit, age limit, etc.) via fax, phone, and electronic PA (ePA). The formulary exception process ensures access to all medically necessary covered outpatient medications and quantities consistent with Section 1927 of the SSA and as amended regardless of the PDL status of the covered outpatient medication.

Aetna's process for the ongoing maintenance of the PDL, including recommendations for adding and/or removing drugs or UM edits, follows a rigorous evaluation process. PDL therapeutic classes are reviewed at least annually, and new-to-market medications and new formulations are reviewed after becoming available

on the market. Our West Virginia PDL and its UM tools including prior authorization criteria, quantity limits, and step therapy requirements, are reviewed quarterly for clinical soundness and cost efficacy; changes are determined by National Pharmacy & Therapeutics (P&T) Committee. If required, Aetna P&T committee recommendations will be submitted to BMS for review and approval prior to implementation. Our West Virginia pharmacy director and chief medical officer participates in the National P&T Committee and addresses West Virginia State-specific needs.

Aetna clinical PA criteria: Aetna's rationale for requiring PA for access to some of the PDL medication includes the following:

- Clinical appropriateness, including verification of medical necessity; verification of proper use, dose, and duration
- Member safety, including preventing adverse drug events based on the member's history, reduction or prevention of over-utilization, inappropriate utilization or abuse, and potential adverse drug events **[BA084]**

Aetna has established protocols and processes in place to develop and implement PAs supporting the clinical review of preferred and non-preferred drugs. Our structured processes include established UM edits requiring authorization prior to dispensing, such as opioid quantity limits. Guidelines to support the medical necessity review of preferred and non-preferred drugs (i.e., those requiring PA or other UM edits) are developed and updated in alignment with nationally recognized treatment standards (i.e., American Psychiatric Association, American Diabetes Association, CMS-recognized compendia), medical literature, manufacturers, U.S. Food and Drug Administration (FDA), and health care providers. These include age restrictions, specialist requirements, quantity level limits, and step therapy. All PA guidelines include the references used. **PA guidelines are reviewed and updated** annually by the P&T Committee when new evidence-based treatment guidelines are developed or there are new FDA indications. All PA guidelines and formulary notifications are published in our newsletter and posted on the health plan website for access by providers and members.

Pharmacy and Therapeutics Committee: Our National P&T Committee structure **comprised of local health plan and national representatives,** leverages expertise across multiple states using the wide breadth of knowledge of health professionals and experts. The National P&T Committee meets at least quarterly and submits findings and reports to the Quality Management Oversight Committee for continuous quality improvement efforts **[BA084]**.

Effective formulary management results: The Aetna Medicaid organization has established a collaborative working relationship with many Medicaid state agencies regarding effective management and monitoring of implemented PDLs. Because of this strategic collaboration with states' Medicaid plans that allow Aetna to determine and manage the PDL and its UM requirements, such as prior authorization criteria, Aetna has successfully avoided unnecessary costs for multiple Medicaid programs through effective formulary management strategies in a clinically appropriate manner, as outlined in **Table 1.1-6 [BA084].**

Table 1.1-6: Formulary Changes and Unnecessary Costs Avoided across All Managed Formularies

Therapy Class	Change	Cost Avoided
Acne Class	Steer to more cost-effective, clinically appropriate medications	$648,513
ADHD	Clinically appropriate quantity limits on ADHD medications to ensure safe and effective use	$292,833
Fluoxetine	Steer to more cost-effective, clinically appropriate formulations and strengths of Fluoxetine	$504,305

Therapy Class	Change	Cost Avoided
Antipsychotics	Clinically appropriate quantity limits to ensure safe and effective use	$153,002 (YTD 6/30/2019)

[BA085, BA086] Addressing the Potential Abuse or Inappropriate Utilization of Controlled Prescription Medication

Aetna's approach to drug utilization review (DUR) which includes but is not limited to managing polypharmacy and inappropriate utilization of controlled prescription medications is consistent with 42 CFR 438.3(s)(4) and (5), Aetna requirements described in Section 1927(g) of the Social Security Act and 42 C.F.R. Part 456, Subpart K. In West Virginia we are aware of the following three specific UM issues concerning psychotropic medications that must be addressed:

- Overprescribing of psychotropic medications when non-pharmacological clinical interventions are appropriate
- Gaps in prescriptions for children/adolescents with conditions in need of continuity of psychotropic medications when placement transitions occur
- Lack of appropriate metabolic monitoring for those prescribed certain medications

Our collaborative, coordinated, and integrated member-centered approach to DUR programs promotes appropriate medication use with special focus on psychotropic medications in vulnerable populations such as our youth and adults members with behavioral health and substance abuse conditions, decreases fragmentation, and increases integration across providers and care settings while building shared capacity to improve medication outcomes and minimizing wasteful spending. This approach includes programs conducted by the Aetna Pharmacy team which is led by our pharmacy director and clinical Pharmacy Medication Management Program (PMMP) under the guidance of our CMO and in collaboration with CaremarkPCS clinical pharmacists, retail, or independent community-based pharmacists and other Aetna clinical staff, specifically care management and health services and quality management team members.

Aetna delivers DUR programs to our members, providers, and the State that foster our purpose of delivering pharmacy benefits and services that are: collaborative with BMS and consistent with CMS Medicaid requirements; structured in development and execution to ensure outcomes measurement; deployed through local West Virginia providers ; utilize proven prospective DUR tools (e.g., SMART PA/sophisticated POS edits) to improve efficiency at the pharmacy, and retrospective DUR strategies to identify targets for intervention and education.

Aetna's West Virginia pharmacy director will work collaboratively with BMS and other West Virginia Medicaid MCOs by sharing our pharmacy DUR program initiatives, results, and lessons learned, thus using our experiences to further develop our DUR programs, support future BMS universal policy, and/or DUR program implementations.

Our comprehensive DUR process, which is guided by the Aetna Medicaid Drug Utilization Review Board, requires our Pharmacy and Clinical teams to develop, implement, and conduct ongoing educational programs for the West Virginia Medicaid pharmacy provider community. Educational initiatives and programs created and conducted recently include, but are not be limited to, provider letters and bulletins on the FDA approval process for follow-on drugs, drug recall process, and monitoring metabolic risks of antipsychotic medications, POS messaging for concurrent benzodiazepines and other controlled substances, and age restriction on products containing codeine, hydrocodone and tramadol to limit use to adults; and provider training sessions, webinars, quarterly newsletters, and other training activities as requested by the State Medicaid programs. This educational approach helps reinforce evidence-based treatment including prevention of polypharmacy and inappropriate or unsafe opioid and controlled substance medication use **[BA085]**.

A sampling of the reports used to monitor and analyze utilization patterns and trends by providing detailed claims information as well as comparative data points, and summary trends are noted in

Table 1.1-7. Reports, which will be specific to the Aetna plan serving children and youth in child welfare in West Virginia, are generated a daily, weekly, monthly, and/or quarterly **[BA085, BA086]**.

Table 1.1-7: Summary of Pharmacy Reporting Specific for Children and Youth in Child Welfare

Report	Description
Prospective Drug Utilization Review (ProDUR) Alerts	Patterns and details on specific alerts generated
Member Drug Use	Medication adherence rates, and therapeutic duplication rates
Prescribing Practitioner Patterns	Patterns and details member claim detail based on prescriber
Polypharmacy Reporting (including, but not limited, to antipsychotics, controlled substances, and HIV)	Identifies potential member referral to care management for engagement and outreach or potential prescriber intervention via Pharmacy Advisor safety program
Prescriber Abuse Analysis	Identifies potential cases of health care providers overprescribing or exceeding cumulative quantity limits for controlled substances
Therapeutic Category Drug Usage	Provides top 10 and 20 drugs in each drug class
Cost Trends	Identifies areas of change within the cost and utilization patterns of medications either filled by members or prescribed by specific physicians or practice groups
Safety and Monitoring	Reviews of controlled substance claims quarterly to identify potential misuse and inappropriate claims
Psychotherapeutic Medication Utilization Review	Monitors psychotropic medication prescribing patterns. Pharmacy reports are combined with medical claims data to identify members on psychotropic medication not receiving non-pharmacologic services.

Armed with medication use and prescribing data, Aetna's clinical pharmacy staff works closely with our Health Services, Care Management and Quality Management departments to collaborate and exchange ideas on programs used to improve member and provider access and use of medications and services. When we are faced with a challenge such as polypharmacy or appropriate use of psychotropic medications, we convene our interdisciplinary team to identify and implement solutions. All departments proactively share data and resources to address the challenges and improve health outcomes for our members.

A program that demonstrates the pharmacy team's integration with our Health Services and Care Management teams and our providers is the **Aetna Medicaid Pharmacy Hospital Readmission Reduction Program.** This program utilizes clinical pharmacists in collaboration with providers and care managers to perform medication reconciliation and review after members are discharged from the inpatient setting. The clinical pharmacist is connected with member and their family in need of transition of care medication reconciliation by Aetna care managers and clinical staff. Additionally, our clinical pharmacist reviews facility discharge reports, care manager notes, and targeted medication profiles to identify members in need of assistance with medications. The clinical pharmacist then outreaches to members so they have access to and understand their medications and how they should be taken. If needed, the clinical pharmacist will engage member's medical and/or behavioral health providers to determine the appropriate medication regimen and treatment plan for the member. When appropriate and if needed, the clinical pharmacist will engage with retail pharmacists to assist with a member's transition to home and long-term medication needs.

As of July 2019, approximately 6 months into the program, our clinical pharmacist reviewed and acted on 10 inpatient discharged members age 7-17 years old. The Pharmacy Medication Management Program clinical pharmacist collaborated with an Aetna care manager on the members care. Medication therapy concerns were identified and addressed with members and providers; concerns included adherence and gaps in care (62.5 percent), drug age concern (6.3 percent), indication concerns (12.5 percent), and formulary opportunities (18.7 percent).

Helping and Educating a Family Post-discharge

Within 7 days of inpatient discharge, our clinical pharmacist assisted a 17-year-old member, Mary (not her actual name) and her mother with her medications; aripiprazole and citalopram which are being used for major depression with PTSD due to recent sexual assault. Upon discharge, Mary received her citalopram. However, the aripiprazole prescription required prior authorization for coverage to ensure safe and monitored use of this antipsychotic medication. Mary's mother informed the pharmacist that after discharge Mary's therapist, Mary and mom decided to hold off on continuing the aripiprazole and to implement behavioral and lifestyle changes to remove some of Mary's stressors. The pharmacist explained that if restarted, aripiprazole would require a PA for coverage and explained the pharmacy PA process to the mother. The clinical pharmacist offered to speak with Mary, her mother, and Mary's provider about medications that could be considered in the future. During the call the clinical pharmacist discussed with Mary and her mother the importance of taking her citalopram daily and being patient because it may take up to 4 weeks to see improvement in symptoms; the pharmacist cautioned Mary that stopping the medication abruptly could cause a recurrence of severe symptoms as well as anxiety and agitation. Mary's mother confirmed that she gives Mary her medications and watches her take them. The pharmacist answered the mother's questions about the therapist's comments about medication "trial and failure" and that time will be needed to find the medication that works best for Mary. At the end of the call, the pharmacist provided Mary and her mother contact information for Mary's Aetna care manager and explained that Aetna has resources available to her, her family and her daughter. Additionally, the pharmacist documented the discussion in our care management system and shared information with Mary's Aetna care manager.

Prospective DUR: The ProDUR program enables us to achieve improved health outcomes and quality of care and reduce costs by preventing inappropriate or unsafe drug prior to dispensing dispensation at the point of sale.

We use a systematic, ongoing process to review the prescribing and dispensing of medications that preserve member access to clinically appropriate medications. Our approach involves a comprehensive review of the member's medication history including SDOH barriers and family support status, before and during dispensing to achieve an appropriate therapeutic regimen and positive member outcomes. Aetna follows the guidance of our National P&T committee and Drug Utilization Review Board which meets quarterly, and reviews efficacy, waste and cost. We work collaboratively with our PBM to review utilization reports to identify provider and pharmacy anomalies.

Aetna utilizes evidence-based, quality driven, and safety messages at the pharmacy to **decrease waste and harm to members**. Our 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.

Our edits comply with 42CFR§456.705. Edits currently in place for our members that resulted in messages that needed to be addressed by pharmacists include the following:

- Dose check, max dose, and low dose alert
- Drug-age, drug-disease, drug-drug interaction, drug-gender, drug-pregnancy

- Excessive duration alert
- Ingredient duplication, therapeutic duplication
- Concomitant therapy edits for high risk medications exceeding a duration threshold
- Multiple pharmacies, multiple prescribers
- Under use alert

Retrospective DUR Strategy and Programs: To support a comprehensive retrospective DUR process for all members and prescribers, our West Virginia pharmacy director and clinical pharmacist (using pharmacy claims data) collaborates with our CMO and Quality Management and Utilization Management teams to monitor and analyze utilization patterns and trends through reports generated daily, weekly, monthly, and quarterly; these reports have detailed claim information, comparative data points, and summary trends. Our program identifies opportunities for improved member care by ensuring clinically appropriate drug therapy is utilized and meets the members and providers therapy goals. Additionally, our Safety and Monitoring Program, which is a retrospective program, serves to reduce instances of fraud, waste and abuse through regular claims monitoring and timely interventions **[BA085, BA086]**.

Based on the clinical teams' assessment of our members and prescribers needs for safer medication use, we deployed programs provided by our PBM and programs developed and vetted by the Aetna DUR Board. These programs are coordinated and integrated to maximize outcomes. Examples of the PBM Safety program's recent activities and results are:

- The Retrospective Safety Review program acts as safety net for situations that may have a negative clinical impact on a member. Prescriptions are reviewed daily for serious drug-to-drug interactions, including polypharmacy **[BA085]**. The prescriber is notified with an actionable communication within 72 hours of the claim processing. This program provides near real-time review and intervention focused on increased member safety and increased prescriber engagement.
- Between May 2018-April 30, 2019 in one of Aetna's Medicaid plans that serves over 5,700 foster members, 24 member drug interaction alert opportunities were sent to prescribers within 72 hours of fill; a 22 percent prescriber response rate noted that prescribers found intervention information useful 26 percent of the time, and no providers found the alert not useful.

Based on our members needs related to medication adherence and gaps in care across targeted chronic conditions (i.e., asthma, diabetes, behavioral health conditions, etc.), the Aetna Pharmacy team utilizes programs supported by our PBM, and programs supported by the Aetna Pharmacy Medication Management Program (PMMP) team that focus on identifying and alerting providers via written and verbal communications to adherence concerns or gaps in medication therapy.

From October 2018 to June 2019 our PBM, on behalf of one of the Aetna Medicaid plans providing care for 5,700 foster children, 159 foster children member adherence concerns were successfully delivered via fax to providers. The most prevalent interventions were members stopping therapy for depression, mood disorders, and asthma. Specific member cases were referred to Aetna care management for follow-up.

Starting in October of 2018, Aetna's Asthma Medication Ratio (AMR) DUR Program approved by the Aetna Medicaid DUR board was implemented by our PMMP clinical pharmacists for our Medicaid plans. This program is designed to improve Asthma Medication Ratio (AMR), a NCQA-HEDIS measure that evaluates adherence to asthma controller medications by members with persistent asthma. In this program we identified all members including our children youth members not utilizing controller medications consistent with guidelines and then implemented clinically appropriate next steps to engage members, their families or care givers, and providers to improve the management of asthma consistent with national evidence based clinical guidelines.

In late fall of 2018, the Aetna PMMP team conducted the following interventions:

- Educated **1,020** providers representing 1,079 members via a call to action education fax which included the prescription fill history for their patients with a suboptimal AMR.
- Educated **248 members and families** on appropriate asthma management, including medication use and strategies to improve adherence using numerous education modalities and combinations (e.g., member care manager assignment, and a clinical pharmacist conducted member education via a phone consultation). Additionally, **198 members received education from our PMMP clinical pharmacist, and 50 members worked with an Aetna care manager.**

Outcome measurements included the following:

- Ninety-five members achieved and AMR greater than or equal to 0.50 after program intervention by the care manager, provider and/ or PMMP clinical pharmacist
- An average percent change increase in AMR of 8.9 percent across all intervention types and combinations was observed. For members who received a clinical pharmacist intervention, a weighted average AMR increase of 15 percent was observed which demonstrates the impact of a pharmacist, member and provider working together to improve asthma management.
- Due to medical claims time lag, the results of a six-month pre/post intervention analysis of impact on ER, and inpatient utilization ('all cause') and pharmacy utilization is still in process.

Additionally, our pharmacy director, working collaboratively with our CMO and clinical staff, has developed a targeted, systematic, and ongoing process of detecting and taking action on drugs of concern. Aetna **monitors the utilization and prescribing of psychotropic medications (including for members under 18), including controlled prescription medications and polypharmacy for members via a monthly claims report from our Pharmacy department.** The CMO and the pharmacy director use the RX Opioid High Utilizers Report and the RX High Utilizers Report, in collaboration with care management staff, to complete a clinical pharmacy review of all members during the member's initial evaluation and care planning process. The intent of this review is to identify members with several prescribed medications in the same or similar drug class along with more than two prescribing practitioners to determine potential safety and drug interaction/risks. Members identified with safety concerns are outreached by care management for a medication review, identification of intervention and communication with prescribing practitioners on identified prescribed medication concerns. The members identified with safety concerns are reviewed at least semi-annually thereafter. Findings are discussed by the health plan care team and follow up initiated as indicated **[BA085, BA086]**.

Polypharmacy: Our Quality Management department identifies foster care and adoption assistance members prescribed antipsychotic medications. When multiple antipsychotic medications are prescribed, our care coordinators perform targeted outreach to the member's State guardian and/or foster parents/caregivers to provide education, determine if the member is having any medication related problems, and to ensure that behavioral health therapy services are in place. Aetna's West Virginia behavioral health medical director and/or clinical pharmacy advisor also outreach to the prescriber to provide consultation and education on appropriate parameters for psychotropic medication use. Our pharmacy analytics for the West Virginia program focus care to the person-centered needs of the child or youth. Our data analytics also include algorithms to identify inappropriate prescribing in response to trauma and other behaviors commonly experienced by children and youth engaged in the child welfare system and identify gaps in appropriate prescriptions. Our enterprise-wide data warehouse includes information from multiple disparate data sets and analytic and reporting tools support this capability. Through system flags, we notify the child/youth's assigned care coordinator so that a multidisciplinary care team meeting can be convened, including our pharmacist and medical director to discuss options. Based on the issue, our pharmacist and medical director may reach

out directly to the prescriber to expedite a treatment change or medication refill to promote continuity of care and stability for our West Virginia Children and Youth program members.

To expand on this initiative, Aetna will be creating a dashboard to monitor the use of psychotropic medications in children and adolescents in the West Virginia Children and Youth program and of those who are receiving behavioral health care services. The dashboard will have the following features:

- Include tracking and monitoring of lab tests and key health indicators
- Produce annual reports can to analyze progress in closing health care gaps
- Serve as a quality improvement tool to look at outcomes of health care and psychotropic medication improvement

Psychotropic medication utilization review (PMUR) plan: Aetna has created steps to monitor psychotropic drugs and prevent unsafe and inappropriate utilization for our West Virginia Child and Youth program members. We currently perform PMUR via our retrospective DUR reports and prospective DUR programs. RetroDUR occurs via reports generated quarterly, although each report is continuously monitored throughout the quarter for members that trigger specific criteria antipsychotic medication use triggers. ProDUR occurs at the point of sale via our pharmacy benefit manager's adjudication system on psychotropic medications filled by our members. When any anomalies are identified, Aetna's CMO, pharmacy director, or clinical pharmacist will review prescribing patterns to identify opportunities for provider consultation via letter, fax, or peer to peer telephonically. Outreach and collaboration with any and all providers, and other pertinent parties associated with the care of our member is conducted to ensure the member and family have access to the appropriate resources needed to positively impact the members' care and meet their needs. Through these interactions, we have successfully modified members' medication plans by educating providers about safer options in their behavioral health medication regimens. **[BA086]**.

Our PMUR program is modeled after the Children's Healthy Administration of Medications Monitoring Program, which Aetna implemented in Florida. As described previously, Aetna utilizes a multidisciplinary innovative team approach to review prescriptions for psychotropic medications used by our children. By using our prescription claims data and established protocols any member meeting the following criteria will be identified and submitted to our multidisciplinary team:

- Any psychotropic medications in a member less than 6 years of age
- Antidepressant, atypical antipsychotic, or mood stabilizer prescriptions in someone 6-12 years old
- Psychotropic prescriptions with no documented BH visits
- Two or more psychotropic prescriptions under the age of 18
- If a member fills a psychotropic medication for 3 or more months with no BH visits

The multidisciplinary team includes our medical director, behavioral health medical director, care manager, behavioral health care manager, pharmacist, and utilization management clinician. The identified member and family will receive outreach from the care manager to review current services and assess for any need. In addition, the member will be connected to a behavioral health specialist, if not already done, and provided continued follow-up based on the member's needs. Additionally, the care manager will coordinate the delivery of specific education around each member's specific medications and proper monitoring of associated labs, if indicated.

Interventions that drive collaboration and appropriate prescribing: Aetna's clinical pharmacists work in collaboration with our West Virginia members, their providers, the Integrated Care team, and the Care Connection team to deliver comprehensive medication management. When medication issues and concerns about polypharmacy are identified, a collaborative systematic process is initiated by which medication regimens are reconciled, 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), guardians, and caregivers. 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.

Aetna proposes to continue developing interventions that foster collaboration in the medication management process and improve treatment outcomes. We will achieve this by creating a mental health consultation program to provide prescribers with access to child and adolescent psychiatry/clinical pharmacy expertise. This approach will enable the following:

- Make available continuing education for prescribers via webinars on best practice standards about psychotropic medication utilization and trauma informed care to educate PCPs, which can be archived and utilized after live events
- Develop in-person and on-line training modules on the appropriate use of psychotropic medications for Department caseworkers, birth parents, kinship and foster parents, courts, and judges
- Expedite medication prior authorizations for members discharging from inpatient psychiatric hospitals
- Develop protocols on appropriate psychotropic medication prescribing for West Virginia members

Aetna recognizes the importance of reducing the use of multiple psychotropic medications in children and adolescent populations. Aetna offers support to our members and families through the collaboration of our clinical pharmacy advisor working with community-based pharmacies experienced in supporting the pharmacy needs of children/youth engaged in the child welfare system. In collaboration with Aetna's adult and child system of care administrator, behavioral health medical director and clinical pharmacy advisor, we will develop protocols to guide their relationships with our West Virginia Children and Youth program members and their foster and adoptive families, supporting medication management, social determinants of health needs assessment, and care coordination.

The Aetna care coordinators, pharmacy director, and clinical pharmacy advisor have worked collaboratively to plan and coordinate care for numerous members in need of medication optimization strategies, care coordination, education on specific health topics and assistance with issues resulting from social determinants of health and health plan resource needs. Also, Aetna's CCTs, including the pharmacy director, clinical pharmacists, and medical director, conduct monthly care conferences to discuss and strategize on next steps needed to support the members we serve.

Targeted interventions: Aetna's written policies and procedures help establish consistency in the processes we use to detect the inappropriate use of psychotropic medications to treat West Virginia Children and Youth program members. For example, Aetna applies PMUR to assess member and provider psychotropic medication over-utilization patterns and to drive the development of interventions and educational activities. Drug utilization review also includes fraud, waste, and abuse prevention; identification of trends that may influence change to the Medicaid programs common list of covered drugs; and educating health care professionals and pharmacies about drug utilization. Based on the various monitoring and trend analysis described, we implement or refine interventions to further improve prescribing and utilization patterns, as well as control costs. A goal of our PMUR program is to reduce the risk of potential complications caused by inappropriate use of medications. Pharmacy claims data is analyzed to identify West Virginia Children and Youth program members whose utilization data contains psychotropic medications that may not be appropriate for their conditions and could place the member at risk. Outreach to those practitioners prescribing medications for the identified member can occur to alert them of our findings.

These interventions will include, but are not limited to, the following:

- Our pharmacy analytics team identifies outlier prescribers, including those overprescribing and inappropriately prescribing. Our algorithms will match national drug code, primary and secondary diagnosis, and place of service to support identification of use of psychotropic medications by West Virginia Children and Youth program members. Providers receive information describing the risks of use of controlled medications and psychotropic medications for this population and the benefits of non-pharmaceutical alternatives.
- Referrals to the Patient Utilization Management and Safety Committee to evaluate identified members' utilization to determine whether they are candidates for pharmacy/prescriber assignment.
- Aetna's Special Investigations Unit reviews cases of outlier prescribing to identify potential FWA. The SIU recovers identified overpayments. The SIU refers cases of FWA to the Health and Human Services Office of Inspector General for further investigation and potential sanctions.
- Communication with the CCT to coordinate medication management activities.
- Our Care Coordination, Utilization Management, Drug Utilization Review, and Grievance and Appeals teams submit quality of care referrals for outlier prescribers. Aetna's medication therapy management program focuses on high-risk members with the most complex and costly medication regimens to identify potential quality of care concerns associated with drug interactions.
- Aetna has identified events that trigger a review of the member's care to identify instances of inappropriate use of psychotropic medications. When we identify an ER visit or inpatient admission for members who are being treated with psychotropic medications, our health plan medical director confers both with the acute care treating physician and with the physician at the facility about preferred clinical practices. Our chief medical officer, the pharmacy director, or a clinical pharmacist contacts the identified practitioner for a review of their prescribing patterns.
  Outreach to the identified practitioner focuses on review of the analysis and education on appropriate prescribing practices. This information is brought to Quality Management/Utilization Management Committee for review and action, including corrective action plans, claims denial, or termination from the network. Physicians who do not respond to colleague mentoring may be brought to the attention of appropriate State agencies.

Figure 1.1-7: Aetna Support of Rex the Rx
Rex the Rx is an innovative approach in West Virginia to educating students about the dangers of misusing prescription medications and provides opportunities for both in classroom and distance education. He appears here with Aetna's own Ted E. Bear M.D.℠

Rex™ the Rx: Figure 1.1-7 shows the presentation of a sponsorship check to The University of Charleston School of Pharmacy (UCSOP) to help expand medication safety education to pre-schools in Kanawha, Cabell, and Putnam counties. **Over the past years, Aetna has provided $50,000 to UCSOP to fund the development of this innovative program.** The funding is assisting with the evaluation and further development of the Rex the Rx program. Rex the Rx teaches pre-K students about medication safety, including how to properly store medication and dispose of prescriptions (with the help of a trusted adult).

Serving members with a history of prescription drug abuse: [BA087] Aetna's approach to serving members with a history of drug abuse is member- centric and driven by the root cause of each member's unique journey. Aetna understands the relationship between early childhood adversities, substance use disorder, and involvement in the child welfare and juvenile justice system. Within the LifeCourse Model, Aetna identifies the goals and needs of the child and the family in the development of the

comprehensive care plan. Many youth have a history of significant trauma and will need access to therapists and peers to help build hope and safety in a path to recovery.

Aetna has a statewide network of behavioral health providers throughout West Virginia and understands the importance access to treatment and wrap around services is to recovery and keeping families intact. A key position in our SOC/Child Welfare program is our recovery and resiliency administrator.

- Builds supportive programs, interventions, and education related to resiliency, member advocacy, person-centered care, foster family and biological family support, recovery maintenance, etc.
- Collaborates with the network development director to coordinate peer support network and other nontraditional providers to serve children and youth
- Advocates for service environments that are supportive, welcoming, and recovery-oriented by working with providers to implement TIC service delivery approaches and other initiatives
- Collaborates with all health plan staff, children and youth, families, and stakeholders to help to ensure all members have advocacy support
- Promotes the hope and person-centered language for recovery within the health plan
- Chairs Member Advisory Committee

Care coordinators have access to numerous reports to identify members in need of assistance. Reports are run at least monthly by care coordinators. Reports include but are limited to the ER high utilizer report, opioids from four or more prescribers, three or more opioid prescriptions within 30 days, the West Virginia Opioid report and substance abuse disorder medication reports. Our care coordinators utilize information in these reports in conjunction with their review of real time emergency data to gather information on opioid or substance abuse diagnosis and then work collaboratively to engage the member and provider to ensure our member has access to all Aetna SUD resources available. Dedicated SUD care coordinators are in each region. Resources offered to providers include, but are not limited to, Mental Health First Aid training, trauma-informed care training, and education on MAT available to our members in need.

To facilitate the identification of members who are transitioning into the Aetna plan with a history of prescription drug abuse, the Aetna team would need the member's most recent assessment and ISP. From the Department, Aetna would need: any applicable discharge reports; targeted medication profiles of at least 12 months of pharmacy claims data; medical and/or behavioral health provider information; pharmacy provider info, and any applicable medical records available, including counseling information.

Our approach to identifying, enrolling, and encouraging compliance with **Aetna's Supportive Managed Care Program**, includes the use of data analytics to identify members, and participation in our integrated care management program for care coordination support and compliance monitoring. The SMCP targets members utilizing 5 to 10 different pharmacies and/or 5 to 10 different prescribers during a quarter and works to put pharmacy and prescriber assignments in place to coordinate their care and access to medications. The program assists members with better self-care management thereby increase their well-being.

Identifying members for participation in SMCP: Each month, members are identified using criteria to evaluate potential high-risk behavior and overuse and/or misuse of prescriptions and/or services, including, but not limited to, controlled substances and non-emergent care provided in an emergency setting **[BA087]**.

A member may be placed in the SMCP if within one consecutive 180-day period the member meets at least one of the following criteria. Please note that this includes a three-month lag of paid claims data in order to give claims time to process. The Lock it Up program is a part of Aetna's national campaign to fight the opiate crisis. This harm reduction intervention is used to support safety by providing members 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, or even accidental death. Members identified via analytic criteria are automatically

placed into the SMCP and given the opportunity to appeal the decision. When the appeal timeframe has been exhausted, the member is assigned a PCP, pharmacy, and/or hospital. Members will not be placed in SMCP until the member's appeal timeframe has been exhausted or the appeals committee decides there is sufficient documentation that supports the member not being placed into the program.

Enrolling members in the SMCP: Enrolling members in the SMCP follows Aetna's Care Connection team and interdisciplinary care team approach described throughout this response. Upon identification of a member who meets analytic criteria detailed previously, the member's primary care coordinator works with the member to make sure they know who their assigned PCP is, have a designated pharmacy or are referred to the State for designation to a local pharmacy. The care coordinator also makes sure the member is aware of their designated hospital for non-emergent care. The PCP, designated pharmacy, and hospital assignment focus is continuity of care and care coordination. This process considers the needs of the member and the importance of maintaining the member's established relationship with the PCP. Any PCP willing to manage the care of our members who are in the SMCP must ensure that the member is able to receive necessary care, including prescriptions from other specialty providers. For PCPs providing medical management and care management, this is communicated with the health plan which then allows the specialist to be compensated for their services **[BA087]**.

The process for enrolling members in the SMCP includes the following steps:

- Members to be enrolled in the SMCP are provided with written notice of their enrollment in the program.
- Enrollment in the SMCP is effective within 60 days from the date the member is provided written notice.
  - Members who meet criteria receive an initial SMCP notification letter by the first of each month.
  - The initial SMCP notification letter includes a description of Aetna's SMCP, the member's assigned PCP, pharmacy, and hospital, their SMCP effective date, and information on how the member can file a grievance, appeal, or State Fair Hearing.
  - The initial notification also includes a description of the integrated care management program, contact information for the member's care coordinator and, information concerning the member's time in the SMCP in the event the member chooses to not actively participate and engage in integrated care management.
- Within 30 days of the initial SMCP notification letter being mailed to the member, a care coordinator contacts the member telephonically to educate them on the SMCP program, the assigned PCP, pharmacy, and/or hospital. The ICM program consists of scheduled calls at least on a monthly basis with a care coordinator who coordinates care for the member consistent with established treatment and care plan goals set by the member's PCP and, if appropriate, behavioral health provider in coordination with the SMCP team, Aetna care coordinator, and member.
- When a member is successful in completing their care plan resulting in a decrease in utilization, the member is reviewed after a minimum of 12 months duration in the program.

Member compliance with SMCP requirements: Through our management of the SMCP, we have learned that successful member behavior change is typically achieved in 24 months; however, we recognize that some members embrace positive health changes. When a member demonstrates positive changes, we allow them to graduate from the program in advance of the 24-month timeframe. If a member fails to remain actively engaged in SMCP, the member's time in the program will be extended to a minimum duration of 24 months with annual reviews **[BA087]**.

Dental Services

BA094	The Vendor should provide dental services for Individuals under 21 years of age as covered services in an amount, duration, and scope to achieve the purpose for which the services are furnished, tor applicable populations.	The Vendor should describe how it will meet this specification.

BA095	The Vendor should remind members of upcoming initial and periodic dental screenings, for applicable populations.	The Vendor should describe the mechanisms it will use to meet this specification.
BA096	The Vendor should make arrangements with Inpatient and outpatient facilities for the provision of dental services to members with special needs, for applicable populations.	The Vendor should describe the arrangements it will make to meet this specification.
BA097	The Vendor should monitor dental screening utilization on an ongoing basis, for applicable populations.	The Vendor should describe the process and mechanisms it will use to meet this specification.
BA098	The Vendor should intervene if a member has not had a dental screening in over one year, for applicable populations.	The Vendor should describe how it will meet this specification.

Aetna care coordinators will collaborate with representatives from SKYGEN, our dental subcontractor, to make sure children involved in the child welfare system in West Virginia have access to appropriate and timely dental care. Currently, **Aetna is the only MCO in West Virginia that has a full-risk contract with SKYGEN.** We are also the only MCO to participate in standalone forums with SKYGEN in which their field representative is onsite with Aetna staff and our providers to answer and questions or concerns related to pediatric dental services. All departments within Aetna are represented and information is presented to assist with systems, provider incentives, member incentives, claims, issues, and any other topic that the provider requests. This has been an ongoing collaboration since 2017.

SKYGEN's dental benefits software platform has been powering their success since their founding in 1993. The system was built from the ground up to administer Medicaid dental benefits. SKYGEN serves over 11 million Medicaid members, with operations in 50 states, the District of Columbia and Puerto Rico. SKYGEN understands the challenges of administering Medicaid programs, and the Enterprise System has built-in features and functionality specifically designed for budgeted health care. Value-based reimbursement is native in the platform, including global budget allocation, capitation, encounter fees, and bundled payment administration.

[BA094] Dental Services for Individuals Under 21 Years of Age

Oral health is critical for complete health, school performance, and especially important for our children that move often to ensure habits are developed early in life. Early intervention and prevention for our youth is primary to oral health. Aetna has had significant success with HEDIS Children's Annual Dental Visits for ages under 21 and understands the importance of closely monitoring children and youth in the foster program.

In 2018, Aetna's HEDIS rate for Children's Annual Dental Visit (members 0-21 years old) in West Virginia was 63.06%, exceeding the goal of 54.93% (Quality Compass 50th Percentile), by 14.80%.

SKYGEN has 25 years of experience working in dental services, including care management to Medicaid or the Children's Health Insurance Program. SKYGEN supports and works to increase utilization of EPSDT screening services and any necessary diagnostic and treatment services for members under the age of 21. SKYGEN will promote EPSDT utilization for children and youth involved in the child welfare system in West Virginia by providing the following services:

- Assisting members with finding an appropriate in-network dental provider
- Assisting members with scheduling appointments
- Assisting members—or heads of household, caregivers and guardians—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 regarding members who are due or overdue for their EPSDT appointment based upon their birthdates and utilization data

- Collaborating with the dental director and the regional Care Connection team if any medical or other complex needs are identified for our members
- Provide data to enhance our FamilyConnect platform for a single care plan for our members

Additionally, SKYGEN actively promotes family involvement in using dental home EPSDT services and achieving good oral health. In our medical home strategy, we will be evaluating opportunities to expand dental into integrated medical homes in the state. To encourage the use of EPSDT services and to achieve the goal of ensuring that children receive age-appropriate comprehensive dental services, SKYGEN's member education and outreach materials for the Specialized Managed Care Program for Children and Youth will include the following:

- Proactive outreach calls with follow-up written notices to noncompliant members' parents, guardians, and caregivers
- Tip sheets for distribution from providers' offices, local service agencies, health clinics, and other community-based health care locations
- Referrals to the Care Connection team to assist members/families with any identified obstacles to care

Aetna supports member needs for regular dental care and maintenance and helps providers understand the importance of oral health.in every primary wellness exam and transition. Aetna's regional CCCTs provide education and attend community events to enforce the importance of oral health to our members and families in the communities where they live. Dental data is fully integrated into our single FamilyConnect record and is available to our members and families, with appropriate authorizations, on an as needed basis. Our goal is to limit the possible barriers to care and improve regular prevention and early intervention. Aetna also understands the relationship between dental care and substance abuse and has begun to focus on dental prescribing patterns as well as an acute focus on the oral health of our SUD members. Many individuals with a history of substance use disorder first experience with opiates occur at their dentist's office and Aetna's campaign works with prescribing doctors to educate on best practices and identify any serious outliers.

As described, Aetna has been collaborating with our dental subcontractor, SKYGEN, and the national Aetna Medicaid organization to address the prescribing patterns of our dentists. We have begun a peer-to-peer dental letter and notification campaign to identify outlying prescribers and make recommendations based on national prescribing standards. In addition, we offer providers educational opportunities and data to assist in how they address their patients.

Our goal is to assure continuity in dental care. We understand that many of our Medicaid members in the child welfare system often change addresses or struggle with social limitations to care. Aetna has coverage for NEMT and works collaboratively with SKYGEN to assist members in transition.

When member location changes are noted on the daily eligibility file or through Department notification, we use geo-access tools to evaluate the member's access to their dental provider within one day of notification. During that same day we notify the Department caseworker, caregiver, foster parent, or member if the dental provider no longer meets access standards. After receiving notification, these individuals have two days to choose a dentist. If no dental provider is chosen within three days of identification of the demographic change, Aetna will apply the auto-enrollment process.

[BA095] Reminding Members of Upcoming Initial and Periodic Dental Screenings

SKYGEN and Aetna, through the integrated care management program and our local CCTs, will provide a combination of written and oral methods designed to effectively inform members, their families, their foster care parents, and Department caseworker about upcoming initial and periodic dental screenings. Aetna's integrated care management approach combines both medical and dental outreach services together to provide whole person care. SKYGEN leverages multimodal communications strategies to notify members of

upcoming and periodic dental screenings for applicable populations, including IVR outreach campaigns and education materials for members.

SKYGEN customer service representatives (CSRs) also make available a member call center to educate members who contact the call center for assistance with making appointments. During the call, the CSRs take the time to educate and remind the member of the importance of keeping appointments and their responsibility for calling the dental provider to reschedule if they cannot make their appointment. This messaging is included in the member handbook, member portal, and member outreach materials.

The SKYGEN member portal can be configured to display translated education and outreach text to accommodate a greater diversity of members. The member portal supports the 10 most popular languages spoken in the United States. Additionally, all member materials, including materials available on the member portal, are written at no greater than a 6th grade reading level.

[BA096] Making Arrangements for the Provision of Dental Services to Members with Special Needs
When communicating with and making arrangements for members with special health care needs, guardians, and system stakeholders about enrollment to a dental provider, Aetna's care coordinators encourage the identification and consideration of past trauma, including dental trauma, the member's cultural beliefs, and environmental/office needs. As an example, if a member has autism or a developmental disability, 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 needs. Our care coordinators conduct warm handoffs to the dental subcontractor to obtain further support. Care coordinators will also coordinate care between dental providers, Department caseworkers, foster parents, adoptive parents, the member, and other dental professionals. These coordination efforts are vital to ensuring that the member receives all necessary dental services and that all services are provided in a trauma-informed and trauma-sensitive manner. SKYGEN's local provider representatives will provide trauma-informed care training for its participating dentists, with support from Aetna staff, as necessary.

Our dental benefits administration subcontractor, SKYGEN will also explore the possibility of membership to the Mid-Atlantic chapter of the Prevent Abuse and Neglect through Dental Awareness (P.A.N.D.A.) coalition, as recommended by the West Virginia Oral Health Program's *Oral Health State Plan 2.0*.[11] P.A.N.D.A engages dentists and dental professionals in identifying child abuse and neglect, domestic violence and human trafficking. SKYGEN provides professional development for our network dental providers on topics like precipitating causes and contributing factors to child abuse and the clinical signs of abuse and neglect.

Aetna care coordinators will work with our dental contractor who will provide outreach and education, help members schedule appointments, and provide mobile clinics to increase access to and utilization of preventative care for children in the child welfare system. The dental contractor offers specially designed dental materials, ER diversion, and intravenous sedation when appropriate for the members.

If the SKYGEN 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 CSRs can assist these callers. The CSR can call the provider's office on behalf of the member to confirm that the provider serves individuals with special needs and treats the member's specific special need(s). Additionally, the CSR will confirm that the provider sees members in the appropriate inpatient or outpatient facility, and that the facility has the necessary accommodations for the member. There are designated inpatient facilities in the network that can provide dental services under anesthesia or sedation for children who are unable, due to their special need, to be served in a general dental office. SKYGEN currently perform services under sedation or anesthesia for

[11] http://wvohc.org/wp-content/uploads/2015/06/2016-2020-WV-OH-Plan-2.0_FINAL.pdf

members who require dental services provided in a hospital or inpatient setting. The CSR can also assist with scheduling the appointment, as necessary. SKYGEN and Aetna know that members have the best experience when their dental and medical needs are coordinated in an integrated approach to care. This model of care coordination provides a more seamless, cohesive experience for members and their guardians.

[BA097] Monitoring Dental Screening Utilization on an Ongoing Basis

Dental gaps in care are monitored on an ongoing basis by Aetna's Quality Management Outreach team through our electronic care management system. Members identified in need of a dental exam are assigned to a quality management outreach coordinator for telephonic outreach, and assistance with finding a provider, and coordinating transportation, if necessary.

SKYGEN develops specific reports to monitor and analyze dental screening utilization and a periodic (monthly/quarterly/annual) analysis of demographics, claims, and encounter data to identify high-risk populations within the membership. Upon implementation, SKYGEN will work closely with Aetna to define the required data, and data integration strategies, needed to appropriately monitor dental screening utilization on an ongoing basis. Aetna works with our dental subcontractor to define the specific reporting and analysis requirements and develop custom reports accordingly during implementation. Within our Family Find program in our care management platform our families' integrated care record is developed and stored and includes the entire oral health history of our members.

[BA098] Intervening if a Member Has Not Had a Dental Screening in Over One Year

Aetna collects information about members' dental screenings and access to dental care during the initial HRA as well as EPSDT screenings and with each of a child's transitions, including home to home and hospital to home. Aetna's CCT identifies dental gaps in care and collaborate with the ICT to address them as part of the care planning process, particularly for new members. We are regularly evaluating access data, ER data, and claims to better understand the gaps in some of our most remote areas. Our Quality Management Outreach team conducts data analysis on claims and encounters to determine service areas with the highest volume of care gaps. The Quality Management 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 and invite them to the dental clinic, educate members and families, and offer a $25 gift card for attending an appointment. If members decline the offer of a visit to the dental clinic, Aetna's quality management outreach coordinators provide education on the need of dental exams. These educators understand the complexity of our members' lives and offer an option for preventive and acute care using trauma informed principles and provide our families with regular communication and local care with our Care Connection teams.

Aetna encourages members to join our Ted E. Bear, M.D.℠ Cub Club to participate in fun wellness activities, including a dental challenge, through information provided on our member website and through care management and community outreach activities. Our Ted E. Bear, M.D. Club program mascot, Ted E. Bear, M.D. (pictured in **Figure 1.1-8**), helps Aetna support community-based events. Ted E. Bear, M.D. promotes health and wellness education that resonates with younger members. Members completing the challenge win a prize. There are currently 596 members enrolled in the Cub Club. In addition, the Community Engagement department provides dental education to various Head Start programs throughout West Virginia, including the provision of dental kits.

Figure 1.1-8: Ted E. Bear, M.D.
Ted E. Bear, M.D. visits children throughout West Virginia to promote healthy choices and activities.

SKYGEN designs member outreach programs embedded in Aetna's population health management and integrated care management programs for those members who have not had a dental screening in over one year. A typical member outreach program consists of various outreach and education including IVR calls, live agent outreach, and reminder postcards. Our dental director will lead our initiative for expanding prevention and early intervention; sharing best practices with our FQHCs, family physicians, physician assistants, and advance practice registered nurses; and providing our families with dental varnish, early access to regular primary care, and acute care.

Utilization Management System and Member Information Systems

BA019	The Vendor should leverage a utilization management system with the ability to include text fields, including, but not limited to, the following:	The Vendor should: 1) Describe the system it would leverage for utilization management services. 2) Describe that system's ability to include the requested text fields.
BA020	Clinical notes	See the parent specification.
BA021	Inpatient requests	See the parent specification.
BA022	Review criteria	See the parent specification.
BA023	Case history	See the parent specification.
BA034	The Vendor should leverage a system with the ability to maintain case history.	The Vendor should describe how it will meet this specification.
BA024	The Vendor should leverage a utilization management system with the ability to support claims payment for physical and behavioral health services by interfacing with other Vendor systems, as applicable, and Department enterprise systems, including, but not limited to, the following:	The Vendor should: 1) Describe its utilization management system's ability to support claims payment for physical and behavioral health services. 2) Identify necessary interfaces.
BA025	Medicaid Management Information System (MMIS)	See the parent specification.
BA026	Call Center	See the parent specification.
BA027	The Vendor should leverage a utilization management system with the ability to support inbound member and provider inquiries by interfacing with other Vendor systems, as applicable, and Department enterprise systems, Including, but not limited to, the following:	The Vendor should: 1) Describe its utilization management system's ability to support inbound member and provider inquiries. 2) Identify necessary interfaces.

BA028	Medicaid Management Information System (MMIS)	See the parent specification.
BA029	Call Center	See the parent specification.
BA030	The Vendor should establish interface(s) and conduct testing that meets all Department-specified interface requirements, including, but not limited to, the following:	The Vendor should describe how it will meet this specification.
BA031	Medicaid Management Information System (MMIS)	See the parent specification.
BA032	Families and Children Tracking System (FACTS)	See the parent specification.
BA033	Integrated Eligibility Solution (IES), when applicable	See the parent specification.

Aetna's robust, integrated management information system (MIS) supports the member/provider journey and increases service efficiency and effectiveness. We support this goal through both the Aetna Medicaid organization's MIS approach and our local West Virginia health plan's UM application and use of this system. The Aetna Medicaid organization has been serving the West Virginia Medicaid population since 1996,[12] and offers information systems that are flexible, scalable, and integrative. This enables our platforms to provide rules-based eligibility, enrollment, customer service, claims processing systems, and web-based care management applications that serve individuals and providers. Aetna augments by bringing national robust expertise, resources, and innovative data solutions. This helps solidify a member care experience that is effective, seamless, and personalized to their individual needs while supporting providers to help them achieve success in meeting their quality and cost outcomes.

Our systems and processes allow exchange of data with providers of all types, including SNS providers. All the more than 137,000 members served by Aetna are currently entered in our UM application, providing a single place to reference member information and improve the efficiency of care coordination. Furthermore, we are a leader in utilizing the West Virginia Health Information Exchange and ADT feeds from PreManage via Collective Medical Technologies to increase the exchange of data between our UM application and health care providers to foster innovative, quality, member-centered health outcomes.

Management information system: Our system is well-positioned to scale and evolve to benefit the health care and service provider needs for all members across West Virginia, including children and youth involved in the child welfare system. Leveraging our deep, local experience and national resources and expertise, Aetna delivers to the Department an inclusive suite of innovative technologies and tools to drive advanced care coordination and delivery transformation. Our proprietary system delivers best-in-class capabilities and performance using the highest industry standards, controls, business continuity, security, and redundancy features to assure the highest level of data protection. We have a national Information Technology team that supports our local health plan team to ensure our technology platform continues to deliver performance, innovation, and value in collaboration with our Department and local partners.

Utilization Management System [BA019 – BA023]: Aetna uses integrated systems and interdepartmental processes to coordinate services for a member. The UM application integrates systems for reviewing, managing, monitoring, evaluating, and improving the utilization of the care and services our members receive, including those provided by subcontractors (e.g., eviCore for pain management and high-cost radiology authorizations, VSP for vision, and SKYGEN for dental services) **[BA019]**. The program helps members and providers use appropriate care and service delivery systems, assess their satisfaction with the process, and discover opportunities to optimize member health outcomes and manage costs. It houses all clinical notes related to a member's care **[BA020],** requests for inpatient treatment **[BA021]**, and a complete case history **[BA023, BA034].** The platform is an indispensable tool to support coordination of care and transmission of health information to provider as

[12] Please refer to footnote 2.

children and youth in the child welfare system change placements, particularly if they move across counties or regions within West Virginia. The UM platform is used for children and youth involved in the child welfare system today in 9 plans across the nation, for over 20,000 children and youth.

The UM business application system has processes to accurately and timely load updated prior authorization requirements **[BA022] (**please refer to **Figure 1.1-9** for our UM data and process flow graphic). The application allows departments to share member and provider information, as necessary and authorized by the member or their family, coordinate procedures such as discharge planning, transition a member from an institutional setting back into the community, authorize post-hospital services, and follow up on complex cases or ER care. Aetna's UM business application system also provides the authorization number and effective dates for authorization to participating providers and applicable nonparticipating providers. Aetna's UM business application system stores and reports the time and dates all service authorization requests received, decisions made regarding the service requests, clinical data to support the decision, and timeframes for notification of providers and members of decisions.

All stakeholders benefit from ready access to local, dedicated, and comprehensive MIS staff expertise in our West Virginia Medicaid program. Our Aetna-designated MIS personnel participate regularly in the Department's MIS calls and other MIS-related work groups (i.e., encounters and technology calls), and adhere to the Department's policies and procedures regarding advance notification of major systems changes and implementations, and communication of changes within the MIS organization structure and prompt updates to point-of-contact information.

We are fully capable of adapting our systems to changes in business practices/policies within required timelines, and our history and experience show we stand ready to assist with any required desk or onsite readiness review.

[BA024] Other Aetna Information Technology Systems

Aetna's UM system works in concert with our comprehensive suite of information technology systems to support care delivery, claims payment, and member and provider services in West Virginia.

Claims processing system: Our claims adjudication system is a HIPAA-compliant, rules-based information processing system. It includes 28 integrated modules that maintain and process health care administration data, allowing us to increase administrative efficiency and improve the quality of care. The system contains every data element required for claims data adjudication. Our **claims hierarchical rules engine** was built with a feature-flagging design that allows us to rapidly adjust the configuration to provide flexibility while minimizing down time and providing greater platform responsiveness. West Virginia claims import rules have been programmed 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, claim adjudication edits are configured within the claims processing system to validate the accuracy and completeness of data allowing for the seamless submission of encounters. The system has over 400 business rules in addition to standard payment rules that are configured to enforce policies and procedures. **[BA024]**

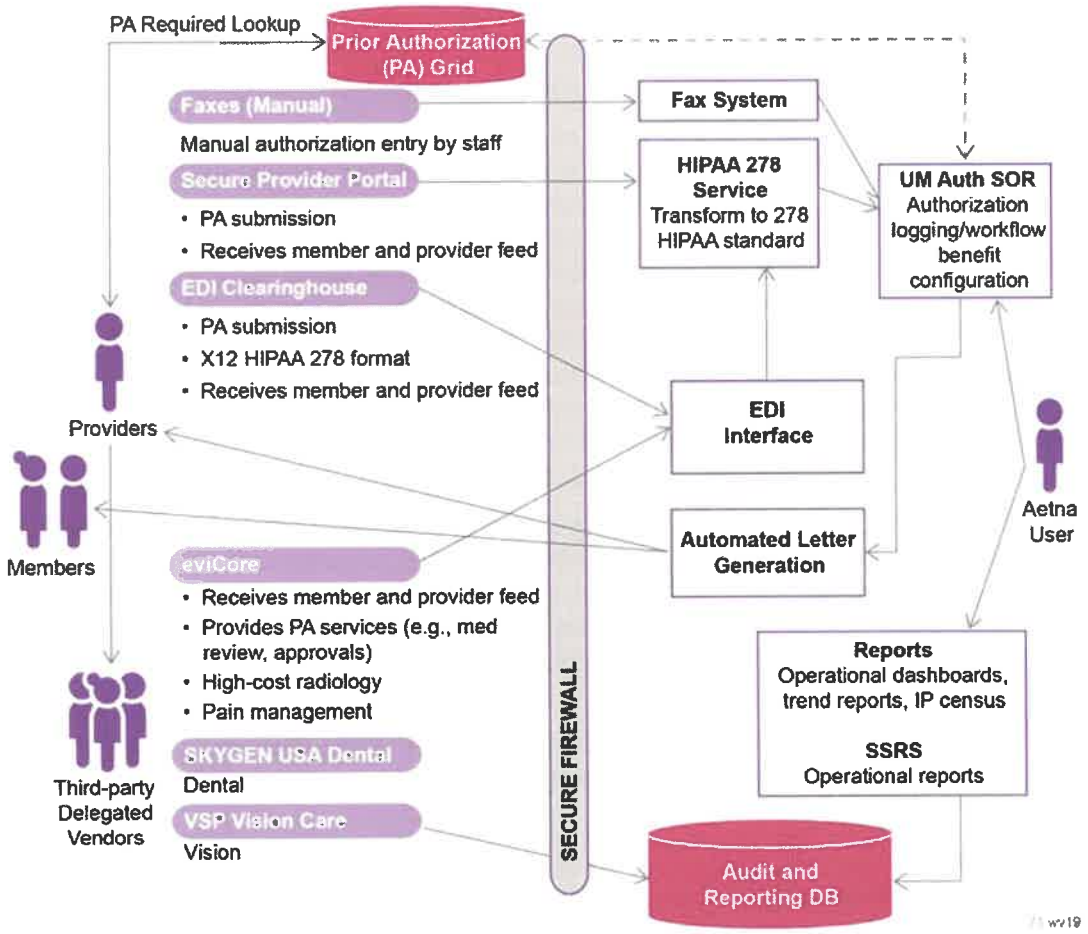

Figure 1.1-9: Utilization Management Data and Process Flow
The utilization management system captures data related to authorization requests and subsequent authorization decisions.

Enrollment system: Aetna maintains an eligibility and enrollment subsystem that updates with information received both from the State and directly from the member. This system allows Aetna to monitor enrollment and identify members requiring immediate services and/or care management and identify opportunities to engage new members and maintain continuity of care. Benefits are available immediately upon enrollment for every individual who selects or who is assigned to our plan.

Aetna has a successful 23-year history[13] working with the Department to use HIPAA-compliant benefit enrollment and maintenance (834) transactions to process and reconcile enrollment data. We follow standard, documented, and approved processes and procedures for receiving and processing enrollment data. Aetna accepts and processes the standard X12 Benefit Enrollment and Maintenance (834), Version 5010 enrollment file provided by the Department as the mechanism to update member enrollment and disenrollment information. We use membership data contained in these data files to manage eligibility, authorize services, and process claim transactions **[BA024].**

Once Aetna receives the 834 files, each member record is fed through our highly configurable rules processor which identifies matches, consolidates, and transforms the member information to ensure proper

[13] Please refer to Footnote 2.

updates to demographic, enrollment benefit plan assignments, PCP assignments, member classifications, waiver type of assistance and tiers type of assistance codes, effective and termination dates, and other critical information. Our proprietary rules engine automatically evaluates such complicated scenarios like split, overlapping, duplicate and consecutive enrollment segments and uses intelligent member matching that considers over 20 attributes to match and identify the right member, all of which increases the auto-enrollment percentages to reduce manual interventions.

The Enrollment Services team identifies, researches, and validates exceptions, making the appropriate updates in the core system and notifying the Department as required. Any manual interventions are managed by the Enrollment Services team ensuring daily 834 change files are processed in one business day. These changes trigger additional benefit changes, and they cascade to all other systems to help ensure change in member eligibility type also changes the benefits coverage. This allows consistency across systems and connects members with their appropriate program benefits, which avoids disruption in member services.

Figure 1.1-10 depicts an example of the Enrollment Manager (EM) Tool dashboard which is currently incorporated for West Virginia enrollment file process status, including displaying any file issues, where the issue has occurred, leading to quicker recovery and continuous service operations for our members. Two separate file processes are shown in these displays; the second one depicting a completion time of 19 minutes. This rapid processing time is a direct result of recent performance improvements we have deployed for all our Medicaid plans.

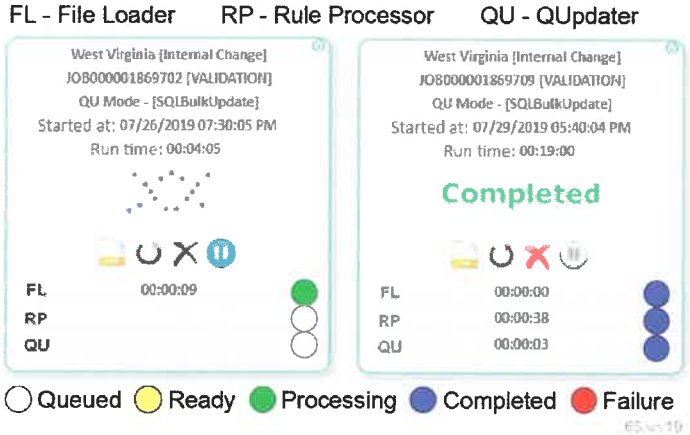

Figure 1.1-10: EM Tool Dashboard Example
Aetna's EM Tool Dashboard depicts enrollment file status for three distinct sub-processes.

Aetna understands that changes in a member's eligibility can impact continuity of care. Our Enrollment Services team meets the Department's technical specifications criteria and 42 C.F.R § 438.608(a)(3) for timely processing of member data and reflecting member enrollment changes electronically on a daily and/or monthly basis.

Encounter data submission system: Our encounter management system is an integrated, HIPAA X12-compliant, single system for encounter management that consolidates submission and reconciliation processes. It performs comprehensive encounter validation through a coordinated set of edits and validation rules that comply with State specific business rules, allowing 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 State requirements and timelines. This helps to ensure accurate, consistent tracking, trending, process improvement, data collection, monitoring, validation, reporting, and error correction. The encounter management system validates encounter files received from all subcontracted vendors (such as vision and pharmacy) for compliance using standard HIPAA guidelines, SNIP levels 1-5. 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. **[BA024]**

Care management system: The electronic care management platform is a central resource that collects and integrates data from multiple sources and for our foster children and youth we utilize our FamilyConnect

platform. The FamilyConnect platform is the location where the integrated care plan is developed and retained. Key principles and privileges allow only permissioned individuals to have access to protected information. Staff complete the HRA, comprehensive assessment, specialized screenings, and the individual plan of care in electronic formats on this platform. Our Care Connection teams utilize FamilyConnect in the regions where our CCTs and members live and can travel. The CCT has mobile devices (e.g., tablets) and can bring FamilyConnect into the field as the ISP is developed. The electronic care management platform has a built-in alert system to notify care managers when required assessment and plan-of-care updates are due if a member has a gap in care and a daily notification of our youth and children in emergency rooms (i.e., ADT feeds). The platform can generate member chronic illness education, stratify members' acuity (immediate upon assessment), and seamlessly move members along the continuum of care management tiers. The platform also stores member additional info and preferences (SDOH, other demographics, and caregiver or family information). **[BA024]**

Population health management platform: The population health management platform provides an organized look at our key populations of members, as well as each individual member, while illuminating member data and information not available in the provider's EHR. Accordingly, it supports practice and member goal achievement, such as for HEDIS metric performance, value-based contracts, transition of care management, and medication management. Utilizing our proprietary electronic population health management platform, we can view the data of children and youth in the child welfare system and previous foster youth as an independent population and as an entire population of children integrated with our Medicaid child and youth data. Specific foster care trend reports will be utilized for early recognition and quality improvement initiatives. This platform collects data, enrollment files, HRAs, care plans, member self-referral and provider referral demographics, cost/utilization reports, pharmacy data, workflows, and gaps in care in a timely manner. Aetna's population health management platform is integrated with WVHIN. This interconnectivity allows Aetna's utilization management and care management staff, providers, and other treatment teams the ability to view real-time, actionable data about a member's admissions, discharges, and treatment needs. Through our robust provider support model, we provide the resource support for system integration, education, and training on the electronic population health management platform. In working with providers who are operating with different configurations of EHR systems in the marketplace, we have found that many EHR systems are not able to connect easily to other systems. We offer our population health management platform solution to select providers as a complementary tool that is aligned with our value based contracting strategy to enhance the availability of actionable data. Where possible, we will leverage tools and technologies like our population health management platform to support providers with expanding their health information technology and HIE capabilities where appropriate and consistent with existing State and federal EHR incentive and expansion programs. **[BA024]**

Grievance and appeals: Our member appeal and grievance processes are simple and user-friendly, affording members the opportunity to voice their issues, concerns, and problems in a non-threatening manner. Our commitment to identify and resolve appeals and grievances timely helps to make sure our members, no matter their background or health condition, receive equitable and effective treatment in a culturally and linguistically appropriate manner, promoting individual self-sufficiency. Grievance and appeals are tracked and trended for early identification and any concerns can be sent to the QM Complaint or QM Appeals Committee for further evaluation and investigation into the concerns raised. If the Complaint or Appeals Committee deems it appropriate, these issues can be escalated through the Quality Management Oversight Committee to further address these occurrences.

Our grievance and appeals application is integrated into our claims processing system and is highly customizable to capture, process, store, and retrieve detailed information on each complaint, grievance, or appeal received. We do not delegate grievances or appeals processing to any unaffiliated subcontractors. Aetna's comprehensive documentation allows us to maintain and track all cases from origination through

resolution. The application is housed in a secure location with access limited to role-based authorities, which includes Aetna leadership, the compliance officer, data staff, and Grievance and Appeal department staff. The application is maintained by the Grievance and Appeal Oversight team. **[BA024]**

Aetna reviews grievance and appeals very carefully, taking account of trends, and addresses issues at the system level in coordination with Department caseworkers any time quality of care issues are identified.

Member and Provider Portals [BA027]:
For members and families: Aetna's website has a variety of helpful sections that provide information to assist members and their families in managing their health care. Features of the member portal include access to the most current member handbook, a comprehensive provider search function and directory, the formulary drug list, how to access translation and interpreter services, health promotion and education information, and much more. The member portal allows the member or their guardian/parent to communicate directly with a plan representative through email, text message, or telephone. The website is compliant with the Americans with Disabilities Act of 1990 (ADA) and meets Web Content Accessibility Guidelines (WCAG), which ensures content accessibility by everyone, irrespective of disability or age.

Aetna's secure FamilyConnect portal provides members, their foster and/or biological parents (as appropriate), the Department caseworker, and other providers with access to claims, health and wellness tools, and CaremarkPCS' member website and secure web portal services via a secured, single sign-on credential. The web portal allows individuals to determine their financial responsibility for a drug; order a refill for mail order prescription; locate a network pharmacy by ZIP code or name; determine potential drug-drug interactions, side effects, and significant risks of drugs; and determine the availability of generic products. Members can also securely review drug history information and access diverse pharmacy tools, which includes the ability to complete both electronic and telephone inquiries about their pharmacy benefit and drug coverage.

For providers: Aetna offers access to the secure provider portal, which improves efficiencies and offers complete accessibility to provider and member data and reports. The portal contains information on provider and member records, claim or authorization status, electronic explanations of benefits outlining claim services payment or denials, dates of service, procedure codes, amount billed and allowed, and amount paid, as well as the status of grievances and appeals. Providers can submit prior authorizations (including pharmacy prior authorizations) and appeals and grievances through the provider portal. This web-based platform allows us to communicate member health care information directly with providers in real time, inclusive of member assessments and care plans.

In addition, we assist providers to optimize the use of their EHR and provide technical assistance to improve utilization of information technology systems, including the Aetna provider portal, to improve provider satisfaction, health outcomes, and care integration. Technical support will aid all providers, including those providing applicable SNS, to do the following:

- Use their own systems, meeting them at their level of sophistication, including EHR support
- Manage electronic submission of claims accuracy and billing
- Leverage HIE tools and increase capability from a data perspective leveraging technology

This level of support will include advice on clearinghouse claims billing and support APM incentives. EHRs are available across internal departments and Aetna staff use them to understand better the member's medical condition and status of medication and durable medical equipment orders. We also use EHRs for gathering data related to performance measures. We generate a daily inpatient and discharge report and share it with PCPs, PCMHs, and the Department for care coordination purposes.

Medicaid mobile application: Our mobile engagement application leverages technology at the member's fingertips through Android and iOS devices, using members' at-the-moment activities and location to deliver access to care virtually anywhere. This resource is available to the parents and foster parents of our younger members after the required releases. With the Aetna mobile app, members and their approved caregivers and family members can get on-demand access to the tools they need to access their children's medical resources. For example, they can find a doctor, request a member ID card, or change their PCP at any time, from anywhere. As the application evolves, we will add functionalities to improve the member experience and care by adding options to complete health screenings and provide feedback to the Aetna care managers. Additionally, the app will be enhanced to provide claim notification information to members and will give members the option to notify Aetna if they view a claim for a service they did not incur (potential fraud flag). The mobile app is compliant with the ADA and meets Web Content Accessibility Guidelines (WCAG 2.0aa), which ensures content accessibility by everyone, irrespective of disability or age.

Aetna also offers automated functions for members through our IVR system. Our member services representatives (MSRs) and IVR track every call in a member module; if a call is not immediately resolved, a follow-up tracker is set. Call tracking queues items to areas such as appeals or to care managers. MSRs can update a member's PCP, review claims and previous interactions, update addresses and phone numbers, and issue replacement ID cards (data is securely sent to the ID card vendor daily for fulfillment). MSRs also have access to our pharmacy benefit manager's system to assist members with real-time pharmacy questions.

Aetna is aware of and prepared to meet the requirements of House Bill 2351.[14] Aetna has an established prior authorization form that is easily accessible and identifiable through the provider portal and on the Aetna website. The website also contains information about the policies, contracts, or agreements offered and clearly defines the specific services, drugs or devices for which a PA exists. The forms include instructions for the submission of clinical documentation followed by an electronic notification of receipt of the PA. Aetna accepts PAs electronically and is prepared to respond to the PAs within two days of the electronic receipt on the PA request for all requests that are either health related or could jeopardize the life, health or safety of the member. All other PA will be responded to within seven days of confirmed receipt of request. Aetna is aware that if information provided is considered incomplete the provider is required to provide the additional information within 72 hours from the time the request is received by the provider or the PA is deemed denied and a new request must be submitted. In the case of a transition of care the services are continued for three months if the services are provided within the state of West Virginia.

[BA031, BA032] Electronic Data Interchange Interfaces

As an existing MCO for the West Virginia Medicaid program, we have an established history of creating and maintaining electronic data interchange (EDI) interfaces with all key regulatory entities' systems (e.g., MMIS **[BA031]** and FACTS **[BA032]**) and other stakeholders, as necessary. The Aetna Medicaid organization has implemented required HIPAA transactions with every State agency with which they are contracted since HIPAA's inception in 1996. We follow a secure process for all file exchange interfaces and use a Secure File Transfer Protocol server to handle inbound/outbound file exchanges.

We verify successful inbound/outbound file transmission, employ a rigorous combination of automated/manual processes to validate successful exchange of files, and notify the Department as applicable. For instance, in the enrollment process, a dashboard provides an end-to-end view of a file's status through each intake step. File monitoring software alerts automatically in the event of a failure and if a failure occurs, production support is immediately engaged to research and resolve the issue. An audit trail for all

[14] WVLegislature.gov

inbound and outbound files and data processed is generated and retained in a separate database that is retrievable for audit and compliance purposes.

Aetna has extensive experience communicating with State agencies and all external partners including stakeholders, vendors, and subcontractors. Our robust file management process ensures all department files are fully implemented and verified in our systems as well as with our subcontractors and network provides. To validate compliance with HIPAA and seamless connectivity/minimal interruption of services provided by all vendors/subcontractors, Aetna is currently in compliance with the recently released Statement on Standards for Attestation Engagements No. 18 (SSAE 18), which has enhanced requirements for adequate control environments for vendors/subcontractors.

In all data exchanges, we strictly adhere to federal and State law for securing and protecting the confidentiality of medical records. These laws include but are not limited to **42 CFR Part 2, 45 CFR Parts 160 and 164,** as well as our internal policies and procedures. Working with the HIE to incorporate data points and supplemental information protocols supports identifying challenges, mitigating risks, and being flexible in coordinating care with the Department and behavioral health and physical health providers. We leverage both provider-facing and internal coordination to improve member health outcomes. We also comply with data governance guidelines and the Health Information Technology for Economic and Clinical Health (HITECH) Act requirements.

[BA025, BA028, BA029, BA031] Medicaid Management Information System

Aetna works closely with the Department, along with its agents, to achieve both successful health care results and effective cost outcomes. Aetna follows a secure and proven process for establishing and maintaining all EDI interfaces. We utilize industry-standard secure File Transfer Protocol servers to handle inbound and outbound file exchanges. When establishing a new EDI interface, we collaborate with the State and trading partners to exchange key information required to establish the secure connection for exchanging files on both sides. These connections enable the implementation of a wide range of data sharing, including all HIPAA X12 file exchanges; examples include enrollment (834), claim payment/advice (835), health care claim and encounter (837I/P/D), prior authorization (278), and capitation premium financial reconciliation (820). In addition, Aetna supports the exchange of custom file interfaces whenever required by the Department or other subcontractor systems. **[BA025, BA028, BA031]**

Aetna also supports critical, real-time HIPAA transactions including eligibility inquiry and response (270/271) and claim inquiry and response (276/277). Additionally, Aetna continually promotes and adopts different transaction formats and protocols including HL7, the messaging standard that enables clinical applications to exchange data.

Aetna's information system design uses powerful, reliable, and expandable data processing systems. The foundation of this platform is a redundant, high-speed local area network and wide area network, with clusters of servers with built-in redundancy. This scalability allows systems to match any escalation in demand associated with the Department's, network providers' and subcontractors' performance requirements, while at the same time maintaining system uptime and performance. Our member services call center runs on a top industry-standard internet protocol switch, which maintains 20 percent extra capacity to cover any spikes and growth spurts. **[BA029]**

Medicaid Management Information System exchanges are handled by Aetna's national team, which works closely every day with our local health plan staff to ensure timely, fully compliant processing of all inbound and outbound files. Aetna Medicaid's Information Technology team takes a business-focused strategy for MIS delivery. Our team is an independent, fully dedicated organization, which serves the Medicaid quality, care, and delivery teams. Our vice president of program delivery, who has over 40 years of health care IT

management experience, leads the Aetna Medicaid organization IT team and is supported by a diverse team comprised of over 250 individuals. The team is organized around specific business functions (digital innovations, member and enrollment, provider experience, claims and encounters, clinical management, and finance and reporting), which allow IT to be nimble and flexible to address the needs of the local Aetna plan. Other dedicated teams are responsible for compliance, governance, infrastructure, global security, architecture, production support, and data and file management, which brings additional expertise to critical data-heavy functions like MMIS exchanges. These teams are fully versed in the latest data interoperability standard, including HL7 and the newer Fast Healthcare Interoperability Resources standards, and partners with the Medicaid Quality team and Aetna to identify appropriate market HIEs, electronic medical record data clearinghouses (i.e., Athena), and directly with large provider practices. The national team works in concert with a dedicated team of local West Virginia managers and support staff to ensure IT processes such as file transfers, enrollment, and claims processing, reporting, and all auxiliary systems are functioning properly and within State guidelines. Local staff works closely with the State's subject matter experts to assist in the delivery of solutions and turn the State's requirements into specific system or process designs for leading-edge solutions. The local team coordinates the integration of all of Aetna infrastructure support areas to ensure required IT resources are appropriately allocated to meet West Virginia's business objectives. **[BA028]**

[BA026, BA029] Call Centers

Aetna has significant experience running local call centers and service lines staffed with knowledgeable personnel trained to support fully the needs of members and providers. Aetna has all of the toll-free numbers necessary to support our service lines which are staffed with personnel specifically trained on the requirements, policies, and procedures of the West Virginia Specialized Managed Care for Children and Youth program (e.g., HIPAA-related concerns, SNS, and Aetna's system of care for serving youth in child welfare programs, etc.). All service lines are accessible via toll-free numbers, which are included on the member identification card, the member handbook, provider handbook, and the member and provider websites.

Our call center and member services staff are trained to use our fully integrated FamilyConnect data system and our UM platform. The calls through the call center are answered by live agents that can address claims, payment, IT, and access concerns. The call center staff also warm transfer claims and operations calls to operations team if further investigation is required. The member services representative follows the member till resolution. **[BA026]**

Located in West Virginia and open on all State holidays, our dedicated health plan customer service center is always staffed to maintain adequate capacity. Based on anticipated enrollment, we use workforce management software to forecast adequate customer service center staffing. We also cross train additional staff on West Virginia requirements, policies, and procedures to provide overflow coverage, with staff that are trained to respond to questions related to child welfare, during high volume times.

Member services hotline: To provide convenient access to treatment or services, referral assistance, and access to information about benefits or claims, our members can contact member services support 24/7/365. The member services hotline gives each member and their family access to member services representatives who work in West Virginia Monday through Saturday, 8:30 a.m. to 5 p.m. Eastern Time with overflow during high peak times handled by cross-trained staff. After those hours, the member's call is automatically transferred to our 24/7/365 national member services hotline with staff who are fully trained in

West Virginia Member Services Call Center Performance

In quarter two of 2019, we answered 13,425 calls in an average of 3.7 seconds, with service level just under 97%, and abandonment rate of 0.5%. Our single-call resolution percent was well over 90% with zero complaints related to member service.

West Virginia program requirements—which benefits members through available, reliable, and easily accessible resources any time a member calls. All member services staff, locally and nationally, can connect members to our 24/7/365 Health Information line (Nurse Line) or 24/7/365 Behavioral Health Crisis Services hotline for clinical support. Member services staff document relevant data in Aetna's UM system. **[BA029]**

The member services line adheres to all language, information, and accessibility requirements established by the Department, including the availability of interpreter services. Additionally, callers who use our member services line can indicate at the onset of the call if they do not speak English and we offer them interpretation services. We engage in 7-1-1 relay services for members who have hearing impairments. Upon request, members with visual needs receive materials and information in large print, braille, and audio. Member services line staff will be trained in topics related to the foster care involved youth, including serving members with chronic conditions, the culture of disabilities and resources available to this target population. **[BA029]**

Prior authorization line: All staff working on the prior authorization line are in West Virginia and dedicated fully to the Aetna Medicaid plan. Providers have a direct-dial number and do not go through IVR or a call tree, which Aetna instituted in response to feedback expressing a need for this. The PA line also has dedicated fax lines. Between January and June 2019, the average speed to answer for the PA line was 7.87 seconds, and the percent of calls answered within 30 seconds was 95.25 percent with an abandonment rate of 0.58 percent.

West Virginia Provider Services Call Center Performance

In quarter two of 2019, we answered 12,773 calls in an average of 12.6 seconds with an abandonment rate of 0.5%, and our Single Call Resolution percent was well over 86%.

Provider support service line: Aetna is committed to continually **improving our providers' experience** and supporting their ability to render quality-driven services to our members. West Virginia providers will have access to our toll-free **West Virginia-based** provider support service line to assist with enrollment, service authorization, contracting, or reimbursement questions or issues, and to resolve provider questions, comments, inquiries, and complaints. The provider service line will be open for in-network and out-of-network provider questions Monday through Saturday, 7 a.m.-6 p.m. Eastern Time. For after-hours calls, callers will receive a Department-approved after-hours message with instructions for leaving a message and requesting a call back, which we will return during the following business day during normal hours of operation **[BA029]**

Pharmacy support lines:

- **Pharmacy help desk and access to medications:** Aetna in collaboration with CaremarkPCS makes pharmacy help desk services available to our pharmacy and medical providers to ensure access to information on covered pharmacy products and services. Aetna provides via our PBM the operations of a toll-free pharmacy help desk 24/7/365 for access by our pharmacy providers
- **Pharmacy PA operations:** Our **local West Virginia-based pharmacy director** provides oversight to the pharmacy PA function, administered by our Medicaid pharmacy prior authorization call center in compliance with BMS requirements. Our national Medicaid team of 62 certified pharmacy technicians and 22 licensed clinical pharmacists collaborate with the West Virginia chief medical officer/medical director to complete timely reviews and determination of PA requests. Aetna's business hours of operation for our pharmacy PA call center are 8 a.m. to 6 p.m., Eastern Time, Monday through Friday. We provide a toll-free call center number where a practitioner can receive an immediate PA decision, including approvals or denials. In addition, we provide two additional methods of PA submission, electronic and fax, which are supported 24/7/365. Aetna's licensed pharmacists will consult on complex cases with the West Virginia - based medical directors before making a final determination or recommendation. The pharmacist or the medical director may contact the prescriber to discuss the case and will consult with a board-certified

provider from an appropriate specialty area when needed, such as a psychiatrist, to assist in determining medical necessity.

Health Information line (Nurse Line): Members have 24/7/365 access to medical information and advice on where to access care through our Health Information Line. This resource is valuable for parents with a child in a new placement, as they may not always be familiar with a child's medical condition and may benefit from discussion their needs with a nurse. **[BA029]**

Behavioral Health Crisis Services hotline: Aetna's **West Virginia-based** behavioral health crisis line provides members with a confidential service available 24/7/365. Aetna staffs the behavioral health crisis line with trained, skilled, **independently licensed** behavioral health clinicians who provide assistance for any type of behavioral health-related concern the member may be experiencing (refer to the section on **Crisis Services** for complete details). **[BA029]**

[BA032] Families and Children Tracking System

Aetna will meet all West Virginia requirements for interfacing with FACTS through our partnership with KEPRO, which has an established system for connectivity and information sharing. In collaboration with KEPRO, Aetna will work with the state to continue to meet their requirements and needs in a timely and efficient manner.

[BA033] Integrated Eligibility Solution

We successfully support Medicaid enrollments with Maximus, the West Virginia-designated enrollment broker, in eight additional states. Aetna acknowledges and confirms we will comply with the expectations and requirements set forth in West Virginia's Medicaid managed care enrollment and disenrollment and the managed care enrollment policies. Aetna's goal is to make member enrollment as seamless as possible by leveraging our extensive experience managing enrollment and disenrollment in our health plans across the country. Our system will be tailored to accommodate the requests and requirements of West Virginia's Medicaid managed care program, which maintains the sole authority in determining eligibility and enrollment membership, thereby creating a positive experience for members. Using our extensive experience, we consistently exceed our agreed-upon service level agreement (SLAs) for the daily and reconciliation files that we process today. Aetna is committed to the 24-hour response SLA for all enrollment-related files as published by the Department, and we accomplish an average response time that processes a file as large as a monthly West Virginia Medicaid Managed Care file of close to 130,000 records in 15-20 minutes.

[BA030 – BA033] Testing Systems

Aetna Medicaid'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 West Virginia state systems such as FACTS, MMIS, and integrated eligibility solution **[BA031 – BA033].** 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.

Our West Virginia Medicaid managed care testing is configured in a dedicated test environment that supports a wide variety of types of testing used during the project lifecycle. Each type of testing, which will be a part of our approach for the Specialized Managed Care for Children and Youth program, 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 the following State requirements: **[BA031 – BA033]**

- **Unit testing**: tests functionality and is executed by developer who builds the code or code module.
- **System testing (positive and negative)**: performed to assess the proper behavior of an application based on business requirements and application design.
- **State testing**: we exchange data file(s) with the State to validate that system changes and logic are compatible with requirements and are certified by the State. We have a dedicated team to facilitate testing between the State, vendors, and Aetna utilizing any State-specific testing tools required.
- **Specialty/performance testing:** assesses 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).
- **Regression testing**: examines the application determine if 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 file load/import, adjudication, payment check run, and encounter process).
- **User Acceptance Testing**: validates the business requirements using defined user acceptance test strategies, plans, script/test cases and verifies that the application/file(s) functions as expected, and no defects are encountered.
- **Production checkout testing**: Confirms that all application changes have been migrated successfully to the production environment and all functionality is working properly.

The different phases of all our testing components are shown in **Figure 1.1-11**.

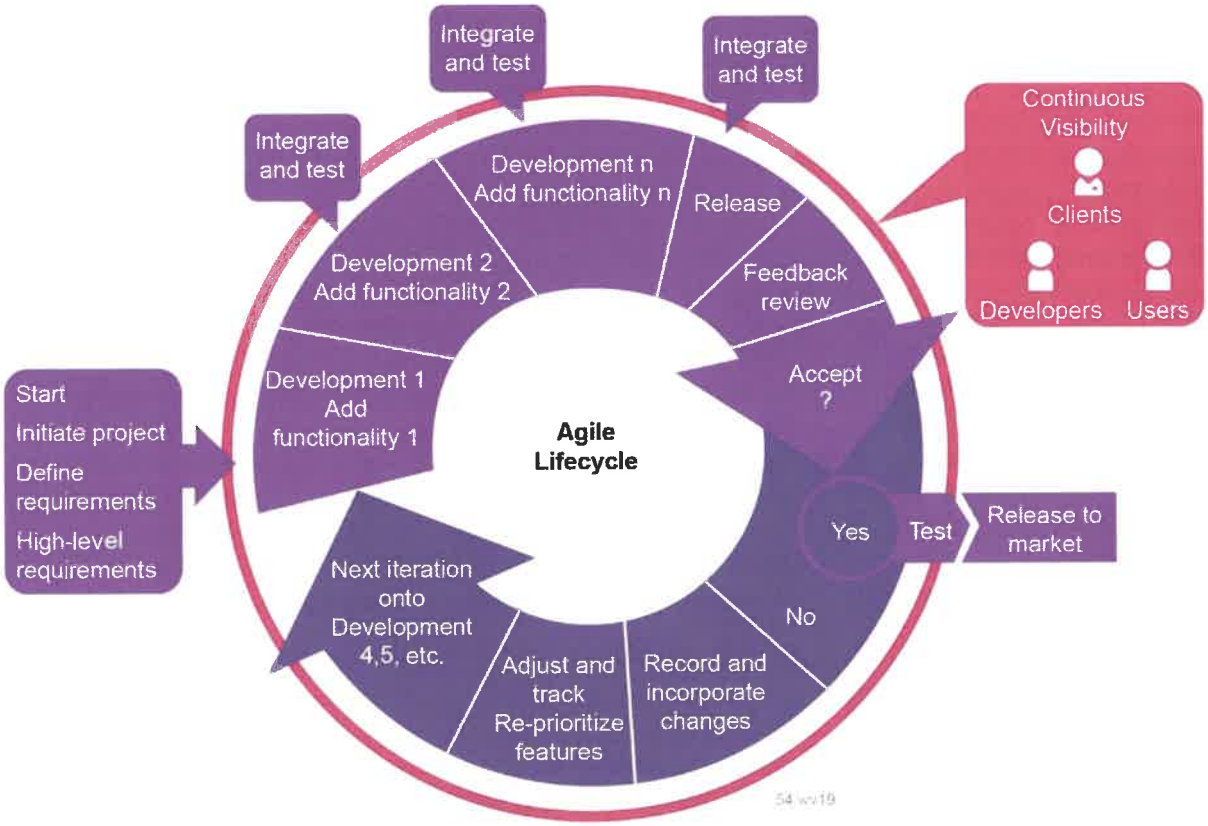

Figure 1.1-11: Aetna's Agile Lifecycle Flow
This graphic depicts the continual flow of data which allows for all components of implementation to be tested thoroughly and exhaustively, including subcontractor changes.

Our testing team leverages the latest industry standard tools and best practices. 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.

2. CARE MANAGEMENT

The Vendor should refer to the relevant specifications located in ***Appendix 1: Detailed Specifications*** (based on the categorization within Column E: Subject Matter Area) and pertinent narrative in ***Section 4: Project Specifications*** in this RFP, and then describe its approach to Care Management below. The Vendor's narrative response should not exceed 75 pages.

Since 1996[1], Aetna has been focused and dedicated in addressing the whole-person needs of children, youth, and young adults who comprise the West Virginia population. Aetna has learned in its broad experience that our members hold the solution to a good life and our job is to offer effective coordination to support them in their journey to better health and overall quality of life. We advance person and family self-sufficiency, recovery, and resiliency using child and family-centered wraparound approaches. As we will describe throughout this section, we offer excellence in our infrastructure, through **localized care management** (CM) **delivered by West Virginians as part of our regional Care Connection teams (CCT)**. We have established trauma-informed care (TIC) as a cornerstone, taking proactive measures to become a **trauma-informed care transformed organization** both nationally and at the local level. To meet the unique needs of children and young adults in West Virginia's child welfare system, we have developed innovations such as the inclusion of dedicated staff, crisis intervention specialists, who will **provide rapid response to children and families in need when children have just been placed in foster care**. Additionally, our children's resiliency building **HERO workshops (Helping Each Other/Everyone Reach Out)** offer participants education regarding the effects of trauma on health and tools that families can use to create supportive networks. We utilize a fully integrated care management framework, evidence-based assessments, and the Charting of the LifeCourse™ framework to develop care plans for all children in the foster system. We have also implemented member- and provider-friendly technology, including our **FamilyConnect** on-demand medical record data home. Our approach to supporting West Virginia children and youth in the child welfare system is based on trauma-informed care, wraparound principles, and is customized to meet the State's goals of increased access to and coordination of integrated services, improved communication among stakeholders, seamless continuity, and reduced home removals or placement changes, while maintaining the safety of the members we serve. Every step of the way, we seek to build on the individual strengths of our members and partners, and collectively we will be steadfast in our mission to support West Virginia in leading system transformation for all families.

Aetna has demonstrated success in providing similar managed care services for children and youth in the child welfare system in nine states (Arizona, Kansas, Kentucky, Louisiana, Maryland, Michigan, New Jersey, Pennsylvania, and Virginia). In our Arizona Mercy Care[2] program, we have had unique experience with children with special health care needs, foster children that have comorbid serious emotional disturbances (SED). We have increased the child welfare behavioral health (BH) service penetration rate from 39 percent in 2014 to 78 percent in 2017, and this level of penetration has since remained stable. Mercy Care also developed a plan that increased the number of completed treatment plan goals, family reunifications, and permanencies in foster placements or through adoption among

[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 was 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.

[2] Mercy Care is not a subsidiary of Aetna Inc. but is managed by Aetna's Medicaid organization.

youths in Department of Child Safety (DCS) foster care and foster care services. Mercy Care's goal was also to decrease children's time to permanency and stability by working in partnership with youth and their families to complete their care plan goals, inclusive of behavioral health, physical health, and social needs as well as treatment needs. Mercy Care took several key steps to reach these goals, including the following:

- Developed The Family Center of Excellence, a provider-based program located in an area of high-volume DCS home removals, with the goal to prevent placement in DCS or support reunification for those already in DCS custody
- Increased collaboration with DCS and local providers to improve communication and synchronize care efforts
- Increased provider co-location in DCS sites to provide more immediate coordinated response and tracking of goal completion
- Developed enhanced family engagement techniques

In Kentucky, through holistic child- and family-centered approaches which utilize interdisciplinary care teams for children and youth in the child welfare system, we offer regional locations, parent education, and tracking of appointments. These activities resulted in demonstrated increased success in the Healthcare Effectiveness and Data Information Set (HEDIS) scores for youth in foster care as compared to those for all children, as described in **Table 2.1-1:**

Table 2.1-1: Aetna Foster Care HEDIS Scores Compared to All Children, Kentucky 2018

HEDIS Metric	Foster Care Score	All Children Score	Difference
Chlamydia Screening: 16 to 20 Years	57.4%	46.6%	+10.8%
Childhood Immunization Status—Flu	53.3%	31.7%	+21.6%
Childhood Immunization Status—Combo 10	24.53%	16.46%	+8.07%
Immunizations for Adolescents—Combo 2	21.3%	18.5%	+2.8%
Childhood Immunization Status—Combo 8	30.8%	19.4%	+11.4%
Childhood Immunization Status—Combo 9	25.2%	17.2%	+8%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	3.1%	2.3%	+.8%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (note: a lower score is considered favorable)	45.0%	61.6%	-16.6.0%

Our local team will incorporate the lessons learned and best practices we have implemented in other states, as well as wraparound enhancements, while customizing our approach based on the unique needs of West Virginians. We understand that the West Virginia population faces social inequities, (e.g., increased likelihood of having experienced Adverse Childhood Experiences [ACEs], instability in parenting attachment, etc.) that affect accessing health care, achieving optimal health outcomes, and meeting personal goals for health and wellness. The 2017 West Virginia Health Disparity report noted key areas of concern for children and youth including infant mortality, low birthweight, teen birth rate,

substance use (including smoking), mental health, physical inactivity, and education.[3] According to the State Rural Health Plan 2018-2022, West Virginia consistently places last in the country with regard to many population health indicators. The state has the highest prevalence in the country of many health conditions obesity, cardiovascular disease, and chronic obstructive pulmonary disease (COPD). The state ranks second highest in prevalence of diabetes, current smokers, and depression.[4] The State Rural Health Plan identifies the following priorities to address these population health rankings:

- Improved access to health services
- Prioritization of known health conditions in rural areas
- Increased providers in rural areas and focus continuing education on rural health concerns
- Encourage citizens to be proactive in their own health care
- Promote active engagement by rural communities

There are currently almost 7,000 youth in foster care from West Virginia according to the July 2019 report from the Department[5]. Almost 7 percent, or 453 children, are being housed out of state, mainly in group homes or long-term psychiatric facilities. West Virginia has been an epicenter for the opioid epidemic with adults suffering with substance use disorder (SUD) which has contributed to the increasing number of foster children in West Virginia.

According to the January 2018 Adverse Child Experiences Coalition of West Virginia's *Stumbling Blocks or Stepping Stones: Findings on Adverse Childhood Experiences (ACEs) in West Virginia*[6] report, as of 2014, 55.8 percent of West Virginia adults report experiencing at least one ACE. This report also noted that by their 18th birthday, 1 in 10 West Virginia adults had experienced child sexual abuse. 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. We recognize that these vulnerable children, youth, and young adults desperately need the highest quality of care and seamless coordination of services to achieve the best health outcomes promised by the wraparound model of individualized care. The impact of ACEs and trauma on children and families cannot be overstated and trauma-informed care approaches are woven into all our care coordination activities to achieve high quality outcomes.

We have developed comprehensive care coordination initiatives to address key health disparities West Virginians face including the high incidence of ACEs, high rates of opioid use, low birthweight, and access to care challenges, to name a few. These approaches, which will be described later in the response, offer best-in-class care coordination to meet the needs of the children, youth, and young adults in the West Virginia child welfare system.

Local Care Management Infrastructure

CM001	The Vendor should coordinate continuity of care between healthcare providers, child welfare providers, behavioral health providers, and care coordinators with an integrated care plan for all children.	The Vendor should provide a detailed description of its approach to meeting this specification. The description should reflect an understanding of this contract's population, services, and stakeholders.

[3] Health Disparities 2017; WVHealthDisparitiesKeyFindings8-17.pdf; https://www.arc.gov/images/appregion/fact_sheets/
[4] 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
[5] West Virginia Department of Health and Human Resources, "Foster Care Placements Report," (2019): accessed August 5, 2019;
https://dhhr.wv.gov/bcf/Reports/Documents/2019%20August%20Legislative%20Foster%20Care%20Placement%20Report.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 August 5, 2019; https://docplayer.net/96887761-Stumbling-blocks-or-stepping-stones.html

CM003	The Vendor should provide training to ensure an integrated care plan is jointly developed and shared among the primary care provider (PCP) and/or specialist serving as a principal coordinating physician, and the child and caregiver(s).	The Vendor should describe how it will meet this specification and who will participate in training.
CM035	The Vendor should provide a care coordination model with stratified services for eligible members according to clinical, social, or other criteria.	1) The Vendor should provide a detailed description of its care coordination model. 2) The Vendor should describe how the care coordination department is organized and the integration of the service types. 3) The Vendor should describe its proposed clinical, social, or other criteria. 4) If applicable, the Vendor should include an explanation of how the Vendor will work with other parties to administer this care coordination, including, but not limited to, subcontractor(s) and affiliate advocacy group(s). Note: The Department expects all members to be eligible for care coordination services.
CM037	The Vendor should monitor screening timelines for member care coordination stratification.	The Vendor should describe how it will meet this specification.
CM047	The Vendor should develop and maintain qualifications and training for Vendor staff who will be involved in coordinating care.	The Vendor should describe: 1) Qualifications and training for Vendor staff who will be involved in coordinating care 2) The Vendor's plan for hiring care coordination staff, including, but not limited to, timeframes, number of care coordinators, and maximum case load *Note: Care coordinators should be dually trained in both Bureau for Children and Families (BCF) and Bureau for Medical Services (BMS) policies.*
CM048	The Vendor should develop and implement steps for care coordinators to establish relationships with their assigned members.	The Vendor should describe in detail: 1) Steps care coordinators will take to establish relationships with their assigned members. 2) A protocol for addressing a member who does not want a care coordinator or cannot be reached once a care coordinator has been assigned.
CM051	The Vendor should collect statistics, according to a set frequency, on care coordinators' progress toward establishing relationships with members.	The Vendor should describe what statistics it proposes to collect and how often.
CM052	The Vendor should monitor and evaluate care coordinators in regards to establishing relationships with members.	The Vendor should describe how it will meet this specification.
CM057	The Vendor should track the completion of care plans.	The Vendor should describe how it will meet this specification.

At Aetna, we support our members' attainment of a meaningful quality of life, optimum health, and overall wellness. Care Connection teams and our System of Care (SOC) administrators work to reduce the inequities and barriers the health system can often present to our members. Our integrated team members all live and work in West Virginia. Care management activities are guided by a team of child welfare experts that understand the resources needed and strategies that work to support stability, build on members' capabilities, and help members achieve their life goals, in collaboration with provider, stakeholder, and community partners.

[CM001, CM003, CM035, CM037, CM047, CM048, CM051, CM052, CM057]
Care Connection Teams

[CM035] Our regional Care Connection teams include care coordinators, utilization management (UM) representatives, concurrent review clinicians and SUD specialists who live in the regions in which they work. A statewide peer support specialist will also support the CCT. **CCT care coordinator staff include care management associates (CMA), care management coordinators (CMC), and clinical care managers (CM-nurse, and CM-licensed clinical social workers (LCSW))** that have extensive experience and training in conducting assessments, facilitating integrated wraparound care planning, utilizing clinical models, navigating the child welfare system, and conducting ongoing care coordination. Our CCTs are flexible and able to focus on the needs specific to local communities. If needed, we adjust staffing to increase the number of peers with increased behavioral health background or increase UM team staffing for members with complex medical needs. **Our CCT also consults with our local behavioral health medical director, to offer specialized coordination, as needed, for any members with behavioral health needs.** For example, the BH medical director may suggest beneficial treatment options that can then be proposed to the member's PCP or patient-centered medical home (PCMH). If needed, a telephone conversation between the BH medical director and PCP can occur. CCTs also work hand-in-hand with our system of care (SOC) administrators as needed to remove service barriers for members, as they arise. The CCT acts as the hub for coordination of continuity of care for members, in partnership with their guardians/families and chosen circle of support, physical, behavioral health, and socially necessary services (SNS) providers, child welfare providers, and all members of the larger CCT and interdisciplinary care team (ICT) **[CM001]. Figure 2.1-1** depicts the regional Care Coordination teams as they are currently configured for Aetna in West Virginia . **These configurations will be enhanced upon hiring of staff for the contract for children, youth, and young adults in the child welfare system.**

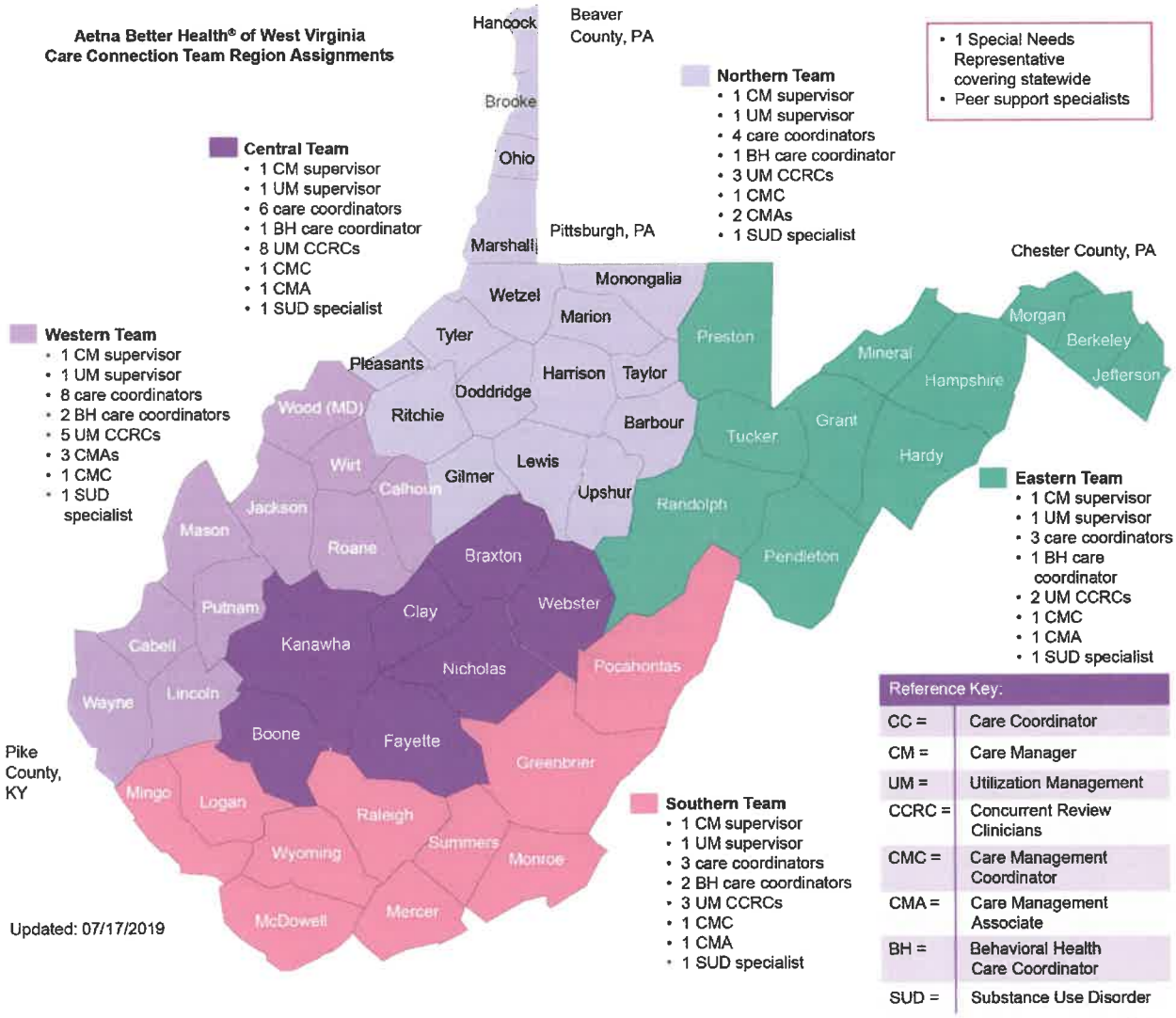

Figure 2.1-1: Regional Care Connection Teams

Aetna has well-established local Care Connection teams in West Virginia that are experts in regional health care needs and available services. Co-location arrangements will be mutually developed and enhanced for children, youth and young adults in the child welfare system. We anticipate new configurations, locations and partners to meet the unique needs of members.

Given our longstanding presence in health care delivery in West Virginia, our regional CCTs have nurtured relationships over many years with state stakeholders, local providers, child welfare experts, and other community resources. We have established productive working relationships with the Department, Child Protective Services (CPS), the Division of Corrections, the Division of Juvenile Justice (DJJ), the Bureau for Medical Services (BMS), and the Bureau of Behavioral Health (BBH). CCT care coordinators participate in in the Department's multi-disciplinary team and case planning process and incorporate the recommendations of the Department's individualized service plan (ISP) into the member's care plan.

CCTs have also built relationships with the providers and community service agencies, which supports smooth coordination of care. Additionally, we embed care coordination staff in many community locations as described in **Table 2.1-2**. 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. In the future, we plan to embed care coordinators within CPS offices of every region which will support the wraparound rapid and cohesive model of care. We are currently working with CPS and two Drug Free Moms and Babies Project sites. This program provides early intervention to mothers and babies affected by substance use disorder. We collaborate with the Perinatal Partnership, CPS, community stakeholders, and providers to complete a Plan of Care Form prior to a baby's delivery. The Plan of Care Form addresses the comprehensive needs of the family. The interdisciplinary care team will complete the form and make referrals to community providers as necessary. Special attention will be given to the infant and mother's medical needs, as well as the mother's substance use and mental health needs. It is designed to help prevent children from entering the child welfare system by connecting mothers to necessary treatment programs and developing a Safe Care plan.

Table 2.1-2: Care Connection Team Co-Location Sites

Region	Provider Location
Northern	• Chestnut Ridge (BH) • Weirton Hospital • Wheeling Hospital (neonatal abstinence syndrome [NAS] program only) • WVU Ruby Memorial
Central	• CAMC (UM and CM): Women and Children's Hospital, General Hospital, Memorial Hospital, and OB GYN Center • Dr. Ammar Shammaa-Women Care Clinic • Highland Hospital-BH • St. Francis Hospital (UM, CM and) • Thomas Memorial Hospital
Western	• Camden Clark • Dr. James Bailes, Cabell Huntington Pediatrics • Edwards Comprehensive Cancer Center • Lily's Place • Marshall Health
Southern	• Beckley Appalachian Regional Hospital (BH) • Greenbrier Valley Medical Center Mercer County • Pavilion (BH) • Williamson Health & Wellness Center federally qualified health center (FQHC)

Embedded Care Coordinators Make a Difference

"Joann Good, RN care manager from Aetna, collaborates with Edward's Comprehensive Cancer Center at Cabell Huntington Hospital weekly, being 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

Care Coordinator Staff Hiring, Qualifications, and Roles

[CM047] To meet all contract requirements and meet the needs of the West Virginia population, hiring and staffing for this contract will begin immediately after the RFP is awarded. 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 along with teleconference interviewing. Aetna has an active data base of potential candidates and has access to a full support team within the Aetna Medicaid organization to assist with hiring, onboarding, and training and to cover any potential deficits that may arise. Our staffing model will include training staff and mentors with extensive knowledge of this population. We anticipate hiring a total of 78 FTE positions to deliver care coordination for children, youth, and young adults in the child welfare system: 27 clinical care managers, 8 care management coordinators, 36 care management associates, 6 care management supervisors, and 1 manager of care management. Maximum care coordinator to member caseloads ratios for each care management tier are as follows:

- Tier 1 Population Health Care Coordination: 1:750
- Tier 2 Supportive Care Management: 1:36
- Tier 3 Intensive Care Management: 1:17

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 an 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.

Each member will have an assigned, dedicated care coordinator. Care coordinators may be care management associates, care management coordinators, or nurse or LCSW clinical care managers. Staff qualifications and role descriptions for the different types of care coordinators are as follows:

- **Care management associate:** Support comprehensive coordination of medical services including intake, screening and supporting the implementation of care plans to promote effective utilization of healthcare services. May be assigned as care coordinator for members in the Tier 1 population health care coordination. Promotes/supports quality effectiveness of health care services. High school diploma or GED.
- **Care management coordinator:** Utilizes critical thinking and judgment to collaborate and inform the case management process, in order to facilitate appropriate healthcare outcomes for members by providing care coordination, support, and education for members using care management tools and

resources. Typically assigned as the care coordinator for members in Tier 2 supportive care management. Bachelor's degree or non-licensed master level clinician required, with either degree being in behavioral health or human services preferred (psychology, social work, marriage and family therapy, counseling).

- **Care manager-nurse:** Nurse care manager is responsible for assessment, planning, implementing and coordinating all case management activities with members to evaluate the medical needs of the member to facilitate the member's overall wellness. Develops a proactive course of action to address issues presented to enhance the short- and long-term outcomes as well as opportunities to enhance a member's overall wellness through care integration. Assigned as the care coordinator for members in Tier 3 intensive care management whose primary needs relate to multiple or complex chronic conditions. May act in role of crisis intervention specialist to respond within 24 or 72 hours to children who have been placed in foster care if they have 3 or more years of behavioral health experience and have had specific crisis intervention training. Further details regarding the role of the crisis intervention specialist are provided throughout the response. Registered nurse with current unrestricted state licensure.
- **Care Manager-LCSW:** Utilizes advanced clinical judgment and critical thinking skills to facilitate appropriate member physical health and behavioral health care through assessment and care planning, direct provider coordination/collaboration, and coordination of psychosocial wraparound services to promote effective utilization of available resources and optimal, cost-effective outcomes. Assigned as the care coordinator for members in Tier 3 intensive care management whose primary needs related to behavioral health conditions. May act in role of crisis intervention specialist to respond within 24 or 72 hours to children who have been placed in foster care if they have 3 or more years of behavioral health experience and have had specific crisis intervention training. Further details regarding the role of the crisis intervention specialist are provided throughout the response. One of the following behavioral health clinical licenses in the state of practice required: LCSW-LPC–LICSW or LICASC minimum of a master's degree in behavioral/mental health or related field.

Each CCT includes an SUD specialist (nurses or LCSWs) who offer expertise around regional resources and referral processes as they relate to SUD services.

We have identified opportunities to expand behavioral health and SUD services utilizing peers. We have hired one peer support specialist who is our first to offer support throughout the State. We plan to incorporate the expertise of the peer support specialist on our CCTs so that they can be available for community and CCT support in each region. Local peer resources have been found to be extremely effective in wraparound care coordination. The peer support specialist will receive specialized training and coaching to serve on the CCT and participate in assessment and care planning. Given the high prevalence of parental substance use disorder as a contributing factor to trauma and home removals, our peer support specialist, who has lived experience with substance use disorders, will be an asset. Peer support specialists possess the ability to engage and connect with members and their families/guardian and kin in a unique and meaningful way that only those with lived experience can. Peer support specialists offer an empathetic bridge and the sooner we can get a biological family engaged and working towards their case plan goals, research indicates the better our chances are of reunification.

Care Coordination Staff Training

Aetna care coordination staff possess extensive knowledge and training across a variety of content areas, processes, and approaches. Upon hire, staff are trained in various content areas both through live training sessions and through online Relias Learning Management System modules **[CM047].** Training topics include not only processes, but clinical models and approaches such as Wraparound, trauma informed care, and ethics as well. Numerous training modules focus on the importance of building

compassionate, person and family-centered relationships with members and the steps care coordinators take to develop these relationships will be discussed in greater detail throughout the response **[CM048].** 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 employees and reviewed during the initial training phase. This manual covers topics such as the following:

- The role of the care coordinator **[CM048]**
- The role of the interdisciplinary team including the following:
  - Support providers in medical homes, assist in assuring integration of services and coordination of care, and help provide care management for members
  - Assure appropriate and efficient care transitions including discharge planning
  - Assess the physical, social, and behavioral risks and needs of each member
  - Provide medication review
  - Provide member health education on complex clinical conditions and wellness programs
  - Assure integration of primary, specialty, behavioral health, and referrals to community-based resources **[CM003]**
  - Maintain frequent contact with member including face-to-face visits, email, and telephone options
  - Assist in developing, updating and monitoring a person-centered care plan **[CM003]**
- 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:

- Trauma-informed care **[CM048]**
- Motivational interviewing **[CM048]**
- Mental Health First Aid
- Family First Prevention Services Act and other federal and State policy.
- Conducting face-to-face visits [**CM048]**
- Cultural competency **[CM048]**
- Gaps in care
- Use of available member education materials
- Assessment and treatment of substance use disorders and American Society of Addiction Medicine criteria
- Behavioral health services
- LGBTQ+ (lesbian, gay, bisexual, transgender, and questioning or queer) 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 [**CM048]**
- Medicaid 101
- Review of BCF and BMS policies [**CM047]**

- Local review of State and county health improvement plans, United States Department of Agriculture local Women, Infants, and Children (WIC)/Supplemental Nutrition Assistance Program (SNAP) numbers-data and education on demographics and socioenvironmental factors

Staff also receive extensive information systems trainings as it relates to the documentation of, storage, and sharing of screenings, assessments, and care plans with members of the interdisciplinary care team including the member/family, PCP, specialists, and others given permission for access by the member family. This training is inclusive of review of our locations which may store and share member assessments and care plans such as: our electronic care coordination system, FamilyConnect, provider and member portals, and any mobile applications **[CM003].**

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 healthcare 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.

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. 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 **[CM037, CM057].** Additionally, leadership monitors the ability and success of care coordinators' establishment of relationships with their assigned members through an observational audit tool that evaluates the care coordinators use of motivational interviewing techniques and wraparound process efficacy. The audits of assessment and care plan documentation (as well audits of calls care coordinators conduct with members and their guardians) 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. 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 skills. 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 **[CM048, CM051, CM052].** 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

Our system of care 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. SOC administrators' efforts include increasing access to telemedicine, increasing the number of training programs for medication-assisted treatment (MAT), and meeting with State Medicaid representatives to request waivers or address barriers.

Health literacy, social determinants of health (SDOH), and navigating the health care system are major challenges for many of our members. As challenges or barriers are identified, most often through multi - disciplinary rounds, the system of care team is responsible for addressing the barrier and developing solutions so that members' experiences are streamlined, and providers can have seamless access to

services for their members. The SOC team is trained in community, local, federal, and national resources and participates in community stakeholder discussions as well as public health meetings.

West Virginia's State goals to increase access to services, improve communication and training among stakeholders, and reduce system fragmentation provide the SOC administrators direction to what services within the system are needed to promote, restore, and maintain the health of members. The delivery system capability is a result of how available resources are organized and managed. Aetna is aware that service gaps are present, including both the absence of specific services and practitioners, 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 for the health plan population, allowing Aetna to activate services.**

The Aetna Medicaid organization uses a SOC model that achieves the following:

- Drives collaboration across agencies and community-based organizations to solve barriers and challenges
- Builds meaningful partnerships and participates in solution identification with providers, state and local agencies and stakeholders
- Identifies gaps and potential systemic solutions that address target populations (SED children, out-of-state children)
- Serves in a cross-functional capacity collaborating with multiple departments, acting as a conduit for both internal and external communication

The West Virginia SOC administrators serve as a resource to the CCT and will collaborate with children and youth key State and community personnel. For example, if the CCT identifies a trend with gaps in services or barriers to continuity of care, the SOC administrators may assist with finding solutions to meet the need or mitigate the barrier. Additionally, for children who may qualify for waivers, the care coordinator can engage the SOC administrators who would then meet with the State waiver office to determine the fastest way to share information to get services to children and families in a streamlined manner. Through strong internal communication avenues, SOC administrators will ensure local staff are aware of and know how to connect to community resources and provider networks for West Virginia's population. Our SOC model includes four SOC administrators. The following describes their roles:

The adult SOC administrator collaborates with adult welfare, adult corrections, and other adult-serving agencies, and is responsible to oversee the adult service delivery system. The adult SOC administrator oversees the following roles and actives:

- Conducts market surveys to determine system gaps and collaborate with health plan staff including value-based solutions, providers, and stakeholders to mitigate gaps
- Develops and implements community support programs and processes that ensure the needs of adults and families are met. Examples of departments include the Bureau for Public Health and the West Virginia Home Visitation Program.
- Focuses attention on foster care population and key systems to strengthen families
- Enhances quality approaches along the continuum of care with a focus on collaborative partnerships with internal and external stakeholders
- Addresses gaps and identify solutions in collaboration with the Medical Management team to mitigate gaps in crisis service delivery including solutions to emergency room (ER) holds, SUDs (opioid epidemic), reduction in out-of-state placements, and developing innovative solutions to serve difficult to place members
- Coordinates with internal departments including network development director to drive coordinated networks to service special populations including adults with history of foster placements and members with childhood trauma

The children's SOC administrator will intersect with multiple internal departments and staff that serve children and youth. The responsibility of the children's SOC administrator will be to coordinate with providers and organizations to address the goal of reducing the number of children removed from the home. The children's SOC administrator and the social service director will work as a unit through West Virginia youth involvement in multidisciplinary teams. The children's SOC administrator will work closely with the following resources:

- West Virginia SNS liaison in building community relationships, services and supports specific to the West Virginia foster care population
- Providers in service regions to address gaps and concerns in rural areas and with complex populations such as foster care and youth
- Network development director to provide a multidisciplinary and comprehensive service array for the needs of children and youth including identification of trauma treatment providers and adoption competent therapists
- Agencies through Help and Hope West Virginia, West Virginia ACES coalition, Drug Courts and HERO workshops with a focus of enhancing support to children and youth
- Child-serving systems including the Child Advocacy Centers, Court Appointed Special Advocates, West Virginia Child Abuse Network to promote community integration and coordinated systems serving the member and their families

The recovery and resiliency administrator will support West Virginia operations in helping to meet contract deliverables including the responsibility to build supportive programs, interventions and education related to resiliency, member advocacy, person centered care, foster family and biological family support and recovery maintenance that focus on the role of members, youth and families in driving their plan of care. As part of the deliverables the recovery and resiliency administrator will be responsible for the following activities:

- Chair the focus group that reports to the Member Advisory Committee
- Collaborate with the network development director to coordinate peer-to-peer networks such as the National Alliance for Mental Illness, West Virginia and other non-traditional providers to serve children and youth.
- Advocate for service environments that are supportive, welcoming, and recovery-oriented by working with providers to implement TIC service delivery approaches and other initiatives
- Collaborate with SOC team members to advocate for member voice and choice principles to be developed and used with target member population

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 perspective which emphasizes the importance of the individual in identifying their goals for wellness and health. The recovery and resiliency administrator will advocate for service environments that are supportive, welcoming, and recovery oriented. The identification of innovative solutions that promote community tenure and reduce out of home placements will be reviewed and implemented to mitigate gaps.

The justice SOC administrator is the single point of contact to communicate with the court and justice systems and acute care contractors, including interaction with mental health courts, drug courts, family courts, and other jail diversion programs. The justice SOC administrator will serve numerous roles including the following:

- Connect multiple systems of care including the West Virginia judicial system and the BCF

The justice SOC administrator will work with the over 200 law enforcement agencies in West Virginia to promote coordination and positive outcomes for our members.

- Intersect with residential hospitals, psychiatric hospitals, the criminal justice system, community providers, and others who interact with offenders
- Coordinate efforts with the SOC team (as well as West Virginia key personnel and staff) to develop services and supports that focus on SDOH
- Develop and build programs and services related to the prevention, treatment, and reduction of SUD in coordination with other judicial agencies
- Address the West Virginia opioid epidemic with the development of preventive services intended to reduce the rate of youth entering out of home care
- Identify crisis response service gaps and development of innovative solutions that reduce potential judicial interaction

The justice SOC administrator will work with all the varied components of the judicial system that may be engaged by the youth and their families including, but not limited to, the following: law enforcement, including state police, sheriff's office, and local police departments, corrections, family court/custody, juvenile justice, prosecutor's office, defense attorneys, probation, juvenile, adult and family drug courts, West Virginia Bar Association, West Virginia Defense Attorney's Association, and the Office of Court Administration.

Figure 2.1-2 depicts our integrated system of care and demonstrates our comprehensive focus on the member and their circle of support's (i.e., the people the member wants to be involved from outside the health care system), primary needs, and goals.

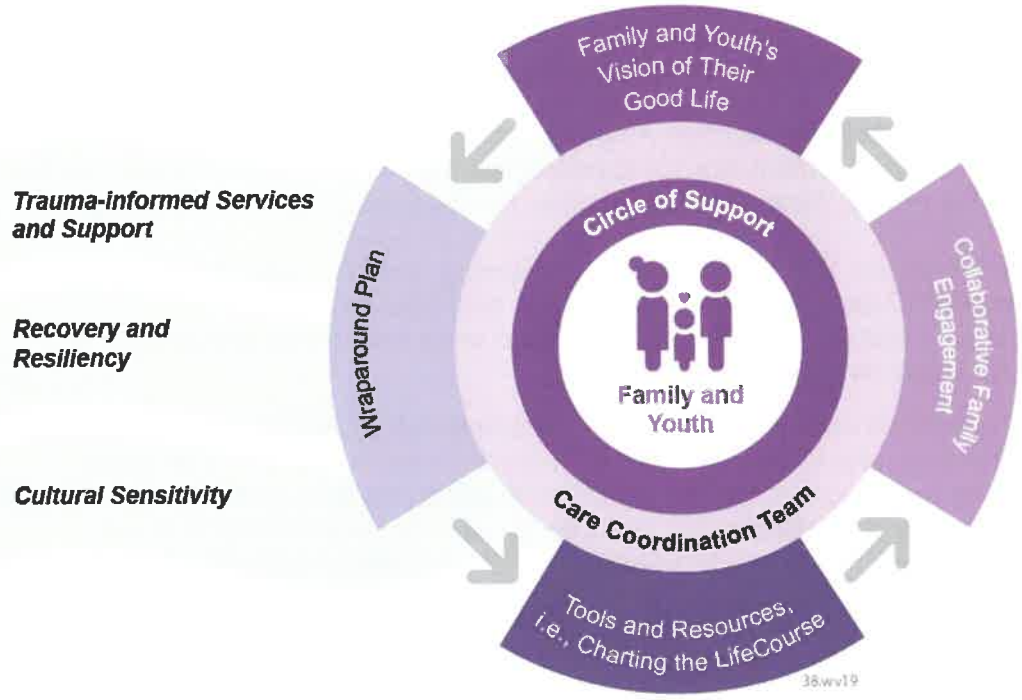

Figure 2.1-2: Aetna's Integrated System of Care
Aetna's integrated system of care includes all health care and related services and supports necessary for members with special health care needs to achieve improved health outcomes.

Care Management Tiers

CM022	The Vendor should identify members for participation in Intensive Care Management (ICM) teams for	The Vendor should describe how it will meet this specification.

	individuals with one or more chronic conditions, for applicable populations.	
CM023	The Vendor should determine the composition of the Intensive Care Management (ICM) team for participating members, for applicable populations.	The Vendor should describe how it will meet this specification.
CM035	The Vendor should provide a care coordination model with stratified services for eligible members according to clinical, social, or other criteria.	1) The Vendor should provide a detailed description of its care coordination model. 2) The Vendor should describe how the care coordination department is organized and the integration of the service types. 3) The Vendor should describe its proposed clinical, social, or other criteria. 4) If applicable, the Vendor should include an explanation of how the Vendor will work with other parties to administer this care coordination, including, but not limited to, subcontractor(s) and affiliate advocacy group(s). Note: The Department expects all members to be eligible for care coordination services.
CM049	The Vendor should establish and implement guidelines for when care coordinators should have face-to-face contact with their assigned members, including, but not limited to, when requested by a Department worker.	The Vendor should describe its approach to care coordinators' face-to-face contact with assigned members, including, but not limited to: 1. Frequency 2. Circumstances resulting in a need for face-to-face contact 3. Goal of face-to-face contact at this frequency and/or in these circumstances
CM050	The Vendor should develop and implement standards for how often the care coordinators will contact members after the initial care coordination contact, based on the member's acuity level.	The Vendor should provide and describe proposed standards for this specification.

All enrolled members will be screened and stratified into one of three levels of care management. Aetna uses a range of tools to stratify children, youth, and young adults enrolled in West Virginia into a level of care management that meets their unique, holistic needs. We use our risk stratification model, screenings, clinical assessments, and evaluation of SDOH, which are all described later in this response, to determine which care management level (intensive care management, supportive care management, or population health care coordination) will best provide each child, youth, or young adult with integrated, whole-person care **[CM035]. Table 2.1-3** depicts the clinical and SDOH criteria for each care management tier.

Table 2.1-3: Clinical Criteria for Care Management Tiers

Care Management Level	Clinical and/or SDOH criteria
Intensive Care Management (Tier 3) **CC to member ratio: 1:17**	• Children entering foster care • Individuals with multiple complex chronic conditions, comorbidities, or co-occurring conditions, special health care needs, medically complex **[CM022]** • Individuals with three or more ED visits or previous behavioral health 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 • Infants with neonatal abstinence syndrome • Children and young adults with abuse and/or trauma histories with significant social determinant of health 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 serious emotional disturbances • Individuals with HIV/AIDS, cancer, chronic renal failure, and other chronic complex conditions
Supportive Care Management (Tier 2) **CC to member ratio: 1:36**	• 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: 1:750**	• 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) • 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 child and the care management tier to which they are assigned. **Table 2.1-4** outlines the minimum frequency of contact expectations and services provided in each care management tier.

Table 2.1-4: West Virginia Children and Youth Care Management Tiers Services [CM049, CM050]

Care Management Tier	Services Provided
Intensive Care Management (Tier 3) **CC to member ratio: 1:17**	• One face-to-face visit (monthly), and as requested by the Department **[CM049]** • One weekly contact • A minimum of two hours per week of care coordination • One meeting with the interdisciplinary care team(monthly) • One care plan update (monthly)
Supportive Care Management (Tier 2) **CC to member ratio: 1:36**	• One face-to-face visit (quarterly), and as requested by the Department **[CM049]** • One weekly contact • One meeting with the interdisciplinary care team (every 90 days) • One care plan update (monthly)

Care Management Tier	Services Provided
Population Health Care coordination (Tier 1) **CC to member ratio: 1:750**	• All West Virginia members will have access to care coordination services and a CCT • Aetna will outreach West Virginia members quarterly to assess any changes in social risks, health conditions, or any other need • One meeting with the interdisciplinary care team every 90 days by regional supervisor • Aetna will educate members and their caregivers on how to contact the health plan should needs arise prior to outreach • Health risk assessment (HRA) will be completed (at least annually) • Health education mailings

The American Academy of Pediatrics (AAP) has identified children in foster care as having special health care needs, due to the prevalence of children in foster care with at least one chronic medical condition (30 percent). Children in foster care have often been shuffled from provider to provider or have not received care prior to foster care and therefore their medical issue may have gone untreated for some time. The AAP also found that 46 to 60 percent of children under the age of 6 have a developmental disability and that as many as 80 percent have a mental health concern. Additionally, 20 percent need significant dental care.[7] For these reasons, most children in foster care will initially be assigned to Tier 3 intensive care management. If ongoing reassessment and care planning updates demonstrate that the child's situation has stabilized or measurable progress toward goals have occurred, a foster care child in Tier 3 care management may transition to Tier 2 care management.

[CM023] Intensive Care Management teams are comprised of the full complement of Aetna CCT staff: care coordinators, UM staff, SUD specialists, and our peer support specialist (when needed). ICM teams will be facilitated by clinical care coordinators (nurse care managers or LCSWs, depending on the unique needs of the child). The ICM team is joined by the larger interdisciplinary care team as the clinical care coordinator facilitates ongoing care coordination with the entire team. At times, SOC administrators may participate in care planning with the ICT as needed to identify creative strategies to removing barriers to access, as they may be aware of new, emerging community resources. Additionally, the ICM may call on the behavioral health medical director for consultation regarding the care of our members. Care coordinators for ICM teams will not have a caseload greater than 1:17 and will, at a minimum, provide the types and frequency of services described in the care management tiers section (described previously).

Care Management Clinical Framework

We have adopted several models which are woven throughout our care planning processes for children in foster care, adoption assistance, and those with special health care needs. These include the wraparound model, the Charting of the LifeCourse framework, the Safe At Home approach, and Family Finding approach. With these tools, we work closely with members and their families to identify key life stages and provide thoughtful anticipatory guidance around major milestones to sustain members' quality of life, avoid unnecessary transitions, and ensure continuity of care. Our trauma-informed care framework will be described later in the response.

[7] Szilagyi, Moira, Rosen, David, Rubin, David and Zlotnik, Sarah, "Health Care Issues for Children and Adolescents in Foster Care and Kinship Care," American Academy of Pediatrics, 136 (4) (2015): accessed August 5, 2019; https://pediatrics.aappublications.org/content/136/4/e1142.long.

The Wraparound Model

In West Virginia, Aetna has experience adopting and implementing a successful wraparound model. Wraparound is a philosophy of care with a defined planning process used to build constructive relationships and support networks for children with emotional or behavioral concerns and their families. It is community based, culturally relevant, individualized, strengths based, and family centered. Wraparound care plans are comprehensive and address multiple life domains across home, school and community, including living environment, basic needs, safety, and social, emotional, educational, spiritual and cultural needs among others. Another defining feature of wraparound is that it is unconditional; if interventions are not achieving the outcomes desired by the member, their guardian and the ICT, the ICT regroups to rethink the configuration of supports, services, and interventions to ensure success in natural home, school, and community settings. In other words, children do not fail, but plans and providers can fail a child. **Rather than forcing a child to fit into existing program structures, wraparound is based on the belief that services and supports should be flexibly arranged to meet the unique needs of the child and their family.**

In alignment with the wraparound model, we maximize resources for children, assign dedicated care coordinators to foster children and children with special health care needs, improve outcomes related to child safety, reduce childhood trauma, and increase empowerment of parents and kinship placements. This wraparound model integrates a large collaborative network to make certain the child's needs are met and the right people are at the table in the child and family-centered care-planning process. Some of these collaborators include the following:

- Families
- Circuit judges
- Lawmakers
- Defense attorneys
- Prosecutors
- Law enforcement
- Education officials
- Providers: medical, social service, and behavioral health
- Payers
- Child advocates
- Probation officers
- Education officials
- Child protective services
- Social workers

All children deserve a permanent home. Care coordinators using the wraparound model work with parents and caretakers to help alleviate the issues of the family, such as abuse and neglect – things that necessitated removal from home and placement in the custody of the state. The belief is that if a child can be returned safely to the home, then the best place for the child is in the home. Wraparound, a community-based model that builds on a family's strengths is used to empower the family to achieve a level of change required for reunification. If a child cannot be safely reunited with his or her family, services are provided to locate and support other permanency options, such as guardianship or adoption. Care coordinators facilitate all services necessary to support the permanency goal for the children in care. In collaboration with referral sources, care coordinators provide for safety and needs assessments, resource acquisition, transportation and visitation, court reports, and authorization of funds for services to family members across multiple life domains. The responsive and flexible wraparound model ensures family voice and choice leading to effective outcomes and permanency over time.

Charting of the LifeCourse

Aetna utilizes the Charting of the LifeCourse framework's tools and resources to support the wraparound foundational model of care. This serves youth in foster care and juvenile justice systems, in concert with their circle of support. This collective approach to family safety, healing and thriving, results in the creation of an individual care plan that addresses covered and non-covered services and focuses on the youth's circle of support (caregivers, family, foster parents, etc.). The care plan helps the circle of support identify what they need to be successful and what they would find useful to them in providing quality care to the member. This approach helps youth by considering what is predictable is preventable and that the individual's biography is their biology. **To address an individual's physical and behavioral health challenges, we must consider the impact their health has in their life story and if we can predict difficulties, we can collaborate to prevent them.** Charting the LifeCourse assists the youth in navigating through challenges to negate isolation by creating encouragement and support.

> "The LifeCourse framework and tools are designed to help individuals and their families plan for and navigate a life that makes sense to them with the support they need," said Michelle C. Reynolds, PhD, associate director of training at the University of Missouri-Kansas City Institute of Human Development. "It is exciting that a national health care leader like Aetna recognizes its value and will be using the LifeCourse framework as it develops its person-centered, holistic model to support children in the Child Welfare system in West Virginia"

Safe at Home

Aetna supports the use of trauma-informed wraparound services, such as the current Safe at Home approach for children and youth in West Virginia. Safe at Home places importance on community recognition of the impact of trauma and on family engagement in service planning. Care planning is conducted with the goal of keeping children and youth in their homes and communities, when it is safe to do so. The wraparound approach is critical to reduce foster care and congregate care and to prevent re-entries. Additional goals include the reduction of the placement of children in out-of-state services and increase in the step-down of youth from placements and/or reunification with family. These goals can be achieved through conducting trauma-informed assessments and delivering trauma-informed care. Additionally, evidence-based services, performed early and often, should be aligned to the needs of the member and their family.

Family Finding

The Family Finding approach is a set of strategies, principles, and skills that aims to ensure children and youth's safety and well-being through strengthening family connections and supports networks. The more a family can build support and resilience within their own network, the greater the likelihood that child welfare/protection services will be shorter and more effective. Family Finding uses various search and engagement techniques to locate connections and stresses the importance of including family in decision making for the young person, ensuring they have a seat at the table. **Family Finding engages with and empowers families to share in the responsibility for safety, permanence and well-being of children.** It is a model that helps create a strong foundation for collaborative family engagement. Meaningful Family Finding activities include the following:

- Location and engagement with supportive people to help parents care for the child in their home, before out-of-home placement is needed or for reunification
- Exploration of whether there are known/kin supports available, should out of home care be needed

- Maintaining/finding connections for young ones in foster care
- Looking for permanency options within the family
- Building social history information
- Connecting youth aging out of care

The wraparound model, Charting of the LifeCourse Framework, Safe at Home, and Family Finding approaches all work together to not only properly understand each child and family's unique circumstances and needs but also to support the active coordination with other providers, state agencies, and community stakeholders and create a single source of truth the integrated care plan. **Figure 2.1-3** depicts the connections and partnerships driven by the CCT to integrated care to children in foster care, adoption assistance, and those with special health care needs.

Internationally Recognized Consultant Guiding Our Approach

Aetna is working with Kevin Campbell, an internationally known youth permanency expert, founder of the Center for Family Finding and Youth Connectedness, and developer of the Family Finding model, which is a set of strategies now utilized throughout the United States and Canada to establish lifelong supports for youth in foster care. Prior to developing Family Finding, Kevin was an administrator, director, and vice president in the social service sector for over 28 years. He has helped over 10,000 youth achieve permanency and continues to help up to 80 foster youth per week through his advanced permanency trainings and technical assistance with agencies nationwide. To date, he has worked with over 200 jurisdictions across over 40 states and Canada.

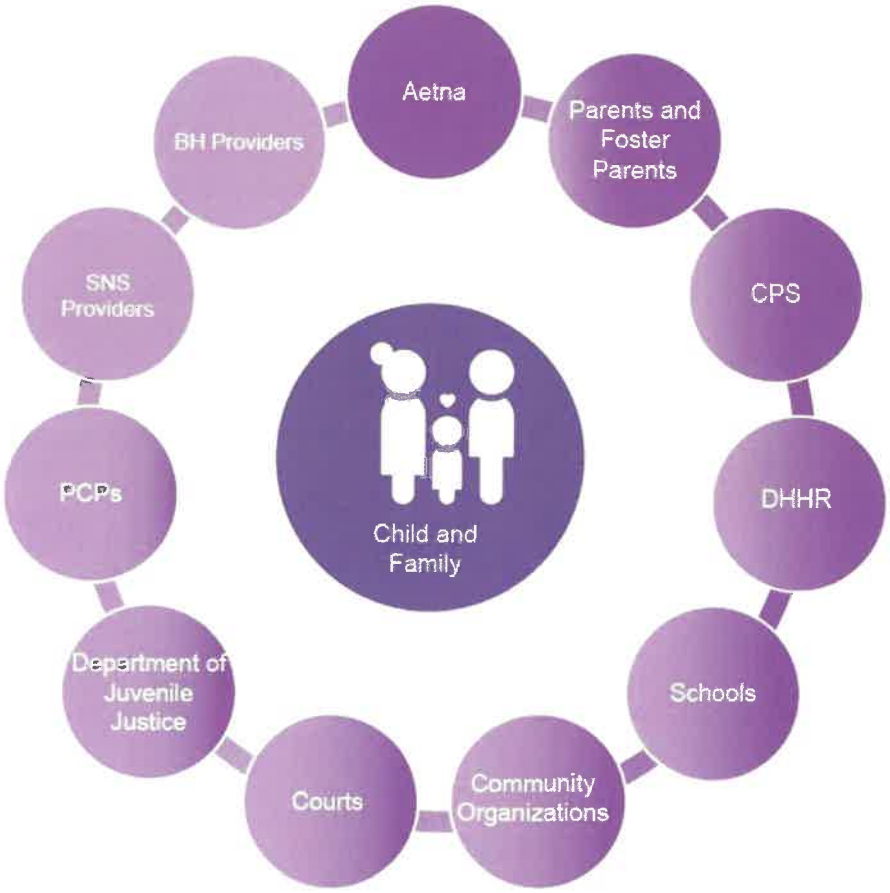

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Figure 2.1-3: Supporting Children and Youth through Care Coordination with Providers and Partners
Aetna supports young people in collaboration with a full range of health care providers, social services, and other system stakeholders

Engaging with Members to Initiate Care Management

CM001	The Vendor should coordinate continuity of care between healthcare providers, child welfare providers, behavioral health providers, and care coordinators with an integrated care plan for all children.	The Vendor should provide a detailed description of its approach to meeting this specification. The description should reflect an understanding of this contract's population, services, and stakeholders.
CM017	The Vendor should identify and track new members with high physical or behavioral health needs to assure continuity of care, for applicable populations.	The Vendor should describe how it will meet this specification.
CM027	The Vendor should leverage population health management risk stratification tools to support stratification of members into risk tiers for care coordination services.	The Vendor should provide a detailed description of its approach to meeting this specification.
CM028	The Vendor should capture data related to social determinants of health, as defined by bodies including, but not limited to, the Centers for Disease Control and Prevention (CDC).	The Vendor should describe how it will meet this specification.
CM029	The Vendor should incorporate data about social determinants of health into its care coordination services.	The Vendor should describe how it will meet this specification.

CM036	The Vendor should screen members for stratification into care coordination services upon enrollment.	The Vendor should describe how it will meet this specification.
CM038	The Vendor should assign members to an appropriate healthcare professional who is formally responsible for coordinating the member's overall healthcare, including, but not limited to, behavioral health, for applicable populations.	The Vendor should: 1) Describe its protocol for assigning members. 2) Explain how the Vendor proposes to define an "appropriate" healthcare professional. 3) Specify whether services are coordinated by the member's primary care provider (PCP) or through some other means, including, but not limited to, a care coordinator.
CM039	The Vendor should use clinical, social, or other criteria to assign members to a care coordinator within a timeframe that the Department approves.	The Vendor should: 1) Describe its protocol for assigning members. 2) Describe its proposed clinical, social, or other criteria. 3) Provide the expected timeframe for care coordinator assignment to the identified member.
CM042	The Vendor should perform screening, assessment, and/or utilization analysis to identify and provide services for members with special needs.	1) The Vendor should describe its methods for meeting this specification. 2) The Vendor should describe any additional screening tools used in this process. 3) If the Vendor proposes to conduct its own health risk assessment, the Vendor should provide a template for the form or protocol.
CM043	The Vendor should perform screening and assessment to identify and provide services for members with behavioral health needs.	1) The Vendor should describe its methods for meeting this specification. 2) The Vendor should describe any additional screening tools used in this process. 3) If the Vendor proposes to conduct its own health risk assessment, the Vendor should provide a template for the form or protocol.
CM044	The Vendor should complete health risk assessments that will be made available upon enrollment to members in applicable populations and/or their caregiver(s), including, but not limited to, assessments specific to members with special healthcare needs.	The Vendor should describe how it will meet this specification.
CM046	The Vendor should use specialized care coordinators for certain conditions, including, but not limited to, experienced pediatric or cardiac nurses and behavioral health specialists.	The Vendor should indicate whether the Vendor will use specialized care coordinators for certain conditions and describe the rationale behind its approach.
CM048	The Vendor should develop and implement steps for care coordinators to establish relationships with their assigned members.	The Vendor should describe in detail: 1) Steps care coordinators will take to establish relationships with their assigned members. 2) A protocol for addressing a member who does not want a care coordinator or cannot be reached once a care coordinator has been assigned.

Aetna utilizes a comprehensive suite of screenings, assessments, and risk factor tools to evaluate early life adversities, acute needs, and resilience factors to effectively engage and stratify members into care management. In doing so, **we strive to understand each unique child and family in the context of their lives,** which will lead to designing a person and family-centered care plan that enhances their quality of life and assists them to build resiliency and reach their individual life goals. These initial evaluation activities ensure we connect members and their families with the appropriate level of care management and encourage member and family engagement from the beginning. All members are eligible for care management services.

Transition of Current Child, Youth, and Young Adult Members to Aetna's Plan

Aetna's transformative vision drives our model for enhanced care coordination supporting the children, youth, and young adults in the child welfare system. To identify and coordinate care for members enrolled in the Department's current service delivery system transitioning to Aetna, we will develop transition policies and procedures in partnership with the Department to identify eligible 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 Department and treating providers leading up to the transition of children and youth to obtain necessary medical records, prior authorizations, medication lists, and any additional pertinent details that we can use to discern members with immediate need. Ideally, we would have this information far enough in advance of implementation to identify immediate needs and gaps in care. The timeliness of obtaining these records, as documented in our Transition of Care policy, is essential to minimizing disruption in services in a population that requires 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 during care transitions
- Monitoring the continuity and quality of care and services
- Ensuring that member has access to needed medications utilizing Aetna or the Bureau of Medical Services pharmacy claims data

In addition to collaborating with the Department and incorporating enrollment data provided, we will 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):

- **Access to Families and Children Tracking System (FACTS):** Allows the health plan to have full access to foster care member information including, foster care contacts, CPS and placement information, medications, last appointments, providers and diagnoses
- **West Virginia Health Information Network (WVHIN).** We will obtain prior medical history, testing, pharmacy, labs and other pertinent clinical information through the WVHIN and accessed through our population health management platform

A specialized CCT, comprised of interdisciplinary staff that is wraparound trained and who are experienced serving children, youth, and young adults similar to the population served through this procurement, will outreach high needs/medically complex transitioning members and their families/guardian, the Department's transition specialist, and the member's Department care coordinator or case worker 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 will review 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 in the child welfare population and the importance of creating an environment of safety that does not cause re-traumatization. With this in mind, at each step, they involve the member and/or

their family/guardian, providers, and the member's CCT in the transition process ensure the member feels supported and heard throughout the change. Our transition coordination 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 will make a preliminary determination of which care management tier to connect the member to for ongoing care coordination based on available data and documentation from the Department regarding the member's historical service and claims data, assessment, and care plan information, initial conversation with the member and their family, and our risk stratification tool (described later in this response).

Initial Identification of New Members

Referrals for supportive or intensive care management: In advance of screening and assessment efforts, Aetna may receive member referrals from community partners or internal sources who, through their day to day work with eligible members, identify individuals that could benefit from care management services. These referral sources include the following:

- State staff from the BMS, the BBH, DJJ, and CPS
- Local law enforcement agencies
- Providers, including primary care, behavioral health, and specialist providers
- The adult system of care administrator will coordinate with DJJ facilities regarding members who are leaving their facilities and will be eligible for Medicaid Services allowing for a more seamless transition
- School-based health centers, faith-based groups, and social service organizations including SNS providers, such as food banks
- Through our partnership with local retail pharmacies, community pharmacists assist in identifying members who are in need of 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

In addition to identification through referral sources, enrollment data, claims data, and risk stratification processes (described later) help to identify when members should be outreached for screening for care management. For example, claims reports can 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.

[CM028, CM029, CM036, CM042, CM043, CM044] Initial Screening of New Members

Upon receipt of a referral or enrollment notification, Aetna begins the initial screening process for all members **[CM036].** 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 behavioral health, and/or related services. These needs are screened in the initial contact with the member and their guardian/circle of support 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 youth (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.

Initial health screening for children placed in foster care: **Aetna will ensure that all children being placed in foster care receive an initial health screening by a medical professional within the 24- or 72-hour timeframe guidelines in alignment with the AAP**.[8] The initial health screening (IHS) serves to identify physical health and/or behavioral conditions that need prompt attention. We will accomplish a referral for this IHS by utilizing our on call CCT staff member who will, upon notification of the child's placement in foster care (via the daily supplemental enrollment file or real time notification to us by the Department or CPS), notify our regional crisis intervention specialist (licensed clinical social workers or nurse care coordinators from the local CCT). The crisis intervention specialist will make initial contact with the member and foster placement or CPS case worker. The crisis intervention specialist (CIS) will immediately coordinate with an Aetna-contracted PCMH or primary care provider (PCP) office to schedule the IHS to occur within the recommended timeframe (24 or 72 hours, depending on the child's situation). The CIS will have access to a list of providers who have agreed to respond to these requests in accordance with timelines and will document the agreed upon scheduled date and time with a task reminder to follow up. Aetna will create incentives for providers to offer initial health assessments in these circumstances. The CIS will verify that the child/caseworker/foster family attended the scheduled IHS appointment via telephonic follow up with the member's guardian. The CIS will also complete Aetna's HRA, our standard brief initial screening tool (described in detail later in this section) with the member and their CPS caseworker. They will support the member, foster placement, and CPS caseworker during the first week following notification of placement to ensure proper connection to services, to identify immediate needs, and to ensure connection to their dedicated care coordinator. They will work with the regional CCT to assign the member to an appropriate Tier 3 intensive care management (additional detail regarding assignment of an appropriate care coordinator is provided later in the response). This CIS will provide a telephonic report to the assigned ICM care coordinator so they may facilitate continued assessment, follow up with the medical professional who completed the HIS, care planning, and ongoing coordination and continuity of care.

Health risk assessment: Upon notification of enrollment of any new member (based on notification via Department 834 files), Aetna's automated outbound screening process is our first attempt to complete the HRA and Health Care Equity Contact Event, or HCE (described later), with the member and their family/guardian **[CM044].** The outbound system contacts member's guardian to attempt to complete the screening immediately upon notification of the member's effective date of enrollment. We disclose to the member and their guardian how we will use the information gathered in screening tools. The HRA is available in English and Spanish and can be completed via multiple avenues based on member and family needs. In addition to completing the HRA through contact by the outbound automated system, HRAs may be completed in person, or via printed or web-based forms. As described previously, members entering foster care will complete the HRA with their guardian and the CIS. **Table 2.1-5** identifies the areas reviewed in the initial HRA screening:

8 Szilagyi, Moira, Rosen, David, Rubin, David and Zlotnik, Sarah, "Health Care Issues for Children and Adolescents in Foster Care and Kinship Care," American Academy of Pediatrics, 136 (4) (2015): accessed August 5, 2019; https://pediatrics.aappublications.org/content/136/4/e1142.long.

Table 2.1-5: Aetna Health Risk Assessment Screening Domains

Domains	
• Confirmation and review of basic demographics • Preferred language read/spoken • General health and emotional health **[CM042, CM043]** • Condition-specific questions • SDOH concerns (food, transportation, housing and utilities, and interpersonal safety concerns) • Utilization of services (PCP, DDS, BH, PT, OT, etc.)	• Medications • School attendance • Functional question • Smoking history • Pregnancy status

Health Care Equity Contact Event: **[CM028, CM029]** The HCE, housed in our electronic care coordination system, is another screening tool we complete upon enrollment with all members, in combination with the HRA. The HCE documents, tracks, and reports on members' social determinants needs, as defined by the Centers For Disease Control and Prevention, and is inclusive of housing, transportation, food insecurity, and personal safety, 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, to connect with Aetna's child SOC and recovery and resiliency administrators or engage 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. **Figure 2.1-4** shows the SDOH areas screened.

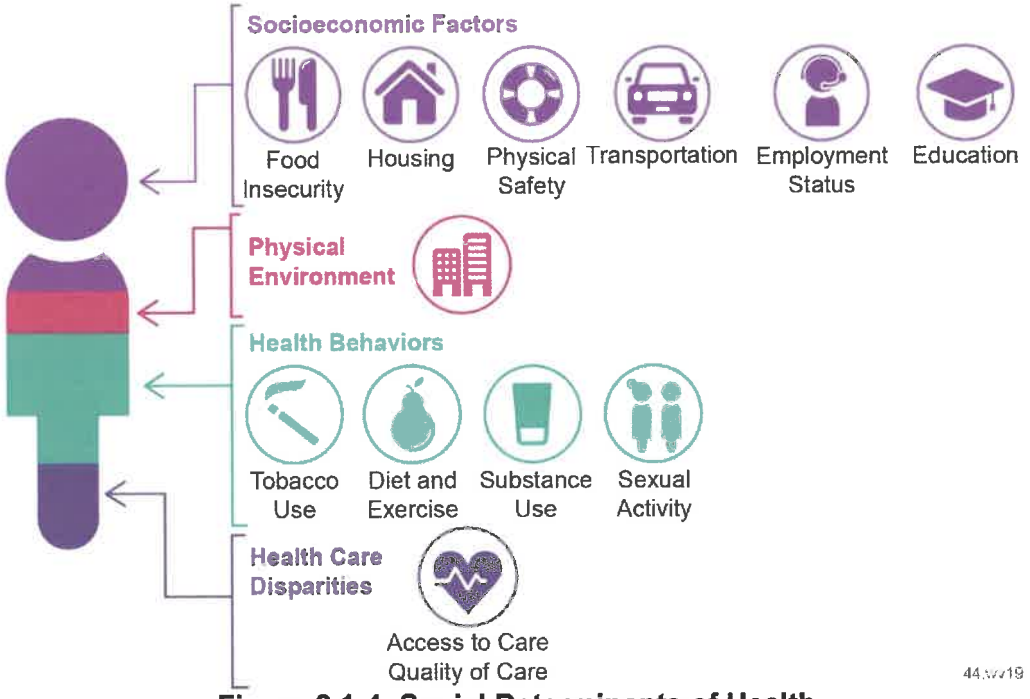

Figure 2.1-4: Social Determinants of Health

Aetna's HRA screens for social determinants of health needs, providing an opportunity for further assessment, support, and care coordination for the member.

Appendix G provides templates of the HRA (also known as the HRQ), and HCE, respectively.

To maximize the number of members completing the initial 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's guardian/CPS caseworker by phone, each occurring on different days and different times to improve the probability of contact. After these attempts, care management staff sends a letter to the member's guardian stating that the telephonic outreach attempts have been unsuccessful and invites the member's guardian to contact Aetna to complete the screening. If a member's guardian 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 local hospitals for our adults, children and youth discharged from an inpatient setting. Care management staff use medical, behavioral health, and pharmacy claims as well as admission, discharge, and transfer (ADT) data from the West Virginia Health Information Network to identify contact information which may improve success in reaching the member and their guardian to complete the screening.

With multiple entry points, data review, and member contacts, we maximize opportunities to engage members to complete screenings 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 with multiple points of access, including the following:

- **Member portal:** Members may complete the HRA in the member portal
- **Population health management platform:** An alert through our electronic population health management platform to the member services representative will allow them to conduct a warm transfer of the call 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:** Members will be able to complete the HRA through our secure mobile application. The HRA data will feed directly into our electronic care management system. This system provides the information technology to conduct care and service coordination from a single platform connecting external providers and multi-system stakeholders in near real time.
- **HRAs completed in the community:** The HRA tool will be available for completion with embedded care coordination staff at CPS offices and other provider locations

The HRA and HCE screening process allows for initial and immediate stratification to either Tier 1 population health care coordination or to additional assessment and determination of referral to Tier 2 (supportive) or Tier 3 (intensive) care coordination. Members that are assigned to population health care coordination (Tier 1) will receive quarterly calls from CMAs, as well as educational mailings. All members providing positive responses to any screening question on the HRA and HCE, who may have multiple chronic conditions, SDOH barriers, special health care needs, or those who are in foster care will receive further assessment and stratification into the appropriate care coordination level (2 or 3). Immediately following completion of the HRA and HCE, these members and their guardians will be warm transferred to a care management associate (CMA) for immediate assessment for enrollment into either Tier 3 or Tier 2 care management.

Outreach questionnaire: When the member and their guardian are warm transferred to the CMA, the CMA will immediately complete a telephonic Outreach Questionnaire (ORQ) assessment with members identified through initial screening for possible referral to Tier 2 or 3 care management. We have experience providing the ORQ across all nine states in which Aetna serves the child welfare/fosters population. Aetna completes an ORQ to further identify care needs and engage children, youth, their guardians and young adults in care coordination. The CMA educates members and their guardian/circle

of support on the tool and its purpose to establish a relationship before asking questions that can be considered intrusive by the member. They take account of the cultural needs of members and families when completing the tool.

The ORQ addresses the following: 1) immediate, current and past health care, mental health and substance use disorder needs; 2) psychosocial, functional, and cognitive needs; 3) SDOH, including education and housing status **[CM028, CM029];** 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.

In addition, the CMA will complete the West Virginia Child and Adolescent Needs and Strengths (WV CANS) and Trauma Screening Questionnaire (TSQ) during this call as well. Upon completion of the ORQ, WV CANS and TSQ, the CMA identifies and warm transfers the member and their family/guardian to a care coordinator who will continue further assessment, care planning, and general care coordination activities with the member and their family/guardian, as described in the following sections.

[CM038, CM039, CM046, CM048] Assignment to a Dedicated Care Coordinator
The thoughtful matching of a member to a dedicated, local care coordinator serves as the foundation for the building of rapport and successful care planning and ongoing coordination. Each enrolled child, youth, or young adult will be assigned to a regionally based care coordinator, who is supported by the other CCT members and Aetna's SOC administrators. The CMA who completed the ORQ, WVCANS and TSQ during initial screening will immediately, during the initial screening call, identify the most appropriate care coordinator and will either warm transfer the member/guardian to that care coordinator, or arrange to have the care coordinator call them back, whichever member/guardian prefers. In either case, the CMA provides the member and their family/guardian with the care coordinator's contact information. Additionally, they will explain the care coordinator's role and what the member/family/guardian can expect to see happen next as care coordination continues. The CMA will ensure the assigned care coordinator has all the screening and other preliminary information obtained during the initial screening contact process.

The assigned dedicated care coordinator acts as a single point of contact going forward and is responsible for coordination of care for all necessary physical health, behavioral health, functional, and wraparound social support services to promote improved health outcomes and member quality of life. The assigned care coordinator has primary responsibility for care coordination, but works in close contact with the member's PCP, who also has a leadership role in the care planning and coordination 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, members are assigned to care coordinators who work and live in the member's community and who have contacts with local partners and providers to coordinate care. Face-to-face and telephonic care management services are delivered by care coordinators who are 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**. For example, children that are deemed medically complex, or infants with a diagnosis of NAS are paired with an Aetna registered nurse care coordinator and placed in intensive care management. Our nurses with neonatal intensive care unit experience are familiar with pediatric cardiology. Children with a behavioral health diagnosis or behavioral health claims are paired with an Aetna licensed behavioral health care coordinator. **[CM038, CM039, CM046]** Our screening tool does allow for members/guardians to opt out of care coordination, if they choose. The option to opt out is also in the welcome letter that goes out to members and their guardians. In

conversation and in our letters, we provide the contact number for member services and the local CCT for the members/guardians who have opted out to contact should the family later decide to engage in care management services **[CM048].**

[CM001, CM042, CM043, CM048] Additional Comprehensive Assessments

The assigned, dedicated care coordinator speaks with the member and their family/guardian following completion of screenings for introductory purposes and to schedule an appointment for further assessment. If 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 and/or their guardian, they will conduct the same outreach attempt process as described in our initial screening process above **[CM048].** The care coordinator will also identify individuals in the member's circle of support and CPS or DJJ caseworkers already working with the member, for the purposes of gathering the assessment information and treatment history they may already possess. For a child who has experienced trauma, it is critical to find ways to minimize the need for them to recount painful events multiple times. This is particularly important for juvenile justice-involved youth who may receive specialized risk/need assessments in the courts or DJJ. Aetna understands youth and families 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 young adult or child's guardian) to child welfare agencies currently working with the child and their family, as well as previous providers, facilities, and sister agencies to obtain the results of their assessments and screeners **[CM001].** 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, child welfare 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 take into account the unique needs of the member and their family/caregiver(s).

The local, dedicated care coordinator conducts post-screening assessments in person with the member and their guardian, within 30 days of completion of initial screenings. 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 **[CM042].** In addition, care coordinators use an algorithmic approach to choosing screening options. As initial screenings such as the HRA, HCE, and ORQ are entered into the electronic care coordination system, the responses re-populate in other assessments with the same/similar questioning. The system provides suggestions to care coordinators about additional 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. Throughout the assessment process, care coordinators utilize tested member and family-centered approaches and motivational interviewing techniques used during the assessment process build strong relationships with members and their families/guardians **[CM048].**

Assessment of Trauma

Care coordinators use the following specific tools during the comprehensive assessment to identify trauma (in addition to the WV CANS Trauma Screen and TSQ which would have already been completed during their initial screening):

- University of California Los Angeles Child/Adolescent Post-traumatic Stress Disorder Reaction Index
- ACES-Q

Assessment of Behavioral Health Needs

It is estimated that upwards of 80 percent of children in foster care have a significant mental health need.[9] 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 behavioral health needs, the care coordinator completes evidence-based assessments and screenings to evaluate behavioral health concerns, including the following **[CM043]:**

- Early and Periodic Screening, Diagnostic and Treatment Mental Health Assessment
- Child and Adolescent Needs and Strengths
- Child and Adolescent Service Intensity Instrument (CASII)
- UCLA Child/Adolescent PTSD Reaction Index
- CRAFFT
- Patient Health Questionnaire-9
- 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:

- 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

Finally, care coordinators complete the Youth Level of Service CM Inventory (YLS-CMI) and Mass Youth Screening Instrument V2 (MAYSI-2) as required for children involved with Juvenile Justice.

With the authorization of the member's guardian, we share all screening and assessment results in real time (or upon Department request) with the member's assigned PCP and permitted provider and stakeholder members of the ICT via our FamilyConnect electronic health record, which is accessible by member and provider portals. These results can also be sent by mail or securely via email to providers upon request, as authorized by the guardian.

[9] Szilagyi, Moira, Rosen, David, Rubin, David and Zlotnik, Sarah, "Health Care Issues for Children and Adolescents in Foster Care and Kinship Care," American Academy of Pediatrics, 136 (4) (2015): accessed August 5, 2019; https://pediatrics.aappublications.org/content/136/4/e1142.long.

The care coordinator utilizes information gained through the assessment process to determine which care management tier 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. Ongoing screening and assessment also continues throughout the member's enrollment. Screenings and assessments are repeated annually, at a minimum, or as triggered by a change in the child, youth, or young adult's functional or health status, or a change in their placement or residence.

Appendix G contains an example of one of the assessments we use to evaluate behavioral health needs.

[CM028, CM029] Social Determinants of Health

Aetna collects and utilizes data regarding SDOH (e.g., food and nutrition, housing, education, transportation, violence, social connections, and other determinants as defined by the Centers for Disease Control and Prevention) to improve the health status of our members. Aetna captures this information through screenings and assessments such as the HRA, HCE, and ORQ. Information related to the member's SDOH is critical in the development of members' individual integrated care plans. Additionally, in 2018, Aetna began stratifying SDOH data across demographic characteristics to identify social determinant of health disparities in our population and subpopulations. 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. Aetna uses member-level demographic and social risk data to target interventions to improve population health. Our approach to the collection of SDOH data includes collection of both individual-level, self-report (or reported by the foster parent), claims data, and internal and publicly available population-level data. We analyze this data annually, and 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.

[CM017, CM027] 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 **[CM027].** Beginning in June 2019, CORE includes census track and zip code data to incorporate social determinant elements at the population level in its predictive modeling. Aetna uses several indicators in addition to CORE, including the HRA, 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 results of CORE stratification are sent to the CCT supervisor via monthly reporting. The CCT supervisor will identify those members identified as possibly needing a different level of care coordination (based on CORE results) and will discuss this with the assigned care coordinator to modify the member's tier level, where appropriate.

Predictive Model of CORE

- CORE results are predictive in multiple dimensions
- The ED model has a positive predictive value of 72.1%, meaning that 72.1% of the time, the predicted ED utilization occurs in the next 12 months
- Our inpatient modeling is exceptional, 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

CORE in conjunction with the data sources described below determine each member's potential risk level. CORE It is based on three risk metrics (please refer to **Figure 2.1-5)**.

- Predictive Modeling (PM) General Risk Score: members in top 1 percent of population based on medical and behavioral health diagnoses, medical service utilization, and pharmacy use
- ED Risk Score: risk of an ED visit within the next 12 months
- Inpatient (IP) Admission Risk Score: risk of an IP admission within the next 12 months

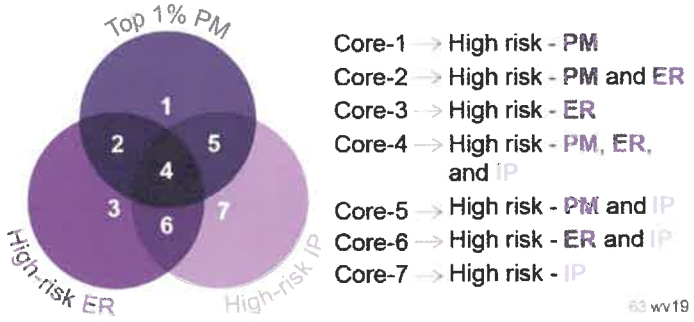

Figure 2.1-5 Aetna's CORE Model
CORE allows Aetna to identify members with a potentially high risk for costly utilization who may benefit from enrollment in care management.

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 at risk for crisis episodes. This practice allows the ICT to intervene at an earlier point with newly enrolled children, youth, and young adults to provide increased support and services to avert potential traumatic events including being placed out of their home. Aetna's rising risk model uses 28 different measures to stratify and score members age 17 and under including measures around specific behavioral health 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. Using this method, the care coordinator and ICT can rapidly identify members and who are at elevated risk that may need to receive services at a higher tier of care management **[CM017].** Once a member is identified for rising risk, the care coordinator will outreach the member and their guardian to further assess the situation and determine the next best course of action, including assignment to a higher tier if warranted.

Monitoring members with high physical or behavioral health needs: Aetna is committed to partnering and with and supporting children, youth, and young adults with high needs in a coordinated and comprehensive monitoring program that emphasizes child 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 the members may have experienced difficulties with accessing and receiving care due to a variety of variables and thus needs to be engaged in the care delivery process to drive optimal health outcomes. Our approach will focus on cultural sensitivity, peer-to-peer support, coordinated care and goal setting. Thus, member care will be monitored closely to ensure the care coordination team is apprised of any changes in status and need for more or less supportive services. Before final determinations and/or changes are made, the ICT and the member will collaborate to discuss all potential options in a collaborative fashion. The ICT will also partner with the member to discuss progress toward care plan goals, address any barriers the member 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 will leverage our relationships with community partners to stay connected to members during critical times ensuring a seamless system of care. For example, the CCT can go onsite to a facility if a member is in inpatient or residential care and convene with all partners, the member, and the member's supports, to ensure the best plan is in place **[CM017].**

Care Planning

CM001	The Vendor should coordinate continuity of care between healthcare providers, child welfare providers, behavioral health providers, and care coordinators with an integrated care plan for all children.	The Vendor should provide a detailed description of its approach to meeting this specification. The description should reflect an understanding of this contract's population, services, and stakeholders.
CM005	The Vendor should collaborate with the Department's pharmacy program to help provide coordinated care for the member, including, but not limited to, those members accessing psychotropic medications, for applicable populations.	The Vendor should describe how it will meet this specification.
CM014	The Vendor should engage in the Individualized Care Planning process for foster care members.	The Vendor should describe how it will meet this specification.
CM024	The Vendor should develop plans specific to each case for members participating in Intensive Care Management (ICM) teams, for applicable populations.	The Vendor should describe how it will meet this specification.
CM029	The Vendor should incorporate data about social determinants of health into its care coordination services.	The Vendor should describe how it will meet this specification.
CM030	The Vendor should establish committees with family members, the member, providers, the care coordinator, and a Department lead to help develop the most appropriate care plans for the member.	The Vendor should: 1) Describe how it will meet this specification. 2) Explain how it proposes to define the "most appropriate" care plans.
CM034	The Vendor should facilitate coordination of care between primary care providers (PCPs) and children's dental providers for applicable populations, including, but not limited to, for children with special healthcare needs.	The Vendor should describe how it will meet this specification.
CM053	The Vendor should identify members in need of treatment plans.	The Vendor should describe the process and/or mechanisms for identifying members in need of such a plan.
CM054	The Vendor should develop, update, and use clinically appropriate treatment plans that address coordination of primary services, specialty services, ancillary services, community and social support, and/or carved-out services for members identified as having special healthcare needs, based on that member's needs.	1) The Vendor should describe in detail the process for developing, updating, and using these treatment plans. 2) The Vendor should provide a sample treatment plan.

We know today that children and youth in the child welfare system face the greatest vulnerabilities to physical and mental health conditions and require seamless access to services and trauma informed care. Our SOC and Care Connection teams understand the health disparities and risk to health equity for West Virginians and care planning is tailored to target these disparities. We have identified the benefits of collaboration in care planning to remove barriers and develop meaningful integrated care plans which include health and life goals as identified by the member and their guardian/family/caregiver(s). An integrated care plan will be created for all members in all tiers of care management **[CM053].** The wraparound model, LifeCourse framework, Safe at Home approach, and Family Finding activities guide care coordination and member and family-centered planning. The member and their family/guardian work in partnership with the care coordinator and ICT members to create the care plan that addresses their chosen goals. Aetna's CCT staff as well as the member's PCP/pediatrician, physical health, dental, and behavioral health specialty providers, peer support specialist, community health workers (CHW), Department caseworker, CPS caseworker, child welfare provider, adoption competent therapists, school representatives, juvenile justice representatives (if applicable), the Aetna clinical pharmacy advisor, and other substance use disorder specialists, can participate in the ICT care planning meeting and ongoing coordination of care, as invited/requested by the member and their guardian/caregiver(s) **[CM001,**

CM005, CM030, CM034]. The ICT also includes extended family members, friends, and community members or other circle of support individuals, as identified by the member and their guardian/caregiver(s). ICTs operate with a 50/50 natural member-to-professional ratio (per national wraparound standards) in order to strengthen the impact of member and family voice and choice. This level of interdisciplinary collaboration, care planning, and coordination occurs for all enrolled children, youth, and young adults assigned to Tier 2 or 3 care management, including for those with special health care needs **[CM034].** The member and their guardian/family/caregiver(s) ultimately determine the makeup of their ICT.

In alignment with national best practices and using the LifeCourse framework, Aetna and our West Virginia CCTs are trained to understand and embrace the core principles of **member and family-centered thinking, planning, and most importantly, living,** as follows:

- 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 internal and external 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 2.1-6 provides examples of personal matters that are important to members during the course of care planning and care management.

Figure 2.1-6: Member and Family-directed Care Planning
Aetna's care planning process meets members' unique needs.

[CM014, CM024, CM053] **All children and youth assigned to any level of care management tier regardless of which population they belong to (foster care, adoption assistance, legal guardianship, individuals with special health care needs) will have an individualized integrated care plan customized to their unique circumstances and needs.** Following completion of initial screening and assessments, the care coordinator develops the integrated wraparound care plan in collaboration with the member and their ICT (within 30 days of completion of the first screening contact with the member and their guardian). All participants invited/permitted by the member and their family/guardian to join the ICT are collaborators with the member in the development of the care plan. Members and their guardian/family are empowered by the care coordinator and other ICT members to play a central role in the development of goals and identification of needs as they relate to their individual integrated care plan. **Figure 2.1-7** highlights our person/family-centered approach to co-creating the integrated care plan with the member and their family/guardian/caregiver(s).

[CM054] The initial screening and comprehensive assessments completed by Aetna care management staff are the foundation against which the ICT verifies that the care plan addresses the member's needs. **Goals, objectives, and services and interventions identified during care planning address all factors that impact the member's health to foster improved health outcomes.** Interventions outlined in the care plan target special health care needs (such as obtaining durable medical equipment for a child with diabetes or arranging for substance use disorder services for youth who are abusing substances). In addition to identification of needed health care services, socially necessary services and other community services to address SDOH are included in the care plan **[CM029].** **The most appropriate care plans are member-driven and provider-informed and ensure collaboration and continuity of care between healthcare providers, behavioral health providers, and child welfare providers to address the goals identified by the member and their family/guardian and circle of support** **[CM030].** Members of the ICT are valued contributors to ongoing assessment, care plan updating, and service delivery, but the care plan must be agreed upon by the member and their family/guardian/caregiver(s).

Member Becomes a Recovery Coach for New and Expectant Mothers

Anna (not her real name) was receiving treatment at the Maternal Addiction Recovery Center (MARC) when she met her Aetna care coordinator. She had a history of heroin and Suboxone use (obtained from the streets). Her Aetna care coordinator conducted face to face visits with Anna every two weeks and continued to offer education, support, and arrangement of services (such as transportation) through her transition to the Recovery Center's MAT program. Anna had lost custody of another child due to her drug use but was determined to keep custody of her newborn. Her Aetna care coordinator assisted Anna through several health issues and guided her on how to get treatment for her hepatitis-C. Anna took her baby to all scheduled well visits and kept her up to date on her immunizations. Anna did remarkable in her recovery and not only holds a job now, but also has her own vehicle. She has also started her own recovery group for new and expectant mothers where she is the recovery coach. She most recently came back to the MARC program and spoke to the girls who are in the program about her success, and ways that they too can be successful in their recovery by utilizing all the people and resources that are available to them.

Appendix G provides a sample member care plan.

Figure 2.1-7 offers an overview of the care management process flow, from initial screening contact to creation of the care plan.

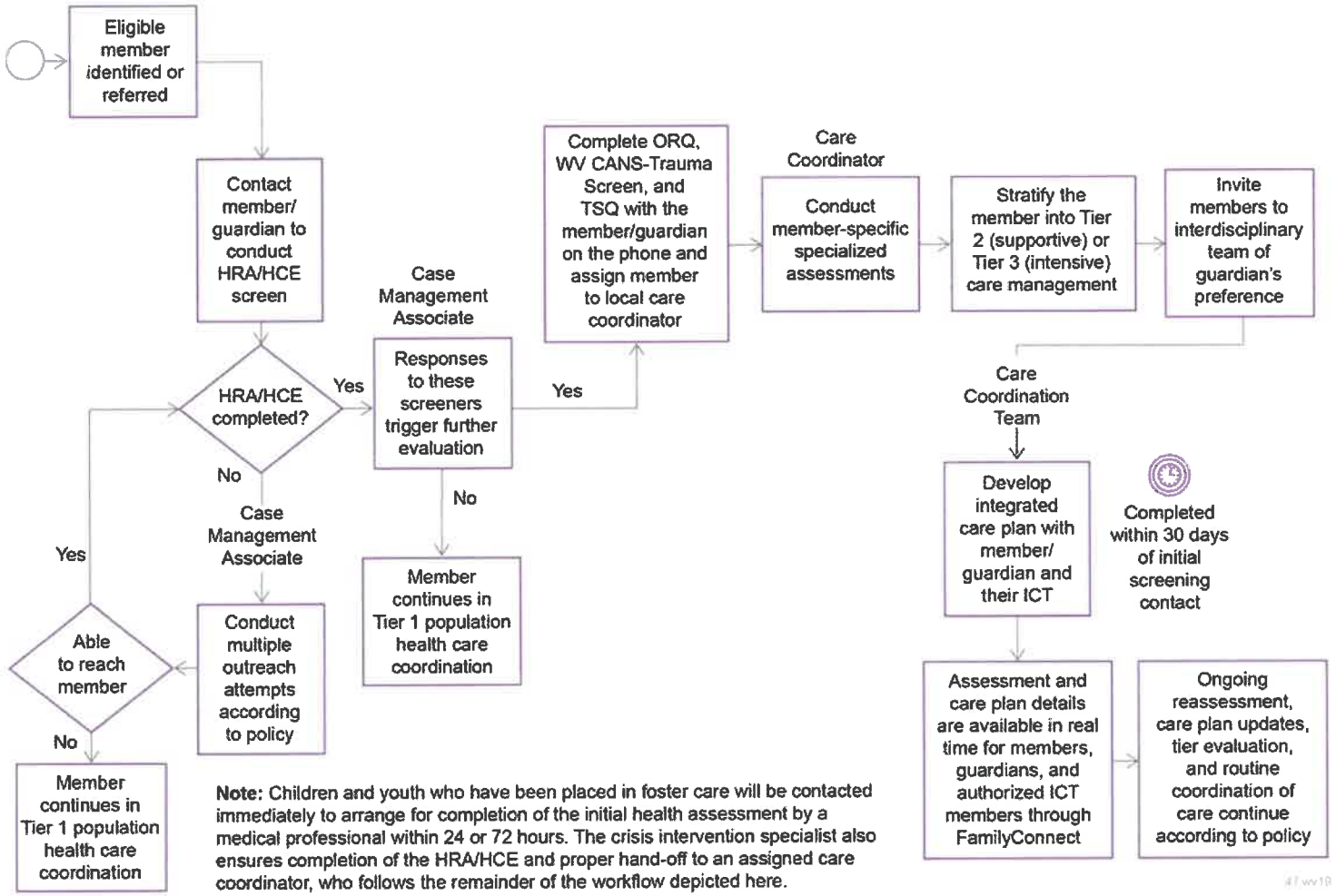

Figure 2.1-7: Routine Care Coordination Process Flow

Care coordination processes include screening, assessment, the assignment of a dedicated care coordinator, creation of the initial care plan, and ongoing coordination of care.

Routine Ongoing Care Coordination

CM004	The Vendor should evaluate and report member progress in meeting goals identified in the individualized service plan (ISP).	The Vendor should describe how it will meet this specification.
CM005	The Vendor should collaborate with the Department's pharmacy program to help provide coordinated care for the member, including, but not limited to, those members accessing psychotropic medications, for applicable populations.	The Vendor should describe how it will meet this specification.
CM018	The Vendor should monitor members' physical or behavioral health needs and respond to changes in acuity over time, for applicable populations.	The Vendor should describe how it will meet this specification.
CM029	The Vendor should incorporate data about social determinants of health into its care coordination services.	The Vendor should describe how it will meet this specification.
CM041	The Vendor should identify opportunities on an ongoing basis for activities or linkages with West Virginia (WV) Children with Special Health Care Needs (Title V) program clinics, providers, or other professionals.	The Vendor should describe how it will meet this specification. This description should reflect an understanding of the West Virginia (WV) Children with Special Health Care Needs program.
CM048	The Vendor should develop and implement steps for care coordinators to establish relationships with their assigned members.	The Vendor should describe in detail: 1) Steps care coordinators will take to establish relationships with their assigned members. 2) A protocol for addressing a member who does not want a care coordinator or cannot be reached once a care coordinator has been assigned.
CM049	The Vendor should establish and implement guidelines for when care coordinators should have face-to-face contact with their assigned members, including, but not limited to, when requested by a Department worker.	The Vendor should describe its approach to care coordinators' face-to-face contact with assigned members, including, but not limited to: 1. Frequency 2. Circumstances resulting in a need for face-to-face contact 3. Goal of face-to-face contact at this frequency and/or in these circumstances
CM050	The Vendor should develop and implement standards for how often the care coordinators will contact members after the initial care coordination contact, based on the member's acuity level.	The Vendor should provide and describe proposed standards for this specification.
CM054	The Vendor should develop, update, and use clinically appropriate treatment plans that address coordination of primary services, specialty services, ancillary services, community and social support, and/or carved-out services for members identified as having special healthcare needs, based on that member's needs.	1) The Vendor should describe in detail the process for developing, updating, and using these treatment plans. 2) The Vendor should provide a sample treatment plan.
CM059	The Vendor should identify providers that do not perform coordination activities and take action to improve coordination.	The Vendor should describe the protocol for addressing a provider that does not perform coordination activities.
CM060	The Vendor should coordinate services with community resources and social services for members in the area served by the Vendor, including, but not limited to, those with special healthcare needs.	The Vendor should describe: 1) Procedures that will be in place for coordination with community resources and social services for members, including those with special health needs 2) Timeframes for identification of such resources and services

Following initial assessments and the creation of the individual's integrated care plan, CCTs continue to provide routine ongoing support and coordination to aid members in achieving their goals.

[CM004, CM018, CM029, CM049, CM050, CM054, CM059]
Ongoing Assessment and Care Planning

As care coordination continues following creation of the initial care plan, the member, their family/guardian, care coordinator and the ICT meet (according to the frequency described previously regarding care management tiers) and discuss the member's progress (or lack of progress) towards their care plan goals in response to the delivery of services identified in the care plan. Our electronic care management system includes tracking of progress towards goals **[CM004].** This review includes assessing whether the member's physical, behavioral or SDOH needs have changed, and informs whether a reassessment or update to the integrated care plan is necessary **[CM018].** We run our predictive risk stratification analysis on all members on a monthly basis, which may also alert us to changes. CCTs and the assigned care coordinator facilitate the completion of updated assessments and care plans with the ICT. Screenings (inclusive of the HRA and HCE, and review of SDOH **[CM029]),** 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. Integrated care plans are updated monthly for members in Tier 2 or 3 care management (and more frequently as significant life changes such as home removal, placement changes, or admission to an inpatient facility occur). Members in Tier 1 care management are outreached quarterly to evaluate whether a care plan update is needed **[CM054].** Care plans will be updated if there is a change in the member's health conditions, the need for socially necessary services, or a significant change in SDOH. Care coordinators set follow up tasks in our electronic care management system to notify them when reassessment and care plan updates are due. 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 with members, such as face to face contact with the member. **Face to face contacts are typically conducted via in person ICT care plan update meetings or home visits needed 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 guardian/circle of support **[CM049, CM050].** Our table in the care management tiers section also described the expected minimum frequency of ICT meetings. At times of reassessment and update of care plans, the member and their ICT 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 member remains assigned to the same care coordinator, but the intensity and frequency of intervention is adjusted to the new tier-based requirements **[CM018].**

During the first half of 2019, Aetna has conducted 1,097 face-to-face visits throughout West Virginia with the current staff of 25 care managers. During all of 2018, Aetna conducted 1,612 face-to-face visits with members in intensive care management (contacting 86% of our members face to face) in all 55 counties. With the rise in the number of face-to-face visits between care management staff and members this year, reports of increased rapport have been noted. Member care management enrollments have increased and opt out rates have decreased from June 2017 to present by 8%. Anticipatory guidance with members appears to be received and accepted through enhanced engagement. Additionally , our readmissions/1000 average dropped from 10.08% in 2018 to. 5.17% in 2019.

As ongoing care coordination continues, if the care coordinator identifies a provider member of the ICT that is not contributing to collaborative activities, they may outreach the provider liaison assigned to the provider for assistance in getting the provider to respond or step in **[CM059].** 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.

[CM054] Coordination of Health Services

In addition to assessment and care plan updating, the care coordinator is responsible to provide members and their families assistance 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 will 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 (or their guardian as applicable) following missed appointments to assist in rescheduling. **Care coordinators assist children, youth, and young adults and their guardians/circle of support with cross-system navigation to ensure every young person receives and attends needed healthcare appointments, socially necessary services, and support identified in the care plan [CM054].** They coordinate all aspects of person and family-centered care, including the following required HealthCheck screenings, required health supervision visits, and 90-day follow-up visits for children in foster care in accordance to frequency expectations given by the Department; primary care via a medical and dental home, care provided at school-based health centers; specialty provider services, respite for caregivers, medication management, management of chronic conditions, and peer support services; and programs to meet members' social determinant needs. This routine coordination occurs during weekly telephonic contacts with the member and their family/guardian or at ICT meetings or other face to face contacts with the member. During these contact points, the care coordinator reviews the care plan and talks with the member and their family/guardian regarding they whether they are attending services outlined in the care plan, as well as whether they are experiencing any barriers to receiving services or medications. If they are facing barriers, the care coordinator can intervene to assist on their behalf in the resolution of barriers.

Innovative Solutions in Rural West Virginia

In McDowell County, the median household income in 2013-2017 was $25,595 and the percent of persons in poverty was 31.7% based on statistics from the census.gov. The rural geography of the county provided many barriers to accessing health care, education, and employment. Aetna collaborated with Big Creek People In Action in War, West Virginia, to utilize the community health worker to improve access to care and engagement with both chronic condition care for diabetes and asthma and preventive care for members in populations identified as having less access to and/or involvement with the health care system (health care inequity) over a three-year period.

[CM005] Coordination with Pharmacy and Medications

Care coordinators and the CCT play a critical role in working with members, guardians, and the ICT 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 **[CM005].** 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. During the initial assessment phase and ongoing care planning process, the chief medical officer (CMO)/medical director and the clinical pharmacy advisor review to identify members with several prescribed medications (polypharmacy) in the same or similar drug class along with more than two prescribing practitioners to determine potential safety and drug interaction/risks. Members identified with safety concerns are outreached by case management for a medication review, identification of intervention and communication with prescribing practitioners on identified prescribed medication concerns. The members identified with safety concerns are reviewed at least semiannually thereafter. Findings are discussed by the health plan care team and follow up initiated as indicated.

Condition-specific medication adherence is evaluated during interactions between the care coordinator and members diagnosed with targeted conditions such as diabetes or asthma. The 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 plan of care/care plan. Our **Psychotropic Clinical Program** monitors psychotropic prescribing for individual members and prescribing patterns in situations where there is a known risk of inappropriate use of psychotropics **[CM005].** Problems identified through this monitoring process may lead to medical peer-to-peer consultation, collaboration with the Department's pharmacy program, a quality of care referral, or other actions, depending on the situation. Our **Member Restriction Program** aims to protect the safety of members who have demonstrated a pattern of dangerous abuse or misuse of their medications. There are strict guidelines around the criteria to place a member on restriction, communication to members regarding their placement in this program, as well as their rights to appeal. Members enrolled in this program are closely monitored and receive education regarding the safe and proper use of these medications. They are evaluated at prescribed intervals to determine if it is safe to remove them from restriction.

[CM029, CM041, CM060] Targeting Health Disparities

Aetna utilizes a regionalized model to impact disparities in each identified care connection team region and individually with the member. Throughout all counties in the State of West Virginia, Aetna has implemented the following interventions to address disparities in each region or identified member need:

According to the Department's *West Virginia's Child Welfare Crisis* May 2018 report, 83% of open abuse or neglect cases in West Virginia involve substance use. Additionally, West Virginia is number 1 in child home removals nationally.[10]

Opioid death and use: According to 2018 claims paid, opioid use was the top diagnosis in all three Medicaid products (Affordable Care Act, Supplemental Security Income, and Temporary Assistance for Needy Families) Aetna has implemented the following interventions to address opioid disparities:

- The CCT has a peer support specialist that covers the whole state of West Virginia. **The peer support specialist, who has successfully overcome their own SUD, can participate on the ICT and offers sponsorship and support through telephonic and home visit contacts with the member and their guardian.**
- Members enrolled in the care management NAS program receive education, support, and assistance with locating treatment. Enrolled members who complete the NAS program can receive a cribette 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, 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 medication assisted treatment facilities with the ability to meet 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 state.
- Each CCT region has an assigned substance use disorder specialist and behavioral health specialist. These specialists are excellent sources of information regarding SUD services and can aid in connecting members to these services.
- Members are outreached and assessed for opioid use through the HRA, facilitating necessary referrals to care management.

[10] 1 Samples, Jeremiah, "West Virginia's Child Welfare Crisis; A Path Forward," West Virginia Department of Health and Human Resources (2018): accessed August 5, 2019;.http://wvahc.org/wp-content/uploads/Prez-on-Child-Welfare-1.pdf.

- Aetna and Drug Free Moms and Babies are piloting a program with CPS to provide early intervention to Mothers and babies affected by substance use disorder. This early intervention can help prevent children from entering the foster care system by providing the birth mother support and assistance with locating necessary treatment programs.

Coordinating Services for a Baby with NAS

Gregory (not his real name) was born in Cabell Huntington Hospital to a mother with a history of SUD and methadone treatment. We provided NAS care management to Gregory and intensive care management to his mother to promote bonding and provide information about infant care. Gregory was transferred to Lily's Place for ongoing treatment. His birth mother decided to place Gregory for adoption and the care coordinator continued follow up and intensive care management for Gregory and his foster parents. The care coordinator provided the foster parents with information regarding the Right From the Start and Birth to Three programs to assist with care and developmental needs. Over a two-month period, Gregory's foster mother reports he has gained more than 3 pounds. He had been experiencing torticollis and was referred for the physical therapy which resulted in quick resolution of the problem. Gregory's foster mother said that the physical therapy staff were amazed at how advanced he is for his age as he was trying to sit up and hold his bottle already and that he is a happy baby. Upon further evaluation it was determined he did not need Birth to Three services as he is meeting all expected milestones as expected. Gregory goes to Marshall Pediatric for follow-up care and he is up to date on all vaccinations. His foster mom says she sends pictures and text updates to Gregory's birth mom, but she does not have physical contact with Gregory. His foster mom says she is grateful for the support and education she received from the care coordinator.

Low birthweight, premature birth: Aetna impacts birth outcomes throughout all counties in the State through the following interventions:

- Referrals to the State program Children with Special Health Care Needs. Children identified eligible for this program require additional care management services to coordinate their complex care needs. In addition to program referrals, the care management supervisor attends the State Children with Special Health Care Needs program meetings **[CM041].**
- The following value-added benefits are available to members during pregnancy and after delivery through our Maternity Matters program:
    - $25 initial prenatal visit reward. Eligibility criteria: Pregnant members statewide. Limits and restrictions: one per pregnancy.
    - $25 postpartum reward- New mothers can earn $25 after completion of one postpartum appointment within 21 to 56 days after giving birth. Eligibility criteria: New mothers statewide. Limits and restrictions: appointment must occur 21 to 56 days after giving birth.
    - Adult preventative dental program-offers up to two check-ups during pregnancy and dental hygiene kit (toothbrush, toothpaste and floss). Eligibility criteria: pregnant members statewide 21 years of age and older. Limits and restrictions: up to two preventive dental check-ups per pregnancy
- The CCT offers a lactation specialist for support and education on breast feeding.
- All care management staff has received training on the Safe Sleep program to educate members on the importance of using safe sleep practices with their newborns.

Smoking during pregnancy: Aetna impacts smoking during pregnancy throughout all counties in the state through the following interventions:

- Members are outreached and assessed for smoking tobacco use during pregnancy through a Trimester Risk Screening assessment; identified members who use tobacco are referred to WV Quitline and offered additional education on smoking cessation. Pregnant members enrolled in care

management who use tobacco are offered continued support and education to encourage smoking cessation.
- Medical management staff participate in the State's MOMS smoking cessation planning meetings.

Access to food: Aetna impacts identified SDOH **[CM029]** such as food insecurity and access to local resources through the following interventions **[CM060]:**
- Aetna sponsors food bank distribution events throughout the state. The events are not specific to only Aetna members, but are open to anyone who attends the event in need of food. In addition to sponsoring food bank events, Aetna has purchased food trucks for the usage of distributing the food out to communities.
- Members outreached for care management are assessed for adequate access to food, those identified needing assistance are provided with local community resources in their area.
- 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.
- Members outreached for/or enrolled in care management are educated on the process of signing up for the State nutrition program, SNAP.
- Members have access to a lactation specialist to assist with breast feeding education and support.

Access to care: Aetna impacts the identified SDOH of accessing care **[CM029]** through the following local resources and interventions:
- Aetna eliminated the prior authorization requirement for home health and school services, supporting telehealth in the home. Offering telehealth services impacts the rural areas of West Virginia that have limited transportation and resources.
- Collaboration with Anytime Pediatrics and Nationwide offering telehealth for pediatric oncology patients.
- **Aetna offers the Family Information Support and Help (FISH) program to communities as an educational forum on child/adolescent topics on mental health. The training is facilitated by the Behavioral Health medical director and is open to anyone in the community.**
- Aetna's Quality Management department sponsors various well child clinic events. Child members who participate in the well child event can receive a gift card.

[CM060] Coordination with Community Resources and Social Services

Throughout the care planning process and ongoing care coordination efforts for all members (including those with special health care needs), 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 as stated previously (or when there is a significant life or health change). 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 **[CM060].** Representatives of organizations offering community resources or social services may be invited for ICT meetings, with permission of the member and their guardian/caregiver(s) as needed.

Partnering with Organizations who Assist LGBTQ Children, Youth, and Young Adults

We recognize that members who self-identify as LGBTQ are over-represented in the child welfare system and they face unique challenges. The experience of LGBTQ youth in foster care is often more difficult than their peers. They experience far more placements than non-LGBTQ youth, and according to a recent survey, 19.6% of LGBTQ youth in foster care were moved from their first placement because of a caregiver request, compared to 8.6% of their heterosexual peers in foster care.11 Therefore, Aetna will partner with local LBGTQ organizations such as Dr. Rainbow/Coming Out for Health in West Virginia, to help ensure this population is identified early in the screening process and that additional risk screenings are administered, as clinically appropriate.

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), KEPRO, Perinatal Partnership, ACES Coalition, Safe at Home, 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 Parent, PROACT, WIC, and Mountains of Hope.

Aetna is utilizing a national award-winning framework to increase and strengthen collaborative practices between child protection caseworkers and community and family partners called **Collaborative Family Engagement (CFE)**. This type of respectful, responsive, and collaborative practice framework has been shown to improve the coordination, satisfaction, and efficiency where multiple systems are involved in the lives of children and their families and caregivers. The approach seeks to remove barriers to collaboration between public child welfare internal cultures and external community-based partners. According to the Child and Family Research Partnership:

> "The CFE project has two primary goals: 1) To increase the number of adult relatives and fictive kin willing to act as a support system for children who have been placed in substitute care, and 2) To strengthen collaboration between Court Appointed Special Advocate volunteers and CPS staff to facilitate better case management and service delivery for the children they jointly serve."[12]

Aetna is also dedicated to engaging local faith-based community organizations to create a network of support for our foster care members and families who are in need or in crisis. Through our work we have identified two potential partners, the Global Orphan Project and Celebrate Recovery. **Collaboratively, we will connect children and families affected by the child welfare system to faith-based organizations, using an online platform called CarePortal.** The CarePortal platform allows for basic and complex requests from caseworkers at government child welfare agencies or other child-serving organizations to be submitted online for review by participating organizations. Each request is then responded to by local faith-based organizations participating in the CarePortal. Every response aims to support, preserve and unite children and families.

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[11] Scraggins, Terry, "For LGBTQ Youth in Foster Care, Finding Home is Hard," (2018); accessed August 5, 2019; https://chronicleofsocialchange.org/analysis/for-lgbtq-youth-in-foster-care-finding-home-is-hard/32813.

[12] The University of Texas at Austin Lyndon B. Johnson School of Public Affairs, "Collaborative Family Engagement: A Promising
Approach to Supporting Children in State Care," (2017); accessed August 5, 2019; https://childandfamilyresearch.utexas.edu/collaborative-family-engagement-promising-approach-supporting-children-state-care.

[CM041] Activities with West Virginia Title V Program Clinics, Providers, and Professionals

Aetna will focus 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 SOC administrators will be working with the Office of Maternal, Child and Family Health (OMCFH) to improve members' sense of safety, the member experience and access to services, and to 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. As described previously, we offer specialized care management for NAS babies and follow them closely for their first year of life. As another example of linkage with the Title V program, CCTs work with schools and school districts to ensure children transitioning (from age 0-3 population) to the school system have IEPs where appropriate. Our adult and child SOC administrators will work with the OMCFH to track success and address any barriers.

Special Care Coordination Circumstances

CM011	The Vendor should collaborate with hospitals, psychiatric residential treatment facilities (PRTFs), residential providers, behavioral providers, and others on discharge planning needs of a member leaving an inpatient facility or changing levels of care.	The Vendor should provide a detailed description of its approach to meeting this specification.
CM012	The Vendor should collaborate with hospitals, psychiatric residential treatment facilities (PRTFs), residential providers, behavioral providers, and others to ensure outpatient services have been established prior to the member leaving an inpatient facility or changing levels of care.	The Vendor should provide a detailed description of its approach to meeting this specification.
CM013	The Vendor should coordinate with the Department to ensure that all needed medication is available to the member after leaving an inpatient facility or changing levels of care.	The Vendor should provide a detailed description of its approach to meeting this specification.
CM015	The Vendor should collaborate with caseworkers to support members experiencing home removals and changes in placement based on Department foster care requirements.	The Vendor should provide a detailed description of its approach to meeting this specification.
CM016	The Vendor should collaborate with caseworkers to minimize the need for removals and changes in placement.	The Vendor should provide a detailed description of its approach to meeting this specification.
CM058	The Vendor should provide episodic and/or catastrophic care coordination interventions.	The Vendor should describe how it will meet this specification.

At times, unique circumstances require more intensive coordination activity. When children, youth, and young adults face possible home removal, placement changes, catastrophic medical episodes, or are planning for a discharge from an inpatient facility, Aetna's CCT takes responsive action to mitigate disruption and ensure seamless coordination.

[CM015, CM016] Home Removals and Placement Changes

We recognize the upheaval that can be caused by home removals or changes in placement and our CCT is trained in providing responsive support and care during these times. During times of significant life changes (including first removal, placement changes, aging out, homelessness, loss of all parents), CCTs will respond to the immediate needs of the situation to foster smooth transitions, through increased communication with caseworkers, and the scheduling of ad hoc care plan reviews. We will reevaluate whether the member should receive additional services or care coordination at a higher level than they are at the present time. Any decisions to intensify or add services will be acted upon immediately. When

these life events occur, we recognize children and youth may experience additional trauma and close and supportive coordination with the member, guardian/family and CPS workers serve to minimize trauma **[CM015].**

It is standard practice for the care coordinator and CCT, through ongoing contact and reassessment with the member, to monitor for any stressors or changes in the home which suggest instability. In alignment with our Safe at Home model and Family Finding approach, CCTs also increase coordination efforts to minimize the need for removals or placement changes when there are signs of impending change **[CM016]. We do this by intensifying coordination and updating care plans to increase wraparound services and socially necessary services to address emerging needs. Intensified efforts may also include increased frequency of face to face or telephonic contacts, reviewing the case in rounds, consulting with our behavioral health medical director, or adding new experts to the ICT (with member/guardian permission) for a limited time to troubleshoot and identify protective measures, interventions, and services that can be added to prevent home removal.** We may consider reviewing non-covered services and make and make an exception to offer such services on a case by case basis. We are aware that removal rates are often based on neglect due to parental substance use (particularly opioids). In these cases, we collaborate to identify possible kinship places. Simultaneously, we also work closely with parents' health care providers and health care coordinators (as permitted by the parents) to ensure they are getting substance use disorder and mental health services, in addition to services to address chronic medical conditions or SDOH that place the child's safe maintenance at home in jeopardy. Aetna recognizes that at some point in the future, the family members of children and youth served under this procurement may be included eligibles for services. We strongly believe this change would make prevention of removal or placement changes more realistic as we could manage the coordination of care (and monitoring of service delivery) for family members, whose healthcare issues may be significantly contributing to the child's trauma, chronic conditions and threats to permanency in the home.

Soon after implementation, we will be implementing **Family Assessment and Stabilization Team (FAST)** intervention services for enrolled youth. Children and youth referred for FAST are most often between nine and seventeen years old in crisis and at risk of imminent admission to a hospital psychiatric unit or homeless as a result of severe family conflict or ejection from a placement. They tend to have no family connection and frequent changes in caregivers. Children and youth are referred by a child welfare worker or county mental health worker. The focus of the FAST intervention is on safety, stabilization, well-being and permanency. The length of the intervention averages 90 days. When a dependent child is referred for a FAST intervention, the referent often states with certainty that the child has no family, either extended or immediate. Aetna staff operates with the belief that every child has a family; every child deserves to be with family, and that every family should be provided the opportunity to safely raise their children. For dependent children separated from family and served in FAST, the single most identified variable contributing to positive outcomes involves meaningful connections with family members. If the child's biological (or adoptive) parents cannot be a resource, Aetna staff begin an extensive search for family, broadening the search to all relatives of specified degree and paying equal attention to the often-overlooked paternal side of the family. We are hopeful that if and/or when family members of children and youth in the child welfare system are carved in as eligible, we will be able to further make use of the FAST interventions.

[CM058] Episodic and/or Catastrophic Care Coordination Interventions

The Aetna care management program is available to all enrolled members. This also includes identified members who have had a catastrophic event (e.g.: newly diagnosed cancer, trauma related injury, an acute behavioral event) occur in their life. Aetna identifies catastrophic events through several avenues

including: utilization review activities (both prior authorization and concurrent review activities); through inpatient alerts and ADT feeds; as notified by providers (physician or hospital); as notified by community partners and parents and or guardians. Once a catastrophic event is identified the care coordinator immediately organizes an ICT meeting. If the member was not already enrolled in intensive care management (Tier 3), they would be assigned to this level due to the catastrophic event and they would 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 would occur at this intensity until such time that reassessment and discussion with the member, their family/guardian, and the ICT identify the situation has stabilized and the member's needs can be met at a lower intensity of care management.

[CM011-CM013] Discharge Planning

Transitioning from one setting to another can be unsettling and even frightening for vulnerable members and their family members or caregivers. 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. We work to promote 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 family/guardian, facility staff, and other members of the ICT.

Assisting with Transitions from Psychiatric Residential Treatment Facilities

Kelly (not her real name) is a 10-year-old girl who had been admitted to a Psychiatric Residential Treatment Facility (PRTF), after being held in captivity for eight years by her mother's boyfriend, who also physically and sexually abused her. She had missed much of her public-school education and was not meeting minimum expectations for her age related to reading and math skills. The family often went without basic necessities such as food, water and facilities to complete routine hygiene tasks. Her Aetna care coordinator worked closely with her therapist at the PRTF and her mother while she was there and began helping them plan for discharge. She helped identify community resources for her mother. The care coordinator made sure Kelly had follow-up appointments with an outpatient counselor and psychiatrist upon discharge from the PRTF, and that her medications were arranged as well. Additionally, the care coordinator communicated IEP needs related to the upcoming school year. Kelly safely discharged to her aunt's home while her mother completed guardianship proceedings. The care coordinator assisted Kelly's aunt with recognizing that she would need to contact the child's school to have the IEP transferred and/or revised prior to the beginning of the upcoming school year. They also discussed the need of having educational transcripts released to the school system to ensure that member would have all necessary documentation and current academic records from PRTF facility.

We modeled our **transitional care management program** on 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 works with members to utilize **FamilyConnect** to facilitate communication and ensure continuity of care across providers and settings
- **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 **[CM012]**

- **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. The member, along with their family and circle of support, are the principal voices and decision-makers in the care process. We serve as their strongest advocates to coordinate care that incorporates evidence-based care and community services with a wraparound approach that addresses social determinants of health.

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 transition of care program is impactful and to guarantee we have sufficient staff necessary to meet the specific needs of our members in each of the nine regions of the state. Working in concert with our locally based CCTs, Aetna assigns transition of care clinicians to specific hospitals and facilities to manage our members' transitions from one setting to another. Discharge planning starts at the time of admission. Transition of care staff complete face-to-face visits with members, which provides us with 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. Care coordinators serving members in Tier 3 function as the transition care coordinator to provide continuity of care and maintain the single point of contact for the member. We enhance this offering with support from telehealth, telemedicine, home telemonitoring services for at-risk members, and post-discharge nurse visits. We will incent physical health and behavioral health providers to increase collaboration when the member's care requires it.

Our care management strategy includes availability of all medical records through connection to the West Virginia Health Information Network. Aetna tracks ADT data and receives real-time notifications through this WVHIN. The care coordinator can retrieve the member's information, including primary care visits, unmet health-related resource needs, and medication and pharmacy history to determine risk. This will enable our care providers to collaborate on creating a comprehensive, real-time data set to share across the provider continuum to promote achieving quality outcomes such as HEDIS scores and preventable readmission reduction.

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, psychiatric residential treatment facilities (PRTFs), therapeutic group homes, residential substance use disorder settings, and transitions out of incarceration. **Table 2.1-6** highlights key components of our program.

Table 2.1-6: Care Transition Approaches for Facilities across the Continuum of Care [CM011, CM012]

Facility	Approach
Rehabilitation services, PRTFs, and therapeutic group homes	Aetna's online referral platform allows rehabilitation providers the ability to make real-time referrals to Aetna transitional care management. Transitional care coordinators collaborate with PRTFs prior to discharge to create a plan for outpatient services when the member returns to the community.
Psychiatric hospitals	Aetna partners 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 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.
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 connection 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 will include a review of 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 their guardian) knows how and where to fill them. The care coordinator will facilitate resolution of any barriers in this process with the member, their guardian, the facility or the pharmacy as needed **[CM013].** 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 manager 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).

Sharing of Assessments and Care Plans

CM002	The Vendor should share information required for continuity of care with the member and their family or caregiver(s).	The Vendor should describe how it will meet this specification, including, but not limited to, communication paths, methods, and/or frequency.
CM003	The Vendor should provide training to ensure an integrated care plan is jointly developed and shared among the primary care provider (PCP) and/or	The Vendor should describe how it will meet this specification and who will participate in training.

	specialist serving as a principal coordinating physician, and the child and caregiver(s).	
CM055	The Vendor should share care plans with a member's primary care provider (PCP) at a set frequency.	The Vendor should: 1) Provide the frequency with which care plans will be shared with primary care providers (PCPs) and other providers. 2) Describe the manner (including, but not limited to, letters or phone calls) in which care plans will be shared with PCPs or other providers. 3) Describe who is responsible for sharing care plans with a member's PCP.
CM056	The Vendor should share care plans with a member's primary care provider (PCP) outside of the established schedule according to guidelines developed by the Vendor and approved by the Department.	The Vendor should describe what events or circumstances will prompt the Vendor to share care plans outside of the established schedule.

Copies of the current and prior assessments and care plans are stored in real time (as they are documented by the care coordinator) in FamilyConnect and are accessible by provider members of the care team (with permissions) at any time via the provider portal **[CM055, CM056].** Data integration is critical to early intervention and continuity of care. FamilyConnect streamlines both the provider and the member experience. FamilyConnect is a shared, electronic health record that serves as the single source of truth for youth and their circles of support. PCPs and health care providers receive training upon orientation (and ongoing as needed) regarding how to access FamilyConnect from their provider relations representative **[CM003].** Care coordinators may also mail or securely email assessments and care plans to providers upon request and if permitted by the member/guardian. Members and their families also have access to their assessment and care plan information through FamilyConnect via the member portal and their care coordinator provides education regarding these tools **[CM002].** The Medical Passport, a tool utilized by foster parents, relatives, fictive kin, and caregivers to document all appointments and medical history, will be housed within FamilyConnect in digital copy which will significantly improve timely communication during instances of placement change.

Patient-Centered Medical Homes

CM006	The Vendor should establish and maintain patient-centered medical homes for its members (in applicable populations) in alignment with the AAP guidelines in the Health Care Issues for Children and Adolescents in Foster Care and Kinship Care manual, including, but not limited to, the following:	The Vendor should describe in detail how it will meet these specifications.
CM007	The application process for providers	See the parent specification.
CM008	Assessment of whether foster care members can continue to receive healthcare in their medical home of origin, and if not, how best to establish and maintain new medical homes	See the parent specification.
CM009	Communication with members and/or their caregivers/families, as appropriate, about patient-centered medical homes for applicable populations	See the parent specification.
CM010	Annual reporting processes	See the parent specification.

Children entering foster care or who are going through the adoption process often have history of receiving inconsistent health care or none at all. They have experienced not only the emotional trauma that resulted in their entering the child welfare system, but often have chronic medical conditions, mental health issues, or developmental disabilities that have not been treated. Sometimes, they have received some care, but have moved from provider to provider as the chaos in their life may have forced them to

move multiple times or because their family of origin had not maintained consistent relationships with providers. A key protective factor and element of resiliency is the presence of continuity in the life of a child. The AAP supports all children's healthcare to be delivered in a Medical Home. Health care providers can serve as an example of consistency, particularly in a PCMH. **Figure 2.1-8** identifies the qualities of a PCMH with added emphasis for elements critical for foster care children, according to the AAP.

CM006 Aetna recognizes the extensive and lengthy process for providers to be formally recognized and certified as PCMHs and that the provider network in the State of West Virginia does not currently have the necessary volume of PCMHs for our members, particularly for those children in foster care. Our population health representatives will work with providers and community resources to strategize regarding the best way forward to move towards the creation of more integrated PCMH model providers throughout the state. Our efforts will be the catalyst for moving the network in this direction through value-based contracting, co-location of care coordinators and behavioral health specialists, and including approaches to working with FQHCs who incorporate behavioral health services.

Figure 2.1-8: Qualities of a Patient-centered Medical Home
The AAP has defined the qualities of a patient-centered medical home with additional expectations for those serving children in foster care.

[CM007] Provider Application Process

Aetna strives to both identify and support our existing medical home providers and enhance provider practices desiring PCMH certification. In light of the extensive formal PCMH certification process, Aetna will begin further development and expansion of PCMH models by initially offering incentives to providers who have implemented actions to align with SAMHSA-HRSA's Center for Integrated Health Solutions Six Levels of Collaboration and Integration.[13] As we develop the incentive program, we will place particular focus on the integration of behavioral health, physical health, SDOH services, improved communication, and enhanced electronic health record and data analytics capacity

To move the provider network toward formal PCMH certification, we will engage in collaborative efforts with our network development team, SOC administrators, provider relations staff, alternative payment model (APM) services contracting representatives, and population health experts to outreach community providers. We will work with local providers to offer education regarding the certification process and will engage the community in discussion regarding how to achieve PCMH certification given the time, effort

[13] SAMHSA/HRSA Center for Integrated Health Solutions, "A Standard Framework for Levels of Integrated Healthcare and Update throughout the Document," (2013): accessed August 5, 2019; https://www.integration.samhsa.gov/integrated-caremodels/A_Standard_Framework_for_Levels_of_Integrated_Healthcare.pdf.

and cost that goes into this process. We will investigate provider interest, who has the best potential to pursue certification, and will partner with FQHCs who may have additional experience in this area. We will delve further into options with behavioral health providers who may be able to expand into and integrate physical health services. Given the elements of certification, we plan to create an integrated community advisory group to discuss strategy and will engage in further discussion regarding PCHM expansion at Aetna's Medicaid National Advisory Council.

[CM008] Continuity with Medical Home of Origin

As part of our initial screening processes, Aetna care coordination staff inquire with the member and their family regarding where the child has received health care in the past and whether they have been happy with those services. If the child and family have been receiving services at a medical home with whom they are happy and with whom Aetna contracts, the child will continue to receive care in that medical home if that is their request. If they are unhappy with the care they have received, care coordination staff will explain the availability of contracted providers and PCMHs in their area (as well as what the role of PCMH entails) and will connect them to the PCMH or provider of the member and family's choice.

If the member has been receiving care from a PCMH that they would like to continue with who is not currently in the Aetna network, the care coordinator will connect with Aetna's network team to pursue a single-case agreement and/or contracting process with the provider. The member's services will remain in place with their medical home for a minimum of 90 days while contracting efforts are made.

[CM009] Member Communications Regarding Availability of PCMH

Aetna provides information to members regarding the availability of PCMHs through multiple avenues. The member handbook contains information regarding covered services, inclusive of PCMHs and the benefits of that model. Additionally, our provider directory will contain an indicator to highlight PCMH providers. Finally, CCTs inform members and their families of the PCMH model and available providers for those children who may most benefit.

[CM010] Annual Reporting Process

Aetna will comply with all annual reporting processes as required for PCMH. Currently we support reporting practices and deliver regular reporting on providers entering into an APM contract with PCMH deliverables such as care coordination, integrated services, and appointment availability, to name a few. We are also tracking existing medical homes and will provide the State with the number of medical homes identified, the number of providers in a PCMH APM contract, and the members attached to a medical home on at minimum a quarterly basis.

Adverse Childhood Experiences and Trauma-informed Care

CM032	The Vendor should develop and implement care guidelines for working with youth who may have been exposed to adverse childhood experiences (ACEs).	The Vendor should: 1) Provide proposed guidelines. 2) Describe direct experience working with youth who may have been exposed to adverse childhood experiences (ACEs).
CM033	The Vendor should establish an organizational structure and treatment framework to recognize, understand, and respond to the effects of all types of trauma, per American Academy of Pediatrics (AAP) guidelines for a trauma-informed practice.	The Vendor should describe how it will meet this specification.

Multiple research studies, including the Adverse Childhood Experiences Study, have confirmed exposure to severe stress and trauma such as abuse, neglect, discrimination and violence increases an individual's risk for serious and lifelong physical and behavioral health issues, poor health outcomes, reduced quality of life, and increased cost of care. Exposure to toxic stress and traumatic events as a

child can result in poor performance at school, inability to maintain employment, inability to sustain social relationships, and place young person at risk for future homelessness and justice involvement.

Adults with justice system involvement highly correlate to experiencing ACEs. In response to the needs of the members we serve, Aetna has developed an organizational approach to creating a workforce and provider network that is trauma-informed, and we have established treatment guidelines highlighting evidence based practices and emerging best practices that offer members healing in relation to all the types of trauma defined by the American Academy of Pediatrics.

[CM033] Organizational Approach to Trauma Informed Care

Aetna is leading with an innovative approach to make an organizational trauma informed care transformation. This includes providing training and education to staff and providers and responding to the results of an organizational assessment that guides each part of Aetna to focus on various principles of the trauma transformation. **We are working with the National Council for Behavioral Health (National Council) in a 2.5-year engagement for this cultural transformation, working with all levels of the organization including our national shared services staff, health plan staff, and health plan providers to affect the outcome of our members in all areas of interaction. In West Virginia we have already made significant gains towards trauma informed care transformation.** We had a kickoff event with the National Council specific to West Virginia, including a day-long training event for all staff. The West Virginia plan has completed the organizational self-assessment and begun workgroups focusing on strategies to move toward total trauma informed care transformation. West Virginia SOC staff will continue to lead and establish structure and mechanisms to drive the trauma informed care transformation principles in the health plan, provider network, and with state regulators and stakeholders. **Table 2.1-7**highlights the National Council for Behavioral Health's Seven Domains of Trauma Informed Care Model.[14]

Table 2.1-7: National Council for Behavioral Health's Seven Domains of Trauma Informed Care

Domain	Description
Early Screening and Comprehensive Assessment	Develop and implement a respectful screening and assessment process that is routine, competently done, culturally relevant and sensitive.
Consumer Driven Care and Services	Involve and engage people who are or have been recipients of our services to play numerous roles in our organizations and to meaningfully participate in planning, implementing and evaluating our improvement efforts.
Trauma-Informed, Educated and Responsive Workforce	Increase the awareness, knowledge and skills of the entire workforce to deliver services that are effective, efficient, timely, and respectful and person centered. Implement policies, procedures and practices that build and sustain a trauma-informed work force.
Trauma-Informed, Evidence-Based and Emerging Best Practices	Increase awareness, knowledge and skills of the *clinical workforce* to deliver research informed treatment services that address effects associated with trauma and honor the core principles of trauma-informed care.
Safe and Secure Environments	Increase the awareness, knowledge and skills of the workforce to create safe, trusting and healing environments. Examine and change policies, procedures and practices that may unintentionally cause distress and may re-traumatize those we serve.

[14] The National Council for Behavioral Health, "Seven Domains of Trauma Informed Care," accessed August 5, 2019; http://www.tristatetraumanetwork.org/wp-content/uploads/2017/05/National-Council-Seven-Domains-of-Trauma-Informed-Care.pdf

Domain	Description
Community Outreach and Partnership Building	Recognize that the people we serve are part of and affected by other systems, and thus assume a leadership role in educating and engaging partners in trauma-informed care.
Ongoing Performance Improvement and Evaluation	Ensure a system is in place to measure performance in each domain. Track, analyze and review data to address challenges and/or reinforce progress.

As a trauma informed care transformed 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. **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. We have trained approximately 2,500 Medicaid staff in foundational trauma training since 2018. In West Virginia specifically, we have trained 85 percent of staff in trauma informed care and our goal is to have 100 percent trained prior to implementation. Some 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
- Application for staff and members

Addressing Trauma with the Help of an Industry Leader

Aetna has partnered with National Council for Behavioral Health to implement our organization-wide Trauma Informed Care Transformation. Aetna leadership at the national and local levels are thrilled to collaborate with an industry leader such as National Council. Aetna recognizes the importance of being the first managed care organization nationwide to join forces with National Council to strategically map out and operationalize the end-to-end process, and to then produce a sustainable and replicable model for all Aetna Medicaid health plans and the Aetna Enterprise.

Aetna is committed to leading network capacity-building in trauma-informed care in the West Virginia plan. **We are about to embark on advancing trauma informed care transformation with our provider network through trainings, provider self - assessments with key providers, and establishing commitments from providers who will participate in a year-long learning collaborative with the National Council.** As all Aetna member-facing staff are trained in trauma informed principles and care, we will also provide training in trauma informed care providers and community stakeholders. We meet providers where they are, conducting the National Council for Behavioral Health's *Organizational Self-Assessment: Adopting of Trauma-Informed Care Practices* to assist individual practitioners and provider organizations to understand their knowledge and capacity in trauma-informed care and

"We greatly appreciate the partnerships we have with Aetna and look forward to future efforts together as we seek to make TEAM's vision a reality where West Virginia is a state where all children can grow and thrive in safe, stable, nurturing relationships, free from abuse and neglect, that support them in achieving their maximum potential as adults so that they can one day nurture safe, strong families of their own."

—Jim McKay
State Coordinator, Prevent Child Abuse West Virginia
A program of TEAM for West Virginia Children

design a program to assist them in their development of trauma-informed practice. In addition, Aetna has developed a proprietary Trauma-Informed Provider Organization Audit Tool that includes domains such as the following:

- Respecting member voice and choice
- Staff beliefs, attitudes and behaviors
- Commitment of leadership to TIC
- Disclosure readiness
- Staff well-being
- Staff knowledge and skills in TIC
- Hospitality to diversity

We offer providers incentives for committing to a trauma informed care transformation, at three levels, based on how much they have adopted trauma informed principles and practices. They are as follows:

- Trauma-Aware:
  - Includes Level 1 (Foundational Awareness) and Level 2 (Enhancing Routine Clinical Practice)
  - Plan budgeted incentive for screening for trauma and reporting to the plan via appropriate Z-codes, or any other approved format
  - Enhanced evaluation and management service reimbursement for visits designed for trauma screening
- Trauma-Informed:
  - Includes Level 3 (Basic Trauma Informed Care) and Level 4 (Advanced Trauma Informed Care)
  - PCPs receive a specified per-member/per-month (PMPM) payment for their assigned member population:
    - Part of the PMPM is for being designated as trauma-informed
    - Part of the PMPM is for conducting screenings and assessments on at least 50 percent of the member panel and assessments on 95 percent of those members screened positive for trauma
  - Non-PCPs receive a plan budgeted amount for trauma screenings and assessments for those screened and found to have trauma
- Trauma-Transformed:
  - Includes Level 5 (Close/Full Collaboration in a Merged Practice) and Level 6 (Trauma Informed System of Care)
  - Providers are awarded financial incentives that result from reduced utilization and cost of certain services following care coordination that occurs from the identification of trauma by the provider

We also plan to include a Trauma-informed Provider indicator in our provider directory.

[CM032] Trauma-informed Guidelines to Serve Children and Youth with ACEs

Although the effects of trauma are detrimental, we know that trauma is treatable. Aetna subscribes to the following tenets as established by the National Institute for Trauma-Informed Care: **we realize that trauma is common; we recognize how trauma affects individuals seeking care; we are committed to implementing TIC best practices; and at all costs avoiding re-traumatization.** 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. The AAP recognizes that many types of violence or trauma may be experienced by the children, youth and young adults in the child welfare system.[15] These include the following:

[15] American Academy of Pediatrics, "Types of Violence and Prevalence," (2019):accessed August 5, 2019; https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/resilience/Pages/Types-of-Violence-and-Prevalence.aspx

- Child neglect and abuse
- Bullying
- Domestic and intimate partner/teen dating violence
- School violence
- Sexual abuse and sexual violence
- Sex trafficking
- Community violence

Trauma may also result from the significant physical or mental illness or death of a family member and substance use in the home. We know this is a significant issue in West Virginia with many home removals related to substance use of the parent (often opioid use) and subsequent neglect of the child.

Our approach to improving health outcomes for members begins with a focus on understanding the experiences and relationships that have shaped the young person's life and how these have affected the course of their childhood development. Health and development are built in relationships over time and across critical and sub-critical periods of development. With each member, we seek to understand how their health trajectories have been affected and work with parents, youth, foster parents, and caseworkers to support basic health practices, which support and strengthen development and growth. This provides a strong foundation for cost-effective delivery of preventive and physical, mental, and dental health care, reducing risks for acute and emergency care.

As described previously, our care coordinators and CCTs conduct screenings and assessments that evaluate for the impact of trauma on a child's health and well-being. All our staff, especially our CCTs, take special care not to re-traumatize during any interaction. We ensure that all our staff and providers understand the impact of adverse childhood experiences and the importance of creating an environment of safety. **Aetna expects that staff and providers will deliver trauma-informed care using best practices such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Eye Movement Desensitization and Reprocessing (EMDR), Child and Family Traumatic Stress Intervention (CFTSI) and Parent Child Interaction Therapy (PICT).**

- TF-CBT is an evidence-based treatment for children and youth who have experienced trauma. It is a components-based treatment model that incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles and techniques. TF-CBT has is most successful with children and adolescents (ages 3 to 18) who have significant emotional problems (e.g., symptoms of posttraumatic stress disorder, fear, anxiety, or depression) related to traumatic life events. It can be used with children and adolescents who have experienced a single trauma or multiple traumas in their lives.[16]
- EMDR is a psychotherapy treatment that was originally designed to reduce the discomfort associated with traumatic memories. Shapiro's (2001) Adaptive Information Processing model suggests that EMDR therapy helps members access and process of trauma and other ACEs that leads to resolution. After successful treatment with EMDR therapy, affective distress is relieved, negative beliefs are reformulated, and physiological arousal is reduced.[17]
- CFTSI is a short-term (5 to 8 sessions), evidence-based early intervention for children and youth 7 to 18 years old that aims to decrease traumatic stress reactions and the onset of PTSD. CFTSI is implemented quickly following a traumatic event or the disclosure of physical or sexual abuse.[18]

[16] The National Child Trauma Stress Network, "Interventions." accessed August 5, 2019; https://www.nctsn.org/treatments-and-practices/trauma-treatments/interventions.
[17] EMDR Institute Inc., "What is EMDR?" (2019) accessed August 5, 2019; http://www.emdr.com/what-is-emdr/.
[18] The National Child Trauma Stress Network, "Interventions." accessed August 5, 2019; https://www.nctsn.org/treatments-and-practices/trauma-treatments/interventions.

- PCIT is a family-centered approach proven effective for abused and at-risk children ages two to eight and their caregivers—birth parents, adoptive parents, or foster or kin caregivers.

Additionally, Aetna expects that providers will organize their practices and agencies to align with the American Academy of Pediatrics' Trauma Guide and Toolkit which offers detailed information regarding identifying and responding to trauma and provides. The Toolkit also suggests additional evidence-based practices that are effective in the healing process while demonstrating support and empathy for the child's situation. When possible, children will be referred to PCMHs with Trauma Informed or Trauma Transformed Designations.

Our local plan has experience in directly working with youth who have been exposed to ACEs. This experience comes not only from our decades of care management work with children and youth in West Virginia, but also through local partnerships. For example, we partner with the Child Advocacy Center located on the campus of Women and Children's Hospital in Charleston. This center is part of the West Virginia Child Advocacy Network serving 43 counties across the state. The goal of this partnership is for the center to notify us immediately if one of our members (child and adolescent) has been potentially exposed to trauma. We met with the Child Advocacy Center staff and explained how we could support families and children with referrals to trauma-informed behavioral health providers, medical consultations and care management. We know that with the right care and interventions, we can improve the child's trajectory regarding their medical and mental health. Family advocates at the Center explain what services and assistance we can offer. If the parent/guardian signs a release, then the Family Advocate calls our designated CCT staff member who confirms if the child is already enrolled in Tier 2 or tier 3 care management and forwards the information to the assigned care coordinator. If not enrolled, the member is assigned to a care coordinator. In both cases, the family is outreached within 24 hours.

Telehealth and Other Technology Solutions to Support Care Coordination

CM019	The Vendor should use telemedicine, telehealth, and telemonitoring services to improve quality and/or access to care.	1) The Vendor should describe how it would use these services. 2) The Vendor should provide examples of successful use of these services.
CM020	The Vendor should use internet and/or web-based services to improve quality and/or access to care.	1) The Vendor should describe how it would use these services. 2) The Vendor should provide examples of successful use of these services.
CM021	The Vendor should identify and implement opportunities to use video conferencing to improve quality and/or access to care.	1) The Vendor should describe how it would use these services. 2) The Vendor should provide examples of successful use of these services.

[CM019] Telehealth: Telehealth has been proven to improve care treatment compliance, decrease both 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, thereby improving available quality and continuity of care. A study published by the Journal of American Medicine Association (JAMA) found that school-based telemedicine visits provided to children with asthma resulted in a higher number of symptom-free days and decreased ED visits and hospitalizations[19]. Moreover, available telehealth services promote the integration of physical and behavioral health care and enable provider-to-provider consultation between PCPs and specialists. Telehealth can be used as an alternative to or to complement traditional service delivery. In alignment with State regulations,

[19] Halterman, Jill, Fagnano, Maria, Tajon, Reynaldo, Tremblay, Paul, Wang, Hongyue, Butz, Arlene, Perry, Tamara, McConnochie, Kenneth, "Effect of the School-Based Telemedicine Enhanced Asthma Management Program on Asthma Morbidity," 172(3) (2018): accessed August 5, 2019; https://jamanetwork.com/journals/jamapediatrics/article-abstract/2667559.

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 physicians, physician assistants, advance practice registered nurses (APRN), nurse practitioners, APRN certified nurse midwives, APRN clinical nurse specialists, licensed psychologists, or LCSWs. In-network providers may use their own approved technology or will be given the opportunity to utilize a plan-sponsored technology platform to enhance access to their members via telehealth. Alternatively, if indicated, preferred West Virginia-licensed vendor partner telehealth practitioners will be utilized, as per West Virginia State regulations to meet both the physical and behavioral health needs of our members using evidence-based protocols. Unless otherwise agreed upon or directed by the Department, provider reimbursement for telehealth services will be equivalent to that given for the same in-person services.

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 of West Virginia.

We currently partner 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.

[CM020] FamilyConnect: FamilyConnect is Aetna's shared electronic health record (including assessments and care plans) which serves as the single source of truth for youth and their circles of support. Members and their guardians/caregiver(s) may access FamilyConnect through the member portal. The Medical Passport, a tool utilized by foster parents, relatives, fictive kin, and caregivers to document all appointments and medical history will be housed within FamilyConnect in digital copy. This will significantly improve timely communication during instances of placement change.

[CM020] Outbound text messaging: Our educational text-messaging program consists of the Lifeline smartphone and targeted messages to remind members to get tests and screenings done. It sends routine reminders to members to support their health goals related to weight management, diabetes, substance use, prenatal and postpartum care, well-child visits, and flu shots. Many of these text campaigns serve as virtual health coaches and allow members to interact and be educated on their specific conditions. Some of the unique monthly broadcast messages we have sent to members include reminders on keeping contact information current with the local Department of Child Protective Services office or even ER diversion and the importance of seeking their PCP first.

[CM020] Mobile applications: Aetna offers a mobile application permitting real-time interactive communication that allows members to speak on the phone or via Healthcare Insurance Portability and Accountability Act-compliant secure video teleconferencing with PCPs and specialists to diagnose symptoms, prescribe medication, and send prescriptions to the member's network pharmacy of choice.

[CM021] Member e-visit and provider to provider e-consults: We provide children, youth, and young adults enrolled in West Virginia face-to-face practitioner encounters via access to real-time interactive audio and video technology. Children, youth, and young adults enrolled in West Virginia will be able to

access their PCP or specialty telehealth provider from their home or desired secure location. The service has proven to improve provider ease of access and decrease avoidable ER visits and hospitalizations. Aetna Better Health of Texas, in partnership with RubiconMD, report the following results from the E-visit methodology:

- Sixty-nine percent of rated e-consults improved patients' care plans
- Forty-seven percent of rated e-consults avoided unnecessary referral, procedures or diagnostics
- Clinicians received an average star rating related to quality of 4.92 out of 5.

Access to Care and Gap Analysis

CM025	The Vendor should conduct ongoing gap analyses to determine the types of services and resources not available in the State.	The Vendor should provide a detailed description of its approach to meeting this specification.
CM026	The Vendor should work with the Department and community partners to increase capacity for those services and resources identified as not available in the State.	The Vendor should provide a detailed description of its approach to meeting this specification.
CM031	The Vendor should develop and implement access to care standards and methodology.	The Vendor should describe how it will meet this specification, including, but not limited, to proposed standards and methodology.

[CM025] Addressing network gaps: 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 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. Provider services staff will collaborate with care coordination staff, SOC administrators, existing providers (including SNS providers), community partners, and network counterparts at the Department **[CM026]** to strategize and create the plan to develop the needed services in the regions where they are most needed.

[CM031] Access to care standards: Aetna will establish provider access to care standards in alignment with required time, distance and appointment wait time standards as outlined in **Section 3.1.2 and Appendix K of the Model Service Provider Agreement**. [CM031] 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, the Quality Management Oversight Committee, and ultimately may face network termination.

When a care coordinator and ICT identify that a member's care is impacted by network gaps or a providers' inability to meet access to care standards, we mobilize resources to identify solutions. The care coordinator may involve the network or provider relations teams to identify alternative provider options or to consider possible out-of-network single case agreements with providers who can meet the member's needs within timeliness expectations.

Member Materials, Education, and Outreach Strategies

CM040	The Vendor should develop education, member materials, and outreach strategies that are appropriate for adults and children and adhere to federal and State marketing regulations.	The Vendor should: 1) Describe any differences in how it will approach adults versus children. 2) Describe any internal processes that may vary between approaching adults and children, including, but not limited to, education, member materials, and outreach. 3) Explain how it proposes to define "appropriate for adults and children."
CM045	The Vendor should provide targeted education programs and identify who will receive these programs.	The Vendor should: 1) Describe its approach to targeted member or medical management education programs. 2) Identify the audience for these programs. 3) Provide the timeframe for creating education materials and educating community engagement and care coordination staff.

Aetna offers member materials, education, and outreach in order to assist members with system navigation and realization of their healthcare goals. **Equipping members with tools regarding 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 care plan.

[CM040] Member Materials and Strategy for Education and Outreach

Member education materials are written with the understanding that our young members have legal guardians and extended family or caregivers present in their lives due to involvement in child welfare. Our materials are geared toward educating both the guardians and extended family and caregivers and educating our young children and youth. The materials are developed in collaboration with our community stakeholders such as advocacy and disability groups. This strategy offers an opportunity to promote engagement that adheres to legal informed consent for care and involvement with minors and promotes engagement with caregivers and children and youth. All materials including member letters are developed in compliance with the guidelines in 42 CFR 438.104 and **Appendix C 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.

Our 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, young adults and their families/guardian contain more complex explanations and information.

With respect to outreach in the context of care management, we have previously described our process to make up to five attempts to reach a member and/or their guardian when conducting the initial screening. Additionally, we conduct similar outreach attempts with members (and their families/guardian where appropriate) who are not attending assessment appointments, care planning meetings, or who have missed healthcare appointments. Should our telephone and face to face efforts to make contact with the member fail, we will send a letter to the member (or their guardian where appropriate) inviting them to contact their coordinator to discuss solutions to resolve barriers to attending ICT meetings or services. The member services section of our proposal provides additional information regarding our broader member outreach and materials efforts. Members of the CCT may also attend community events which involve some in person outreach activity.

[CM045] Targeted Member Education

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 healthcare resources.

We have already created a large library of printed and web or electronic-based materials; therefore, we will be able to implement 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 'in the know' about new available educational resources. Any new community engagement or care coordination staff hired for this program will be trained prior to the go-live date regarding member educational materials. 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 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 better convey education material.

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 young 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.

We have several **educational pamphlets** covering a variety of topics. These are written with an adult audience in mind but are relevant for the types of health issues children, youth and young adults in the child welfare system may be impacted by. 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

Aetna's **Foster Care HERO (Helping Each Other/Everyone Reach Out) workshops** are provided to children and families in the community. These workshops offer participants education regarding the effects of trauma on health, tools that families can use to create supportive networks of peers, family members, and friends, an overview of the Family First model, and tips to strengthen community connections to support child safety and health goals. Attendees learn how vulnerability, courage and worthiness, can lead to opportunities, bravery, and pride. Aetna is partnering with KVC, a local community organization, to identify the foster care members who would benefit from attending these workshops. These workshops are especially valuable for children before they age out of the foster care system. The workshops bring together children youth and families to develop support networks, identify gaps and plan for the highest level of independence for the youth. **Our first HERO workshop was facilitated in July 2019** by Dan Martin, who was previously a manager with Child Protection Services in Ontario. Mr. Martin pioneered the approach under the mentorship of Kevin Campbell, founder of the Center for Family Finding and Youth Connectedness. **Figure 2.1-9** is a picture from our July 2019 HERO workshop.

Figure 2.1-9: Aetna's First HERO Workshop, July 2019
Workshop facilitator Dan Martin explains a timeline developed by a foster youth to map out their 40 placements in West Virginia.

We offer **technology-based methods** for providing additional health education. We inform young 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 them, we can send them text messages, including a link to download our member mobile application through which they have the option of completing their health risk screen. 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.

3. COMMUNITY/STAKEHOLDER ENGAGEMENT

The Vendor should refer to the relevant specifications located in ***Appendix 1: Detailed Specifications*** (based on the categorization within Column E: Subject Matter Area) and pertinent narrative in ***Section 4: Project Specifications*** in this RFP, and then describe its approach to Community/Stakeholder Engagement below. The Vendor's narrative response should not exceed 25 pages.

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. We have served the needs of West Virginia Medicaid members since 1996[1], and during our 23-year history in the Mountain State, we have administered benefits and services to West Virginians in all 55 counties. **We are West Virginians**, with lifetime relationships; deep roots in our communities, schools, and places of worship; and a shared cultural richness that empowers us to make a real difference when addressing social determinants of health (SDOH), integration and quality of care, and outcomes for our neighbors, friends, and fellow citizens—West Virginia's most vulnerable children and youth.

Aetna's goals include, but are not limited to, improving health and social outcomes for West Virginia's youth and the impacts on their families and helping to reduce the number of children removed from the home through increased family-centered care that provides necessary and coordinated services to all members of the family. We expect a smooth transition into West Virginia's foster care segment, as we have experience serving West Virginia's Medicaid population as well as serving thousands of children and youth in the child welfare system on a national level.

Our locally based, seasoned, and expert West Virginia team leverages the experience and resources of Aetna Inc., a Fortune 50 company, with more than 160 years of experience as one of the nation's leading diversified health care benefits companies. This includes 30 years of continuous, active participation in Medicaid managed care programs. The Aetna Medicaid organization presently has Children's Health Insurance Program experience in 11 states and experience with members in the child welfare/foster care system in 9 states. This experience informs our approach and drives our dedication to meeting the needs of children/youth and families. Our fully integrated, child-centered, family-oriented, and holistic approach guides our decision-making, informs our policies and culture, and fosters our ongoing efforts with State agencies and all stakeholders.

In addition to our national experience, Aetna has decades of experience providing high-quality pediatric health, mental health, and dental care to children, youth, and young adults. We continue to strengthen our practice as we incorporate the remarkable changes in the science of childhood and adolescent development, as well as knowledge of the impacts of early life adversities and toxic stress exposure. Our core innovations which form the foundation of our model of practice for supporting members with elevated adverse childhood experiences (ACEs) scores and complex trauma are consistent with the practice standards of the American Academy of Pediatrics and supported by research at Harvard's Center on the Developing Child. Aetna has made significant investments in exploring and offering **evidence-based approaches and models** on the frontiers of 21st century science for children involved with child protection systems. Aetna is experienced and uniquely qualified to service children in foster and residential care, and Aetna is positioned to act as an

[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 was 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.

enabling partner with the State of West Virginia to move child protection services toward a primary and secondary prevention approach consistent with the Family First Prevention Services Act and the vision of the Children's Bureau at the United States Department of Health and Human Services.

Community/Stakeholder Engagement

Aetna is deeply invested in the communities we serve. Our longstanding presence across West Virginia allows us to uniquely leverage our sensitivity to discrimination for those communities that struggle with debilitating poverty. Being in and of this region affords our members the opportunity to rely on the trust we have built up with their families in support of their deep desire to keep their children safe and well cared for. We are committed to assisting all West Virginia families struggling with poverty, addiction, limited resources and access, and other SDOH barriers such as transportation, internet, and cellular access. Our work with West Virginia families is an excellent example 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.

Lily's Place Achieves Positive Outcomes

Aetna supports pregnant women 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. The 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 the 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, the NAS program achieved the following outcomes:

- Fifty-nine percent 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 percent.
- Eighty-two percent of babies remained with their birth mother and were not removed from the home and/or placed in foster care. In the second quarter of 2019 this number increased to 91 percent.

Aetna care coordinators are purposely located in and around West Virginia communities, as these are the areas in which they live and work. It is essential to provide community-based services conducted by community living and connected folks—not strangers from a large city. West Virginians value working alongside their neighbors, and not having things done for them or without their knowledge. Most West Virginians are patriotic, as the state has one of the highest per capita veteran populations in the nation.[2] They maintain strong religious and ethical values and hold high standards for families. Values and land are passed on from generation to generation. When neighbors are in need, West Virginians help each other. They share labor, food, and medications amongst each other.

Figure 3.1-1: Aetna's Support for PROACT
Aetna gifted $400,000 to PROACT to help with efforts to care for people suffering from addiction.

This culture of sharing has been identified as one of the risk factors in the opioid crisis. Medications are shared when transportation is a barrier to visit a doctor, or when there is not enough money to buy medications. Aetna is well-positioned to serve West Virginia's families with successful innovations that go

[2] "Top Five States: Veterans as a Percentage of the Total Population," accessed July 31, 2019; https://ballotpedia.org/Fact_check/What_state_has_the_most_veterans

straight to the heart of the opioid epidemic, such as the NAS prevention program. Aetna's collaboration with Huntington's Lily's Place has produced extraordinary results for many mothers and their babies.

Aetna also gave a $400,000 grant to the Provider Response Organization for Addiction and Care Treatment (PROACT) in Huntington, as shown in **Figure 3.1-1**. PROACT provides comprehensive 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 members suffering from addiction. This grant to support PROACT is a good example of Aetna's approach to collaboration in support of the communities we serve. This grant directly supports PROACT and Aetna's work with the opioid addiction problem along with other drugs.

As Aetna continues to expand our community presence in West Virginia, it is apparent that the strengths of the people outweigh the negative stereotypes, and the people themselves will help us build **a healthier and happier state**.

NAS Program Success Story: Mother Maintains Sobriety, Delivers Healthy Baby

Mary* was homeless, addicted to OxyContin®, and pregnant at 20 years old. Mary tried to kick Oxy many times and was all too familiar with the excruciating pain of withdrawal. Thinking about her baby going through the same pain broke her heart and drove her to find help. Mary had heard about Lily's Place and Aetna's care managers from a friend who was previously in the same situation. Mary made that brave call to Lily's Place, which immediately engaged an Aetna care manager named Sharon.

Sharon met with Mary later that day at a homeless shelter. Sharon was kind and non-judgmental as she listened to Mary tell her story. Sharon validated Mary's fears and asked her to describe what she knew happened for her friend who was successful at Lily's Place. Mary's optimism slowly began to grow as Sharon assured her that she too could recover and focus on health for her and her baby. Sharon described the process and how she would be there for Mary every step of the way. Mary agreed to the help when she realized that she wanted freedom from her situation as much as she wanted her baby healthy. Sharon helped Mary enroll in care, and together they scheduled appointments with an obstetrics and gynecology provider, a neo-natal care unit, and eventually Lily's Place. Sharon also made sure Mary moved through each stage of her pregnancy, delivery, and postpartum care as smoothly as possible. Sharon was providing care management services and helping Mary with basic needs, transportation, and most importantly, the tender loving care Mary desperately needed when she was too scared to carry on and at risk of relapse.

Mary's daughter was born slightly premature but strong, and her toxicity levels were negligible. Mary maintained her sobriety long before her third trimester, therefore; she was able to safely deliver her baby and hold her afterward. The bond was instantaneous, and Mary felt a rush of pride in herself and immense gratitude for Sharon's expertise and caring.

*Not her real name

Coordinating Care Across Child-serving Systems

CS001	The Vendor should coordinate care across child-serving systems, including, but not limited to, the educational system, community services, and after-school programs.	The Vendor should provide a detailed description of how it will meet this specification. This description should reflect an understanding of child-serving systems in the State.

Aetna will coordinate care with child-serving systems, such as education, community, and after-school programs at the local, regional, and state levels in the interest of improving care coordination for individual children and families while simultaneously ensuring larger scale system change. Many child welfare system-involved youth and their families are served by federally qualified health centers (FQHCs). These community-based organizations provide comprehensive primary and preventive care, including medical, oral, and mental health/substance abuse services to persons of all ages, regardless of their ability to pay or health insurance

status. **Aetna currently has network contracts with every one of these primary care centers** where many of the members see their primary care provider (PCP).

Community health centers (CHCs) are comprised of FQHC and FQHC look-alikes. CHCs provide comprehensive, affordable, and accessible health care services to patients of all ages. Sliding fee schedules are available for those who qualify. Medicare, Medicaid, and third-party payments are accepted. Numerous CHC satellite clinic sites make health accessible for West Virginians. There are currently 31 CHCs in the state with approximately 180 total sites.[3]

At the local level, our care coordinators will connect directly with teachers, after-school care providers, and other community providers to join the family's circle of care team and involve them directly with individualized interventions and supports ranging from Individualized Education Program (IEP) support, vision and hearing checks, and dental screenings. IEP supports can occur in the classroom as foster youth need behavioral interventions and teachers need assistance with implementing environmental improvements and responding to specific student accommodations. Our regional and state leads will meet and engage with education department leaders, community-based and after-school leaders to hear their perspectives on unmet needs for West Virginia families, and then enlist their direct involvement in stakeholder teams. These leaders' involvement as stakeholders will make certain that West Virginia removes the barriers children face to achieving success with schools, access to after-school activities and linkage to effective community-based programs.

Educational System

Educators and other school staff members are vital to each child's development and growth. Aetna would create a process by which our care coordinators regularly touch base with the schools serving children/youth in the child welfare system to make sure the school is informed of the child's care plan, living arrangements, and any challenges the child is facing. Aetna-facilitated circles of family care teams can access school-based resources that will address a child's behavioral needs while supporting teachers and classroom aides with environmental interventions. Behavior specialists can instruct teaching staff how to intervene with escalated children, how to prevent escalations, and how to manage classroom dynamics that can lead to disruptions, suspensions, and even expulsions. This type of classroom environmental and skill-building assistance is best accomplished through collaboration with school administrators, school counselors, and teachers.

"Aetna has been and is actively working with the Mason County FRN (Family Resource Network) to build community relationships and partnerships for the betterment of the community. They have partnered with us on projects such as The Greenbrier Dream Tree, tobacco prevention presentations in school classrooms, oral health presentations, Teen Institute training, workforce presentations, back-to-school events, baby pantry events and baby showers, career connections trainings, Halloween Block Party events, Mason County Family Christmas events, and many other events.

The partnership with Aetna is absolutely critical to the success of what the Mason County FRN plans and provides to the community. I fully support Aetna in their endeavors towards foster care and Medicaid health care coverage."

—Greg Fowler
Executive Director, Mason County Family Resource Network

Aetna works closely with **all school systems** across West Virginia. 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. Our care coordinators outreach to students and their family members to provide overall

[3] "Primary Care," accessed August 2, 2019; https://dhhr.wv.gov/dpc/primarycare/Pages/default.aspx

care and support, and **our outreach is not limited to just our plan members**, as the services we provide target the Medicaid demographic. 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.

We also collaborate with West Virginia Head Start to engage parents by connecting them with comprehensive and essential services that promote health, wellness, and education. Our Community Development team works with Head Start programs around the state. We participate in parent and staff meetings where easy-to-understand wellness information is distributed and discussed. Some of the topics include the importance of wellness exams, healthy eating, and healthy activities/behaviors.

According to the Centers for Disease Control and Prevention, West Virginia's high school students are well above the national average in all forms of tobacco use (cigarettes, e-cigarettes, electronic vapor products, smokeless tobacco, and all forms of cigars). For some tobacco products our WV youth are engaging in is more than double the national statistic. 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 youth. To that end, we have partnered with Stanford University to develop the Tobacco Prevention Toolkit, which aimed at preventing middle and high school students' use of cigarettes, cigars/cigarillos, chew, hookah, and electronic cigarettes. The target audience is children ages 11 to 17. The program offers an in-person curriculum, with lengths varying from 5, 8, or 10 sessions. Each session is between 30 and 50 minutes long. The program is deployed at schools, and Aetna is committed to implement this program in many of our West Virginia schools.

Community Services

Aetna works with numerous local organizations to focus on and support various topics, such as health care, government housing, food instability, employment, and education, because these are direct contributors to improving the SDOH for children in the child welfare system and their families. Community services can respond to basic needs, resources, and informal supports that families need in concert with formal medical and behavioral health services.

"The Family Resource Network (FRN) is a 501C 3 agency which 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

The West Virginia Family Resource Network, aligned under the Bureau of Children and Families (BCF), are organizations that respond to the needs and opportunities of the community. Currently, 47 FRNs serve 55 West Virginia counties. Working with community members and public and private organizations, the FRNs develop innovative projects and provide needed resources for their local areas. Some examples of FRNs primary work areas include the following: substance abuse prevention, community development, early childhood programs, child abuse prevention, economic development, foster care placement, resource development, and food or non-food essentials assistance. These are only a small sampling of the many diverse efforts in which FRNs may be engaged. How they choose to address these

issues can also vary greatly; one FRN may choose to address food insecurity by implementing a weekend food backpack program while another works to organize a community garden or food drive.

Aetna has close relationships with the West Virginia FRN in each county, as we have found this is a great way to get involved at the community level. We also collaborate with FRN stakeholders to solve urgent problems, and work on approaches such as community development, early childhood programs, child abuse prevention, economic development, foster care placement, and resource development.

Aetna has worked with TEAM for West Virginia Children on multiple efforts, and we were the first managed care organization (MCO) in West Virginia to pair with TEAM's Our Babies: Safe and Sound Campaign, which is focused on promoting infant safe sleep and preventing shaken baby syndrome. Over 20 care managers participated in an onsite training in February 2018, and our clinical care manager has participated in quarterly topical calls, annual competency training, and the Let's Talk About Safe Sleep statewide meeting in August 2018. Aetna supported over 500 families with safe sleep education and almost 400 families with portable cribs so that infants had safe places to sleep.

We are also a member of the West Virginia ACES Coalition and a co-sponsor in bringing the Connections Matter initiative to West Virginia. Developed by Prevent Child Abuse Iowa, 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. Over 50 certified Connections Matters trainers conduct workshops and trainings across the state to educate the public on the intersecting topics of ACEs, trauma, brain development, and resilience. Connections Matter utilizes an evidence-informed program, along with real-world and concrete examples to demonstrate how ACEs adversely affect brain development and health outcomes, and how caring connections serve as a primary buffer in the negative effects of trauma. Connections Matter ultimately strives to promote the building of more resilient, compassionate, and trauma-informed communities, thus allowing all children and individuals to succeed. We also sponsored the first training by the West Virginia Primary Care Association for school-based health workers regarding ACEs.

Aetna, the Claude Worthington Benedum Foundation, and the West Virginia Primary Care Association were recently recognized as the sole funders of the West Virginia ACES Coalition.

Aetna recognizes the relationship between health care disparity and food insecurity especially in West Virginia with 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. Aetna has a longstanding relationship with West Virginia's two food banks, Facing Hunger and Mountaineer Food Banks. These food banks work with local feeding programs around West Virginia to reach children who rely on the National School Breakfast and Lunch Programs and backpack food programs. Each day, public schools across the state serve more than 180,000 students healthy, well-balanced meals.

In February 2018 there was a prolonged teacher's strike, and because schools were closed, those feeding programs were sharply reduced and in many locations they were completely halted. Aetna gave $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.

Figure 3.1-2 shows our Aetna team volunteering at a mobile pantry event in Monongalia County, which we sponsored with the Mountaineer Food Bank. **Figure 3.1-3** shows the truck we purchased for Mountaineer Food Bank to help with their mobile food pantry events. 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. Since 2018, Aetna has sponsored the distribution of **65,669 pounds of food**.

Figure 3.1-2: Mountaineer Food Bank Mobile Food Pantry
Aetna volunteers organize food items to distribute to participants.

Aetna also works with faith-based individuals and 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 through community forums with support from the governor, U.S. and state senators and representatives, and the attorney general.

We are also active with the following entities:

- Various city and county housing authorities, such as the Housing Authority of Mingo County, Housing Authority of Wayne County, Huntington Housing Authority in Charleston, and Kanawha Housing, 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 promoting increased Medicaid enrollment
- West Virginia Healthy Kids Partnership to address health disparities and improve health outcomes

Figure 3.1-3: Mountaineer Food Bank Truck
The truck is used primarily for mobile food panty events statewide.

Aetna provides **care coordination** by assessing the needs of both children/youth and their family members by connecting them to appropriate services, such as food banks, employment agencies, etc. We also work closely with State agencies to help connect families to the statewide programs and services that best meet their needs. When there are gaps in care, Aetna works with community-based organizations to quickly meet those needs together. One example is the Family Information Support and Health (FISH) program, which provides education to families about common mental health conditions that affect children and youth, including ACEs. The program was inspired by the loss of a child who was a family friend of one of our team members. FISH was created to raise awareness and provide support and resources regarding mental health in children. Training is provided by our behavioral health medical officer in concert with our training collaborative, which will design, deliver, and improve trainings and coaching models for each local and regional service delivery area.

After-school Programs

Over 108,000 students in West Virginia are unable to access after-school programs[4], and over 54,000 of them are alone and unsupervised after school on any given day[5]. After-school programs can boost academic performance, promote physical health, and provide a safe, structured environment for the children of working parents. Our members can join a participating after-school program of their choice and receive $50 annually toward the cost of membership. Foster care members can request participation through their care manager or the Member Services or Community Outreach departments. Parents or legal guardians are required to give consent.

Aetna actively participates in a variety of after-school programs throughout West Virginia. We support the FRC after-school program at Marcum Terrace in Huntington, and participate in after-school programs in the areas of Bradshaw, War, and Welch in McDowell County.

We recognize that **lack of sufficient transportation is a potential barrier** that keeps children from participating in after-school programs. Many families live in rural areas of West Virginia and as such are too far away to easily access after-school programs, as well as much-needed services and supports. Transportation barriers will need to be addressed in the new Children's Foster Managed Care model for children to be served expeditiously and remain and/or reunify with their families. Transportation is also a life domain that can be met creatively and with community supports rather than through expensive formal services. Aetna will approach this urgent need through a multidisciplinary team approach, like we will with every systemic and family barrier.

Transportation will be an issue for Aetna's **Member Advisory Committee** (MAC) to address, create innovative ways to solve this issue, and implement solutions in the regions that do not have transportation resources in place. The process for designing solutions is the same process that will be adhered to with the individual child and family interdisciplinary teams, which includes the following components:

- Identify the life domain and unmet need
- Articulate a positive outcome
- Identify barriers to success
- Brainstorm all possible solutions within the parameters of no- or low-cost, easily accessible, flexible, responsive, and sustainable by the family/community after formal services have closed out
- Agree on the most feasible solution and design plan
- Delegate tasks to a point person with a timeline
- Document and report out regularly on progress, barriers and solutions, and a conclusion with results and example success stories

To best address this issue, Aetna will work closely with Susan Gamble, EdD, director of the West Virginia Statewide Afterschool Network. Ms. 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, churches, and nonprofit agencies that have graciously stepped up to meet this community need. Aetna will approach facilitating this problem-resolution process for transportation needs, and for that matter, any other need that does not require expensive, system-driven resources and staff.

[4] "After School in West Virginia," accessed July 14, 2019; http://www.afterschoolalliance.org/policyStateFacts.cfm?state=WV
[5] "Benefits for Youth, Families, and Communities," accessed July 14, 2019; https://youth.gov/youth-topics/afterschool-programs/benefits-youth-families-and-communities

Relationships with CPS Workers and Coordinating Needs of the Child

CS002	The Vendor should establish relationships with Child Protective Services (CPS) workers and coordinate the needs of the child to reduce duplication of services and improve access to service needs.	The Vendor should provide a detailed description of how it will meet this specification. This description should reflect an understanding of the Child Protective Services (CPS) system in the State. With regard to improving coordination, the Vendor should describe how it will structure interactions between CPS workers, providers, and the Vendor to be efficient and effective.

West Virginia CPS social workers have been inundated with cases over the past two years due to a marked increase of children entering the foster care system. Children are coming in with complex unmet needs and symptoms associated with exposure to toxic stress. For these children to heal and return safely to their families, CPS workers need the assistance of Aetna care coordinators and clinicians.

Success Story: Collaboration with CPS Supports Expectant Mother

Sandra,* a CPS worker, called her colleague, Maggie, an Aetna care manager. They had worked together to help young women in serious need. Sandra told Maggie about a young, pregnant mother named Susan,* who was picked up by police. Susan's toddler was in emergency foster care, and Sandra was assigned to be the worker for Susan and her daughter. Sandra knew how quickly Maggie would move to engage with Susan, listen to her without judgement, and make sure that Susan's little girl would get contact with her mother. Maggie also linked Susan to community resources for her basic needs.

Susan was reluctant at first, but then realized that both women were there to help her get clean and to make sure she and her daughter were safe, had a place to sleep, and had food to eat. Susan chose recovery because she didn't want her baby to go through the pain of withdrawal that she experienced. Susan let Maggie's and Sandra's compassion and care guide her to healthy choices. Susan delivered a healthy baby girl and she expressed her heartfelt gratitude to Maggie and Sandra. Sandra called Maggie's supervisor to let her know how valuable the work is that Aetna care managers perform and specifically how much she relies on Maggie and values their collaboration.

*Not their real names

Our care coordinators and clinicians work in tandem with CPS social workers as soon as referrals are made. Aetna can take over during crises and engage with the youth and parents while activating crisis stabilization and launching the family care team process. With such high caseloads, CPS workers are not able to provide full engagement and stabilization. Aetna care coordinators consider their collaboration with CPS workers to be essential to the successful care of foster children. Coordinators will take the time to engage with CPS workers and learn their preferences for communication, family care team involvement, risk notifications, documentation, and court reporting. Coordinators will tailor their interactions with CPS workers according to their preferences. Collaborative court presentations and reports will alleviate a great deal of the CPS worker's mandated responsibilities. Collaboration throughout the child's involvement in the system will ensure high quality care and the accurate report out on plans, alternative interventions, risk, and positive outcomes.

CPS workers have historically been in the 'bad guy' role with families in crisis facing the removal of their children. These workers are an extension of the court and as such have a very difficult role in the process. Care coordinators and peer collaborators are skilled at explaining this difficult role to youth and families while bridging them back in a constructive way to their worker and the system. The result of successful bridging work is anything from the CPS worker being a member of the family care plans, to judges supporting numerous alternatives to traditional medical treatment for foster youth. The course of care and system involvement for foster youth progresses more smoothly when a CPS worker is freed

from the stress of playing such a difficult role as well as from the details of comprehensive case management.

Aetna care managers actively collaborate with CPS workers. **Connections have been forged** in support of children and families in crisis. Care managers understand the burden and pressure carried by each CPS worker as the representative of the courts. Parents who lose their children to the system vilify the CPS worker as their children are physically removed from their homes, from their arms. The parents are experiencing the darkest moments of their lives and the entire family is traumatized by the removals. The CPS worker is caught in an extremely sensitive and challenging situation while they are performing the most difficult function of their jobs. The worker may even experience vicarious trauma after a few removals. Our care managers have taken the time to listen to CPS workers describe how difficult their job is and how heart-wrenching the experiences are as well as the bind they find themselves in when their desire is to help families heal and remain together safely. Aetna care managers provide understanding and validation of the pain and support with alleviating the demands of the workers' jobs. Our care managers **take on numerous functions** for the CPS workers, as their case loads are ever-increasing due to the opioid crisis and marked increases in removal rates.

Relationships with Child Welfare Workers in Addition to CPS

CS003	The Vendor should establish relationships with child welfare workers in addition to Child Protective Services (CPS), including, but not limited to, workers who provide case management, case planning, and permanency planning while the child is in care.	The Vendor should provide a detailed description of how it will meet this specification. This description should reflect an understanding of the child welfare system in the State.

Collaborating with social workers from the Department is one of the most important relationships to forge in support of the families they serve. Aetna will implement **Collaborative Family Engagement** (CFE); a national award-winning model designed to build and strengthen collaborative practice relationships between child protection case managers and community-based professionals and volunteers. The CFE project is a collaborative effort between CPS and Court Appointed Special Advocates (CASA) that uses a **team-based approach** to identify and engage family and fictive kin for children in substitute care. As the State child welfare agency, CPS is mandated to investigate reports of child maltreatment and place children in the protective custody of the State when they cannot safely remain in their homes. CASAs are community volunteers who are appointed by local judges to serve as advocates for children who have been removed by CPS. Aetna care coordinators join with these important entities to achieve the following outcomes: 1) increase the number of adult relatives and kin willing to act as a support system for children who have been placed in substitute care, and 2) strengthen collaboration between CASA volunteers and CPS staff to facilitate better case management and service delivery for the children they jointly serve.

At the time of referral, the care coordinator will contact the referring worker as soon as a referral is made to understand the worker's perspective, establish ongoing communication agreements, and decide how best to collaborate on next steps with the child and family. There may be more than one worker providing case management, planning, and permanency, and **our care coordinator will engage with each worker** in support of each phase of care for the child. For many circles of care, a co-facilitation model works well with the social worker and the care coordinator, as they can share the leadership of team meetings until the family is to the point where they can facilitate their own meetings.

Our local Care Management team possesses years of expertise actively engaging outside entities and working closely with them to address the needs of each of our members. They developed an integrated care management (ICM) program which integrates the member's physical and behavioral health care needs, working with contracted providers using a bio-psychosocial clinical model to evaluate the

individual needs of each member and their identified needs related to physical and behavioral health. The ICM program incorporates a fully integrated system of care approach which includes the following:

- Community-based physical and behavioral health care, and psychosocial services
- Planning and facilitation through care coordination and evaluation
- Support and advocacy for individuals, their families, and representatives
- Promoting quality cost-effective outcomes

Many children and youth in the child welfare system experience trauma as a result of their living situation, coupled with removal from their home. Aetna has joined the National Council for Behavioral Health to create a systemwide transformation initiative to address the impact of trauma among our members, and we are honored to be **one of two Medicaid plans** committed to a systemwide trauma approach. Our team members completed an organizational assessment that will result in an action plan to further our goal of becoming trauma-informed, and our efforts will also focus on supporting and assisting providers in becoming trauma-informed. Expected outcomes include the improved health, well-being, and quality of life for our members. First and foremost, trauma-informed care (TIC) is about being present with children and families in a way that does not re-traumatize them. Mindfulness practices make certain that providers are aware of their own levels of stress, that they ground themselves before contacting children and parents, and that they focus on listening deeply to the people they serve. Trauma-informed organizations focus on creating welcoming environments, on whole-person care practices that address the effect of trauma held in the body-mind, and on the process of care delivery so that children and families are respected and heard all throughout care. Practitioners are fully trained in ACEs and the negative effects of toxic stress as well as the re-traumatization experienced by system involved youth and parents.

Communications with the Judicial System

CS004	The Vendor should establish communications with the judicial system to help drive that the services being ordered for the child are in the child's best interest and most medically and/or socially appropriate.	The Vendor should provide a detailed description of how it will meet this specification. The description should reflect an understanding of the interactions between the judicial system and child welfare system in the State.

Aetna will work diligently to collaborate with the judicial system at local, regional, and state levels to drive system change in support of services being ordered to meet the specific needs of families in care. At the local level, our care coordinators will work with the Department workers and probation officers from the West Virginia Juvenile Division Services to prepare for and present to the courts the individualized care plans and the rationale for the requested services and supports. We have developed an innovative model of care that supports care plans of our members with evidence-based and promising practices as well as community-based programs that will meet socially necessary services (SNS). Together, the care coordinator and the worker can explain how the services are medically and/or socially necessary and in the best interest of the child. The judicial system representatives need an opportunity to understand how these services will effectively meet a child and family's needs before they are approved. Care coordinators and **Aetna leads are well-versed in these interventions** and can describe their effectiveness in relationship to the child and family plan presented before the court. At the State level, we need juvenile justice leaders to assist with the sponsorship of a new approach to care that ultimately drives the reduction of children entering the system as well as a reduction in the current number of open cases. System change of this magnitude will require champions of change from the judicial system that will join a dynamic governance stakeholder team. At the regional level, representatives will be needed for more local-level change as well as for participation on the training collaborative.

The lack of access to timely and tailored legal assistance is a significant barrier for foster children and their families and perpetuates a cycle of disparity. Our members will have access to a dedicated attorney and paralegal though Legal Aid of West Virginia, which aims to disrupt the cycle of returning people to the unhealthy conditions that would otherwise bring them right back to the clinic or hospital. The attorney and paralegal will provide civil legal services to stabilize the lives of our members and their caregivers.

Benefits include legal services to all members and their families, including the following:

- Establishing permanent custodial relationships through representation in adoption, guardianship, or custody proceedings
- Increasing income supports for families, including navigating issues with government benefits or child support
- Removing barriers to employment by providing assistance with expungement and driver's license issues
- Increasing access to education by assisting with school enrollment issues and obtaining services to help children while in school
- Preventing homelessness and increasing access to safe, affordable housing
- Free statewide legal clinics

Informing the Court of Alternative Services

CS005	The Vendor should inform the court of alternative services that best meet the child's needs, as deemed appropriate by the Department.	The Vendor should provide a detailed description of how it will meet this specification. The description should reflect an understanding of court orders, how the Vendor's expertise and care coordination can help inform services provided, and circumstances under which the Vendor would provide these alternatives.

Aetna care coordinators will inform the court of the alternative services that best meet the child's needs and are approved by the social worker as the Department representative. How the information is shared can range from individual child hearings to full trainings for the court provided by the training collaborative. Alternative services have proven to be more effective and far less costly for many children and families who are system involved. An example of an alternative service is the use **of peer collaborators** to engage with youth to bridge between them and many formal services rather than first contact being between the worker and the child. Peer collaborators have lived experience, which affords them credibility with young people who are afraid and distrusting of professionals.

Another alternative service is the **wraparound planning process** and service delivery model which provides intensive services and supports in the home, schools, and communities rather than the more traditional approach of removing children and placing them in residential care or even hospitalization. Effective wraparound has reduced out-of-home placements and hospitalizations across the country. We appreciate the need for the court to have a better understanding of what these alternative services are and how they specifically meet needs as compared to more traditional treatment methodologies. **Aetna will work with the Department social worker** to present these alternatives with descriptions, data, and the associated outcomes for the individual child and family. Court representatives will also participate in courses offered by the training collaborative that will further explain alternative services and their effectiveness. This collaborative approach to informing the courts models the collaborative care team model and demonstrates shared accountability and shared success.

Relationships with Applicable Department Agencies and State Advocacy Groups

CS006	The Vendor should establish relationships with applicable Department agencies and State advocacy groups, including, but not limited to, the following:	The Vendor should provide a detailed description of how it will meet this specification. The description

		should reflect an understanding of Department organization and State advocacy stakeholders.
CS007	Child advocacy centers (CACs)	See the parent specification.
CS008	Court appointed special advocates (CASAs)	See the parent specification.
CS009	The West Virginia Child Abuse Network, as defined by applicable State Code, as defined by the Department.	See the parent specification.

Aetna intends to **support, and champion large-scale system change statewide** to improve the outcomes for foster youth, to improve wellness, and to reduce the number of children entering the child welfare system. This large-scale change requires full engagement of families and all stakeholders, strategic planning and implementation, collaboration on all levels supported by easier online access to health records, court reports, care plans, and outcomes data. Aetna is prepared to lead this change and to offer our expertise in the areas of physical, behavioral, and emotional health. We know that large-scale change will require in-depth relationships with leadership from Department agencies and state advocacy groups. This innovation requires collaboration at the State, regional, and local levels, which mirrors the collaboration needed at the direct care level for families.

[CS006] Applicable Department Agencies and State Advocacy Groups

Aetna established relationships with key stakeholders over the past 23 years that will be called upon to support this vital system change effort. Aetna recognizes that department agencies and advocacy groups have a desire to make a difference for foster youth and hold a wealth of information needed for the success of the Aetna West Virginia model. Aetna will approach the formal involvement of these key stakeholders with the same respect as it will with children and families. It is not the intention of Aetna to duplicate efforts or to assume we know information that is within their current scope and responsibility. **Our primary focus will be to engage, learn, and collaborate** in a manner that fosters deep connections and comprehensive care for youth and families.

[CS007] Child Advocacy Centers

Aetna will reach out to the leadership of the child advocacy centers (CACs) and extend an invitation to participate on Aetna's Stakeholder Governance Council as well as the regional level teams to obtain full representation in the implementation and oversight of an innovative model of care for children and families. **Our child welfare system director lead will be the primary liaison** for the CACs' participants and will meet individually with them to make certain their perspectives and potential concerns are understood and addressed leading to ongoing high-quality care for children.

Members of our Care Management team recently visited the CAC at CAMC Women's and Children's Hospital in Charleston to meet with the center's program coordinator and family advocates. Aetna's team provided details about our care management program, including how we can support the center's efforts in accessing needed services and TIC providers. The process involves the family advocate explaining to the family/guardian that Aetna is the child's managed care company and how our care manager can assist in locating needed resources and services. The center also provides brochures on our care management program.

Families are required to sign a Release of Information (ROI) for the center to contact us to let us know the child has been evaluated. Our care manager is the single point of contact for the center to call with a referral. Once our care manager receives the referral, she checks to see if the child is enrolled in care management, and if so, notifies the Care Management team. If the child is not enrolled in care management, the referral is assigned to a care manager. In both scenarios, the care manager outreaches the family within 24 hours to offer support and facilitate enrollment into care management services. Our goal is to identify children early on who have experienced trauma, educate families on the

impact of trauma, and hopefully develop resilience skills for the child such as connecting directly with caring adults, learning self-soothing skills, knowing and sharing their emotions directly, and being able to name the positive things in their lives. The center staff was enthusiastic about our offer of support.

We also provided a $5,000 grant to the CAC at CAMC Women's and Children's Hospital to help them hire a full-time mental health therapist to better serve the children/youth and families cared for by the center. Building capacity and increasing access to mental health services in West Virginia is critical to our collective success. We will be able to accomplish this through continued support of services in schools, homes, and other alternative accessible sites, as well as through the expansion of telehealth services and other digital solutions. Access, however, is not enough. Services must be able to meet the unique needs of these children and families through evidence-based practices, particularly as it applies to the impacts of trauma on health. **We have committed ourselves to being a trauma-informed organization**, recognizing providers who perform these specialized services, and supporting the great initiatives already present within the state

[CS008] Court Appointed Special Advocates

Aetna's care coordinators appreciate how important CASAs can be in the lives of children involved in the child welfare system, and they will work to include them in the **family circle of care**. The care coordinator will make sure the CASA understands the new model of care and how the CASA can contribute to the care plan. The care coordinator will bridge the CASA to the family, explaining their role as both a CASA as well as a team member and dispelling any negative stigma the family may have regarding CASAs in general. CASAs have served vital roles on the individual care team across the country for many years and children in West Virginia will benefit from their inclusion on teams and on the training collaborative.

[CS009] West Virginia Child Abuse Network

Aetna has a longstanding relationship with the West Virginia Child Advocacy Network (WVCAN). We work closely with WVCAN to help support their fight against child abuse. We actively collaborate with WVCAN to help them connect stakeholders and professionals to the resources they need for all children to have access to safe and quality care, as well as support their initiatives, such as SHINE, which seeks to eradicate the shame and stigma of sexual abuse that haunts children.

Our manager of community development will extend an invitation to the WVCAN director to become a member of our Stakeholder Governance Council to provide guidance and assistance on topics related to child abuse to make certain the new model of care is effective in its reduction of child abuse and addresses the safety of children in care. These outcomes are shared by everyone at all levels of care and the WVCAN representative can expect to be a part of a dynamic team of leaders who share the same concerns in their commitment to do better by West Virginia's children and families.

"The West Virginia Foster, Adoptive, and Kinship Parents Network (Network) appreciates the support Aetna has shown for West Virginia foster parents. I have personally met with Aetna leaders on several occasions to discuss the needs of foster, adoptive, and kinship parents and those of the children in their homes. We have been given ample opportunity to share concerns and suggestions and learn how Aetna can help foster families in the role of an MCO. Aetna also provided financial support for the Network in its early stages of development, helping us to serve more foster families. We are grateful for their commitment to foster families in our community."

—Marissa Sanders, Director, West Virginia Foster, Adoptive, and Kinship Parents Network

Communications with Foster Parents

CS010	The Vendor should establish communications with foster parents based on Department foster care guidelines.	The Vendor should provide a detailed description of how it will meet this specification. This description should reflect an understanding of the foster care system in the State.

Aetna's care coordinators will be reaching out to and fully involving foster parents on circle of care teams in support of individualized services and supports for each child. As circle of care participants, foster parents can expect to not only be up to date on plans, but to have input on the design of interventions and strategies. If a child is placed in a foster care home, the foster parents will be asked where they would like circle of care meetings to be held and the best day/time of the week to facilitate their full involvement. Care coordinators will make certain foster parents help design and implement a care team communication agreement with specific attention paid to crisis response. As services, supports, and resources become more available online, Aetna will educate its membership on all the various Wi-Fi access supports throughout West Virginia.

As the system moves from long-term out-of-home foster placements and residential treatment to services wrapped around the families and short-term stabilization care, foster parents are a vital resource for informing the design and implementation of this change. **Foster parents will continue to have an important role** as they move to providing short-term care within a circle of care team process. Foster parents hold the expertise for how to make that transition and what they will need to be successful.

Collaborating with the Bureau for Public Health

CS011	The Vendor should collaborate with the Bureau for Public Health (BPH) to increase the number of families enrolled in the West Virginia (WV) Home Visitation Program.	The Vendor should describe how it will meet this specification. Note: This program has demonstrated that its engagement in the lives of families has helped to reduce the risk of a child being removed. More information can be found at https://www.wvdhhr.org/wvhomevisitation/

Aetna's manager of community development, in collaboration with our director of quality, will meet with the BPH to establish a strong connection and to better understand the BPH perspective on the low home visitation enrollment rate and potential solutions to implement in the new model. The BPH lead will be an integral member on the State and local-level teams to ensure the increased enrollments continue and that families have ongoing access to much needed resources. Aetna peer collaborators will reach out to youth and families to better understand the barriers to enrollment from the family perspective, to explain the benefits of membership, and linkage to enrollment.

To support the varied ways in which West Virginians prefer to receive and integrate new information and their need for consistent online access, Aetna will include multimedia information for those who prefer auditory/visual materials. Aetna will also make sure members are fully apprised to the numerous ways in which internet access is available. We have an excellent example of a current collaboration with the use of peer support services that has both increased enrollment, but which has also directly contributed to decreasing the number of children pulled into the system.

Aetna is currently engaged in cross-system collaboration to meet the needs of young children with substance-abusing parents involved with the child welfare system. We hope to work with the State in initiatives such as peer support services and explore promising programs such as **START**, which integrates addiction services, family preservation, community relationships, and best practices in child welfare and substance abuse treatment. The program aims to reduce recurrence of child abuse and neglect, improve substance abuse disorder treatment rates, build protective parenting capacities, and

increase the county's and State's capacity to address co-occurring substance abuse and child maltreatment. START pairs specially trained CPS workers with family mentors, who have at least three years of sobriety and previous involvement with CPS, to work with families. The program also works with substance abuse treatment providers to ensure START participants have quick access to intensive treatment. Decision-making is shared among all team members, including the family and court.

Recent research has found that mothers who participated in START achieved sobriety at nearly twice the rate of mothers treated without START. The program has also proven to be effective at keeping children at home. Children in families served by START were half as likely to be placed in State custody as compared with children in a matched control group. In early 2016, START was given a provisional scientific rating of 3 (Promising Research Evidence) and a provisional 'high' rating for Child Welfare System Relevance Level through the California Evidence-Based Clearinghouse for Child Welfare.

Engaging Community-based Child Welfare Organizations

CS012	The Vendor should engage community-based child welfare organizations to help provide family-centered treatment that goes beyond traditional medical care.	The Vendor should provide a detailed description of how it will meet this specification. The description should reflect an understanding of State community-based child welfare organizations and family-centered treatment.

Aetna views relationships with community-based child welfare organizations as essential to successfully providing family-centered treatment beyond traditional medical care for the simple reason that these agencies have been serving foster youth and their families for decades. We will approach these organizations with respect and the desire to learn about their experiences providing non-traditional services and the barriers they have encountered. Aetna stands to learn a lot from these organizations as it moves to designing a more cohesive and seamless model of foster care. We understand that a combination of traditional medical care with alternative community-based supports for SNS will give foster youth and families the best chance for health and reunification over time. Aetna has made a point of researching numerous child welfare organizations to ascertain who can join the collaborative effort from governance to family circles of care. Aetna intends to work fully with these organizations so foster youth have a full array of resources to address unmet needs across all pertinent life domains.

Initial and Ongoing Training

CS013	The Vendor should provide initial (during implementation) and ongoing training for advocates and other stakeholders.	The Vendor should describe in detail the audience(s), frequency, method(s), and topic(s) for this training.

Aetna is a continuous learning organization, and we believe each person is a lifelong learner. Aetna also understands that adults learn and retain information when it is presented in a multifaceted approach, including; presentations, experiential, in-vivo demonstrations, and in the field coaching among other modalities. A tenet that drives our training plan is the need for each Aetna staff member to teach others.

Our approach to the child welfare system draws from numerous best practices, innovative national trends in child welfare reform, and the goals of the State to reduce the number of children in the child welfare system and prevent system involvement on the front end.

We will convene and launch a training collaborative comprised of trainers from each key stakeholder entity which will design, deliver, and improve trainings and coaching models for each local and regional service delivery area. Aetna will facilitate the collaborative as well as provide train-the-trainer, capacity-building curricula.

Aetna and the training collaborative will provide initial and ongoing training for all advocates and other stakeholders with comprehensive details on the following:

- Foster care system best practices
- Community, State, and federal resources
- The unique physical health and behavioral and social needs of youth in child welfare, foster care, and juvenile justice systems

Key components of the training will include TIC, ACEs, and NAS crisis intervention services, and evidence-based practices to provide understanding and empathy to our staff on the trauma and stress often inherent within the West Virginia populations served under this contract. Trainers will be well-versed in adult learning styles and include multimodal approaches to curriculum design ranging from visual, kinesthetic, and auditory components.

Aetna and the training collaborative will also provide a comprehensive review of the Family First Prevention Services Act and other federally mandated services for the West Virginia foster care population within the training.

In addition to Aetna's commitment and implementation experience, we also understand the commitment of West Virginia to transform the child welfare system and be a leader in implementing the federal Family First Prevention Services Act legislation. Aetna has built the knowledge and capacity to be a collaborator in the goals related to the Family First Prevention Services Act in West Virginia. Our model of care focuses on strengthening families and focusing on preventing crisis as the first line of support. We have internal expertise on the child welfare system. We will collaborate with the West Virginia University School of Social Work, a Title IV training site, to build our internal capacity to advance the goals of Family First in collaboration with the State. We will also work to expand our knowledge of efforts already underway to implement Family First such as prevention initiatives and identify ways we can build capacity where needed. We will not reinvent the wheel, but instead find ways to add value and fill gaps.

Family First Prevention Services Act

This act reforms the federal child welfare financing streams, Title IV-E and Title IV-B of the Social Security Act, to provide services to families who are at risk of entering the child welfare system. The bill aims to prevent children from entering foster care by allowing federal reimbursement for mental health services, substance use treatment, and in-home parenting skill training. It also seeks to improve the well-being of children already in foster by incentivizing states to reduce placement of children in congregate care. It provides a new avenue for services to address substance abuse and mental health treatment needs that by some estimates are anywhere from 30% to more than 60% of child welfare and foster care placements.[6]

Coordinating with Child Placement Agencies

CS014	The Vendor should coordinate with child placement agencies to ensure each agency has access to the most up-to-date records, as appropriate.	The Vendor should describe how it will meet this specification.

To support continuity of care, Aetna care coordinators use **Aetna FamilyConnect**, the shared, electronic health record which serves as the single source of ongoing information for foster care children/youth. We understand the fragmented nature of the current foster environments in terms of clinical, social, and programmatic documentation, and are prepared to address this significant gap. We have designed an information management system for the purpose of integrating all components of the delivery of care to

[6] "Families First Act," accessed August 1, 2019; https://www.cwla.org/families-first-act-provides-intervention-to-prevent-foster-care-placements/

our members in West Virginia's child welfare system. Aetna's quality assurance/quality improvement protocol ensures the review of documentation to identify quality improvement needs, training and retraining needs, and efficacy to the principles of the model as identified by accurate documentation of the process, family voice and choice, and individualized care indicators.

Aetna FamilyConnect has the capability to securely store and transmit information and interface with subcontractors and other relevant systems. The data systems will be integrated so that medical, behavioral, demographic, and treatment information about children/youth in West Virginia's foster care system can be compiled in one secure, central source. The **Medical Passport**, a tool utilized by foster parents, relatives, fictive kin, and caregivers to document all appointments and medical history, will be housed within Aetna FamilyConnect, which will significantly improve timely communication during instances of placement change to ensure continuity of care. All information is only shared with the consent of the West Virginia member or their guardian. This proprietary, integrated digital system serves as a records repository with access for all key players involved with the children and youth enrolled in West Virginia's child welfare system, including the members of our Care Coordination teams, educators, representatives from community-based organizations and social services organizations, and staff at State agencies. This supports our person-centered model of care in which one care plan is developed that incorporates service and support needs identified by each stakeholder. This approach contributes to the defragmentation of the health care delivery system for children and youth enrolled in the system and reduces member, provider, and family burden to make the health care system navigable for legal guardians and children.

The Aetna integrated planning process and care team can address confidentiality concerns by having the parent/guardian available to sign releases at any given time during the team planning and ongoing implementation. They can also approve the full involvement of the school personnel on the care team during which they sign an Oath of Confidentiality form that suffices for the protection of protected health information. The care coordinator brings blank forms to the care team meeting each time a new member joins the team. Aetna is proposing a **One Child, One Plan** approach to care teams, plans, services, and documentation. As Aetna coordinates care across providers, parents and guardians will be at the table approving shared information and integration each step of the way. This system is currently used in a similar capacity today at Aetna and will be expanded to meet the needs of all stakeholders. The care coordination platform is web accessible today for providers and will be expanded to grant appropriate data and document visibility for members, their peer and care circles, clinical staff, biological parents, kin, and other guardians. The platform will facilitate the rapid inclusion of disparate documentation, including paper reports, enrollment lists, school transcripts, foster parent notes, training media, case worker notes, and any other support documentation related to the child.

Our Approach and Methodologies to Community/Stakeholder Engagement

West Virginians put stock in the power of community. They do not need to be convinced of what a strong community can do. What they need is a thorough understanding of how engagement in a new model of care will help them heal and bring their babies and children home. There is fear and distrust of a system that has reacted to their struggles and overwhelming poverty with perceived punishment and the removal of their children. The State has heard its citizens and has called for leaders and organizations that will step up and help in a manner that respects families and believes in their inherent ability to heal their communities to help them thrive. Engagement starts with children and families becoming active in their communities, and then eventually moving into leadership positions to better assist and give back to their neighbors. Children and families who are resilient in the face of compound trauma are supported best by providers and systems that are embedded in their communities as resiliency thrives within healthy relationships. Aetna is embedded all throughout West Virginia's communities and, as such, is best

positioned to support resiliency at the individual, community, and regional levels. This comprehensive approach ensures that resiliency is sustained over time as relationships are created and deepened between neighbors, children, and Aetna employees.

West Virginia's families have a lot to say about their needs and how the system had not worked for them.

We are a company that focuses on **wellness and preventive health opportunities** for its members. With the rising number of youth entering the child welfare system it is necessary to maintain that focus and work collaboratively with system entry points that include families, criminal justice, medical, education, and behavioral health. Early intervention will decrease foster care placements and improve health outcomes for children and their families. These same entry points also serve as part of a connected system of parental, medical, behavioral health, law enforcement, judicial, and educational child welfare supports.

As with families, child welfare system stakeholders do not need an MCO to remind them of their primary purpose, nor do they need an MCO to duplicate their efforts. There are many departments, providers, community groups, and leaders who desperately want to make a difference in West Virginia. The State needs an MCO that can bring everyone together to focus on a common vision with an integrated strategic plan that addresses significant health concerns, keeps children safe at home, and improves lives. Aetna will approach all stakeholders with the **same respect and spirit of engagement** as they do with families. We are interested in learning 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.

"Marion County Family Resource Network proudly works alongside Aetna in working to protect and serve families and children that work with and are served by foster care services. Aetna has been present at our events and has distributed information to families that have been a great help to the people we serve. We count Aetna as a valued partner in working to keep Marion County children safe and our families healthy."

—Frank Jarman
Director, Marion County FRN

Aetna has extensive relationships and collaborations in West Virginia that focus on physical health and removing barriers to access. From FQHCs and hospital emergency rooms to perinatal drug-free mom sites and school-based health centers, **we have been at the forefront** of initiatives and projects that focus on improving health and increasing access to much-needed services and resources. One 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.

The Department's county-level NAS data for 2017 showed the overall incidence rate of NAS was 50.6 cases per 1,000 live births (5.06 percent) for West Virginians.[7] The average length of hospital stay for infants with NAS is 17 days, costing nearly $1.5 billion annually, and approximately 80 percent of these hospital costs are covered by Medicaid. NAS treatment for infants with less severe symptoms is $2,600 in a special care nursery, or $4,000 daily in a neonatal intensive care unit.[8] The primary approach of non-judgmental and caring care management with one-on-one support providing referrals, resources, and enrolling the newborn immediately into health care coverage has contributed to the impressive success. Member outcomes have included full-term healthy babies, a family preserved, sobriety, further education, and employment. To support the West Virginia Perinatal Partnership in their efforts, Aetna gave them a

[7] "DHHR Releases Neonatal Abstinence Syndrome Data for 2017," accessed July 25, 2019; https://dhhr.wv.gov/News/2018/Pages/DHHR-Releases-Neonatal-Abstinence-Syndrome-Data-for-2017-.aspx
[8] "WV Medicaid Covers an Innovative and Less Costly Treatment Model for Opioid-Affected Infants," accessed July 25, 2019; https://nashp.org/wv-medicaid-covers-an-innovative-and-less-costly-treatment-model-for-opioid-affected-infants/

$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). Current evidence on breastfeeding during MAT focuses on the amount of medication in breast milk and the benefits of breastfeeding to infants with NAS. Although there have been numerous studies exploring interventions to increase breastfeeding in the general population, little is known about how to support and promote breastfeeding among mothers on MAT.

According to the National Technical Assistance Network for Children's Behavioral Health, 1 in 5 children will experience a mental health disorder, and 1 in 10 will experience a mental health issue that is so significant it impacts the child's ability to function socially, academically, and emotionally. Therefore, 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 youth attending middle/high schools in Kanawha County to improve health outcomes.

Cabin Creek Health Systems has established school-based health centers that offer preventive and acute and chronic medical care, as well as counseling and mental health services, health education, and sometimes dental care, to children/adolescents, families, and staff at the target schools for this project. Marshall Health has years of experience and success in effectively coordinating care through school-based health centers and effectively developing transferrable community health worker program models that increase quality of care and health outcomes while reducing cost among populations with chronic disease. By working with Cabin Creek and Marshall Health, our integrated system will provide coordination of care and integration of behavioral health services through a patient-centered health delivery approach that will result in cost-effective, coordinated care that meets the complex, individualized needs of the at-risk youth targeted by this project. The system will incorporate youth families, foster families, and/or other supports into a system of care team, and all care delivered will utilize a trauma-informed care approach.

Aetna's Integrated System of Care Model

West Virginia is the second most rural state in the country based on the number of residents living in communities of 2,500 persons or less.[9] As a result, fragmentation of health care and human services resources is pervasive. Aetna is aware that service gaps are common, including both the absence of specific services and practitioners, and inadequate capacity of services that are present. This may be challenging in rural regions as well as in impoverished urban locations.

The best approach to caring for the children and youth in West Virginia's child welfare system is one which incorporates a **collaborative effort from stakeholders across the spectrum**: families, politicians, judges, health care providers, educators, law enforcement, social workers, etc. Therefore, Aetna proposes creating an integrated system of care model that best meets the needs of all affected children and youth in the State's child welfare system.

The Aetna Medicaid organization uses an integrated system of care model to improve delivery system capability. The model includes a full spectrum of effective community-based physical, behavioral, and oral health care treatment services along with psychosocial services and supports for individuals and their families and circles of support that achieves the following:

- Drives collaboration across agencies and community-based organizations
- Builds meaningful relationships with members and their families/circle of support

[9] "West Virginia State Health Plan," accessed July 25, 2019; https://hca.wv.gov/policyandplanning/Documents/Background%20Material/shpRurPollard.pdf

- Addresses peoples' cultural and linguistic needs such as language and cultural differences that can create barriers for adults with limited English proficiency. Our model gives consideration to members with visual and hearing impairments/disabilities; need for American Sign Language, braille, etc.
- Recognizes and honors member voice and choice
- Acknowledges the impact of trauma on member, youth, and family populations and seeks to implement innovative solutions to reduce that impact on quality of life

More than simply a collection of various resources in a mature system of care, **all the pieces work together** to help our members achieve important clinical and functional outcomes at home, in school, at work, in the community, and throughout the remainder of their lives. The goal is for West Virginia families to work collaboratively with public and private organizations to ensure supports are built around West Virginia youth strengths and needs.

Integrated System of Care Model Stakeholders and Structure

The integrated system of care model would be governed by a board that includes stakeholders who are best positioned to address the challenges of West Virginia's child welfare system. The goal of the board is to proactively educate, inspire, and engage all involved stakeholders and the community at large. Aetna will take the lead in identifying and inviting the most appropriate stakeholders who are deeply involved and committed to ensuring the best interests of each child and youth in West Virginia's child welfare system are addressed and taken into consideration.

Aetna's proposed stakeholder engagement and advisory structure (**Figure 3.1-4**) is designed to convene voices at all community and system levels with members, families, and their circle of support leading the way. Our approach is firmly rooted in current relationships, current ubiquitous needs in West Virginia, and based on shared common barriers to success. The cornerstone of our approach is driven by the principles of collaboration, respect, transparency, effectiveness, and efficiency. From the individual member's Care Coordination team to the stakeholder board, our infrastructure, business practices, and policies are driven by the principles of collaboration, respect, transparency, effectiveness, and efficiency. There are feedback loops between each level of governance and direct service to inform model design, improvements and quality assurance. Aetna facilitates the connections, focus, and documentation of each level to support a high-functioning, coordinated, and integrated system of care.

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 youth and their families. Given the difficult social environments in West Virginia, the youth and families we reach out to for membership in the governance structure will likely have strong emotions, painful memories, and even current fears about the system. Aetna has the skill sets to assure these youth and families that their experiences are learning lessons, and that is the very reason why we need their expertise and leadership to transform the system and to make sure West Virginia families have **voice, choice, and preference** each step of the way through their experience with Aetna and the continuum of care.

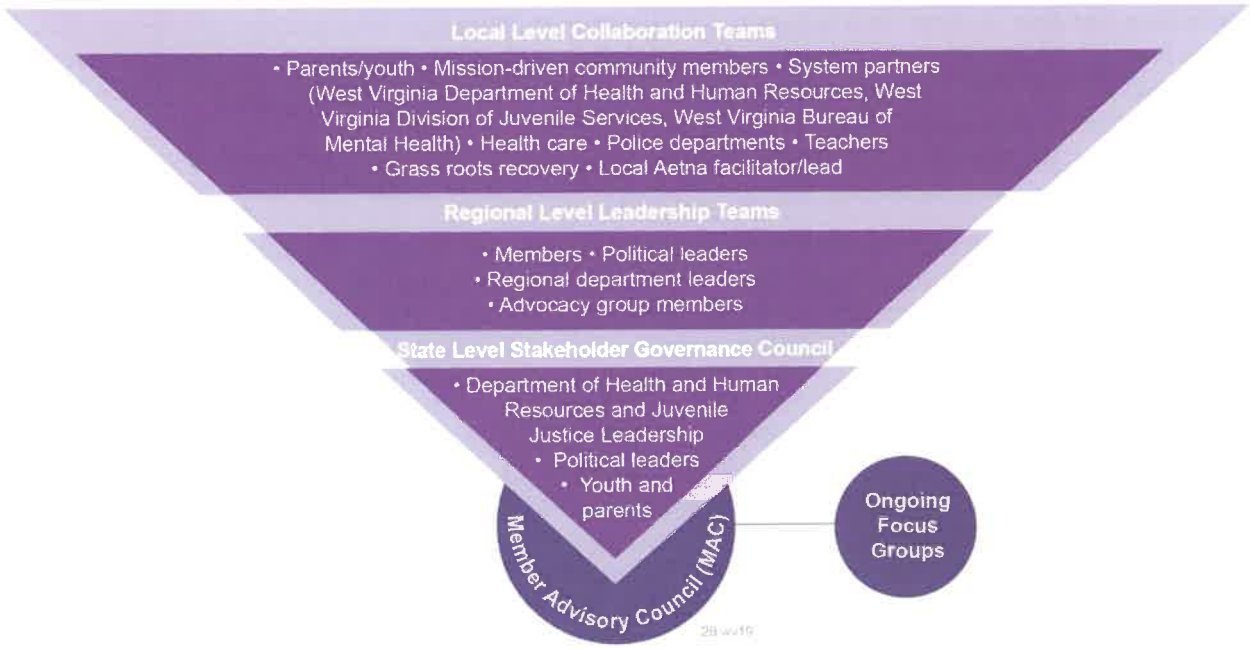


Figure 3.1-4: Aetna's Stakeholder Engagement and Advisory Infrastructure
Our stakeholder engagement and advisory infrastructure is intended to support our integrated system of care model.

Examples of our proposed organization include the following:

- **Local-level collaboration teams** comprised of youth and parents, mission-driven community members, referring departments, school district leads, health care representatives, grass roots recovery group leaders, and local Aetna leads/facilitators. Aetna local leadership will follow the orientation and invitation steps for full membership. **Example membership** includes Lily's Place (Huntington), psychiatric residential treatment facilities (PRTF), foster parents, parents, youth, local schools, local police, local health providers, local attorneys, youth, child protection staff, juvenile justice, behavioral health, recovery professionals, after school and child development-focused professionals, and local housing and social service providers.
- **Regional-level leadership teams** are made up of representative members from local-level collaborative teams and civic leaders, regional referring department leads, school board members, advocacy group leaders, faith community leaders, and Aetna regional leads. Our regional leadership team will begin outreach, orientation and invitations to leadership for each of the organizations and individuals that will help guide the model at the regional level. **Example membership** includes Parents as Teachers, Mountain State, Healthy Families, The Arc of Mid-Ohio Valley, Circle of Parents Support Group, Help Me Grow West Virginia, Our Babies: Safe and Sound, Newborn Hearing Screening Advisory Committee, Children with Special Health Care Needs, Youth Advocate Program, Family Resource Network, Family Support Program, PRTF, CASAs, public defender's office, legal advocates, and Aetna regional leadership.
- **The State-level Stakeholder Governance Council includes members who are elected** representatives of the regional level leadership teams and represent divergent perspectives from youth and parents to department leads, political leaders, juvenile court presiding judges, judicial leaders, education department, leads in the BCF, Bureau for Behavioral Health and Health Facilities, Bureau for Medical Services, BPH, Department of Health and Human Services Office of Drug Control Policy, Perinatal Partnership Substance use in Pregnancy Committee, March of Dimes, Maternal and

Child Health Committee, Clinical Committee for the West Virginia Health Information System, Safe at Home, The First 1,000 Days, West Virginia Kids Health Partnership, State police, West Virginia Child Abuse Network, and Aetna's senior leadership. Aetna has started reaching out to key individuals from many of these departments and organizations to introduce the governance concept in the context of our integrated system of care for children in the foster care system and to invite them to the Governance Council. A partial list includes the following individuals:

- **Kelli Caseman**, Charleston, WV. Ms. Caseman is the director of Child Health for West Virginians for Affordable Health Care and leads the West Virginia Kids' Health Partnership.
- **Susan Gamble**, Charleston, WV. Director, West Virginia Statewide Afterschool Network.
- **John Kennedy,** Charleston, WV. School-based/behavioral health coordinator, West Virginia Primary Care Association.
- **Tricia Kingery**, Nitro, WV. Executive Director, West Virginia KIDS COUNT. She is also Coordinator of West Virginia's ACEs Coalition.
- **Cyndi Kirkhart**, Huntington, WV. Ms. Kirkhart is the executive director of the Facing Hunger Food Bank. Facing Hunger's service area currently includes 248 agencies across 17 counties in West Virginia, eastern Kentucky, and southeastern Ohio. Seven of those counties are in West Virginia.
- **Shane Randolph**, Gallipolis Ferry, WV. Mr. Randolph is the coordinator of the Family Resource Center (FRC) at Marcum Terrace in Huntington. The FRC is in the largest government housing development in the state.
- **Mike Toothman**, Colliers, WV. Mr. Toothman is the retired director of Youth Services System, Inc. in Wheeling, WV.
- **Charlene Zirk**, Moorefield, WV. Ms. Zirk is the director of the Hardy County Child Care Center, which serves the childcare needs of many low-income, working families.

> "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, to 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**

Aetna has an extensive list of potential members and will continue to reach out to, educate, and invite these important leaders to the stakeholder board, ensuring that our oversight body has divergent perspectives held by strong advocates all focused on better outcomes for foster youth and families.

- **The Member Advisory Committee (MAC)** comprised of youth and parents, adoptive parents, kinship parents and foster parents with lived experience, foster care alumni, who voluntarily participate with the goal of improving outcomes for foster youth and their families. The committee will meet every quarter for the first year and then every six months thereafter, to discuss issues they are encountering with our model and recommend solutions. We will report to the Department the committee's recommendations of when and how concerns have been addressed as well as sharing how and why procedures have or have not changed based on recommendations. We will provide viably solutions and timelines for completion. This report must be submitted by the Department to the Secretary and the Legislative Oversight Commission on Health and Human Resources Accountability and the public in a timely fashion and will be available on our Specialized Managed Care Plan for

Children and Youth website. Aetna will establish and maintain a statewide uniform reporting system to collect and analyze data relating to complaints for the purpose of identifying and resolving significant problems faced by foster children and foster parents as a class. The data will be submitted to the Bureau for Children and Families within the Department and the Legislative Oversight Commission on Health and Human Resources Accountability on a quarterly basis.

The MAC will host **focus groups** annually for the purpose of getting vital information on six critical topics: access, service delivery, gaps in support systems, engagement with system staff, cultural competency, and consumer knowledge of services and supports. Although we communicate with and assist individual members on a regular basis, we recognize the power of hearing firsthand stories from individuals who have been directly involved in the child welfare and adoption assistance systems outside of our direct member interactions. The MAC assists in this process by soliciting member feedback and opinions regarding issues related to access and the quality of care and services provided to members as well as potential programs, activities, and educational materials. Our system of care administrators, specifically the child and the recovery and resiliency system of care administrators will coordinate multiple consumer-focused coalitions that will include enrolled members and their families and caregivers. We will engage the families and caregivers of children with special needs through focus groups on a monthly basis, as outlined in Section 12.6 of the Model Service Provider Agreement.

We will use these opportunities to hear from those impacted by the child welfare system firsthand and develop collaborative solutions that address the unique situations facing this population. We currently meet with BCF on a monthly basis so we can collaborate and discuss potential topics for focus groups related to children with special health care needs to make certain useful information is collected. These interactions can also help Aetna identify ways to advance Family First across the state and assist in the collection of information useful to us and our key stakeholders, such as BCF. Aetna will conduct at least 12 focus groups throughout the year with youth, families, and foster and adoptive parents that reside in the community and utilize SNS. The focus groups will be used to provide the Department with feedback on where services are being most impactful, so programmatic changes may be made to improve the overall health of the program.

Aetna will also provide the following:

- **The Training Collaborative** led by Aetna's training director which includes provider network trainers, referring department leads, CASAs and court leads, peer and parent collaborators. Example membership includes KVC Health Systems, PRTF providers, Parents as Teachers, Safe at Home, Birth to Three, Juvenile Justice, First 1,000 Days, Foster, Adoptive, Kinship Association, West Virginia Association of Social Workers, 4-E Funded University Training Staff, behavioral health, and parents' attorneys.
- **Care Coordination teams** comprised of the youth, parents, family and extended family members, friends, and community members, as well as professionals at a 50-50 percent natural member to professional ratio (per National Wraparound Standards).

Our structure will employ the required leadership, management, direct care, and ancillary support positions as well as other positions that will be integral to the success of the collaborative model, such as a new training director who will facilitate a robust training collaborative comprised of trainers across the various stakeholder groups and the provider network. The training director will oversee the design of a train-the-trainer model, thus ensuring sustainability across the regions. We will contract with, train, and oversee a provider network that will provide a full continuum of supports and services necessary for providing comprehensive, community-based wraparound care. Aetna's department leads will provide facilitation of design, implementation and oversight in an inclusive and collaborative manner within cross-departmental work teams. Each facilitator will be fully trained in business acumen, strategic planning, and oversight

competencies to facilitate high-quality care, continuous quality improvement, efficiencies and effectiveness, and sustainability over time. Training topics will include, but are not limited, to the following:

- Introduction to our integrated system of care model and the Family First Prevention Services Act call to action
- Our system of care model, principles, outcomes, measurements, and care components
- Overview of and purpose for the governance and leadership teams at all levels
- TIC in the context of ACEs specific to West Virginia children and families
- Orientation to CPS, juvenile justice, behavioral health, and youth and family involvement
- In-depth understanding of individualized care, roles and responsibilities, principles and standards of care, formal services as well as informal supports and SNS resources
- Life domain assessment of need and comprehensive care
- The youth and parent perspective and the importance of voice, choice, and preferences

Department of Education and Local School System Stakeholders

As Aetna anticipates reaching out to include Department of Education representatives, we need to be sensitive to understanding how teachers and school health personnel are often not included on children's care teams, let alone invited to participate on governance stakeholder teams. Educators across the nation have experienced a severe lack of resources in relationship to foster care children with unmet special education and behavioral health needs; therefore, our model of care will need to be sensitive to the teachers' and administrators' angst that has built up over decades. This angst is welcomed as a powerful entree into the governance structure and its mission to make certain this innovation does not leave children in the child welfare system and their schools in a lurch without sufficient educational assessments and appropriate resources.

Judicial Stakeholders

Involving key stakeholders from the courts and child advocacy entities will require a thorough description of the new, innovative model of care and rationale based on the Family First Prevention Services Act as well as the research that supports the innovation before these stakeholders get onboard with the model and its primary purpose to keep West Virginia's children safe at home. Many court representatives in the state will already be aware of the opioid epidemic and the subsequent marked increase of children pulled into the system; these are the individuals who would be the best stakeholders to participate constructively on the governance structure teams. Key collaborations with juvenile court judges will ensure that alternatives to removal and treatment are understood and supported. These relationships also afford Aetna the opportunity to quickly access information that juvenile court judges have, allowing for rapid access to data points that aid in expeditious and more accurate care for youth and families. These examples of linkage, education, and inclusion of diverse perspectives illustrate how Aetna will tailor the approach to reaching out to and involving key individuals and organizations that will own and improve the integrated system of care model, the continuum of services, and the collaborations that will ensure system transformation.

4. Member Services

The Vendor should refer to the relevant specifications located in ***Appendix 1: Detailed Specifications*** (based on the categorization within Column E: Subject Matter Area) and pertinent narrative in ***Section 4: Project Specifications*** in this RFP, and then describe its approach to Member Services below. The Vendor's narrative response should not exceed 50 pages.

As a West Virginia quality leader with a **Commendable rating from the National Committee for Quality Assurance**, Aetna exemplifies a statewide commitment to our members and communities through superior outcomes, achieving optimal member experience, and supporting and advancing statewide goals including the nine care coordination goals and objectives of this procurement for West Virginia's Specialized Managed Care Plan for Children and Youth. Our transformative vision drives our model for concierge support and enhanced care coordination supporting the children and youth in foster care, adoption assistance, and involved in the West Virginia Department of Corrections and Rehabilitation (WVDOCR) services. Our model is aligned with the Family First Prevention Services Act and West Virginia regulations and initiatives. Our local, member-centered approach focuses on individuals' holistic health needs by providing access to and delivery of cost-effective health care and social necessary services (SNS), which leads to enhanced coordination of care and access to services, improved communication amongst stakeholders, reduced fragmentation, and meaningful and complete electronic health records.

Member Communication

MS010	The Vendor should facilitate connecting members to community resources and social services.	The Vendor should describe how it will connect members to community resources and social services, and should demonstrate its understanding of available community resources and social services in the State.
MS023	The Vendor should provide methods for members to contact the member services department, including, but not limited to, the following:	The Vendor should: 1) Describe methods for members to contact the Vendor member services department. 2) Describe hours of operation. 3) Describe its member services hotline call transfer protocols and decision trees.
MS024	An emergency hotline	See the parent specification.
MS025	A toll-free number	See the parent specification.
MS026	The Vendor should transfer calls between the member services department and subcontractors for review, if applicable.	The Vendor should describe how it will meet this specification.
MS029	The Vendor should train member services representatives on topics including, but not limited to, the following:	The Vendor should describe how it will meet this specification, including, but not limited to, proposed training frequency and curriculum.
MS030	Serving members with disabilities and chronic conditions	See the parent specification.
MS031	The culture of disability	See the parent specification.
MS032	Resources available to members	See the parent specification.
MS033	The Vendor should, on an ongoing basis and at a set frequency, provide training to staff that perform outreach to members with special healthcare needs upon enrollment.	The Vendor should describe how it will meet this specification, including, but not limited to, proposed training frequency and curriculum.

MS034	The Vendor should use and report to the Department on customer service performance standards, including, but not limited to, the following:	The Vendor should describe how it will meet this specification.
MS035	Member-to-representative ratios	See the parent specification.
MS036	Call answering time, with a minimum of 83% of calls answered in 30 seconds	See the parent specification.
MS037	Call abandonment rate not to exceed five percent (5%)	See the parent specification.
MS038	Single contact resolution	See the parent specification.
MS040	The Vendor should use warm transfer protocols for its member services and other applicable departments.	The Vendor should describe how it will meet this specification.

Aetna's local member experience in West Virginia and vast knowledge supporting foster children and children and youth involved in child welfare offers a real-world, community driven approach to effectively communicating with our members and their circle of support—their legal guardians, child welfare staff, foster families, biological families, and caregivers.[1] Our approach is customized to each community and the unique needs of the children, youth, and stakeholders in those communities. We have learned that ongoing collaboration with State agencies, families, and providers is the most effective way to design a system of care for children and youth involved in child welfare. We will offer a comprehensive approach to support, inform, and empower our members and their circle of support through ongoing engagement and collaboration with the Department, Bureau for Children and Families (BCF), Child Protective Services (CPS), WVDOCR, providers, community advocates, and community stakeholders. This collaboration drives Aetna's member services approach—our communication, outreach, welcome, education, and access to information, tools, and resources, including member rights and member grievance and appeals—reflects our ongoing commitment to providing an optimal member experience, and exceeding the needs of the State and our members, their families, and their local communities.

With an understanding that West Virginia's children and youth are particularly vulnerable due to intensive health care needs and past lack of primary, behavioral health (BH), and dental care, Aetna strives to create a compassionate, collaborative, yet efficient process for new and returning members, their families and caregivers. Aetna understands every West Virginia member has a different story, whether neglect, adverse events, instability, or justice issues exist, we will combine Aetna's commitment to continuously work collaboratively with members, the Department, BCF, CPS, WVDOCR, and our communities as we develop outreach and educational materials and provide access to services (e.g., the member services call center and information to facilitate member engagement). This process will ensure the necessary and swift coordination between Aetna, the Department, BCF, and WVDOCR to allow West Virginia children and youth members to begin receiving services immediately upon entering the Specialized Managed Care for Children and Youth program.

At Aetna, our **Common Purpose** means that we engage our employees around a shared commitment to our members. 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. 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. For example, if our members have changed placement, our Member Services and Care Coordination teams work swiftly and collaboratively to assure member guardians have immediate access to a primary care provider (PCP) based on

[1] Aetna's definition of member throughout the Member Services section includes the member's legal guardian, defined as the child or youth, the legal guardian, and designated authorized representatives such as foster families, kinship relatives, relatives, and caregivers.

preference and proximity, and have the necessary information such as the member identification (ID) card detail in time for the provider appointment. 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, which supports the State goals for enhanced coordination, access to care, reduced fragmentation, and improved communication across stakeholders. 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.

[MS024 – MS026, MS029 – MS038, MS040] Member Services Call Center

Our member services 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 through hiring and staffing practices, our hours of operation, our telephone protocols, our staff training, and our telephone performance. We describe the RFP's member services specifications in detail throughout this call center section, but as examples of our demonstrated values and accountability, our West Virginia member services call center achieves the following:

- Responds to all our member[2] needs quickly by answering **13,425 calls in quarter two of 2019 in an average of 3.7 seconds, with a service level, or call answering time, just under 97 percent of calls under 30 seconds (the State requirement is 83 percent), and abandonment rate of 0.5 percent[3] (the State requirement is <5 percent)** in our existing West Virginia Medicaid call center
- Supports the State's objective for enhanced coordination of care and access to services through our concierge model of member services support, offering immediate, direct linkage to care coordinators, clinicians with BH expertise, nurses, providers, and other medical and clinical staff for urgent clinical and crisis support
- Supports the State's objective for reduced fragmentation and seamless continuity of care by making certain our member services representatives are fully trained in topics customized toward the unique needs of West Virginia foster, adoptive, former foster, and children and youth involved in CPS or WVDOCR such as the following:
  - **Mental Health First Aid (MHFA)**
  - **Trauma-informed care (TIC) and West Virginia's trauma transformation learning collaborative**
  - The unique needs of West Virginia children and youth involved in foster care, adoption, WVDOCR, and CPS including the culture of disability and SNS
  - Access to immediate crisis and clinical support
  - Person and family-centered approaches
  - Social determinants of health (SDOH)
- **Augments our West Virginia call center with the around-the-clock availability** that supports the State's objective for **seamless continuity of care** through after-hours access to our fully trained, member services representatives in our **24/7/365, national Member Services department.**

[MS023, MS025] Hours of Operation

We are compliant with the **Model Service Provider Agreement (SPA)** for assuring our call center is open for at least nine hours a day. West Virginia's local member services hotline is in **Charleston, West**

[2] When we use the term member or members in the remainder of this section, we are collectively referring to members, their legal guardians, and legally authorized representatives.
[3] Service level is the same measure as call answering time, which is the term used and defined in the Member Services specifications in the RFP.

Virginia. We currently operate via one, toll-free number from 8 a.m. to 5 p.m. Eastern Time, Monday through Friday and on select State holidays **[MS023, MS025].** Our toll-free phone number can be found in our member handbook, on our website, and in our member welcome materials. **[MS023]** 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 member services calls to our national call center, a centralized call center in Phoenix, Arizona. The national team assumes the role of the West Virginia-based member services 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 member services staff will be trained in West Virginia Children and Youth program-specific covered services, State, Department, BCF, and CPS policies, and it has access to the same electronic tools used by the West Virginia-based Member Services team. **Members receive the same exemplary service with consistent messaging and information.** For calls requiring clinical support, the national member services representatives have the same access to the Health Information line (nurse line) and BH Crisis Services hotline; the member services representative completes a warm transfer of the member so we can address their clinical issues.

[MS023, MS025] Call Routing

Our member services 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 member services hotline, our interactive voice response (IVR) system will route them appropriately by allowing members to choose the department that best meets their needs **[MS025].** Members initially hear an interactive voice prompt welcoming them to Aetna and advising calls are recorded and monitored for quality assurance purposes. The same message is offered in Spanish with a prompt to press option number one to connect with a Spanish-speaking representative. The remaining prompts are as follows:

- Press number two if you are experiencing a mental health crisis or are calling about a member who is currently experiencing a crisis
- Press number three if you know your party's extension
- Press number four if you are a member
- Press number five if you are a provider
- Press number nine to repeat these options **[MS023].**

Members who speak a non-English prevalent language receive appropriate assistance through member services representatives who immediately engage our language interpreter services for interpretation. If all representatives are currently assisting other members, the system places the member on a brief hold and connects the member to the next available representative.

[MS023, MS038, MS040] Warm Transfer Capability and Single-call Resolution

Our telephone management system supports seamless transfer of calls (three-way and other conference call capabilities) between our Member Services department and all other departments including Care Management and our BH Crisis Services and Health Information hotlines, as well as external numbers. Member services representatives also use three-way conference calling functions when assisting members, caregivers, and legal guardians to schedule appointments or connect with community resource agencies (e.g., food banks). Member services 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. **[MS023]** Member services representatives complete a warm transfer when making three-way calls. For example, the representative will 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 **[MS038]** and that the member's needs are fully met. **[MS040]** Our member service representatives always request a callback number in case of technical difficulty.

Our member services representatives strive and have resources available for single-call resolution supported by our policies and procedures. 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 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 member services representative or supervisor by notifying via instant message and completing a warm transfer including explaining to the member they are seeking assistance to immediately resolve the concern. Member services representatives are trained on techniques such as de-escalation, active listening, and showing empathy to aid in single-call resolution. **[MS038]**

Figure 4.1-1: Easy-to-Access Services for Members

Aetna's member services representatives are able to support members in a variety of ways, including connecting them to essential services.

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 member services representative reviews the call documentation platform, determines if they can resolve the issue, or escalates to a senior or supervisory member services staff. Member services representatives review the call documentation platform daily, assuring all member and caller follow-up needs are met. The member services director reviews reports to monitor timely resolution and to reassign open records or allocate additional resources, assuring all follow-up calls are completed. Call records can also indicate if an outbound call is needed to inform the member of final resolution and are closed when all follow-up is completed.

[MS010, MS023, MS024, MS026] Concierge Support and Call Center Decision Trees

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 4.1-1** illustrates our member services representative as a direct connection to the assistance and services our members need. Our member services representatives provide assistance to a member or other callers before connecting them to subcontractors, other departments, or community resources including verifying necessary release of information forms for callers who are not the legal guardian. We are equipped to handle the first steps of inquiries and questions on behalf of our care coordinators, grievance and appeals, and member advocate staff, 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 health plan or State program staff. If a member or member's family calls with questions about accessing SNS, our member services representative would determine whether there are any other questions they can answer, such as locating and describing SNS services available to the member, prior to offering a warm transfer, if needed, to a care coordinator. Member services 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. Member services representatives will be fully trained on SNS and SNS providers, answering questions as indicated. Representatives will offer assistance including warm transfer to the child or youth's care manager to answer questions about authorized SNS services and supports. **[MS010, MS026]**

[MS024, MS026] Link to Care Coordinators and Crisis Support
Member services staff are trained and have desktop procedures that guide on how to identify emergencies, and medical and BH triggers, and complete a warm transfer to care coordinators, nurses, or clinicians with BH expertise. Representatives recognize that unique needs include that a high percentage of callers may be caregivers or guardians calling on behalf of a child or youth, and that the children and youth have higher likelihood of special needs such as disabilities or BH needs. Representatives initially offer concierge support using skills learned in **Mental Health First Aid (MHFA), trauma-informed Care (TIC), and the unique needs of West Virginia children and youth involved in CPS, including the culture of disability.** 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 coordinator of the referral to 911. If a member expresses or describes behavioral health needs or crisis such as description of uncontrollable behaviors, notification that the member cannot access prescribed medications, or notification of a placement disruption, the representative responds compassionately while sending an instant message to the BH instant message distribution list indicated in the crisis call desktop procedure and completes a warm transfer to the care coordinator. The representative keeps the member engaged on the phone, explaining the steps being taken and initiating the warm transfer. **[MS026]**

Our Care Management team offers a comprehensive, integrated program and staff—licensed social workers, nurses, peer support, and medical directors—available during business hours to handle incoming transfers from our Member Services department. The Care Management team is extensively trained in the unique needs of West Virginia children and youth, and possesses the education, experience, and skill to resolve our members' clinical or crisis concerns. When the concern indicates the need for immediate crisis support, such as dispatching a mobile crisis team, the care coordinator completes a warm transfer to Aetna's BH Crisis Services hotline. The care coordinator assures timely notification to CPS workers for all unexpected and crisis issues that arise, assuring continuity of care.

Our **BH Crisis Services hotline** is our dedicated emergency hotline for our children and youth in the foster care system and individuals receiving adoption assistance, especially newly assigned caregivers who may have a child or youth with an unfamiliar condition. **[MS023, MS024]** The hotline is available 24/7/365 to members, families, caregivers, and State agency staff for urgent and emergent BH needs. Licensed clinicians complete crisis assessments and provide care advice and health education; provide information about Aetna clinical services; and assist callers and providers with handling crises for West Virginia members. Clinicians are trained on West Virginia covered services and programs, as well as how to access them. They are experienced in telephone crisis assessment and intervention, mental health disorders and treatment, and management and intervention for crises. Clinicians can complete warm transfers of members to their assigned care coordinator during business hours when care coordination is needed, or when a change in the member's needs requires reassessment or a new referral. The clinician documents in the electronic care

management system, creating an alert for the specific assigned care coordinator to follow up on a member's care plan—a critical resource that benefits members by providing **seamless continuity of care.**

Health Information line: As a value-added service, Aetna offers our West Virginia members access to nurses on our 24/7/365 Health Information line. Nurses complete nursing assessments and provide care advice and health education; provide information about Aetna medical services; and assist members with urgent or acute medical issues. Nurses are trained on West Virginia covered services and programs, as well as how to access them. For example, nurses will help a caregiver secure durable medical equipment for a child with disabilities by documenting and flagging the caregiver's communicated concerns in the electronic documentation platform. They are experienced in telephone nursing assessment and intervention, nursing health education, and management and intervention for crises. Nurses can complete warm transfers of members to their assigned care coordinator during business hours when care coordination is needed, or when a change in the member's needs requires reassessment or a new referral. The nurse documents in the electronic care management system, creating an alert for the specific assigned care coordinator to follow up on a member's care 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 Member Services 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 nurse; if the call is routed to a nurse or clinician who speaks English only, the nurse or clinician can immediately engage our 24/7/365 interpreter services at the onset of the call. The nurse or clinician receives a **whisper tone** indicating the caller is Spanish-speaking and sees a **written readout on the face of their telephone notifying support needed for** a Spanish-speaking caller. If all nurses or clinicians are currently assisting other callers, the system places the caller on a brief hold and connects the member to the next available nurse or clinician in the call queue.

We Know and Live in West Virginia: Member Services Staff and Community Involvement

Our Member Services department staff know and live in West Virginia. We take our community involvement seriously and see it as part of our **Common Purpose**, as each member of our community is a member of our family. **Kelley Mitchell**, our member services director, is a native West Virginian. Not only does she bring a professional, experienced framework to the call center—she developed a proactive service model for high-volume providers who serve children and youth—she has volunteered with low-income youth whose parents are incarcerated or involved with substance use, helping them to attend church camp or providing resources to attend school prom at no cost. **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 provider, 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."

[MS010] Link to Community Resources

Aetna member services representatives know West Virginia—they live in West Virginia local communities. Member services representatives access multiple, comprehensive sources to identify local, community resources for West Virginia members including use of our internal community resource database, collaboration with our care coordinators including care coordinators embedded at local facilities, and collaboration with community health workers and peer support staff. Our internal community resource database is web-based and offers search functions by ZIP code and further categorized by food, housing, goods, legal, transportation, health, financial assistance, education, work, and social services. Representatives and care coordinators elicit as much detail as possible from members, connecting them to their preferred and easily accessible resource. Resource information is available nationally for all ZIP codes and is updated regularly to reflect the most recent community-based and social service resources. Members and their families can access the same database via our website and the Aetna mobile application. For example, if a member is in need of food assistance, the member services representative coordinates with Mountaineer Food Bank or Facing Hunger Foodbank or completes a warm transfer and assures connection and assistance by that community resource before ending the call. If members have access to a smartphone or laptop/computer, representatives spend time on each call educating members how to navigate local search engines and website resources as needed. Representatives will offer warm transfers to SNS providers for members inquiring about a specifically authorized service. **[MS010]**

Families, children, and youth involved in child welfare often experience barriers to care such as lack of transportation to health care appointments or lack of healthy food in the family home. These social determinants of health have been well-documented as barriers to adequate health care. Aetna has recently entered a formal collaboration with the Global Orphan Project and Celebrate Recovery for use of their community resource application, **CarePortal**, customized to meet the unique needs of West Virginia children and youth in the foster care system and individuals receiving adoption assistance. CarePortal is a web-based application that links Aetna care coordinators to local church congregations that can offer support and donations directly to families. Examples of supports and donations include items such as furniture, transportation, clothing, or food. Aetna's member services representatives and care coordinators will submit a specific request on behalf of a member into the web-based application. CarePortal will share the need with the three closest congregations to the location of the member. The first church to accept the request coordinates with the representative or care coordinator to deliver items and donations directly to the family's home. CarePortal supports all faith-based congregations and is available to members regardless of the members' faith or religious affiliation. **[MS010]**

CarePortal is a promising practice that operates in 25 states and has effectively assisted thousands of children and families involved with child welfare agencies. Every request made supports the Family First tenets of prevention, early intervention, and family reunification in one of nine ways. For example, requests for items and donations are used to assist families to stay safely together, to reunify after separation, or to establish housing for older youth who are leaving the foster care system after transitioning to adulthood as outlined in **Table 4.1-1.**

Table 4.1-1: CarePortal Platform

Support	Preserve	Unite
Improve a child's well-being care	Help prevent a child from entering placement	Help reunify a biological family
Strengthen a biological family placement	Help preserve foster/kinship care	Help place a child in foster/kinship care

Support	Preserve	Unite
Support a youth aging out of foster care	Help preserve an adoptive placement	Help unit a child with an adoptive family

Aetna will collaborate with the Department, BCF, and CPS to determine strategies for implementing CarePortal in our local West Virginia communities. Our commitment is to implement in phases and continue to support the overall growth and expansion of CarePortal throughout the state.

[MS034, MS035 Member Services Staffing

Our Member Services department adheres to the requirements outlined in **RFP Attachment C,** and is staffed with 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 foster care market call volume trends, and State-required performance standards. Our estimated member to representative ratio is 3,167:1. **[MS034, MS035]** Calculation for this ratio includes adding additional representatives to serve the West Virginia Specialized Managed Care Plan for Children and Youth project. We will train all existing West Virginia Medicaid member services call center staff to serve the Specialized Managed Care Plan for Children and Youth project, assuring an adequate number of representatives to handle incoming calls and concerns. 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. **Table 4.1-2** provides an overview of the functions, brief job descriptions, and qualifications for our member services staff:

Table 4.1-2: Key Personnel of Member Services Department

Member Services Position	Functions	Brief Job Description	Qualifications
Member Services Representative	Answers questions; resolves issues; explains member rights and responsibilities; logs complaints and appeals; educates on covered, non-capitated, and value-added services; assists navigating website, member portal, or mobile application; directly connects to care coordinators, nurses, and clinicians	Handles customer service inquiries via telephone, internet, or written correspondence; documents and tracks interactions; participates in required training, meetings, and quality reviews	Ability to multitask; analytical skills; oral and written communication skills; understanding of medical terminology; problem-solving skills; attention to detail and accuracy; negotiation skills; customer service experience; high school or General Educational Development completion
Senior Member Services Representative	Same functions as member services representative plus the following serves as subject matter expert providing technical assistance to representatives; coaches and trains representatives; completes and delivers internal quality reviews	Same as member services representative plus coaches and trains representatives; completes and delivers internal quality reviews	Three years of experience in a customer service environment; demonstrated ability to handle multiple assignments competently; customer service experience; associate degree or equivalent work experience

Member Services Position	Functions	Brief Job Description	Qualifications
Member Services Supervisor	Develops, evaluates, and coaches staff; assesses staff performance and provides feedback; monitors performance metrics; maintains collaborative relationships and effective communication; selects and retains high-caliber, diverse talent; liaisons with other departments; analyzes data and identifies trends; and implements action plans	Responsible for performance of senior member services representatives and member services representatives; oversees call center performance and maintains performance metrics; hires and retains staff	Two years of experience leading customer service teams; experience with call center environment required; negotiation skills; prioritizes effectively; project management skills; oral and written communication skills; leadership and staff development; associate degree or equivalent work experience
Member Services Director	Oversees the Member Services department in a local call center; monitors contractual performance requirements, recommends corrective action; develops and maintains collaborative relationships with CPS, providers, and families; develops, trains, evaluates, and coaches employees, assuring quality standards; monitors training requirements; builds a cohesive team; creates tools, job aids, and training materials that support exemplary member experiences; analyzes and reports on process, systems, and policy redesign	Maintains oversight of operational functions including member enrollment and assuring members have access to covered services; executes local strategic and operational plan in support of contractual requirements; plans, directs, and implements procedures that assure quality-driven member experience and satisfaction including oversight of member complaints; identifies and resolves technical, operational, and team barriers; manages a team of professional employees and/or supervisors	Five-plus years of experience managing high-volume call centers; three years health care experience preferred; customer service experience; multiple years of proven leadership experience; proven leadership skills managing large high-performance teams; demonstrated negotiation skills; bachelor's degree in a closely related field; and an advanced degree preferred
Member Advocate	Responsible for interacting with the children, youth, and families involved in CPS; connects to resources; collaborates with the care management director, care coordinators, and SNS liaison; provides member support related to enrollment, access, and continuity of care issues; supports members throughout any grievance or appeal activity; assists members in obtaining materials in alternative formats; supports and addresses needs of children and youth in foster	Responsible for interacting with children, youth, and families involved in CPS, State agencies, and internal Aetna departments, ensuring referral and connection to appropriate resources; support during member grievance, appeal, and State Fair Hearing	At least five years of experience in health care working with low-income and foster care populations and cultural sensitivity; bachelor's degree or higher; based in West Virginia

Member Services Position	Functions	Brief Job Description	Qualifications
	care; interacts with members in a culturally sensitive manner		

Aetna will have a member advocate that is compliant with the **RFP Attachment C.** The member advocate is a local, expert staff that lives and works in West Virginia and whose primary responsibility is to interact with children, youth, and families involved in CPS, State agencies including CPS case workers, and internal Aetna departments, ensuring they are referred and connected to appropriate resources and access to care. The job description will include assisting members with filing or writing complaints, grievances, and appeals, and providing support during complaint resolution; informing members about their benefits, rights, and responsibilities; assisting with enrollment, access to care, and continuity of care issues; and supporting members and their families to navigate the system of care. When necessary, the member advocate notifies State agencies and CPS case workers of concerns, and documents full and complete records of all interactions and activities in the grievance and appeal application. All documentation related to grievance and appeal issues is logged in the tracking system described in Member Grievance and Appeals section. Our member advocate serves as a culturally competent point of contact for our members. Members learn about the role and availability of a member advocate by calling the member services hotline and through written materials such as our member handbook, website, newsletters, educational materials, and/or coverage determination and complaint and appeal notices. Members can access member advocates by calling directly or calling the member services hotline.

[MS029 – MS033] 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 workforce and partners that operate with integrity and transparency. Aetna **leverages our national training expertise and local experience to incorporate the needs of West Virginia members into our comprehensive training processes** for member services. Member services staff, including our member advocate, complete three weeks of classroom, online, and interactive training during new-hire initial training, described in **Table 4.1-3**. 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 a member's 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, identification, telephone etiquette, call servicing, documentation, and West Virginia program requirements. Supervisors complete audits, review scores, and identify areas for improvement with staff on a monthly basis and more frequently, depending on need. Additionally, **our entire Member Services department receives 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; daily debriefs between the supervisor and representative;

training by the senior representatives during bimonthly staff meetings; quarterly training on quality initiatives such as documentation and exemplary member experience practices; on-the-spot, real-time support from senior representatives through chat and instant messaging; annual classroom training; and online webinars. We review and update training curriculum annually or as programs change to follow State requirements, State and federal laws, and West Virginia regulations. We update and provide additional trainings as needed when we have new systems that require navigation or as West Virginia programs are updated. We incorporate feedback gathered from automated surveys, quality satisfaction surveys, and Member Advisory Committees 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 member services during new-hire onboarding, monthly department trainings and annual refresher trainings on items such as code of conduct, Healthcare Insurance Portability and Accountability Act (HIPAA), protected health information (PHI), fraud, waste, and abuse, and record retention.

Training topics include MHFA, TIC, ongoing BH training via Relias Learning Management System, technology-based training via Aetna Learning and Performance Center, and any other State-specific training. Aetna designates time off the phone for representatives to complete scheduled training. **Table 4.1-3** outlines training topics, curriculum description, and the training timeline. **[MS029 – MS033]**

Table 4.1-3: Member Services Training Curriculum

Training Topic	Training Curriculum Description	Training Timeline/Frequency
Covered and Value-added Services	Overview of covered services including physical, behavioral, SNS, and dental services, preventive services, role of the PCP and assignments, how to access services, how to provide appointment scheduling assistance, out-of-network services, limitations, and medical necessity; the member handbook; member grievance and appeals; Aetna's value-added services and related benefits	New-hire initial training and as program changes occur; monthly training on BH services; current staff upon program implementation
West Virginia Requirements	Overview of Managed Care Plan for Children and Youth program and related requirements including member rights, member grievance and appeals, and advance directives; unique needs for foster, adoptive, and children and youth involved in CPS; unique needs of children and youth involved in juvenile justice/WVDOCR; regional and service area distinctions	New-hire initial training, as program changes occur, current staff upon program implementation
Enabling Services and Cultural Competency	Overview of enabling services, federal regulations, and State requirements; 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, Children and Youth program unique needs, interpretation services, use of teletypewriter, culture of disability, **[MS031]** disabilities and chronic conditions, and disability accommodations **[MS030]**	New-hire initial training, annually

Training Topic	Training Curriculum Description	Training Timeline/Frequency
Assisting Members with Limited English Proficiency	Overview of West Virginia population, engaging members with limited English proficiency, and instructions on how to access 24/7/365 subcontracted interpreter services	New-hire initial training
Assisting Members in Locating Providers and Community Resources	Review of member handbook, instructions on how to navigate Aetna's care management provider search portal, website provider search function, and mobile application; overview and navigation instruction for community resource databases including Family Resource Network, CarePortal, Aetna's internal database and local community resources available to members **[MS032]**	New-hire initial training
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 BH crises; warm transfer and escalation protocols; using principles identified in MHFA and TIC 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, MHFA, and TIC **[MS033]**	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 (ANE)	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

[MS034, MS036 – MS038] Call Center Tracking, Monitoring, and Performance

Aetna has superior call center monitoring practices that result in exceeding the State 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, member services supervisors and our workforce management department monitors telephone performance and call routing in real time and make adjustments, making sure that every West Virginia member's call is handled efficiently. Call monitoring trends are used to project future staffing levels, assuring our Member Services department is sufficiently staffed to respond to member needs. All calls are recorded and available for quality monitoring and 1:1 coaching with our member services representatives. We review

calls for service excellence, accuracy of information provided, and adherence to policies via our Net Promoter Score (NPS) program.

Our enterprise telephone system includes a suite of tools enabling member services supervisors, managers, and our national Workforce Management team to respond to daily, weekly, monthly, and seasonal trends in call volume. We use these tools to track and trend performance including service levels, or call answering time, call abandonment rates, and single-call resolution. We adjust staffing accordingly, anticipating future call volume or forecasting—**a quality-driven process** that allows us to meet West Virginia children and youth members' needs and consistently exceed the performance standards established by the State. Forecasting data from both our West Virginia and Arizona call centers is used to determine staffing and create schedules with sufficient staff to address member needs and satisfy the State performance standards. **[MS034, MS036, MS037, MS038]**

Aetna's has dedicated workforce management staff and 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 trained member services representatives from other Medicaid plans. This occurs quickly and seamlessly, as cross-trained representatives are already skilled, or designated, 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 member services 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 and NPS programs. All calls are recorded for quality assurance and stored in our electronic database. Aetna has designated quality analysts who complete at minimum for four calls per month per representative, which is documented in the electronic, phone recording system. Member services 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 member services 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.

Aetna implemented a method to measure the member experience that incentivizes staff toward our Aetna **Common Purpose** initiative—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 NPS program measures each member's experience through a post-call automated survey that elicits each member's responses to individual calls by asking the caller to rank their recent experience using a scale of 1 to 5, with 5 being the most satisfied. Member service representatives offer each caller an opportunity to complete this survey at the end of each hotline call. Members complete the brief, automated survey and provide feedback on how likely they are to recommend Aetna to friends and family. Any calls ranked with a low score are immediately forwarded to supervisors who listen to the call and provide coaching. Representatives can promote a positive member experience with use of the automated survey, and assuring member concerns are addressed efficiently, effectively, and with service excellence. **[MS034]**

Aetna demonstrates our commitment to West Virginia through superior performance in customer service standards identified by the State. In quarter two of 2019, **we answered 13,425 calls in an average of 3.7 seconds, with service level or call answering time just under 97 percent (the State goal is 83 percent), abandonment rate of 0.5 percent (the State goal is <5 percent), and our single-call resolution percent was well over 90 percent with zero complaints related to member service**. As

part of our single-call resolution initiative, **we made 3,970 outbound calls** in the second quarter of 2019 to assure our member's inquiries were resolved at first contact. We adhere to the State'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 Children and Youth program. **Table 4.1-4** outlines our most recent performance for 2019, year-to-date.

Table 4.1-4: Member Services Call Center Customer Service Performance Standards, YTD 2019

Calendar Month	Calls Answered	Service Level, or Call Answering Time (State Requirement 83%)	Abandonment Rate (State Requirement <5%)	Average Speed of Answer in Seconds
April	4,830	95.19%	1.1%	5.3
May	4,406	98.80%	0.1%	1.1
June	4,189	95.86%	0.3%	4.6
Quarter 2	**13,425**	**96.58%**	**0.5%**	**3.7**

Call center industry standard for NPS is that 74 percent of NPS are ranked favorably and any score over 70 percent is considered "world class" service. Aetna's internal goal is 80 percent. We developed and implemented incentives via a reward and recognition program called, **"You Nailed It!"** to create friendly competition across our representatives and Medicaid Member Services teams. We track and report all NPS scores to encourage and motivate our teams and individual member services representatives to improve NPS scores, and offer the following:

- **Individual awards:** Each month the representative with the most improved NPS score will be incentivized for each call that is ranked a 5, the top score, on the NPS post-call survey
- **Team awards:** Member services team with the highest NPS and the most improved NPS score receives a trophy, a recognition certificate, and other incentives

In May 2019, the West Virginia Medicaid member services call center won the Aetna national award for most-improved by an increase in NPS of 15% and is leading the way of top scores for **June 2019 of 80.5%**, exceeding Aetna's internal goal and demonstrating that we are "world class". **We nailed it!**

Member Welcome, Outreach, and Education

MS001	The Vendor should identify and reach out to members (or their caregiver or caseworker as appropriate) with the most immediate service needs leading up to and immediately following implementation of a program.	The Vendor should describe how it will meet this specification.
MS002	The Vendor should provide outreach and training on an ongoing basis to youth and young adults and their respective caregivers who are eligible for services.	The Vendor should describe the audience(s), frequency, method(s), and topic(s) for this outreach and training.
MS003	The Vendor should collaborate with community partners to help design materials that best meet the needs of the populations being served.	The Vendor should describe how it will meet this specification.
MS004	The Vendor should leverage information technology (IT) solutions to improve access to information, including, but not limited to, the following:	The Vendor should describe how it will meet this specification.
MS005	Member health records (by the member, caregiver, and/or provider as appropriate)	See the parent specification.
MS007	Other member rights and responsibilities	See the parent specification.

MS008	The Vendor should distribute an informational welcome packet to families impacted by the transition.	The Vendor should describe any particular communication strategies it would use or information it would include in this welcome packet, including, but not limited to, the Vendor's appeals process.
MS009	The Vendor should develop a community resource library, including, but not limited to, member handbooks, newsletters, and/or care coordinators.	The Vendor should describe how it will meet this specification.
MS011	The Vendor should develop materials for members, including, but not limited to, members with special healthcare needs, in accordance with federal and State marketing regulations.	The Vendor should describe how it will meet this specification.
MS012	The Vendor should consult with persons with disabilities and advocacy groups while developing materials for members with special healthcare needs.	The Vendor should describe how it will meet this specification.
MS013	The Vendor should use a methodology, including, but not limited to, claims history and proximity, to assign members in applicable populations to a primary care provider (PCP)	The Vendor should describe in detail its proposed methodology for primary care provider (PCP) assignment, particularly for new members when auto-assigning to a PCP.
MS014	The Vendor should notify members in applicable populations of primary care provider (PCP) assignment.	The Vendor should describe how it will meet this specification.
MS015	The Vendor should educate members in applicable populations of the right to change primary care providers (PCPs).	The Vendor should describe how it will meet this specification.
MS016	The Vendor should conduct follow-up communications to ensure members in applicable populations are aware of the primary care provider (PCP) assignment.	The Vendor should describe how it will meet this specification.
MS017	The Vendor should conduct outreach and transition planning efforts directed toward members with special healthcare needs.	The Vendor should describe how this outreach will be conducted.
MS018	The Vendor should mail member handbooks on an ongoing basis, according to an established turnaround time, and including, but not limited to, the following:	The Vendor should provide a proposed turnaround time for mailing, on an ongoing basis, updates to the member handbook and ad hoc handbook requests.
MS019	Updates to the member handbook	See the parent specification.
MS020	Handbooks requested ad hoc by a member	See the parent specification.
MS021	The Vendor should provide enabling services—including, but not limited to, assistance with complaints and grievances—to members with physical or developmental disabilities.	The Vendor should describe how it will meet this specification.
MS027	The Vendor should educate members about the ability to request out-of-network referrals.	The Vendor should describe its processes and mechanisms—including, but not limited to, the member handbook—for meeting this specification.
MS028	The Vendor should educate member services representatives on the out-of-network referral process.	The Vendor should describe how it will meet this specification.
MS041	The Vendor should establish and implement a 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. This process should include, but not be limited to, the following:	The Vendor should describe its new member enrollment and education process, including member contact, from the time of initial notification of the member's enrollment through the first month of actual enrollment. This description should establish the order of steps and associated timeframes.
MS042	Member contact, including, but not limited to, welcome calls, welcome letters, and/or home visits	See the parent specification.

MS043	Outreach to members who are difficult to contact, including, but not limited to, disabled members and members without telephones	See the parent specification.
MS044	Processing and issuing identification cards	See the parent specification.
MS045	Distributing member handbooks	See the parent specification.
MS046	The Vendor should distribute to members preferred drug list (PDL) and formulary changes affecting members' care.	The Vendor should provide a general description of how it would meet this specification, if pharmacy benefits are carved in at a future date. This description should include, but not be limited to, timeframes and methods of delivery.
MS047	The Vendor should work with the State health exchange during the first six months of the contract to deliver to the Department an implementation plan for an electronic health record (EHR) system that serves as a health passport for members.	The Vendor should describe how it will meet this specification. Per the American Academy of Pediatrics (AAP), the health passport should include, but not be limited to, the child's chronic health problems, allergies, medications, psychosocial and family histories, trauma history, and developmental and immunization information.
MS048	The Vendor should provide a publicly accessible, secure website with information targeted to members that adheres to federal and State marketing regulations.	The Vendor should describe how it will leverage its website to help meet the needs of members.
MS049	The Vendor should provide a secure member portal that allows members to log in and access benefit information, including, but not limited to, the following:	The Vendor should describe the abilities of its member portal and how the portal will be leveraged to help meet the needs of members.
MS050	Medical records	See the parent specification.
MS051	Authorization status	See the parent specification.

Aetna extends our **Common Purpose** tenets to members from the point of enrollment through ongoing services by assuring high-touch, personalized, outreach and education that meets each member's unique needs. Our children and youth involved in CPS not only deserve the best care, but deserve interactions that support their rights, remove barriers to optimal health outcomes, and empower families to strengthen and preserve their abilities, desires, and strengths, and contribute to the pathway for positive transitions. Our welcome and outreach begins at the time of enrollment. We have extensive experience expediting enrollment for children and youth involved in CPS and assuring high-touch, frequent interactions that exceed State requirements for outreach and education. We customize our approach based on Collaborative Family Engagement and implementing a systemwide governance structure that includes ongoing collaboration with States agencies such as the Department, BCF, CPS, WVDOCR, providers, advocates, families, and community stakeholders. Members have support and resources available via multiple communication methods that allow them to understand the managed care system, navigate services and support, and progress toward optimal health. This includes our outreach from enrollment through the member's first month, and thereafter, ongoing, our member education materials developed in collaboration with local, community-based families and stakeholders, and our technology solutions and innovations that make it easy for members to navigate through care.

[MS001, MS008, MS013 – MS021, MS027, MS028, MS041 – MS046]
Enrollment, Welcome and Outreach

Aetna enrolls all new children and youth in the West Virginia Specialized Managed Care Project program directly into our care management program within one day of receiving the daily enrollment file. Member services representatives, the member advocate, and care coordinators collaboratively welcome members to our program and conduct initial outreach using telephone, in-person/in-home visits, and

written correspondence (e.g., mail, email, and fax) according to the frequency and intensity of contact contractual requirements and as designated in our intensive care management program designed for West Virginia children and youth. Initial contact is made telephonically within the first 24 hours of receiving the daily enrollment file by a care management staff who completes outreach to the member's guardian and/or CPS case worker and facilitates scheduling and completion of RFP-required health care assessments in the required timeframes. **[MS001, MS042]** Our automated processes and member services call center staff support welcome and outreach to the program through distribution and explanation of our welcome packet, member ID card, member handbook, and education about member rights, grievance and appeals, and enabling services, PCP assignment and reconciliation, and distribution of the PDL. We support members with special healthcare needs by assuring federal- and State-mandated enabling services, assuring our member services representative, member advocate, and care management staff understand the unique needs via training and ongoing support, and completing outreach to members with the most immediate service needs as quickly as possible.

Once identified and enrolled, our care management staff contact the member's BCF case worker, legal guardians, and caregivers to gather demographic, case history, and provider information and schedule the initial assessment within mandated timeframes. Care coordinators will make five attempts to reach foster parents, social workers, or other caregivers on different dates and at different times of the day to assure contact is made timely. **[MS001]** We apply alternate methods for members who are disabled, without a telephone, and difficult to reach including use of mailers for program enrollment. If we are not able to reach foster parents, a social worker, or other identified caregivers during our initial outreach or a member does not have a telephone, we conduct in-person visits as part of our outreach attempts. We further collaborate with our system partners such as community health workers or CPS case workers to visit the member's home or residence if needed. If a child or youth is being prescribed medications and we have knowledge of this at time of enrollment, our care coordinators reach out to the prescribing pharmacy to inquire if foster parents or caregivers will be picking up medications and ask the pharmacy staff to call the care coordinator when they are onsite. Care coordinators travel to emergency shelters, hospitals, clinics, and other locations as needed to assure initial contact is completed. **[MS041, MS043]**

[MS041] Welcome Contact

Guardians, foster parents, or other authorized caregivers receive a welcome text that reads, "Hi, it's Aetna Better Health! As a member, you get messages with important info about your health and benefits. Reply STOP to opt-out of receiving messages." Care management staff provide an overview of the following items during initial contact with the guardian and/or caregiver (if the caregiver is not the guardian, the care management staff secure written permission from the guardian):

- Inquire about urgent health needs or previously scheduled services, and inform of our policies for obtaining covered and value-added services
- Verify receipt of the welcome packet and ID card
- Provide our telephone numbers including member services, BH, and Health Information hotlines, and their direct contact information, and the address of our website
- Advise about Aetna's automated, outbound call for health risk questionnaire screening and, if necessary, completes it in person with the member present
- Inform members of their right to continue certain, existing services
- Review what to do in an emergency
- Verify PCP assignment, inquire about their most recent visit, and encourage necessary well-child visits
- Advise of opportunities for learning about our policies and benefits in greater detail

- Confirm that members have access to a complete and up-to-date list of network and SNS providers, inform them how to obtain such a list including addresses and telephone numbers for such providers, and assist in navigating the member portal or mobile application

If care management or member services staff identify new demographic information during initial contact, we place a note in the member record and warm transfer callers to the Department, assuring demographic updates are properly recorded. We accept addresses for emergency shelters and other non-traditional places of residence. We document all outreach attempts according to State and contractual requirements, including the nature and disposition of those attempts. **[MS041]**

[MS008, MS042] Welcome Packet

Aetna mails each member a welcome packet. We make at least three attempts to contact new members following the initial care management contact that occurs within 24 hours of enrollment using telephone and mail correspondence. Our welcome packet and materials are customized to meet the unique needs of West Virginia children, youth, their families, foster parents, and caregivers by providing the following required items, and other printed materials deemed appropriate for the region or population served:

- A welcome kit and letter, information about the member's PCP, including the PCP's name, phone number, and Aetna's member services and hotline phone numbers **[MS042]**
- A member handbook that details all of the following: rights and responsibilities; advance directives; grievance and appeals processes and contact information; benefits (in and out of network); important phone numbers; how to access our website and mobile application; availability of free translation and interpretation in over 200 languages, which include West Virginia's top prevalent, non-English languages, through our vendors; free auxiliary aids and services upon request from members and how to access those services
- A description of and contact information for the Department's Ombudsman program and how to access the program; contact information for the West Virginia enrollment broker; the proximity of emergency care and urgent care facilities; information on how to access non-emergent transportation; education on the importance of the PCP selection; information on how to use different levels of service; and the differences between managed care, fee-for-service care, and having no insurance.

Members who are blind or have visual impairments may access our member handbook in electronic audio format, large print, or braille, or by calling us for information. **[MS008]**

[MS044] Member Identification Card

Aetna's Enrollment department is responsible for facilitating the provision of timely ID cards within the timelines referenced in the **Model Service Provider Agreement**. A card will be provided for every West Virginia member. The ID card will include the West Virginia name and logo, the member's ID number, the name of the member's PCP, the PCP phone number, and phone numbers for Aetna member services and the crisis hotlines. Aetna has a strong history of meeting enrollment turnaround time goals for member receipt of the card. It is delivered within five business days of receipt of the daily enrollment file containing the member's information. Member ID card images are available upon enrollment on our secured mobile application and our secured portal. **Figure 4.1-2** illustrates the front and back of our West Virginia card as viewed in the Aetna mobile application. Members can request a new ID card using the self-service functions embedded in our IVR automated messaging when they call the member services hotline. Members select the appropriate option and can obtain the information from our operating system. **[MS044]** Member services representatives can validate a member's address and reconcile the demographic information via a warm transfer to the appropriate State agency.

Aetna recognizes that each member in the West Virginia Specialized Managed Care for Children and Youth program is impacted by frequent transitions and placements, increasing the likelihood of a lost ID card. Member services representatives can educate and inform members of the **multiple ways to secure the information** on a West Virginia member ID card, including the following:

- **Printing a member ID card via our member portal**
- **Viewing and using the member ID card via Aetna's mobile app**

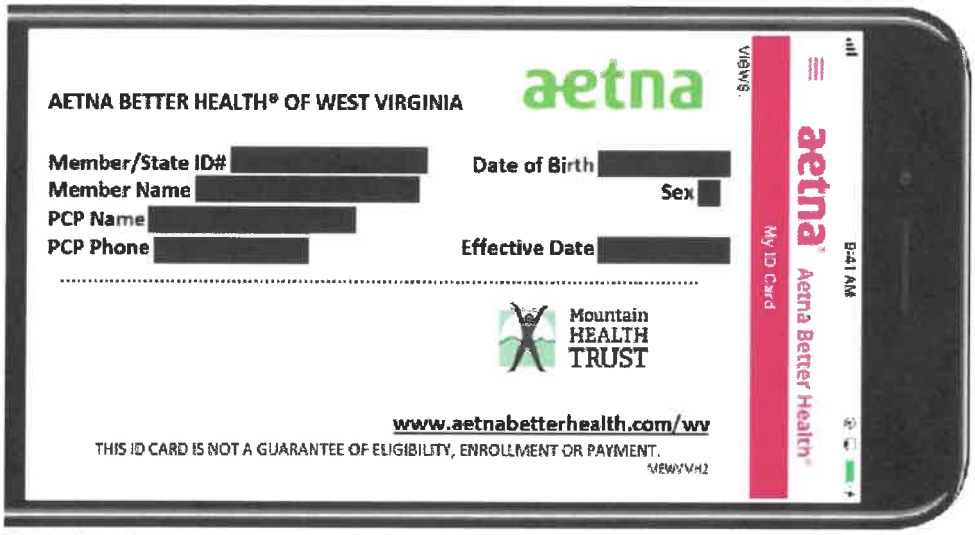
Our member services representatives can help reissue new cards 24/7/365, and we will reissue an ID card within five days of the request as follows:

- We will reissue an ID card for foster care members for the following reasons:
  - A member, child welfare staff, caregiver, or foster parent reports a lost card
  - A member has a name change
  - A member, child welfare staff, caregiver, or foster parent requests a new PCP or dental provider
  - The member moves to a new placement
  - Any other reason that results in a change to the information disclosed on the foster care member's ID card
- We will reissue an ID card for foster care members for adoption assistance members for the following reasons:
  - The member or adoptive parent reports a lost card
  - The member has a name change
  - The member or adoptive parent requests a new PCP
  - Any other reason that results in a change to the information disclosed on the member's ID card

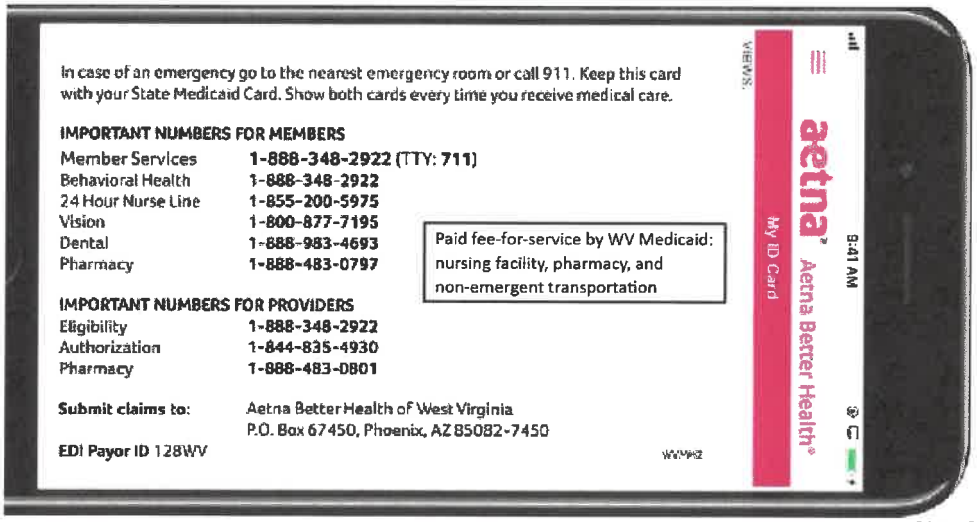
Figure 4.1-2 depicts an Aetna member ID card as viewed on our smartphone mobile application.

Mobile Application ID Card

Front of card



Back of card



34 :wv19

Figure 4.1-2: Aetna Member ID Card

Aetna offers members important benefit and contact information located on the member ID card via our mobile application for smartphones.

[MS018 – MS020, MS045] Member Handbook

Aetna maintains a strong line of communication and partnership with State agencies and community stakeholders. Our Implementation team will coordinate with State agencies on using and adhering to State templates to develop our member handbook, specifically, all requirements outlined in the **Model Service Provider Agreement**. Our handbook is available in English and other prevalent languages as determined by the Department, and as requested by member inquiries. Additionally, the member handbook contains a description of and contact information for our Member Services (including member advocates), Care Management, Quality Management, and Grievance and Appeals departments. We mail new members and per ad hoc member requests, **[MS020]** the West Virginia member handbook in five

business days. We notify members at least 14 calendar days in advance of program changes **[MS019],** and we mail member handbooks ad hoc as requested by a member, **[MS018]** and post the electronic version to our member portal in a singular file. We affirm that we will review our handbook at least annually after initial enrollment 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. In addition to any changes needed throughout the year, we will request State approval prior to member distribution. **[MS019, MS025, MS045]**

Aetna is committed to our **Common Purpose** and meeting the needs of West Virginia's children and youth involved in CPS. We are currently developing a member handbook specifically designed with the unique, health literacy needs of West Virginia children and youth in mind. This **youth-friendly handbook** offers our children and youth involved in child welfare easy-to-read and attention-grabbing methods that actively engage our younger members' understanding of Aetna's managed care system. The goal of the handbook is to capture the attention of young people and get them interested enough to participate in their health care activities. The development of this handbook includes using the State-designated template and customized language appropriate to children, youth health literacy levels that validate their experiences, and colorful, unique photos. We will submit this handbook to the State, assuring review and approval prior to distribution. **Figure 4.1-3 is a sample** illustration from our member handbook for West Virginia children and youth. Alternative formats such as audio and video are available upon request, assuring our members who have disabilities have opportunities to learn about Aetna's services. **[MS045]**

Aetna tracks all new member welcome outreach contact, assuring adherence to State requirements. We track all contact attempts whether through our automated, outbound call system, telephonic, in-person, mail, or email, and review tracking reports to assure adherence to timelines. We complete additional outreach via automated and live calls, mailers, and in-person contact for all unsuccessful attempts. Staff designated to complete additional contact reviews our system for updated information to make another attempt at contact. We report to the Department all members we have been unable to contact within the first 30 days of enrollment, along with the nature and disposition of those attempts. We will report this data in accordance with the State's specific requirements and timeframes.

Figure 4.1-3: Aetna WV Children and Youth Handbook
Aetna's Specialized Managed Care for Children and Youth handbook is designed for children and youth health literacy needs, assuring resources that support our members' engagement in health care.

[MS013 – MR017] PCP Assignment and Outreach

Aetna recognizes our new members' right to maintain PCP and specialists already involved with the child, youth, or family. We have developed an enrollment and PCP assignment workflow to support this and other unique needs of children and youth enrolled in the Specialized Managed Care for Children and Youth program. **[MS017]** If a new member does not select a PCP with 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: **[MS013]**

- **Foster care members:** Assignment will be based on where the member's child welfare staff case is located (which is usually the Medicaid region where the child's family of origin resides). The member will be auto-assigned to their current PCP if a PCP is currently identified. If the member does not have a currently assigned PCP, the CPS case worker, caregiver, or foster parent can voluntarily select a PCP. Or, Aetna will auto-assign the member a PCP within two business days of receipt of notification of the member's enrollment in the program utilizing claims history, proximity, and specific system logic containing the Department's guidelines and our priority providers.
- **Adoption assistance members:** The adoption assistance member's Medicaid region of residence is determined by the adoptive parent's official residence. If an adoptive parent or member does not voluntarily select a PCP upon enrollment in the program, we auto-assign a PCP within two business days of receipt of notification of the enrollment in our program utilizing claims history, proximity, and specific system logic containing the Department's guidelines and our priority providers. **[MS013]**

Figure 4.1-4: illustrates how multiple processes run concurrently to assure PCP assignment, reconciliation, and delivery of the member's welcome packet.

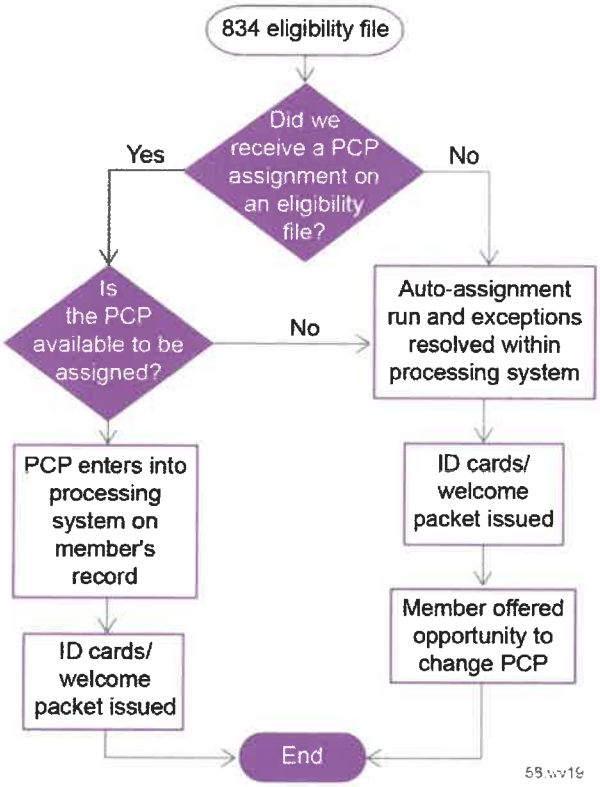


Figure 4.1-4: New Member Enrollment, PCP Assignment, and Welcome Packet Workflow
Aetna is equipped to effectively manage PCP assignment and distribution of the member welcome packet for children and youth involved in CPS.

Aetna, the Department, CPS staff, WVDOCR, foster parents, and adoptive parents will coordinate all communications to ensure that members are assigned to a PCP/practice that best meets their individual needs and presenting concerns. If the foster care member has an existing PCP when newly enrolled with Aetna that is identified as a good fit for the member's needs, the member will continue care with the PCP. If requested by the member, foster parents, and/or adoptive parents, the member will be reassigned to a PCP that best meets their treatment needs. **[MS017]** All requests from the Department, CPS staff, WVDOCR, foster parents, and/or adoptive parents for PCP reassignment will be fulfilled within two days of the initial request. Notification of the reassignment will be sent to the member and their foster/adoptive parents the next business day and then a new ID card is issued. **[MS014]** We distribute enrollment and PCP updates to our providers and subcontractors on a regular basis to assure seamless continuity of care.

Because the member/PCP relationship is critical to successful treatment and coordination of care, our care coordinator and member services staff work with members to make sure we prioritize their preferred choices. **[MS017]** Members are notified about their right to change PCP in our welcome packet and the member handbook and as applicable per calls to our member services hotline or during telephonic or in-person visits with the member's care coordinator. **[MS015]** Aetna's care coordinator conducts follow-up communication with new members/guardians/system stakeholders to inform them and verify their PCP assignment and will assist in making changes as needed. Care coordinators identify and assist in appointment scheduling and complete follow-up calls to assure attendance. **[MS016]** When telephonic

outreach is not successful, care coordinators use alternate strategies, email, text, and mobile application messaging for communicating with members.

[MS027, MS028] Out-of-Network Referral Education

Aetna educates members about their ability to request out-of-network referrals and the out-of-network referral process through individual calls to our member services hotline or care coordinator. The out-of-network referral process is outlined in our member handbook, which is mailed to members and available on the Aetna website and member portal. **[MS027, MS028]** This includes education about our network, member's rights to choose out-of-network providers including keeping existing providers or specialists, and member responsibility for out-of-network provider choices. Member education occurs during our initial contact and in-person visits, during calls to the member services hotline, and ongoing as needed. Our education always includes the member's preferences for location, provider type, and enabling services and/or accommodations. Our staff are trained on the provider network including how to navigate the provider portal on the website and provide navigation assistance to members during calls and visits and receive ongoing updates about in-network providers at monthly staff meetings and via email.

[MS046] Distributing Preferred Drug List Distribution

Aetna distributes our PDL and updates to the PDL in multiple ways including offering links to the State-approved PDL on our Aetna website and through education offered by the member services hotline, in our member handbook, or care management staff during all points of contact, telephonic, in-person, or in home. Members can call or email the member services hotline or their designated coordinator for assistance locating the State PDL. The member handbook is distributed within five days of enrollment via mailing, request, or viewing online on our website. Member services staff and the care coordinator will guide members during calls on how to navigate the website or will email the link or PDF document to members as needed. We educate members during initial contact and through calls to member services on understanding and where to find the State PDL. Members can also access pharmacy and PDL information via our electronic member handbook. **[MS046]**

[MS007] Member Rights

Our Member Services team leverages all call, email/mail/written, 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 member services hotline staff educate callers about how to find member rights on the member website as applicable during individual calls to the hotline. Aetna maintains policies and procedures formally acknowledging member rights and responsibilities and communication methods to inform members and providers of those rights and responsibilities. We understand and will comply with all requirements outlined in the **Model Service Provider Agreement** and federal and State requirements and laws on member rights. Our policies include member's specification of rights such that each member has a right to the following:

- To receive information in accordance with the standards set forth in this contract
- To be treated with respect and due consideration of their dignity and privacy
- To accessible services
- To choose providers from among those affiliated with the 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 ability to understand
- To request and receive their medical records, and to request that they be amended or corrected, for which the MCO will take action in a timely manner of no later than 30 calendar days from receipt of a request for records, and no later than 60 calendar days from the receipt of a request for

amendments, 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 a prompt resolution of issues raised by the member, including complaints, grievances, or appeals and issues relating to authorization, coverage, or payment of services
- To offer suggestions for changes in policies and procedures
- 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
- To be furnished health care services as set forth in this contract

We protect and promote these rights by assuring the following:

- **Member privacy:** We understand the sensitive nature of PHI and children and youth placed in foster or kinship care placements, including the importance of taking care to understand who is in the child's life and has access to that information; our procedures ensure the confidentiality of medical records and any other health and enrollment information that identifies a particular member in accordance with federal and State regulations
- **Accessible services:** We ensure that all services, both clinical and non-clinical, are accessible to all members, including those with limited English proficiency or reading skills, with diverse cultural and ethnic backgrounds, the homeless, and individuals with physical and mental disabilities; we ensure that members have the right to access emergency health care services, consistent with our member's determination of the need for such services as a prudent layperson, and post-stabilization services
- **Provider choice:** We understand the importance of provider and specialist continuity for members with special healthcare needs, and we allow each member to select their PCP from among those accepting new Medicaid members in accordance with Article III, Section 3.2; members who are referred to a specific provider for any service other than primary care must have an opportunity to refuse care from the designated provider and to select a different affiliated provider
- **Provider-member communications:** We do not prohibit or restrict a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member who is their patient for health status, medical care, or treatment options, including any alternative treatment that may be self-administered; any information the member needs for deciding among all relevant treatment options; or the risks, benefits and consequences of treatment or non-treatment
- **Participation in decision-making:** We encourage the member's parent or legally authorized representative to facilitate care or treatment decisions; we provide for member or representative involvement in decisions to withhold resuscitative services, or to forgo or withdraw life-sustaining treatment, and comply with requirements of federal and State law with respect to advance directives including the following:
  - Providing written information to clients concerning their rights under State law to accept or refuse medical or surgical treatment and to formulate advance directives and concerning the MCO's policies with respect to the implementation of such rights (this information should be included in the member handbook)
  - Documenting in the member's medical record whether the member has executed an advanced directive
  - Not conditioning the provision of care or otherwise discriminating against a member based on whether the member has executed an advance directive
  - Ensuring compliance with requirements of State law respecting advance directives
  - Providing education for staff and the community on issues concerning advance directives

We do not prohibit or restrict a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member who is their patient for the member's right to participate in decisions regarding their health care, including the right to refuse treatment, and to express preferences about future decisions. Aetna ensures that members' freedom to exercise their rights will not adversely affect their treatment by Aetna or by providers, and we will not prevent or prohibit providers from advocating on behalf of members or advising members. Aetna informs members of their rights and responsibilities in the member handbook and member newsletters in accordance with State and federal regulations. Providers are educated about members' rights in the provider manual and newsletters.

Quality management processes provide members and providers a venue to express concerns about member rights and responsibilities through tracking complaints, grievances, and appeals as well as through member surveys. 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. We evaluate and report trends to the Quality Management Oversight Committee, the Aetna Board of Directors, and the Department. **[MS007]**

[MS001, MS017] Transition Planning for Members with Special Healthcare Needs

Aetna has experience in other markets successfully managing transition planning for members with special healthcare needs including assuring frequent telephonic and in-person contact by the members' care coordinator, offering support through our member services hotline staff, and expediting enrollment to ensure members have immediate access to care. Our care coordinator completes initial contact with members within 24 hours of receipt of the daily enrollment file and assures the in-person, initial health assessment is completed within the required timeframes. **[MS042]** The care coordinator provides an overview of the program including mailed materials, the member ID card, covered services, SNS, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, out-of-network referrals, and the care management program. Member services staff support new member transitions by assisting with PCP assignment, answering questions about out-of-network referrals, completing warm transfers to the State for changes in member demographic information, arranging transportation, accessing SNS, and utilizing enabling services. Aetna has designated policies to support seamless transition planning for members with special healthcare needs. **[MS001, MS017]**

We recognize that our members involved in CPS and our members who have disabilities or are using SNS, have urgent care needs. As a result, we have internal system processes in place to expedite enrollment. Upon receipt of the daily enrollment file or notice from the Department, we can **enroll a member in our system within two hours.** Enrollment is updated in our business application system so that benefits can be accessed upon enrollment. We can also work directly with our dental vendor and our other subcontractors that administer services to our members to get enrollment expeditiously updated in their respective systems as needed. All our ancillary applications and enrollment exports are then updated overnight. Our main goal when handling expedited enrollments is ensuring that our members do not experience any barriers to care. This process is supported by care management and member services hotline staff outreach that is conducted over the telephone via calls to the hotline or in-person during care management activities. **[MS017]**

Rapid access, changing placements, and drops in access lead to enrollment gaps for members with special healthcare needs. Other variables that may be impacting enrollment is why our reconciliation process is so critical. To customize our successful enrollment program, the Aetna care coordinator will serve as the lead with support from the Member Services department to resolve enrollment and eligibility issues, engage peers in the community, and resolve issues using existing community resources where feasible and appropriate. When we identify changes in demographic information of a member, care

coordinators or member services representatives contact the appropriate State agency to coordinate updated demographic information. **[MS017]**

Sometimes our members with special healthcare needs require additional assistance to understand how to navigate their system of care. In July 2019, we added a **peer support specialist** to our West Virginia Care Management team. The peer support specialist can support our members in multiple ways including helping understand how to navigate our system or our MCO, understanding medical necessity criteria, or understanding the importance of EPSDT. The peer support specialist will collaborate with advocacy organizations that support disability rights to promote best practices for our care management program and the Member Services department. **[MS017]**

[MS021] Enabling Services

Aetna adheres to all language, information, and accessibility requirements outlined in the Title III Americans with Disabilities Act (ADA), including the availability of translation and interpreter services. We aim to hire bilingual and multilingual staff that are fluent in West Virginia's most prevalent non-English languages, based on Department data and State need. Aetna provides members with a wide range of language services and accommodations for limited English proficiency and special needs including the following:

- Informing members of their right to language assistance for in-person visits, telephone calls, and in written materials at every point of contact, including calls to the Member Services department, member materials, signs in facilities and provider offices, other in-person meetings, and telephone communications
- Training all staff and providers to identify and respond to a member's need for language assistance services
- Supplying, at no cost, translation and interpreter services through our member services representatives who are certified translators as well as vendors who employ Certified Medical Interpreters
- Reviewing language assistance vendor activity reports and conducting assessments of member language preferences and service quality

Our Member Services department connects members with prevalent languages immediately to our language interpretation vendor who offers immediate, no-cost interpretation to members in over 200 languages. Our member services representatives are fully trained in and utilize West Virginia Relay Services for members who are deaf or hard of hearing. The first time a member calls our member services hotline and requests an interpreter, we enter a memo on the member's record in our electronic care/claims management system, so all department members are aware the member requires language assistance. The memo notes the language needed and the services we provided.

Aetna places high value on helping make sure members are appropriately educated on their health care and their rights as members through quality customer service. Our member services, care management, and member advocate staff are thoroughly trained and prepared to assist members telephonically, in-person, or via written communication including use of and connection to enabling services. Members are educated about the grievance and appeal system and their right to file a grievance or appeal about any aspect of their care or service, including, but not limited to, physical health, BH, prescription drugs, and community engagement. Members are educated about the grievance and appeal system, along with any changes through written materials (e.g., member welcome packet, handbook, website, and letters). Additionally, we provide written materials to all our subcontractors, at the time of contract and whenever changes are made, so they can effectively support and assist our members with filing a grievance or appeal. Member education materials are written at a sixth-grade reading level or less and include the following:

- Availability of assistance in the filing process, including interpreter services, translation services, sign language, teletypewriter [TTY] through Relay West Virginia, and physically accessible meeting spaces and reasonable physical accommodations
- Procedure for filing a grievance, appeal, and State Fair Hearing
- Right to representation (e.g., self, family member, attorney, relative, friend, or provider)
- Information on how to access the Managed Care Ombudsman's office
- Procedures for exercising the rights to request a State Fair Hearing within a specified timeframe
- Requirement that internal appeals must be exhausted before requesting a State Fair Hearing
- Right to continue benefits at the current level of appeal requested within the specified timeframe
- Communication that the member may be required to pay the cost of services furnished if the final decision is an adverse decision to the member.

Our member grievance and appeal processes afford members the opportunity to voice their issues, concerns, and problems with the assurance that there will be no discrimination based solely on their filing a grievance or appeal. We resolve grievances and appeals in a timely manner and help to ensure that our members, from all racial, ethnic, and cultural backgrounds, receive equitable and effective treatment in a culturally and linguistically appropriate manner. We make sure that no punitive action is taken against members, their authorized representatives, or providers who support them for filing a grievance, appeal, or State Fair Hearing.

Whenever needed, the member advocate assists members with completing forms and navigating other procedural steps, from initial filing through requesting a State Fair Hearing. Aetna provides information in English and other prevalent languages, as well as in alternative formats (e.g., interpreter services, translation services, audio tapes, sign language, large font, and teletypewriter [TTY] through Relay West Virginia). We also make other reasonable accommodations available to all members and have accessible meeting spaces for members with physical disabilities who wish to file a grievance or appeal, or present information, or otherwise participate in person, at no cost to the member. We document all cases in our grievance and appeal application inclusive of those received from the State. Each case is automatically assigned a tracking number/unique identifier that links together all components of the case. This tracking number is used to identify individual cases for processing and to monitor each case throughout the process. All information pertaining to grievances, appeals, and State Fair Hearings are maintained in accordance with the applicable record retention policies and HIPAA standards to protect member privacy. **[MS021]**

Aetna employs several methods to determine a provider's compliance with ADA standards for physical accessibility and reasonable accommodations including adherence to Aetna policies about parking, exam and waiting rooms, and accessible equipment for Medicaid members with physical or mental disabilities. Aetna assesses a provider's capability during onsite visits, through credentialing and re-credentialing processes, monitoring member complaints, grievances, and appeals, and gathering information used in our provider directory. Our online directory indicates a provider's ability to fulfill a member's needs, such as physical accessibility and accommodations. These indicators are available across all provider types, including long-term care, home health, nursing care, and home- and community-based providers to help make sure the member selects the right provider.

[MS003, MS007, MS011, MS012] Member Education Materials and Customized Education

Aetna has demonstrated the breadth and depth of our experience and understanding the needs of West Virginia Medicaid throughout our years serving the State. Our mission is to continuously deepen our presence in the communities we serve, with a special focus on children and youth involved in CPS throughout West Virginia. 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 State agencies, members, providers, community-based organizations, and other stakeholders defines us as a loyal organization driving the statewide mission to create a healthier West Virginia.

Aetna participates in many statewide activities, including hosting and attending health and resource fairs, presenting and exhibiting at conferences, and sponsoring numerous community events where we provide member outreach and education. Our approach aligns with federal and State requirements. All outreach materials (e.g., posters, flyers, brochures) are written at or below a sixth-grade reading level, contain a minimum of 12-or 14-point font, meet all language requirements, and are State-approved and distributed throughout the state to members and potential members to prevent selective distribution. Member outreach materials are available at community events and/or given to community partners to distribute to members and the community at-large. Community partners include State agencies, federally qualified health centers, faith-based organizations, schools, homeless organizations, public health departments, family resource centers, community action agencies, public libraries, and other community-based organizations. A key component of our outreach plan is to ensure Specialized Managed Care for Children and Youth members understand how adopting a healthy lifestyle greatly increases their overall quality of life. Therefore, we continuously search for ways to promote health literacy and address SDOH, as well as provide ongoing education to members and their communities.

Aetna's Community Outreach team creates annual outreach plans designed to be hyperlocal and targets each of the state's regions and adheres to our system of control process. We work collaboratively with the following West Virginia organizations that serve members with special healthcare needs: schools, Family Resource Network, Mountaineer Food Bank and Facing Hunger Foodbank, Adverse Childhood Experiences Coalition, Healthy Kids, libraries, after-school programs, and the Affordable Healthcare "Medicaid Matters" group. **[MS003]** The plan informs how we develop member communication, materials, and engagement and its execution is carefully monitored by our Community Outreach and Quality Management teams. **[MS011]** We target our member engagement to grassroots efforts by reaching members on an individual level in conjunction with our deep relationships with community-based organizations (CBOs). We are honored to have close working relationships with many CBOs, as we value our combined impact in the communities we serve. We use information learned to inform our member communication and materials. We have sponsored and/or co-chaired the following CBOs that serve West Virginia children and youth:

- **Mountaineer Food Bank and Facing Hunger Foodbank**: We provided emergency backpacks during the 2018 West Virginia teachers strike and a strategic community investment to support operations and food for families in need
- **Children's Home Society of West Virginia**: We provided a strategic community investment in 2018 to support operations that help children find lifetime families and preserve existing families
- **Mission West Virginia**: We provided a strategic community investment in 2018 to support foster family recruitment and parenting training
- **Foster Care 5.29 Run/Walk**: We provided a strategic community investment in 2019 to support foster children's college funds **[MS012]**

Our outreach plan is a comprehensive list of member engagement that encompasses our member handbook, education collateral which includes our suite of health literacy courses, a web-based member portal, member website, community sponsorships, provider and member newsletters, Member Advisory Committee, provider education, and a calendar of community events which we commit to yearly. Aetna's community outreach manager is responsible for developing our annual outreach plan. After the plan is developed, it is distributed to our executive leadership (chief executive officer, chief operating officer, chief medical officer, and chief financial officer) for approval. After executive leadership approves the

plan, it is sent to our local compliance officer for a review of contractual compliance and approval. Once approved, the compliance officer will submit the outreach plan to the State for approval. Our control and approval process for all outreach materials is in the subsection "Verification and Tracking Process for outreach Materials and Activities."

[MS011] Community Outreach that Drives Customized Member Education

While the majority of West Virginia's overall population is comprised of Caucasian, English-speaking individuals, there are pockets of diversity across the state. These differences are not just characterized by race and ethnicity but by religion, gender, and sexual orientation. Aetna promotes a community-based approach to service that includes being culturally and linguistically competent. All materials and approaches to care are people-centered to diverse populations. Our outreach plan encompasses the following communication vehicles:

- **Printed materials:** Aetna's outreach coordinator develops printed member materials in coordination with our Community Outreach department. The content and form is reviewed by our Community Outreach department and compliance officer for Aetna brand standards and contract compliance to ensure the content is in a language and format that are easily understood, is at or below a sixth-grade reading level using the Flesch-Kincaid readability score, and published in a 12-point font and available in an 18-point font or larger. All written materials comply with the ADA, are available through auxiliary aids, services, and alternative formats, are offered in English and other prevalent languages, and are provided through oral interpretation services for any language. The approval process for our printed materials is the same as our annual outreach plan mentioned previously. We customize materials based on the unique needs of our members and region-specific needs. For example, **Figure 4.1-5,** Prevention Really is the Best Medicine, illustrates our targeted campaign on preventive health care education for families. **[MS011]**
- **Advertising**. Aetna is deliberate in the methods and modalities we employ to reach our members. We research which mediums best reach the members in the areas we serve and target our communications accordingly. Content is developed by each respective department owner (e.g., Community Outreach, Member Services, and Quality Improvement) in conjunction with the Community Outreach department. The content and form is reviewed by our Community Outreach department and compliance officer for Aetna brand standards and contract compliance to ensure the content is in a language and format that are easily understood, is at or below a sixth-grade reading level using the Flesch-Kincaid readability score, and published in a 12-point font and available in an 18-point font or larger. All written materials comply with the ADA, are available through auxiliary aids, services, and alternative formats, and are provided through oral interpretation services for any language, including taglines for the top prevalent, non-English languages. The approval process for our advertising and social materials is the same as our annual outreach plan. **[MS011]**
- **Text and newsletter campaigns**. We engage members through various text and newsletter campaigns. We offer welcome texts and campaign-specific texts that support wellness such as getting a flu shot or scheduling EPSDT appointments. Every flu season we remind members to get their flu shot. Content is developed by each respective department owner (e.g., Community Outreach, Member Services, Medical Management, and Quality Improvement) in conjunction with Community Outreach. The content and form is reviewed by our Community Outreach department and compliance officer for Aetna brand standards and contract compliance to ensure the content is in a language and format that are easily understood, is at or below a sixth-grade reading level using the Flesch-Kincaid readability score, and is Web Content Accessibility Guidelines ADA website compliant. We engage a vendor to help us reach our members via text and email. As part of this process, before entering any subcontract, the Aetna Digital Governance team reviews the subcontract to confirm compliance with federal accessibility standards. Texts and emails are available in Department's identified prevalent languages and can be provided through oral

interpretation services. The approval process for our written materials is the same as our annual outreach plan mentioned previously. In addition, our compliance officer is responsible for ensuring member privacy per HIPAA laws and regulations and will obtain and necessary photo release documentation and approvals. **[MS011]**

- **Events and sponsorships**. Our Community Outreach team members live in the communities we serve. We have three community outreach professionals who cover all regions of the state, and the vast majority were raised in the areas in which they live and work. Aetna is an active participant in the communities we serve, and we continuously seek out meaningful community collaboration through engagement in events and sponsorships. Our outreach plan will be developed in collaboration with the Department, BCF, and CPS. The plan illustrates our commitment to West Virginia and our calendar of committed events and sponsorships. We will seek out new opportunities for events such as hosting events in locations where CPS families access services (e.g., Women, Infants, and Children agencies. We go beyond funding to build sustainable partnerships that drive improved health outcomes addressing SDOH gaps and barriers.

Prevention really is the *best* medicine

Preventive care counts

Your child doesn't need to feel sick to see the doctor. In fact, the best time to go is before there is a health issue. Your child's doctor wants to make sure your child is healthy and doing well. The doctor will look at your child from head to toe, checking for health problems you may not know about. The doctor also will see if your child is growing and developing like other children their age.

Your child's checkup

Keep a record of your child's shots. Bring it with you to every appointment. Each visit includes a complete exam.

Your child's doctor will:

- Do a complete physical exam
- Check your child's growth and development
- Check your child's vision, hearing and teeth
- Give shots as needed
- Order lab work as needed (for example, a blood test)
- Answer any questions you have, like what foods are good for your child
- Find any health problems before they become serious
- Get to know your child so they can take better care of him or her

Usual schedule for checkups

- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months
- 3 yrs - 20 yrs (one every year)

Of course, you should always call your doctor or set up a visit anytime your child has:

- Trouble sleeping
- Behavior that's troubling or different than usual
- Fever of 103 or higher
- Rashes or skin infections
- Frequent sore throats
- Trouble breathing
- Gained or lost a lot of weight

Teens need to get yearly checkups too

During teen and early adult years, teenagers bodies will change a lot. It's important for them to have a yearly checkup so their doctor can track this progress. During your teen's exam, their doctor may talk to them about school, friends, changes to their body, eating right and exercising, sleeping, shots and tips to keep your teen safe.

This is general health information and should not replace the advice or care you get from your provider. Always ask your provider about your own health care needs.

Aetna Better Health® of West Virginia

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Figure 4.1-5: Sample Member Outreach Material

Aetna's member materials target the unique needs of members, informing and engaging into critical health care services and supports.

Engagement with our community via member-facing social media applications allows us to keep our finger on the pulse of our families' and communities' needs and concerns. Aetna will bring social campaigns to life that engage members, their families, and community advocacy groups and organizations that support foster, adoptive, and child welfare-involved children and youth in collaboration and with prior approval from the Department and BCF. If approved by the Department and BCF, Facebook would be our primary platform to help drive awareness and consideration of our families', disability and advocacy groups', and stakeholders' needs, and retention of existing members. We would open a single page that allows for Aetna-branded content. We would launch an Aetna page that will house all West Virginia Specialized Managed Care for Children and Youth program social posts moving forward to be used by all State plans. **[MS012]**

Aetna's outreach materials are provided in alternative formats, such as large print, audio, or braille, in a manner that takes into consideration the special needs of those who are visually impaired, hearing impaired, or have limited reading proficiency. We inform the public that our materials are available in alternative formats, as well as how to access those formats. We practice multiple methods of communication, including, but not limited to, written, telephonic, face-to-face (when applicable), and American Sign Language interpretative services to any person who requests such services at no cost. **[MS011]**

Opioid addiction is a prevalent issue across the country. In West Virginia, families are losing loved ones to the opioid crisis as deaths due to drug overdose are on the rise. **Recovery is the first step to becoming independent from drugs. To aid in this effort, Aetna contributed $400,000 to PROACT** in support of medication-assisted treatment (MAT), peer support recovery, job placement, and individual and group therapy services for members and families struggling with opiate use disorders. We also contributed **$50,000 to the University of Charleston, School of Pharmacy** for safety around taking opiate medication and supported community events on safety around taking medications. Aetna has also provided a strategic community investment of **$5,000** to **FMRS Health Systems, Inc., Turning Point for Families,** which provides substance use intervention for pregnant women with children 12 months or younger. Aetna's support included funds for newborn supplies, breastfeeding, and infant development education, YMCA membership fees.

Aetna has contributed $455,00 to services and programs that uniquely support West Virginia children and youth and their families including substance use intervention for opiates, opiate medication safety promotion, and support for pregnant mothers and newborns seeking substance use interventions.

Foster care children and children and youth involved in child welfare need comprehensive support to build resiliency around trauma including education and support offered to key school personnel who interact daily during the school year with members. In 2018, Aetna leveraged our existing collaboration with Raleigh County and Fayette County Schools and FMRS Health Systems, Inc. by offering strategic

"FMRS Health Systems, Inc. and Aetna have developed a strong working relationship directed towards insuring the provision of high-quality behavioral health services to West Virginia children and their families. Aetna has been supportive of the development and provision of evidence-based practices and outcome-driven services at FMRS. They have also sought input from the provider perspective and I have been honored to serve as a behavioral health representative to their UM/QM Committee. look forward to continuing this collaborative relationship through this grant opportunity."

—Randall R. Venable, MA
Psychologist-Chief Clinical Officer
FMRS Health Systems, Inc.

community investments for equipment and startup costs for **Trauma 101 training and education programs,** and to support mental health professional staff. FMRS Health Systems, Inc. has provided Trauma 101 training to Fayette County Schools Special Education and Psychologist departments on Life Space Crisis Intervention, a nationally accepted, trauma-informed training. FMRS Health Systems Inc. provided teacher-child interaction training to Fayetteville Elementary School during spring of 2019, and Aetna provided a strategic community investment for staffing to include a licensed, master's level therapist.

[MS002] Outreach and Training to Eligible Youth, Young Adults, and Caregivers

West Virginia families need engagement that builds trust and supports bringing children and youth home and strengthening families. Aetna has the knowledge, capacity, and governance structure to be West Virginia's partner in the goals related to Family First Prevention Services Act including outreach and training for eligible children, youth, and their caregivers. We will institute a governance approach that supports our statewide collaboration with the Department, BCF, CPS, juvenile justice and WVDOCR, providers, SNS providers, families, foster, kinship, and adoptive parents, and children and youth. This approach includes an ongoing collaborative relationship at all points of entry for eligible children, youth, and their caregivers in the CPS system including, but not limited to, medical and emergency medical, BH and BH crisis, juvenile justice, removal and referral to SNS, and education and school system. We have designated health plan staff that are responsible for State-, system-, policy-, and community-level collaboration, especially as it relates to developing support, outreach, and training opportunities at system points of entry, and will provide oversight of outreach and training strategies. The designated health plan staff—our system of care administrators—include administrators who oversee the children's systems, adult system, the juvenile justice system, and recovery and resiliency. System of Care administrators also use feedback from our 12 focus groups for members and families with special healthcare needs, satisfaction surveys (Consumer Assessment of Healthcare Providers and Systems) that elicit feedback about children with chronic or behavioral health conditions from both members and providers, and utilization data to inform our policies, outreach, and training strategies, and to facilitate discussion in monthly and ongoing forums with State agencies.

Our governance approach and existing West Virginia community outreach efforts inform our outreach and training strategies for eligible children, youth, and caregivers. Our current method for engaging eligible children, youth, and caregivers includes multiple strategies such as hosting community health fair events at local schools and non-Medicaid clinics such as rural health clinics. For example, our Community Outreach team offers eligible populations items such as back-to-school supplies and printed materials on topics such as family wellness, growing up healthy, or proper use of the emergency room. We educate eligible children, youth, and caregivers about Medicaid enrollment and services and connect them, if necessary, to appropriate managed care or community and social resources. Our materials are developed with our eligible target audience in mind and include easy-to-understand language and pictures such as our wellness activity coloring book for children. We identify appropriate topics for our events based on the unique needs of the members we serve and customize them based on regionally specific needs. We have identified the following topics in anticipation of serving children, youth, and families in the Specialized Managed Care for Children and Youth program, including, but not limited to, the following: understanding CPS/eliminating stigma, understanding the managed care system and use of services, family wellness, and understanding the Family First framework and how it supports strengthening families. Our system of care administrators and Community Outreach teams will collaborate with the Department, BCF, CPS, and SNS providers to identify the most appropriate strategies including frequency and audience(s) for targeted, regionally specific outreach and training. **[MS002]**

[MS021] Multicultural Outreach

Aetna's Multicultural Outreach team is a center of excellence that provides multicultural insights and strategies, including making translation and interpretation services available in over **200 languages and American Sign Language**. We also provide telecommunication options for members who are deaf or hard of hearing through our language line services. Written materials are translated in Department-designated prevalent languages and as requested by our members. **[MS021]**

[MS004-MS005, MS007, MS009, MS047 — MS051] IT Solutions that Improve Access to Care

Aetna leads the industry with IT solutions that engage members, families, and their circle of support in Aetna's care and services and improve access to care. This includes innovative solutions for member medical records, the health passport, member appeals, member rights and responsibilities, and health education programs. We offer IT solutions that improve access to care including a proprietary electronic health record customized for the system and member needs of children and youth enrolled in the West Virginia Specialized Managed Care for Youth and Children project, including our secure Aetna website and member portal, and our mobile application. Our IT solutions are compliant with the mandatory requirements for records retention, WVOT security policies, and State and federal regulations for websites. Our internet, intranet, and extranet applications associated with this contract are compliant with Section 508 of the Rehabilitation Act of 1973, as amended by 29 United States code (USC) &794d, and 36 Code of Federal Regulation (CFR) 1194.21 and 36 CFR 1194.22.

[MS009, MS048] Aetna Public Website

Aetna's publicly accessible, secure website offers a comprehensive, single source of easy-to-navigate information critical to the needs of our members. Our website includes information and links to the following resources:

- Benefits, covered and value-added services
- Provider search including filters for searching by specialty, geography, quality, and trauma-certified
- Care management programs including how to access care coordinators
- Important telephone numbers such as member services, BH Crisis Services hotline, and the Health Information line
- The member handbook including member rights **[MS007]**
- Link and entry to the member's personal medical records, services, and service authorization status
- Health education and prevention information and programs
- Links to the BCF Ombudsman program
- Community resource library that includes links for local 2-1-1, links to the Family Network Resource libraries, Mountaineer Food Bank, Facing Hunger Foodbank, United Way resources, and Women, Infant, and Children resources **[MS009]**
- Health education topics such as healthy eating and smoking cessation. Resources are available in multiple media formats including media, print, and podcasts. **[MS048]**
- Member newsletters **[MS009]**

[MS004-MS005, MS047-MS051] FamilyConnect—Aetna's EHR and Health Passport Strategy

Aetna has developed a seamless continuity of care experience for our members, families, and systemwide partners that reduces fragmentation and is in alignment with designing systems of care identified by the American Academy of Pediatrics guidance for children involved in child welfare. **FamilyConnect**, Aetna's proprietary, electronic health record offers capability to integrate data from multiple sources, serving as the single source of truth for children, youth, BCF, and their multidisciplinary teams. FamilyConnect will integrate data from multiple sources—BCF, Families and Children Tracking System (FACTS), emergency room admission, discharge, and treatment feeds, West Virginia Health Information Network (WVHIN) system, and providers—allowing for near, real-time information sharing of

each member's assessments, care plan, progress, and updates. FamilyConnect promotes seamless continuity of care as all multidisciplinary team members can access the most recent member updates at the point of service. Care coordinators have access to FamilyConnect via technology that accompanies the care manager during in-person and in-home visits. Members, their circle of support, and BCF case workers can view the same updates, authorization status, and records 24/7/365 using our member portal or mobile application on their smartphone. Aetna will collaborate with the Department, BCF, CPS, and other State agencies prior to implementation and during the first six months to customize and deliver FamilyConnect to our statewide partners. **[MS004, MS005]**

Care coordinators act as the single point of contact on each Care Coordination team, and document and upload member reassessments, referrals, authorizations, and provider updates into FamilyConnect, providing a holistic, near real-time view of each member's needs. Member care plans are updated at least monthly, making certain progress, barriers, and change in needs are monitored and documented. The care plan is updated any time there is a change in the member's needs, per member request, per contract requirements, and at minimum, annually. Care coordinators support timely documentation for timely updates of each member's health passport, in accordance with the American Academy of Pediatric guidelines, including chronic health conditions, medications, allergies, psychosocial and family history, trauma history, immunizations, and developmental history. If there is a significant change, the care coordinator conducts an in-person visit to complete reassessments and assures referrals and care plan updates are documented in FamilyConnect.

Aetna will encourage commitment to FamilyConnect participation by offering contractual incentives to all providers for participation in FamilyConnect and the WVHIN. We will also collaborate with the Department, BCF, CPS, providers, and community stakeholders to develop and implement an electronic solution to the West Virginia health passport, allowing for a single, shared repository for West Virginia children and youth involved in child welfare. Given the current status of fragmented health records for West Virginia children and youth involved in child welfare secondary to multiple placements in various regions or out-of-state, FamilyConnect offers a unique, innovative solution to assuring seamless, near real-time coordination of care that reduces fragmentation and supports continuity of care. **[MS047]**

Aetna members can access their secure and confidential member portal via the public-facing website or through Aetna's mobile application for smartphones. Aetna's member portal is secure and confidential, and we consult with CPS on who can access the member portal on a case-by-case basis. Once determined, members can access comprehensive information about their individual care and view electronic health record and health passport information. **[MS049]** Members have access to information related to their care, program, and services through easy-to-use functions on the Aetna mobile application including menus that offer quick access to each member's health record for frequently requested items such as making a PCP change as illustrated in **Figure 4.1-6.** Members can access multiple resources in their individual health record including their member ID card, medications, care plan, support circle, claims and authorizations, and resources. **[MS004, MS005, MS050, MS051]** Members can easily and readily search for providers using our Aetna mobile application provider search function.

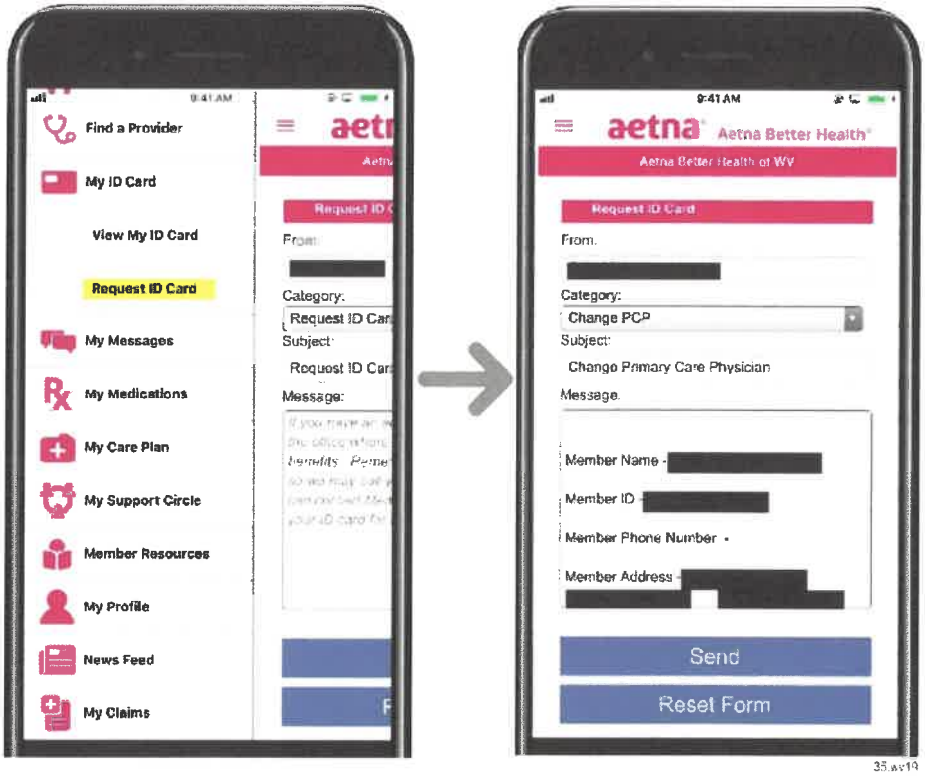

Figure 4.1-6: Aetna Mobile Application—Member Health Record/PCP Change
The Aetna mobile application features menus for each member's health record and includes functionality to make a PCP change.

Members can also receive text messages customized to their needs based on health conditions, preventive care, or appointment reminders. We inform members of their option to receive text messages from us through information found in the member handbook, our website, and via contact with member services staff. If a member chooses to receive them, we can send them text messages through our mobile application. An interactive, mobile program sends personalized text messages at no cost to program guardians 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

With the Department, CPS, and guardian permission, Aetna will collaborate with our text program vendor to design text campaigns specific to the unique needs of West Virginia Specialized Managed Care for Children and Youth program needs.

Members can easily access our provider directory from the Aetna mobile application. **Figure 4.1-7** illustrates how easy it is to find a provider by location, specialty, office hours, language spoken, hospital affiliation, and other filterable indicators. When members call the member services hotline, our representatives will take time to educate members on downloading the mobile application and navigating

the various functions described, assuring understanding. If a member is using the mobile application, they can quickly connect to a member services representative for individual troubleshooting.

Connections for Life Smartphone: Aetna offers a **value-added service** especially impactful for children and youth involved in CPS, assisting to maintain contact with their siblings and friends when they have been separated. Eligible members can receive a no-cost smartphone and wireless plan or laptop, helping them connect to key local and national resources. Member services and care management staff assist members on using the smartphone and provide technical assistance and training around technology literacy. Connections for Life smartphones are available to members ages 13 to 17 who have been placed out of home. Laptops are available for members 18 and older. Both devices reduce isolation and related barriers to care by offering immediate, accessible ways to connect with care coordinators, CPS case workers, member services hotline staff, and crisis staff on the BH and Health Information hotlines.

Figure 4.1-7: Aetna Mobile Application—Provider Search
The provider search function in our Aetna mobile application offers an easy, quick way for our members to search for a provider that meets their specific needs.

Member Grievances and Appeals

MS004	The Vendor should leverage information technology (IT) solutions to improve access to information, including, but not limited to, the following:	The Vendor should describe how it will meet this specification.
MS006	Appeal processes	See the parent specification.
MS007	Other member rights and responsibilities	See the parent specification.
MS022	The Vendor should ensure the Contract Liaison/Medicaid Administrator monitors grievances—including, but not limited to, grievances related to subcontractors—for enabling services for members with physical or developmental disabilities.	The Vendor should describe how it will meet this specification.
MS021	The Vendor should provide enabling services—including, but not limited to, assistance with complaints and grievances—to members with physical or developmental disabilities.	The Vendor should describe how it will meet this specification.
MS034	The Vendor should use and report to the Department on customer service performance standards, including, but not limited to, the following:	The Vendor should describe how it will meet this specification.
MS039	Turnaround time for member requests	See the parent specification.

Aetna recognizes the need for additional oversight of the quality of and access to care for our members enrolled in the Specialized Managed Care for Children and Youth program, and we assure that support to our members in our grievance and appeal processes. We will include, inform, and collaborate with State agencies including CPS when issues are identified and utilize our member advocate to provide the additional support necessary for members with special healthcare needs. We ensure our contract liaison/Medicaid administrator monitors grievances and appeals, and implements policy level, operational, and training or program change necessary to meet the needs of the Specialized Managed Care Children and Youth program.

Aetna's Member Services department plays an important and critical role educating our members about grievance and appeals rights and procedures. We thoroughly train our member services representatives, staff, and our member advocate about grievance and appeals policies, procedures, and State requirements, assuring 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 and online, and by calling the member services hotline. Aetna's grievance and appeal system goes beyond basic requirements to foster a culture of high-quality performance throughout our operations and promote member engagement and individual 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 will exceed the State's expectations.

[MS022] Compliance with State and Federal Requirements

Aetna complies with all the requirements and principles of the grievance and appeal system, including compliance with all State and federal laws and regulations referenced therein, including, but not limited to, **Model Service Provider Agreement**, West Virginia Statutes 33-25A-12 and 42 C.F.R. §§438 Subpart F.

Our member grievance and appeal processes are simple and user-friendly, affording members the opportunity to voice their complaints, issues, concerns, and problems in a non-threatening manner.

Whenever necessary or requested, our member advocate is available to support members during the grievance and appeal processes. Upon receipt the facts of a case are reviewed to determine appropriate classification and processing. Issues related to the denial, reduction, termination or suspension of services is classified as appeals. Issues related to dissatisfaction with anything not related to the denial, reduction, termination or suspension of services are classified as grievances.

Our commitment to identify and resolve grievances and appeals timely helps ensure our members, no matter their background or health condition, receive equitable and effective treatment in a culturally and linguistically appropriate manner, promoting individual self-sufficiency. Aetna retains responsibility for all other grievance and appeal processing, investigations, and resolutions/decisions. We are currently working toward delegation of dental appeals and grievances to our subcontractor to be in alignment with other payors in the state. We retain oversight of the delegated vendor through weekly reporting, quarterly joint operating meetings, and case file audits. Aetna's existing grievance and appeal infrastructure, standardized processes, and staff training optimize compliance, and help ensure fairness.

Aetna maintains a comprehensive grievance and appeal system that includes grievances, appeals, and State Fair Hearings. We have established grievance and appeals processes that are further supported with Medicaid best practices acquired through our Medicaid experiences in 16 states. We will leverage our experience and best practices to ensure that we meet and exceed the requirements in West Virginia. Our member grievance and appeal processes and staff accomplish the following goals:

- Protect and promote member education regarding grievances, appeals, and State Fair Hearings through enhanced member education and training on rights, responsibilities, problem prevention, and easy access to information related to member dissatisfaction, grievances, and appeals
- Provide comprehensive staff training to assist members and to facilitate smooth operation of the grievance and appeal process to achieve prompt resolution
- Verify that member grievances and appeals are acknowledged and addressed in a manner that supports an equitable outcome
- Facilitate the resolution of issues that potentially affect access to services, quality of care, member choice, and safety
- Support compliance with contractual requirements, NCQA standards, and applicable federal and State laws and rules
- Maintain accurate and complete records, including all required documentation to enable Aetna to track and review the progress and outcomes of all grievances and appeals throughout the process
- Comply with State and federal compliance reporting requirements
- Provide advanced IT applications that include tracking, document retention, performance evaluation, and sophisticated data analytics to link grievances and appeals to reporting capability for the State, root-cause identification, and operational, clinical quality, and care management improvement opportunities
- Maintain accountability through a contract liaison/Medicaid administrator/ responsible for investigating culture sensitivity issues, monitoring for trends, connecting and coordinating with local agencies, assisting members and their representatives throughout the process, and serving as a subject matter expert to provide both internal and external grievance and appeal training **[MS022]**
- Maintain accountability through the chain of command to make sure there are prompt and thorough responses to findings and lessons learned from data analytics on root causes and quality improvement opportunities to achieve the provision of high-quality, cost-effective health care services.

[MS022] Staff Training and Involvement

The Grievance and Appeal department is responsible for the management of the member grievance and appeal system. The contract liaison/Medicaid administrator position monitors processing of all cases and conducts daily real-time quality reviews to help ensure timely and accurate processing according to West Virginia Statues. **[MS022]** The grievance and appeal coordinators are responsible for processing all member grievances, appeals and State Fair Hearings. This includes documenting the substance of each case including all information submitted as part of the initial review, any new information submitted with the request and the relevant clinical care guidelines as applicable, the resolution of individual cases, coordinating resolutions, and tracking data and reviewing for trends in quality of care or other service-related issues. The Grievance and Appeal department staff reports to the chief operating officer. This reporting structure allows for reporting direct to health plan leadership to enact any needed change. The contract liaison/Medicaid Administrator will make recommendations based on observations and documented trends to improve care and will make policy-level and operational decisions within two business days and claims decisions within five business days, and ensures the quality of documentation with members, swift resolution of grievance, appeals, and complaints, and a positive, member experience.**[MS022]**

Aetna complies with all the requirements and principles of the grievance and appeal system, including We maintain and disseminate internal policy and procedure documents, as well as provide role-specific training for grievance and appeal, member services, provider services, care management, and clinical review staff to help ensure they are fully educated on the grievance and appeal processes. We thoroughly train all our staff to identify potential grievances and appeals, emphasizing the importance of member confidentiality and privacy throughout the grievance and appeal processes. Our goal is to make the process of filing an appeal or grievance as uncomplicated as possible by removing any undue administrative challenges. Our member services staff including our member advocate provides members with thorough and accurate information regarding grievance, appeal, and State Fair Hearing processes and procedures, using our member handbook as a guideline. We communicate with members proactively, compassionately, and with understanding of each member's unique culture and individual needs.

Medical directors are responsible for rendering medical necessity decisions; they are physicians who were not involved in any prior decision-making and are not a subordinate of any such individual. Only a provider of the same or similar specialty with the appropriate clinical expertise in treating a member's condition or disease is the decision-maker for any appeal of a denial that is based on medical necessity, grievance regarding the denial of an expedited resolution of an appeal, or a grievance or appeal that involves clinical issues. Our clinical staff is available to review expedited cases for our members to receive decisions on care or services as quickly as possible. We may employ an outside independent reviewer to assist in the determination when required to achieve same or similar specialty match if we do not have a medical director who meets the specialty of the provider requesting the item or service being appealed. The results of the independent review are reviewed by our medical directors and considered when making the determination.

[MS006-MS007, MS021] Notice of Adverse Benefit Determination

Care coordinators, our member advocate, and member services staff can assist members in understanding and following guidance provided in our notice of action determinations. Our notice of action process provides for a written notice of action to members or their designated representative in accordance with West Virginia statutes. The notice of action is written in easily understandable language, explains the adverse benefit decision, and includes the following:

- Dates, types, and amount of service requested

- Date of the decision and the date of the notice
- Effective date of the action if it results in a reduction or termination of ongoing or previously authorized services
- A phone number at the health plan that members may call to obtain information about the Notice of Action
- Detailed description of the decision made or the decision that will be made in plain language
- Medical basis for the decision, the policy, or criteria utilized as part of the decision-making if the decision was based on medical necessity
- Statute, regulation, policy, or procedure, if the decision was based on a statute, regulation, policy, or procedure
- Explanation of the member's right and how to request an appeal, and the criteria when the appeal process can be expedited
- Information the member must complete for the appeal process before requesting a State Fair Hearing
- The right to seek an expert medical opinion from an external organization in cases of medical necessity at the State's expense, for consideration at State Fair Hearings
- Member's right to represent themselves or designate a representative when requesting an appeal
- Member's right to submit additional information and to obtain copies of the file reviewed as part of the decision-making at no cost to the member
- Member's right, if applicable, to continuation of services and how to request continuation of services.

Members are informed they may be required to pay for continued services when they make the request for continuation. We send written notice of action for standard requests to the member as quickly as the member's health condition requires or within 10 business days from receipt, and for expedited requests, within 72 hours from receipt. For standard authorization decisions to deny or limit services, Aetna will provide notice to the attending provider and hospital by telephone or fax within one working day after making the determination. Our Notice of Action process will comply with 42 CFR 438.404. **[MS006, MS007, MS021]**

[MS006, MS007, MS021] 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 appeals, if requested or if we identify a need. Member assistance may include auxiliary aids and services, such as interpreter services and numbers that have adequate TTY-TTD and interpreter capability. Upon receipt of a member grievance or appeal, our team logs the concern and assigns it for review. A grievance and appeal coordinator reviews all the facts to determine whether the case should be processed as a grievance or appeal, and whether it should be expedited. **[MS021]**

When a member or their designated representative requests the review of an action where we denied, reduced, suspended, or terminated an item or service (typically through a notice of adverse benefit determination), the review is conducted in accordance with our member appeal process. When a member or their designated representative is dissatisfied with service or other concerns unrelated to an appeal, the review is conducted in accordance with our member grievance process. When the grievance is about the service or care they received from a provider, we always secure member permission to utilize their name to investigate the grievance. Grievances may be filed at any time; appeals must be filed within 60 calendar days of the initial denial. If we identify a potential quality of care issue, we forward the matter to our Quality Management department for review and investigation, and simultaneously continue with the grievance process.

Our published member communication materials inform members how to designate a representative, to act on the member's behalf, at any time during the grievance and appeal process. To verify the authority of designated representatives, Aetna requires authorization to be in writing and 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 free of charge. 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 should contact the Grievance and Appeal 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. **[MS006, MS007]**

Any member may continue to receive services during the appeal or the State Fair Hearing process under the following circumstances:

- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
- The member requests an appeal or State Fair Hearing within 10 calendar days from the mailing of the notice of adverse benefit determination or appeal decision letter or the intended effective date of the proposed service termination, suspension, or reduction
- The services were ordered by an authorized provider
- The original authorized period has not expired
- The member requests extension of benefits

The member is informed that they may be financially liable for the services that were rendered during this process if the appeal or State Fair Hearing decision is adverse to the member. For appeals that meet the criteria for continuation, the grievance and appeal coordinator notifies the Utilization Management department to continue benefits at the current level. Members continue to receive benefits during a pending appeal or State Fair Hearing until either of the following events occurs:

- The member withdraws the appeal or request for a State Fair Hearing
- The member does not request a State Fair Hearing with continuation of benefits within 10 calendar days from the date the adverse appeal decision letter is mailed
- The State Fairing Hearing decision is adverse to the member

If the final resolution of the appeal or State Fair Hearing is in favor of the member, the grievance and appeal coordinator notifies utilization management of the outcome of the decision to authorize the service. If the final resolution of the appeal or State Fair Hearing is adverse to the member (the decision upholds our action), we may recover the cost of the services furnished to the member while the appeal or State Fair Hearing is pending to the extent that services were furnished solely because of the requirements of this section.

Verbal appeals are acknowledged at the time of receipt and members are asked to submit a written, signed appeal, unless the member is requesting an expedited appeal resolution. To facilitate receipt of the signed appeal, we document the substance of the appeal in the acknowledgement letter and provide a postage paid envelope for the member to send us their signed appeal. We proceed with the case even if the member does not return the appeal statement to address all member concerns. To establish the earliest possible filling date for verbal appeals, our grievance and appeal coordinators document the receipt date as the date of oral inquiry. We acknowledge verbal grievances at the time of receipt. We send a written acknowledgement letter for all standard appeals and written grievances within three calendar days of date received.

Aetna provides members with the opportunity to present evidence, testimony, and allegations of fact or the basis of the grievance or appeal, in person and in writing. All information submitted with a grievance or appeal is thoroughly researched, including investigation into the matter, a review of any prior documentation, medical review criteria and communication with the provider, member or member's representative, and vendor or staff member involved as appropriate. If additional clinical information has been received with the grievance or appeal, the case is presented to the original decision-maker for review to determine whether they can overturn their original decision. This is an effort to deliver requested items or services to the member as quickly as possible.

If the original reviewer is unable to overturn their original decision (or if no new clinical information is received), the case is presented to another appropriate reviewer not involved in the initial determination and not a subordinate of any person involved in the initial decision individually or as part of an Appeal Committee for review. For cases involving medical necessity determinations, denial or expedited resolution or clinical issues, the case will be heard by a health care professional who has the appropriate clinical expertise. The reviewer for the appeal considers all comments, documents, records, and other information without regard to whether to such information was submitted or considered in the initial adverse benefit determination.

In accordance with 42 CFR 438.408 (c) , the resolution time period for a grievance or appeal may be extended up to 14 calendar days if the member requests the extension or at our request when we show there is a need for additional information, and how the delay is in the member's best interest. If the resolution timeframe is extended and it was not requested by the member, we attempt to give oral notification of the extension and send written notice of the delay within two calendar days of the decision and within the appropriate timeframe. The written notice of extension informs the member that they may file a grievance if they disagree with the decision for the extension.

[MS021] Verbal and Written Notification

Aetna verbally resolves all standard verbal grievances within 30 calendar days of receipt. Aetna member services and member advocate staff provide our members with any assistance needed including enabling services if the member would like to submit a written grievance. The verbal resolution includes the results of the investigation and actions related to the grievance. **[MS021]**

Aetna resolves and sends a written notice for all standard written grievances and all appeals as expeditiously as the member's health condition requires, but in no case exceeds 72 hours for expedited grievances and appeals or 30 days from receipt for standard written grievances and all standard appeals, unless there is an extension. For expedited cases we attempt to provide verbal notice of a decision followed in writing within the 72-hour timeframe. When we reach a decision prior to the 30-calendar day timeline for standard cases, our staff is required to send written notification within 3 calendar days of the decision, to avoid undue delays in responding to our members. The grievance and appeal application uses the date of receipt to automatically calculate the due date for completion, allowing our staff and managers to track and monitor case timelines. The written grievance resolution or appeal decision notice includes all required information, including, but not limited to, the following:

- Results of the process and the date it was completed
- Right to request a State Fair Hearing and the processes involved to request a hearing for appeals not resolved wholly in favor of the member
- Right to request assistance in the filing process
- Right to request a continuation of benefits while the State Fair Hearing is pending and how to make such requests
- Notification that the member may be held liable for the cost of those continued services if the hearing decision upholds our adverse benefit determination

- Reference to the benefit provision, guideline, protocol, or other criterion on which the appeal decision was based
- Notification that upon request the member can obtain a copy of the actual benefit provision on which the appeal decision was based and reasonable access to copies of all documents relevant to the grievance or appeal at no cost

When needed, Aetna may also provide verbal notice of the resolution to ensure ease of understanding by the member.

[MS021] Member State Fair Hearing Process

After exhausting the internal appeal process, the member or their authorized representative may request a State Fair Hearing within 120 calendar days from the appeal decision letter. Our member advocate will be assigned to all State Fair Hearing cases, assuring necessary enabling services and member understanding each step of the way. **[MS021]** The request may be made in person, by telephone, voicemail, email, through the website, or in writing. The State Fair Hearing process provides members with an opportunity for a State Fair Hearing before an impartial hearing officer. The parties to the State Fair Hearing include the health plan, the member, and their authorized representative, including a provider, or the representative of a deceased member's estate, or a foster care member over age 18 designated representative.

When a State Fair Hearing has been requested, Aetna will provide information regarding whether an appeal has been filed, the date the appeal was filed, and the resolution of the appeal. This information will be provided within one working day of receiving the request from the State Fair Hearing Office. If the request for State Fair Hearing regarding a standard appeal is received by Aetna, we forward the case file to the Department within the State-required timeframe. If the hearing officer reverses our decision to deny, limit, or delay services that were not furnished while the State Fair Hearing was pending, we promptly authorize or provide the disputed services, and as expeditiously as our member's health condition requires, but no later than 72 hours from the date we receive the notice from the State Fair Hearing reversing the decision.

Expedited Review Process

Upon receipt of an expedited verbal or written appeal, a clinical reviewer immediately reviews the case to assess the urgency of the issue being appealed to the member's current health condition, to determine whether the issue meets the criteria for expedited processing. If the issue fails to meet the expedited appeal criteria, we transfer it to the standard appeal process and maintain the original received date and notify the member verbally within 24 hours of the transfer and send written notification within 2 calendar days. The notification informs the member that they may file a grievance if they disagree with our decision to transfer the case to the standard review timeframe.

Grievances are processed in an expedited timeframe whenever the grievance is the result of the denial of expedited processing of a prior authorization request or an appeal, or when Aetna takes an extension on the processing of a prior authorization request or an appeal. Appeals are processed in an expedited timeframe whenever the item/service being appealed is pre-service, the provider requests expedited processing, the provider supports the member's request for expedited processing, or anytime it is determined that waiting the standard timeframe could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. Neither written confirmation nor the member's written consent is required for the provider to act on the member's behalf to request an expedited appeal.

When processing an expedited grievance or appeal, Aetna complies with all required criteria related to the resolution of the issue, as described previously in the standard appeal process, including the review

of all records and information without regard to whether the information was considered in the initial adverse benefit determination, and that the case is decided by an appropriate decision-maker. Members and their representatives are also advised of their rights, as described in the standard appeal process description, including the limited time to present evidence and information, and the right to receive a copy of the case file at no cost. Aetna resolves expedited grievances and expedited appeals within 72 hours of receipt. We attempt to provide verbal notification followed by written notification within 72 hours. Our written notice includes all required information, including information on how to request an expedited State Fair Hearing, if the decision is adverse to the member. Upon resolution of the expedited appeal, we also make reasonable attempts to contact the member or their representative to inform them of the decision

[MS004, MS006, MS034, MS039] Data, Reporting, and Trending

Aetna's grievance and appeal records are housed in our inclusive system, which houses all correspondence, letters created, and staff actions taken on the case. **[MS004, MS006]** Member services staff receive updates on grievance and appeal trends via email and during staff meetings, including any policy or program changes supporting those trends. Member services 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, including the following:

- Date of receipt of each case
- Case type
- Staff member assigned to process the case
- Member ID number
- Short, dated summary of each issue consistent with State-specific categories
- Name of the person filing the case, including the member, their authorized representative, or any representative,
- Date of the review or review meeting, and the date of decision
- Resolution for grievances
- Date of decision for appeals and hearings and the criteria used in rendering the decision
- Date of communication of the resolution/decision.

We capture this documentation both to meet the State and federal requirements, and because it allows us to maintain and track all cases from origination through resolution/decision. Our system contains a standard suite of reports and queries by case type of complaint, grievance, appeal, or State Fair Hearing that we utilized to track cases throughout the process. To support the accuracy and integrity of our grievance and appeal data and reporting, Aetna has programmed its grievance and appeal 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 grievance and appeal 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 year-to-date TAT are currently 100 percent timely.** **[MS034, MS039]** 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. This module automatically assigns the date of documentation and allows for the member services representative to document the full content of the call. Regardless of whether the member representative can resolve the member's or their authorized representative's issue, call tracking will be assigned to the Grievance and Appeal department. The Grievance and Appeal department reviews the department 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 Member Services department will be documented and closed for tracking and trending. Any case that was not resolved by member services will be documented in the grievance and appeal application and the formal grievance or appeal process will begin. Upon resolution of the grievance or appeal case, the call-tracking system will be updated with basic information such as date of decision and the decision of 'overturn,', 'upheld,' or 'partial uphold.' This information allows member services 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 HIPAA regulations of communicating the minimum amount necessary for member services to do their job. If the member has detailed questions the call will be transferred to the grievance and appeal staff member who is processing the case.

[MS004, MS006] Quality Improvement

The grievance and appeal manager utilizes standard queries and reports in our electronic tracking system to monitor cases throughout the process, to monitor timeliness and accuracy, and to identify and report trends for potential opportunities for improvement. **[MS004, MS006]** The grievance and appeal manager also conducts daily and monthly audits to validate consistency and quality standards. Audit results are reported to compliance and plan leaders.

Review of the grievance and appeal data may include, but is not limited to, the following: the number and types of grievances and appeals received, including identification of the top 10 types; the disposition and status of all grievances and appeals; the type of service and dollar amount for all overturned denials; and the average TAT for resolution by type of grievance or appeal based on a monthly time period. The data is aggregated to protect member privacy. Consistent evaluation of grievances and appeals trend data allows for the Compliance department and executive staff, in conjunction with the Quality Management department, to improve on medical, network, operations, and management areas identified through grievance and appeal tracking that requires additional focus.

All data collected is reported to the Appeal Committee, Service Improvement Committee (SIC), Quality Management/Utilization Management (QM/UM) Committee (appeals), and Quality Management Oversight Committee (QMOC) at least quarterly (more frequently if appropriate), summarizing the frequency and resolution of all grievances and appeals. Data from health plan experience, results of oversight activities, and the need for any corrective action plans identified internally or by the Department are presented to our grievance and appeal and quality committees. Aetna is committed to assuring collaboration with the Department and BCF and will invite State agency staff to participate on our SIC, assuring communication at State and policy levels about grievance and appeal trends and related operational or program changes.

The Grievance and Appeal Committees are responsible for reviewing trends and may be responsible for reviewing individual grievance and appeal requests along with all supporting documentation. Grievance and Appeal Committee participants may represent Compliance, Provider Services, Member Services, Claims, Medical Management, Utilization Management, and other departments, depending on the

specific case. Participants also include the director of operations, who is authorized to engage other departments (as necessary) and to implement improvement activities and execute corrective action plans as needed.

The quality committees include cross-functional representatives from Member Services, Provider Services, Compliance, Care Management, or other departments as needed (please refer to **Table 4.1-5**). Participants on the SIC and the QMOC include senior leaders at the health plan. This ensures that individuals with the authority to take corrective action participate in the decision-making and can prioritize trends, opportunities for improvement, and corrective actions to address the issues affecting individual member satisfaction, to stabilize trends within the delivery system, and to meet performance standards. These individuals hold relevant departments to deadlines and actions specified in the corrective action plan and helps ensure completion within the timeframes specified. **Table 4.1-5** outlines this detail.

Table 4.1-5: Cross-functional Oversight Representatives

Cross-functional Representative	Format	Frequency	Location(s)
Appeal Committee	Meeting	Biweekly	Review and decide appeals. Track and trend data, analyze, identify concerns and root cause for appeals filed, and collaborative solutions
Grievance Committee	Meeting	Biweekly	Review and decide appeals. Track and trend data, analyze, identify concerns and root cause for appeals filed, and collaborative solutions
QMOC	Quality-of-care reporting	Quarterly	Executive oversight of the quality management program; review, recommend, and provide feedback to the Quality Management/Utilization Management Committee based on recommended clinical and service quality improvement studies
Service Improvement Committee	Meeting	Quarterly	Track and trend suggested improvement opportunities
Quality Management	Quarterly file review	Quarterly	File review to validate compliance with grievance and appeal system policies, procedures, and contract required standards

Appeal overturn decisions are reviewed both at the plan level and at the Medicaid segment level. The review includes specific reasons for overturn as well as the vendor or provider associated. This allows us the ability to identify both process trends as well as provider-specific trends. Through this process we can identify opportunities for provider training and education, which is implemented through our Provider Services department. If a trend is identified with a particular provider, we conduct targeted training. This process is also utilized to identify and implement internal changes, to improve member services, and reduce provider administrative burden.

5. NETWORK DEVELOPMENT

The Vendor should refer to the relevant specifications located in ***Appendix 1: Detailed Specifications*** (based on the categorization within Column E: Subject Matter Area) and pertinent narrative in ***Section 4: Project Specifications*** in this RFP, and then describe its approach to Network Development below. The Vendor's narrative response should not exceed 50 pages.

In support of our commitment to quality, ready access, and innovation to maximize member health, advance health equity, and address social determinants of health (SDOH) within a flexible, value-based approach, we have developed, and we continue to develop, a robust statewide provider network capable of meeting the health care needs of West Virginia Specialized Managed Care for Children and Youth members in an accessible, timely, and convenient manner. Our superior quality outcomes and value-based arrangements support State goals while demonstrating a commitment to providing an optimal member and provider experience. Aetna has established a physical health and behavioral health provider network that provides adequate access and serves all counties in the state. Aetna's approach to establishing a physical health and behavioral health provider network goes beyond adequate access, to focusing on ensuring that the vulnerable members in foster care or receiving adoption assistance have easy access to high-quality, integrated, personalized health care services.

Aetna's network development and recruitment strategies are an integrated component of our clinical program models, allowing us to anticipate and flexibly respond to changing member needs, support State program goals, respond to emerging best practices, and improve member outcomes. We continuously work to make sure providers are available at the right location within the appropriate timeframe to meet the needs of West Virginians and their families (including member, family, caregiver, community supports, and others who assist with care support and member wellness) with a focus on improving whole-health outcomes. 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
- Integrating network development activities with clinical practice models and State goals including assisting in reducing the number of children in the foster care system.
- Collaborating with the Department, Bureau for Children and Families (BCF), local case workers, socially necessary service (SNS) providers and community stakeholders, as well as Aetna System of Care (SOC) staff and other internal departments to identify network development opportunities that support State goals, including reducing the number of children removed from their home.

Statewide, Multidisciplinary, and Comprehensive Provider Network

ND001	The Vendor should establish a statewide provider network containing providers that can provide a multi-disciplinary and comprehensive service array, either through their own practice or through collaboration with other providers.	The Vendor should provide a detailed description of how it will meet this specification.
ND002	The Vendor should establish a statewide provider network that is accessible to children and their caregiver(s).	The Vendor should provide a detailed description of how it will meet this specification.
ND004	The Vendor should establish a statewide provider network that provides for continuous communication with stakeholders.	The Vendor should provide a detailed description of how it will meet this specification.

ND005	The Vendor should establish a statewide provider network that has capacity in rural areas.	The Vendor should provide a detailed description of how it will meet this specification.
ND006	The Vendor should establish a statewide provider network that has capacity across specialty lines of physical health and behavioral health.	The Vendor should provide a detailed description of how it will meet this specification.
ND007	The Vendor should address deficiencies in the Essential Provider and Specialty Provider networks in relation to travel times and distances that may be experienced by a member.	The Vendor should describe what constitutes a deficiency in the Essential Provider and Specialty Provider networks, based on its understanding of Department provider network standards, and its approach to addressing these deficiencies.

Aetna's goal is ensuring development and ongoing management of a comprehensive primary, specialty, and behavioral health provider network of qualified and clinically advanced care providers so each member receives the very best in health care services. We deeply value and depend on our provider partnerships to create programs and practices that are fair and simple to implement so that providers can stay focused on what they do best, providing high-quality care to their patients. For more than 23 years[1], Aetna has worked collaboratively with West Virginia health care providers to deliver services to Medicaid members, with a special focus on medically fragile and chronically ill infants, children, and young adults with complex physical and behavioral health care needs. Through this experience, we have learned that developing and maintaining an all-inclusive integrated care network requires continuous assessment of network gaps, ongoing efforts to recruit and maintain providers, and innovated solutions to improve access and quality of services to our members.

Through our national experience, we have also learned to effectively implement new programs and approaches to care and facilitate system changes, particularly for vulnerable populations such as foster care and adoption assistance populations, including those with juvenile justice involvement. For example, the Aetna-administered Mercy Care[2] plan in Arizona began serving more than 12,000 children and youth in foster and out-of-home care in 2014. Between 2014 and 2019, the number of children and youth in out-of-home care in Maricopa County has safely reduced to 8,000 and continues to decrease. Assisting foster care children to move on from child protection, preferably back to their birth families if possible, results in increased stability for the children and youth, and cost savings to the State. Mercy Care estimates that the reduction in children and youth in foster care and out-of-home placements contributes to a savings of over $3.5 million per year to the State Medicaid agency. A key component to achieving these successes has been our collaborative relationships with providers that have helped to ensure children and youth, as well as their families and fictive kin, receive timely services through an integrated, whole-person approach.

The Aetna-administered Mercy Care plan has safely reduced the number of children and youth in out-of-home care in Maricopa County by more 4,000, resulting in increased stability for the children and youth, and cost savings to the State. A key component to achieving these successes has been our collaborative relationships with providers to help ensure timely access to needed services.

This integrated and member-focused approach is particularly critical when addressing needs of vulnerable and high-needs populations, such as children and families in the foster care system and

[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 was 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.

[2] Mercy Care is not a subsidiary of Aetna Inc. but is managed by Aetna's Medicaid organization.

receiving adoption assistance. Our network, clinical, and quality departments work together in a variety of ways, such as assessing service needs, identifying network enhancements through new providers and expanded arrangements with current providers, and developing incentives and alternative payment arrangements designed to enhance quality of care and health outcomes for our members.

[ND004] Communication, System Collaboration and Outreach

Aetna's communications approach is guided by a philosophy of cross-sector partnerships and collaboration to reduce silos and duplication, taking a community approach to supporting the success of youth and their families who are involved in foster care, juvenile-justice involvement, and/or child welfare. We will actualize this philosophy through employing a Governance Roundtable model. This Governance Roundtable model provides a flexible structure including local, regional and State-level roundtables, which serves as a governance framework to inform our work and make sure the children and families served receive top-level services that help them achieve the outcomes they want and deserve for their lives. Aetna believes that the roundtable is a critical governance framework to support members and their families in receiving integrated, effective, and timely support during critical periods of risk and the resulting opportunity of receiving sufficient high-quality health, mental health, and social services.

Each member of the governance body brings a unique perspective on the needs of families involved in the foster care, juvenile justice, and post-adoption systems of care. A governance structure that includes divergent perspectives by design mirrors the person-centered care coordination model. This robust model of oversight also ensures that decisions are informed by broad and divergent perspectives, creating solutions far more viable than those derived from a narrow/homogeneous stakeholder planning process.

These roundtables will be made up of the following representatives:

- Youth and parent partners, including fictive kin, and adoptive and foster parents
- Aged-out foster youth representative
- Leaders from government agencies at the local, regional, and State level, including the Department, BCF, and juvenile justice
- Service providers
- Education system professional
- Parent support and youth-led organizations
- Law enforcement, juvenile justice, and legal system professionals
- Mental health, public assistance, housing, and human trafficking prevention groups
- Colleges, employment, creative arts, and vocational programs
- Representatives from nonprofit organizations or businesses who work specifically to support and enhance the quality of life for the youth enrolled in the West Virginia program
- Aetna executives and staff

The roundtables, which will be led by Aetna's SOC leaders, convene on a routine basis exploring actions and coordination between systems, agencies, and individuals to support families and transition-age youth at the earliest opportunity to safely stay together and build on the individual and family well-being. These coordination efforts are aimed at the goal of advancing person and family self-sufficiency, recovery, and resiliency.

Focus on coordination and communication: The goal of the roundtable approach is in common view of the importance and components of services, supports, programs, and policies that reach families early and focus on building individual child and family well-being as a primary outcome. Feedback and insights from the roundtable sessions will help to inform processes and practices. The provider relations director will also utilize this information to identify provider training and education topics and initiatives.

Roundtable sessions will specifically address needs of former foster youth and youth aging out of the foster care and juvenile justice systems, and at-risk families and youth. Aetna proposes to partner with the Department, BCF, and juvenile justice in all regional service areas to provide a local community approach to cross-sector planning and system improvement with the following goals:

- Drive system assessment and improvement
- Reduce silos and build cross-sector relationships and collaboration
- Serve the whole member through medical, behavioral, and social health integration, and reduce the number of children in out-of-home placements
- Invest in technology to fully integrate care management and simplify administration
- Collaborate with State agencies, and public and private companies to improve access and reliability of internet capabilities to support increased use of telemedicine

[ND001, N002, ND005, ND006] Established, Statewide Network

Our network management goal is to work with providers to ensure every member child and youth involved in the foster care system and receiving adoption assistance receives the best possible health care outcomes regardless of the care setting. We deeply value our provider partnerships and have developed meaningful relationships to support them in the care of our members, while working with Aetna to bring about system change. The hallmark of our goal is ongoing provider engagement and support that fosters health care integration at the system level and at the service level by ensuring collaboration brings about communication and coordination with providers, caregivers and members to make good health happen.

We are expanding upon our existing, extensive, and experienced West Virginia provider network to deliver high-quality medical and behavioral services, and social, foster, and adoptive care supports. Delivery of quality health care to Aetna members is dependent on a diverse, comprehensive, and clinically competent network. Our network consists of acute care hospitals, children's hospitals, behavioral health providers and trauma-informed behavioral health practitioners, medical specialists as well as an array of pediatric specialists and sub-specialists, which are focused on medically fragile and chronically ill infants, children, adolescents and adults. Given our strong network of providers, we provide our members deep knowledge of the needs/challenges facing members across the State of West Virginia, particularly Children and youth with complex care needs, including those with Adverse Childhood Experiences (ACEs), and backgrounds in the justice system, childhood trauma, or just members with high needs and high costs with complex comorbid and poorly managed conditions. We know factually these individuals have tremendously higher rates of medical, behavioral, and mental health conditions than many of their peers. Therefore, our contracting strategies in West Virginia concentrate beyond hospital-based and system-based health care providers and practitioners that demonstrate network adequacy and provider accessibility, but we emphasize integrated clinics, federally qualified health centers (FQHCs), rural health care and crisis clinics, post-crisis navigators ,and community mental health centers and providers. **[ND001]**

Aetna currently contracts with several foster care service and Safe at Home providers, such as KVC and Necco and was the first managed care organization (MCO) to contract with Lily's Place. Our case managers have established relationships with these providers, to support coordination of care for children at risk, who have not yet been removed by West Virginia BCF. This preventive step is used to reduce the number of children and youth removed from their homes.

Nationally, for more than 30 years, Aetna has been a leader in partnering with state Medicaid agencies to improve access to high-quality specialty and behavioral health care services and provider networks. Our West Virginia network currently serves approximately 137,000 West Virginia Medicaid members. Health care is delivered locally, however, which means our locally based Network 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. Our Network Development team is responsible for establishing our provider network; contracting negotiations; ensuring network adequacy and accessibility across West Virginia; monitoring for counties, cities, and towns where a gap in our network might occur or where a critical specialty is under-represented and additional providers are needed to prevent a gap care delivery and ensure disruptions do not affect member access to care.

Currently, Aetna has contracts with over 11,177 providers, including more than 1,312 primary care providers (PCPs), 4,346 specialty physicians, 578 behavioral health specialists, and all West Virginia FQHCs and rural health clinics (RHCs). Aetna has also 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 children and families. Our network and accessibility to services, as highlighted in **Table 5.1-1**, meet current State Medicaid requirements. Aetna is continuing to accelerate expansion of our existing provider network to deepen and broaden access to primary, essential, and specialty care providers, including hospitals, clinics, home health and respite care providers, and other key providers from the behavioral system and juvenile justice, and community-based service agencies. We will continue to make it our goal to meet State requirements and ensure member choice and access to high-quality health care across the continuum of services. **[ND001, ND002, ND005, ND006]**

Table 5.1-1: Aetna Provider Network Adequacy and Accessibility

Provider Type	Number of Available Practitioners	Availability 2018
Primary Care Providers		
Internal Medicine	152	99.9%
Family Practice/General Practice	465	100%
Pediatrics	250	100%
Nurse Practitioners	334	100%
High-volume Specialists		
Obstetrics and Gynecology (OB/GYN)	393	99.8%
Otolaryngology/Ear, Nose, and Throat	133	87.7%
Ophthalmology/Optometry	382	99%
General Surgery	492	99.7%
High-impact Specialty		
Oncology	214	100%
Other Frequently Used Specialties		
Allergy	53	100%
Audiology	75	100%
Cardiology	370	100%
Chiropractic	179	100%

Provider Type	Number of Available Practitioners	Availability 2018
Dermatology	57	100%
Durable Medical Equipment	314	100%
Endocrinology	73	99.5%
Gastroenterology	147	100%
Hematology	128	100%
Home IV Therapy	17	99.8%
Neurology	236	100%
Neurosurgery	56	90%
Nephrology	95	99.8%
Orthopedics	232	100%
Orthotics and Prosthetics	39	99.5%
Physical Therapy	206	100%
Plastic Surgery	40	94.3%
Podiatry	111	100%
Pulmonology	141	100%
Speech Therapy	33	97.9%
Thoracic Surgery	74	99.4%
Urology	104	100%
Hospitals—Basic Services (Urban)	77	100%
Behavioral Health Providers		
Psychologists	168	100%
Psychiatrists	152	100%

To demonstrate our commitment and goal to ensure a robust system of providers that afford member choice, we develop and make readily available a Network Development and Management Plan that focuses on accountability and transparency in our network development policies and procedures, as well as strategies and communications that impact our network of providers. Central to the Network Development and Management Plan, is both an understanding and the practice of what we are truly working toward; a comprehensive SOC that is centered on the member and the member's needs. As we continue our network build efforts, we employ a comprehensive and ongoing process of assessing our current network, identifying opportunities to improve access to care in a manner that is responsive to member needs, recruit and engage providers, and monitor to anticipate system changes.

[ND007] Identification of Current Network Gaps

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 GeoAccess® analysis to pinpoint areas within the state, within counties, and deeply into each city where network adequacy and

provider accessibility can be enhanced by carefully evaluating 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. We know, for example, through our analytics that acute care and children's hospitals, behavioral health practitioners and certain specialists such as, endocrinology, dermatologist, orthopedic surgeons, oncology, OB/GYN, infectious disease and sub-specialists are the most likely areas for network gaps. Aetna uses these assessment and measurement tools as the primary means of demonstrating achievement of network adequacy compliance with West Virginia provider network access requirements and expectations. We will apply the Department's provider network standards to assess travel time and distance for members to access essential and specialty providers and will recognize an essential or specialty provider deficiency when a member does not have ready access to such providers.

If a member cannot access a pharmacy, hospital, PCP, or essential or specialty provider, then the network is not adequate (deficient) for that member, regardless of whether our network technically meets the Department's definition of adequate. 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.

Aetna understands the critical role essential providers play in meeting the needs of low-income and underserved populations, such as FQHCs and RHCs. Through our contracts with all the FQHCs and RHCs in West Virginia, we are in compliance with requirements to have as many FQHCs and RHCs as necessary to permit member access to participating FQHCs and RHCs without having to travel a significantly greater distance past a non-participating FQHC or RHC.

West Virginia has known areas of provider shortages in some rural areas. Based on our knowledge and experience working 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 IV therapy, neurosurgery, nephrology, plastic surgery, and thoracic surgery. Additionally, throughout the state, there is limited availability and accessibility to certain specialty providers, including otolaryngology, neurosurgery, and plastic surgery. These challenges in accessibility to specialty services are heavily driven by the state's rural nature and unique geography. We are continuously working to close any gaps, but if a member is in need of specialty services that are not local, our Care Coordination team and Provider Relations teamwork with members to locate an alternate provider, telehealth, or transportation to meet their immediate needs.

In assessing the needs of children and youth served under the Specialized Managed Care for Children and Youth program, we are aware of the specific regional, local, and specialty provider access to care challenges, and are well-positioned to proactively identify and respond to likely gaps and solutions to make sure member needs are met. For example, we recently contracted with River Park Hospital, a behavioral health facility located in Cabell County, which offers inpatient and psychiatric residential treatment facility services. Since behavioral health benefits were migrated to the MCOs in July 2015, River Park has declined to contract with us, due to reimbursement rates. For the last several years, Aetna has continued to work closely with River Park on a case-by-case basis to make sure our members received needed services. As a result of our efforts to establish and maintain this relationship, we were able to reach an agreement for River Park to join Aetna's network. We are also in the process of contracting with Neurological Associates, a large neurosurgery and orthopedic surgery practice in

Kanawha County, which has historically declined to contract with West Virginia Medicaid MCOs. Due to a provider shortage, Aetna has worked collaboratively with Neurological Associates on a case-by-case basis. By leveraging this longstanding relationship, we were able to identify and negotiate a contract with Neurological Associates, utilizing our alternative payment model (APM).

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. We currently have Care Connection teams (CCT) co-located with providers in every region of the state. Our CCTs are comprised of Care Coordination staff that live and work in their assigned regions, and have established productive working relationship with the Department, BCF, juvenile justices, Bureau for Medical Services (BMS) and Bureau for Behavioral Health (BBH). CCTs have also built relationships with provider and community service agencies, to support smooth implementation of individual care plans, including identifying and resolving potential gaps in network accessibility.

We continually assess our network's ability to meet future projections of member needs. To address the unique needs of children, youth, and families under this program, we will leverage and expand on our current assessment tools, and will include the following methods:

- Evaluating current population demographics and consider projected population demographic needs, anticipating cultural and health disparities as an integral part of our annual network monitoring plan and Quality Management/Utilization Management Committee meeting process
- Inviting provider participation and input on future network needs through our Member Advisory Committees, participation in provider association meetings including the Primary Care Association
- Developing opportunities for participation and feedback through the Governance Roundtable model, 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
- Obtaining 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
- Inviting provider participation in a variety of educational forums and webinars to share ideas, questions, and concerns, as well as future network needs/projections
- Constantly seeking feedback, suggestions, and innovative ideas from providers to help offer better access and increase member convenience. This includes review of provider satisfaction results.
- Identifying network needs: The Provider Relations team is crucial in identifying network needs to ensure timely access for members. Upon referral from the integrated care team or other community organizations, they conduct research and outreach to providers to mitigate any potential gaps in care.
- Utilizing member and provider referrals in adding providers requested
- Utilizing annual monitoring, which triggers recruitment action as we review GeoAccess reports

Since 2016, Aetna has hosted Regional Provider Forums at six locations across the state. Aetna is currently the only West Virginia MCO to host Regional Provider Forums, which offer West Virginia providers an opportunity to receive updated training, learn about new initiatives, and discuss emerging issues occurring at the local level. These forums have helped Aetna to identify opportunities for improvements to our prior authorization and claims processes and have also helped us secure new provider contracts.

Our network development approach is designed to meet all contract requirements, including access standards, appointment times, after-hours availability, type and number of facilities, and ancillary, behavioral health, and vision providers, including essential and specialty providers. We successfully manage our networks for high-quality, culturally diverse, credentialed, and physically accessible provider groups to increase access and choice. When we identify an essential provider or specialty provider deficiency, we utilize a variety of strategies to increase provider capacity through our comprehensive approach to provider recruitment. These strategies, as detailed elsewhere in this section, include but are not limited to, APMs, use of single-case agreements, leveraging border state providers, and telemedicine/telehealth. When necessary and appropriate, we may request an exception, as outlined in **Model Service Provider Agreement Section 3.1.2.1**

Strategies to Increase Provider Capacity and Meet Needs in Gap Areas

ND002	The Vendor should establish a statewide provider network that is accessible to children and their caregiver(s).	The Vendor should provide a detailed description of how it will meet this specification.
ND003	The Vendor should establish a statewide provider network that incorporates evidence-based best practices and interventions.	The Vendor should provide a detailed description of how it will meet this specification.
ND004	The Vendor should establish a statewide provider network that provides for continuous communication with stakeholders.	The Vendor should provide a detailed description of how it will meet this specification.
ND005	The Vendor should establish a statewide provider network that has capacity in rural areas.	The Vendor should provide a detailed description of how it will meet this specification.
ND006	The Vendor should establish a statewide provider network that has capacity across specialty lines of physical health and behavioral health.	The Vendor should provide a detailed description of how it will meet this specification.
ND009	The Vendor should take action if notified of inappropriate wait times before a member is seen by a provider.	The Vendor should describe its standards for member wait times.
ND011	The Vendor should provide monthly reports to the Department on underserved areas of the State where the Vendor believes additional socially necessary services (SNS) providers should be permitted to enroll to address a gap in care.	The Vendor should describe how it will meet this specification.
ND012	The Vendor, and/or any benefits management subcontractor(s), should monitor and evaluate ongoing access to services, including, but not limited to, the following:	The Vendor should provide a detailed description of the methods it will use to meet this specification.
ND013	Time/distance	See the parent specification.
ND014	Appointment timeliness, by provider type	See the parent specification.
ND015	The Vendor should ensure member access to covered services in areas where the provider network standards do not require a specialist.	The Vendor should describe how it will meet this specification.
ND032	The Vendor should establish and implement guidelines for which specialists will be able to serve as a primary care provider (PCP) for applicable populations, including, but not limited to:	1) The Vendor should provide proposed guidelines. 2) The Vendor should describe its proposed processes to meet these specifications.
ND033	The circumstances and process under which a member may select a specialist as his/her primary care provider (PCP)	See the parent specification.
ND034	Any managed care organization (MCO) approvals required	See the parent specification.
ND035	Any restrictions on the types of specialists that can serve as primary care providers (PCPs) for foster care members or other members with complex needs	See the parent specification.

We are continually enhancing our network to expand the number, scope, and types of practitioners, to meet the unique care needs of our members, including geographic distribution and specialty providers. Our network solutions and approaches to a provider delivery system for West Virginia children, youth, and families involved in foster care and adoption assistance are built around the following four principles:

- **Maximizing member choice**: We understand that member choice is particularly important to meeting the unique needs of West Virginia's children and families, and continually work to offer members options when selecting providers for their health care including location, gender, quality, experience, availability, cultural competency, and clinical preparation.
- **Easily accessible services:** We have ongoing processes to monitor our network and identify innovative solutions to provide health care services that are locally available and convenient to access, taking into consideration how our West Virginia children and family members access services and how providers manage member care. Examples of solutions include the following: offering financial incentives to encourage providers to expand services and hours and implement evidence-based practices such as trauma-informed care (TIC), assistance in identifying and implementing accommodations to support member accessibility needs, and the use of telehealth. **[ND002]**
- **High-quality care**: Through our network contracting strategies, provider training, and coordination with internal departments, we have developed and will continue to assess mechanisms to support accountability and transparency against quality of care outcomes. We address evidence-based best practices as part of our monthly new provider training, and quarterly ongoing provider training, and monitor provider performance through our quality program. Additional strategies that may be used include aligning financial incentives and APMs with implementation of innovative care models to support system transformation and increase positive care outcomes in a cost-effective manner. **[ND003]**
- **Member-focused provider relations**: Assisting our providers in implementing new care models, which support integration and seamless care coordination with physical specialists, behavioral health and substance use disorder providers, and SNS providers is a critical component to the effectiveness of the West Virginia model and improved member outcomes. Aetna, through our ongoing training and engagement initiatives, and collaborative relationships with both providers and stakeholders, will work to identify and develop processes and mechanisms to support continuous communication in furtherance of improved member care and quality outcomes. **[ND004]**

We use the following strategies to improve provider capacity and address identified network gaps:

- **Innovative provider collaborations and agreements:** Aetna is currently contracted with several foster care service providers, including KVC, Necco, and Children's Home Society. Additionally, we are contracted with several providers of Safe at Home services and other wraparound services within the state. Our care coordinators coordinate with all these providers for kids at risk, who have not yet been removed by child protective services and need more intensive services. We are fully committed to contracting and collaborating with all the other organizations, including co-location of staff in provider offices throughout the state. We are also continuing to explore and develop creative solutions, contracting strategies, and other opportunities that will arise from the pending Children with Serious Emotional Disorder Waiver (CSEDW) and changes coming under the Families First legislation.

Aetna is committed to improving the lives of West Virginia's children at risk and has provided grants to KVC, Mission WV, the Charleston Children's Advocacy Center, Florence Crittenton Services, and the Children's Home Society, to support their efforts in meeting the needs of the children and families they serve.

- **Recruitment of out-of-network providers:** To proactively provide consistent access to services and avoid gaps in care, we recruit out-of-network providers with whom we have authorized care or

executed a single-case agreement (SCA). We assess use of out-of-network services routinely to verify that our network contains adequate numbers and types of providers and use this information to evaluate recruitment opportunities.

- **Collaboration with child welfare organizations:** Aetna is also exploring opportunities to partner and collaborate with regional child welfare organizations in a way that positively disrupts the current status quo of child welfare. We are committed to finding creative solutions to bring health and safety back to families and communities and meeting the complex needs of these children so they can safely remain in their communities.
- **Recruitment of providers through stakeholder identification:** Members, families, and advocates are highly successful in identifying potential providers in the community. Our Network team, through participation in the Governance Roundtables and coordination with regionally located CCTs, will work to engage and recruit those providers identified through these community-based relationships into the managed Medicaid network.
- **Recruitment of providers through large contracted practices:** We leverage our relationships with large in-network practices, to help identify, recruit and contract with small practices and solo practitioners that are referring patients to the large practice but are not yet a part of Aetna's contracted network.
- **School-based clinics:** Continue to contract and collaborate with school-based clinics, which serve high rates of children in the foster care system and/or residing with extended family members, such as grandparents.
- **Community clinics and fairs:** Aetna routinely partners with providers to offer community health clinics and fairs, to improve access to wellness visits and other necessary services.

> Aetna employees are dedicated to serving West Virginia and improving the lives of our members. Amber Rucker, manager of network relations, helped to facilitate a health fair that was held in collaboration with the Clay County Middle School's on-campus, school-based health office. Through the clinic, students who were Aetna Medicaid members were able to schedule and receive a well-child visit at the school. After their appointment, Amber talked to the children about a variety of health topics, such as nutrition and dental care, as well as factors impacting health including if they received three meals a day, inquired about any issues at home, and their family setting. The children were also given a gift bag that included a toothbrush, blanket, school kit and $25 gift certificate. Seven of the 12 children served during the clinic reported they were not living with their parents, with most of the seven having been placed with family members. Some of the children reported that they no longer have contact with their parents. Aetna will continue to meet members where they are to determine what we can do to support them

- **Expansion of access through telemedicine:** In addition to the previously stated strategies to improve provider capacity, we will utilize 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 including physicians, physician assistants, advance practice registered nurses (APRN), nurse practitioners (NP), APRN certified nurse midwives, APRN clinical nurse specialists, licensed psychologists (LP), and licensed clinical social workers (LCSW). We will also support the use of telehealth by our in-network providers using their own approved technology or will be given the opportunity to utilize a plan-sponsored technology platform to enhance access to their members via telehealth. Alternatively, if indicated, preferred West Virginia-licensed vendor partner telehealth practitioners will be utilized, 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, thereby improving available quality and continuity of care. Moreover, available telehealth services promote the integration of physical and behavioral health care and enable provider-to-provider consultation between PCPs and specialists.

[ND005, ND011] Capacity in Rural and Underserved Areas

Enhancing access to health care for members in rural and other areas with insufficient accessibility is an important part of how Aetna meets members where they are. This essential aspect of our commitment to provide personalized care is founded in our local, member-centered approach that focuses on individual's holistic health needs by providing access to and delivery of cost-effective health care services. The rural nature and unique geography of West Virginia creates opportunities for improving access to services for our members who may have a geographic obstacle obtaining needed care.

Aetna recognizes a tailored approach is needed to improve member access in non-urban and underserved areas. For this reason, we have implemented and continue to fine-tune our **effective West Virginia strategy** that leverages our experienced West Virginia Provider Relations and Care Coordination Teams (CCTs), who have grown up in and now work with these communities and are supported with our extensive experience nationwide. These vested staff members will be intimately familiar with the existence and needs for new providers or provider types, and they will have solid relationships with the provider community, therefore, able to promote the need for more providers. We continuously monitor providers leaving and entering rural areas to enhance our provider network, especially in hard-to-reach areas. Our primary goal is being member-focused to help our diverse members achieve their health ambitions. We have learned that the most effective way to increase access is not through one effort, but a combination of efforts. This includes, but is not limited to, telemedicine, contracting solutions, member benefits, and community resources including the collaborative Governance Roundtable sessions.

We have a demonstrated ability to respond to network obstacles. Through our relationships with providers, members, and their families, and other key stakeholders, we will continue our work to improve choice and access in these communities. For example, in the western part of the state, we identified an area where, due to the rural nature and geography of the region, members were significantly closer to a medical center in Pikeville, Kentucky, than to providers in West Virginia. Through Aetna Better Health® of Kentucky, we were able to work with the medical center in Kentucky to improve access to necessary services for our members in the western region of West Virginia.

Aetna also understand the significant adverse impact of opioid use on West Virginia's children, youth, and families, and the importance of improving access to services in rural areas, including the need for more medication-assisted treatment (MAT) providers. We currently have value-based contract arrangements with providers such as **University Physicians and Surgeons** (also known as 'Marshall Marshall') and Charleston Area Medical Center Clinically Integrated Network and are continuing to explore opportunities to expand with other providers. We will leverage these established provider relationships to facilitate referrals and access to services for parents of children and youth receiving services in the program, to better achieve the goal of maintaining family stability and improve children's ability to safely remain in their communities.

Personalized Approach Leads to Enhanced Partnership with Chesapeake Healthcare Center

An Aetna representative visited Chesapeake Healthcare Center on February 6, 2019 to introduce herself to the chief executive officer (CEO) of the facility and develop a relationship with the CEO and her staff. While there she answered prior authorization and benefit questions with the CEO regarding Aetna members. As a result of this personalized outreach, the Aetna representative was invited to attend the grand opening of the center on March 13, 2019.

While at the ribbon-cutting ceremony, the Aetna representative met and spoke with West Virginia Attorney General, Patrick Morrisey. She told Attorney General Morrisey she was representing Aetna and he expressed that he was extremely impressed that an MCO would show their dedication to providers by attending the provider's celebration. He also asked if Aetna would pay for the osteopathic manipulation that Chesapeake Healthcare Center would be using as an alternative to prescribing opioids. The Aetna representative told him with confidence that osteopathic manipulation was a covered service with Aetna!

The Aetna representative's attendance at this event further solidified Aetna's relationship with Chesapeake Healthcare Center and is an example of our dedication to the success of West Virginia's providers.

To the extent required, Aetna will make all reasonable effort to contract with West Virginia SNS providers. Additionally, Aetna will provide the Department with a monthly report on underserved areas of the state that identifies opportunities where socially necessary providers should be permitted to enroll to address a gap in care. As described previously, our Provider Network department regularly monitors the network to identify gaps and opportunities to improve access to providers. The network development director will meet at least monthly with the SOC staff and Care Management staff to review information from across the plan including stakeholder feedback, grievance and appeals, and utilization data, to identify gaps or needs in rural and underserved areas of the state, and assess whether such gaps may be appropriately met through the use of SNS providers. We will collaborate with the Department to develop assessment criteria for reviewing potential SNS providers, which may include such elements as the following:

- Verifying the SNS provider would be acting within the scope of applicable license, certification, or other requirements
- Confirming the SNS provider has the capacity to render such services timely
- Enrolled with the State for SNS

The provider relations director will be responsible for submitting the required monthly report, along with information regarding any SNS providers Aetna believes should be permitted to enroll to address an identified gap in care. **[ND011]**

[ND006] Capacity Across Specialty Lines of Physical and Behavioral Health

Aetna will, based on Department provider access to care requirements, ensure access to the full range of specialty and facility services providers for members in applicable populations with complex needs. Aetna has consistently met requirements for adequacy for the last 23 years. Our experience serving at-risk youth through our Medicaid plans has taught us about the importance in offering our members as robust a network as possible, to support delivery of person-centered, culturally sensitive care. We continually assess our network to confirm our specialist network continues to meet the needs of the complex needs population, and will apply these practices to meet the needs of the foster youth and adoption assistance population, including access to an array of pediatric specialists, behavioral health and substance use providers, and other SNS providers.

Our network currently meets 100 percent of the access requirements for psychologists and psychiatrist, and we continue to add new providers, including River Parks and Logan-Mingo. Logan-Mingo is in the

state's southern region and is the only provider of behavioral health/medically assisted treatment in the area. We have also contracted with all the CSEDW groups, in order to prepare for this highly vulnerable population.

Aetna is uniquely positioned to utilize our experience and knowledge of the state, regional, and local challenges. 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 provider, children's systems, and Specialized Managed Care for Children and Youth members.

[ND015]
Access to Covered Services where the Provider Network Standards Do Not Require a Specialist
Aetna's approach to network management is member driven. We continually work to go beyond network standards, to make sure our members have access to covered services that are necessary to meet each member's needs. Through our experience working with high-needs children and youth, including those involved in the foster care system and adoption assistance programs, we know the importance of providing access to a wide array of specialist services in a way that maintains the child's connection to local community supports. Our goal is to provide access to all SNS for the children and youth enrolled in this program, and to improve health and quality of life outcomes.

We recognize that certain regions and counties in West Virginia present greater challenges in offering easily accessible services, due to limited or no availability of certain specialty providers in those areas. To make sure members in these regions have access to covered services, we have developed a variety of solutions and initiatives that may be used, dependent on the specific member circumstances and needs.

These solutions include, but are not limited to, the following:

- 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. In many cases, access to border state providers not only improves access to specialty providers, but also reduces member travel time because border state providers are located closer to West Virginia members than in-state providers. We will continue to collaborate with these plans to assess and identify opportunities to improve service delivery for children and youth in the foster care and adoption assistance program. Aetna Better Health of West Virginia currently has letters of agreement or contracts with a variety of border-state providers including, but not limited to, 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
- Use of a single-case agreement (SCA), if a non-contract specialist is available in or near the member's location
- Facilitating access through telemedicine and telehealth, as permitted by State laws and regulations
- Use of border state and other out-of-state providers, in collaboration with BCF and the legal guardians or fictive kin
- We have established and are continuing to improve access to MAT services through contracts with West Virginia University Health System and Marshall, by sponsoring MAT trainings, and through efforts to connect our activities with the resources available through the University of New Mexico

School of Medicine's Project ECHO® (Extension for Community Healthcare Outcomes) to improve access to MAT services, and to sponsor MAT trainings.

[ND032 – ND035, MR018] Capacity and Assignment of Primary Care Providers

As required by **[MR018]** and the **Model Services Provider Agreement Section 3.2,** Aetna will monitor PCP panels for compliance with BMS' limit of Medicaid members assigned per PCP, for applicable populations.

Aetna has established policies and procedures for monitoring participating PCP panel status and capacity, which includes the following:

- PCP capacity monitoring, including metrics to maintain compliance with the limit of 2,000 members per each PCP
- PCP notifications of panel size
- Changes in the PCP panel status

We will continue to furnish each PCP with a report of current assigned members, not later than five business days after the end of each month, unless the PCP agreed to an alternative schedule. Additionally, we will continue to make this report available to PCPs through our secure provider portal.

Through the monitoring process described previously, Aetna will continue to make sure Medicaid member caseloads for PCPs in our network do not exceed 2,000 members per PCP. Our monitoring process includes monitoring PCP caseloads and member access to PCPs through claims and service utilization data. We also use the PCP monitoring results to inform our network development and recruitment activities to support identification of potential future needs and proactively work to expand the network and ensure ongoing timely member access to PCPs services. We have processes that address establishing PCP ratios in circumstances involving PCP teams, such as teaching facilities where residents and physicians' assistants serve as a PCP, under the supervision of an attending physician.

If we identify, or receive notification that the Department has identified, a PCP total Medicaid member caseload exceeds the 2,000 Medicaid member limit, we will analyze the assigned membership and either reduce the caseload for the PCP or seek an exception. Aetna will work with the PCP and the Department to obtain consent for any exceptions, and will request for exceptions as required by the Department, including the following:

- Continuation of established care
- Assignment of a family unit
- Availability of mid-level clinicians in the practice that effectively expand the capacity of the physician
- Inadequate numbers of providers in the geographic area

PCP Assignment and Member Selection

Aetna has, and will maintain, written policies and procedures for assigning each of its members to a PCP within five calendar days of the member becoming enrolled with Aetna. We assist members with PCP selection through a variety of outreach strategies, including providing information in the member welcome packet and member handbook. Our Member Services staff are trained to assist members in identifying available PCPs, including identification of special or unique member needs, such as cultural preferences. To further assist our members in selecting a PCP, we are in the process of enhancing provider-specific information that will be available in our provider directory. The additional information currently being assessed and developed includes identifying providers that have adopted a trauma-informed care (TIC) model and a Provider Quality Rating System.

Our processes for assigning PCPs to members includes consideration of key known facts regarding each individual member and their family. Factors considered include, but are not limited to, the following:

- Current provider relationships
- Claims history
- Age
- Input from the Department caseworker
- Disabling conditions or chronic illnesses
- Child's placement (physical location)

Aetna understands the transient experience many foster children face, and the importance of maintaining relationships with an established provider whenever possible. While we utilize the stated factors in assigning PCPs, we will review other available information and coordinate with other involved agencies, including BCF, juvenile justices, and local case workers, to prioritize maintaining established relationships and community connections.

Once we assign a PCP to a member, we send written notice to the member or their representative, including the PCP's name, address, and office telephone number. The notice also includes information on how the member can select a new PCP, as well as how to access assistance via the member website and our Member Services department. The notice also includes information for members with disabling conditions, chronic illnesses, or who are Supplemental Security Income-eligible, that they may choose a specialist physician to serve as their PCP, provided the specialist physician agrees to perform all PCP duties required in the contract and that such duties are within the scope of the specialist's license.

Aetna has designated the following providers a PCP, as appropriate:

- Certified nurse midwives
- Advanced practice nurses (nurse practitioners)
- Physician assistants
- Physicians with the following specialties:
  - General practice
  - Family practice
  - Internal medicine
  - OB/GYN
  - Pediatrics

In addition to providing members with information on PCP selection at the time of initial enrollment with Aetna, Aetna may maintain written policies and procedures regarding Medicaid members' selection or assignment to a new PCP when such a change is requested by the member, when a PCP is terminated from the MCO, or when a PCP change is ordered as part of the resolution to a formal grievance proceeding. In cases where a PCP has been terminated, we allow affected members to select other PCPs or make a reassignment within 15 calendar days of the termination effective date.

Members may initiate a PCP change at any time, for any reason, and may make such a request either in writing or over the phone. Aetna may initiate a PCP change for a Medicaid member under the following circumstances:

- The member moves or there is a change in the placement of a child in foster care and the assigned PCP location no longer meets the access standards
- The member requires specialized care for an acute or chronic condition, and the member and MCO agree that reassignment to a different PCP is in the member's interest
- The member's PCP ceases to participate in the MCO's network
- The member's behavior toward the PCP is disruptive, and the PCP has made all reasonable efforts, or attempts within 90 calendar days, to accommodate the member
- The member has taken legal actions against the PCP

Guidelines for Specialists Serving as PCPs

In addition to the provider types identified previously, Aetna establishes and implements guidelines regarding which specialists will be able to serve as a PCP for applicable populations under the Specialized Managed Care for Children and Youth program. Aetna will establish and implement guidelines and processes that address when specialists will be able to serve as PCPs for foster care and adoption assistance members. Any member, or their parent or legal guardian, or a provider may request that a specialist be assigned as a member's PCP. 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. **[ND032, ND033]**

Aetna will send the identified specialist a notice informing the specialist of the member request that the specialist serves as their PCP and 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 (EPSDT) services
- Identification of any PCP provider training the specialist may be required to complete

The PCP will also 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. **[ND034, ND035]**

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, and as required by **[MR017],** Aetna will monitor the specialist's provision of PCP services, through the mechanisms generally used to monitor PCP services, including through monitoring of data through the West Virginia Health Information Network, claims data, and record reviews.

[ND009, ND012 – ND014]
Compliance with Travel Times/Distance and Appointment Timeliness Requirements

As described previously, Aetna's statewide, comprehensive network is designed to comply with State availability and access standards. We continuously monitor our network to identify network gaps and opportunities to improve out network to provide our member with choice and timely access to high-quality providers. Aetna will amend its network accessibility standards for the Specialized Managed Care for Children and Youth program, consistent with Department requirements, and will implement changes to such network standards, including county- and region-specific requirements applicable to Department-identified, frequently used specialists.

As a component of our current network analysis and recruitment strategies, we regularly review reports of Medicaid-enrolled providers and outreach to any non-contracted providers. Through this process, Aetna has, and will continue to maintain, a network that mirrors the Medicaid-eligible providers, to the extent possible. As a result, we will be well-positioned to proactively address network availability and accessibility changes. In addition to ongoing efforts to contract with eligible Medicaid providers, we will leverage our deep knowledge and experience working with local communities and providers across the

state, to proactively identify services needs and gaps, and develop creative solutions for making sure members in the Specialized Managed Care for Children and Youth program have access to all necessary covered services in a timely manner. Specific strategies that we will use including collaboration with KEPRO, SNS providers, and out-of-network providers. As described previously, we will also leverage border-state providers, such as Big Sandy Health Care, Pikesville Medical Center, and Cincinnati Children's Hospital, through the Aetna Medicaid organization's health plans in bordering states.

Aetna's network development director is responsible for identifying network gaps and opportunities for improving and monitoring the network of providers to make sure identified needs are promptly acted upon. SOC staff will meet routinely with the network development director and provider relations director to review network adequacy data, identify opportunities for network enhancement and growth, and review the status of the recruitment plan.

Aetna will implement steps to monitor provider compliance with required time, distance, and appointment wait time standards under the Specialized Managed Care for Children and Youth program. 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.

Aetna monitors its providers regularly to determine compliance with these requirements, including monitoring accessibility reports, member concerns, conducting secret shopper calls, 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. Standards for wait times and appointments, disability access, competency, expertise, cultural sensitivity, and hours of operation are communicated through the provider manual, provider forums, during site visits, and in training documents. In addition to our standard monitoring activities, we will monitor compliance with Specialized Managed Care for Children and Youth program requirements through our integrated SOC model to support members and providers.

[ND009] Supporting Members and Providers in Scheduling Appointments

Aetna uses our integrated SOC model to support members and providers with improving the outcome of their health. Children and youth served under this program will all have an assigned Aetna care coordinator. The assigned care coordinator will be responsible for supporting members, their parents (including foster and adoptive parents), fictive kin, legal guardians, and providers with access to necessary services, including transitions in care and scheduling appointments when needed. The care coordinators will work with the Member Services and Provider Relations teams to address unique needs or access to services when specific challenges are identified. For example, the care coordinators will outreach to the Provider Relations team for assistance in finding providers who are available to provide specialized services. Member Services staff are also available to directly assist members in obtaining the appointments to further support member access to timely services.

Because of our intensive monitoring and outreach activities with providers to ensure compliance, we actively support our PCPs in the scheduling of appointments for cardiologists, dermatologists, endocrinologists, licensed mental health specialists, neurologists, OB/GYNs, orthopedists, psychiatrists, and pulmonologists. We also recognize that providers benefit from additional support, which includes call center support to identify and contact specialists accepting new members and help schedule appointments, and locally embedded provider relations support, care management outreach, and field-based community health workers. Our Provider Relations meet regularly with Care Management and

Member Services staff to respond to both individual needs and to identify trends for targeted network development.

Strategies to Monitor Compliance with Provider Network Standards

ND002	The Vendor should establish a statewide provider network that is accessible to children and their caregiver(s).	The Vendor should provide a detailed description of how it will meet this specification.
ND008	The Vendor should measure and regularly verify network compliance standards.	The Vendor should describe its methods and how often it will verify network compliance standards.

Aetna actively monitors our provider network, including **all provider types**, for compliance with the provider network standards in order to identify and mitigate network accessibility issues or provider noncompliance with policies and procedures that affect member's reasonable access to care delivery.

[ND008] Routine Monitoring to Verify Network Compliance Standards

We understand the unique needs of the children and youth involved in West Virginia's foster care and adoption assistance program, and our monitoring will include providers such as MAT, substance use, and behavioral health specialists. We continually evaluate reports, including GeoAccess 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. GeoAccess reports are generated annually and reviewed by health plan and network leadership. Network staff will formulate a plan to close any identified gaps based on data or member feedback. We use our provider data warehouse to create a suite of monitoring tools and reports to identify network gaps.

> Mingo County has limited behavioral health providers, and many of our members in that area were receiving their behavioral health services through the only available provider, who was not contracted. After an extended recruitment effort, the provider has joined Aetna's network and has added an additional PCP to their practice to better support coordination of care.

Aetna continually assesses our network and make sure the network evolves to proactively meet identified needs. To assess and identify the needs of members in the foster care and adoption assistance programs, we will utilize a variety of internal reports, as well as data and feedback from our SOC staff and other internal departments, the Governance Roundtable members, community organizations, and other system partners. Our strategy for monitoring provider network compliance uses a holistic approach, to obtain a comprehensive view of system needs and potential network gaps, and to identify network development opportunities to support system transformation. It is imperative that the network not only achieve adequacy, but also be user friendly to our members in as close to real time as possible. Data and reports are reviewed on a daily, weekly, monthly, quarterly, and ad hoc basis, and detailed in **Table 5.1-2.**

Table 5.1-2: Network Monitoring Data and Reports

Reporting and Monitoring Activity	Data or Report Description
GeoAccess reports	We review GeoAccess reports 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
Network Adequacy	We review utilization data including prevalent conditions, SCAs, provider referral issues (availability of specialties), providers-gained-and-lost report,

Reporting and Monitoring Activity	Data or Report Description
	and unplanned network exit report to confirm sufficiency of the type and number of providers
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.
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
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
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
Interdepartmental Reporting	We have implemented a formal interdepartmental process that allows the Provider Relations department to collect, trend, and respond to network needs our staff may identify outside of the other data and reporting mechanisms, such as challenges identified by our care coordinators or informal discussions with community organizations, including access or capacity concerns related to special needs
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 potential availability or accessibility issues, perform root-cause analysis, and develop corrective action plans, if necessary
Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey	We review and analyze CAHPS survey results and create action plans for opportunities for improvement identified through the survey

In addition to the listed data sources, we will utilize feedback from stakeholders, including feedback and insight obtained through the Governance Roundtables and Regional Provider Forums. When we identify a network gap or opportunity for enhancement, our Provider Relations team formulates a plan to improve the network. The results of our monitoring efforts are reviewed by our Service Improvement Committee, which also monitors any action plans to make sure identified gaps are addressed.

Our goal is to maintain a comprehensive network of providers that demonstrate a pattern of practice that understands the unique needs of West Virginia's children and youth in foster care and adoption assistance programs. We continually work to offer our members the highest quality providers near where they live, work, and play. Our success is based on our demonstrated commitment to engage and collaborate with key stakeholders, community organizations, providers, members, and their families.

[ND002] Strategies to Meet Member Multilingual, Multicultural, and Disability Needs

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 comprehensive plan includes strategies designed to assist our staff, providers, and subcontractors with integrating cultural and linguistic competence and health literacy into every aspect of our organization. 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. Cultural competency is part of the fabric of our organization, and it should infuse every aspect of member interaction and local, community-based care delivery.

To deliver quality health care services, it is necessary to understand the needs of our members, particularly their cultural and linguistic needs. This understanding enables us to provide, through our provider partners, culturally competent services and to assess where disparities in health care outcomes exist. This awareness is particularly critical to children and youth receiving services under the Specialized Managed Care for Children and Youth program, who have experienced increased rates of adverse childhood events, trauma, and out-of-home placements. All our contracted providers, including behavioral health, receive cultural competency training at orientation and on an ongoing basis, 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
- SDOH and TIC
- 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

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.

Meeting Member Linguistic and Cultural Needs

Our network will deliver care in a culturally competent manner based on the prevalence of languages (including American Sign Language) and ethnic groups. Based on our experience working with children involved in foster care, adoption assistance, juvenile justice, and at other at-risk youth, we understand the need to recognize cultural needs as including each child's unique family culture, as well as the impact of trauma and ACEs. 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, youth culture, and family dynamics. Aetna is, and will continue, to implement additional provider competencies across the network, including a formalized Trauma Informed Care Recognition Model and supporting providers in completing Training in Adoption Competency (TAC) through Center for Adoption Support and Education (C.A.S.E.). These programs are

both designed in increase provider competency and awareness in how services are delivered to at-risk youth and will further support recognition and response to unique needs of this population. Aetna will provide incentives to providers related to adopting TIC and TAC. Additionally, our provider directory will include flags to help members identify providers with these enhanced competencies.

In addition to monitoring provider adoption of TIC and TAC, we will continue to monitor and evaluate our network's compliance with meeting cultural and linguistic needs. We obtain stakeholder feedback on network composition, operations, and quality improvement initiatives. We evaluate current population demographics and consider projected population demographic needs, anticipating cultural and health disparities as an integral part of our annual network monitoring plan and Quality Management Oversight Committee meeting process. Standards for competency, expertise, and cultural sensitivity are communicated through the provider manual, during site visits, and in training documents. Aetna's provider directories indicate the provider's cultural and linguistic capabilities including languages spoken by provider or skilled medical interpreters at the practitioner's office, such as staff that speak in Spanish or American Sign Language, as well as gender, board certification, and accessibility for persons with disabilities.

Meeting Member Disability Needs (Access, Accommodations, Equipment)

Aetna employs several methods to determine a provider's compliance with 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 interest in identifying providers with key accessibility to care opportunities such as providing oversized exam tables, specialized staff assistance for members with needed care requirements, or materials in braille to serve the varied health care needs of our members.

Aetna assesses a provider's capability during onsite visits, through credentialing and re-credentialing processes, monitoring member complaints, and 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 patient quality of care are reported, investigated, and when necessary, corrective action plans and enforcements are put in place to address the concern.

Strategies for Recruitment and Retention

ND010	The Vendor should continue to build upon the provider network and credential new providers across the State for applicable populations.	The Vendor should provide a detailed description of how it will meet this specification, including, but not limited to, a general recruitment plan with mechanisms to build network access.
ND016	The Vendor should recruit specialty care providers and hospitals, for applicable populations.	The Vendor should describe how it will meet this specification.
ND017	The Vendor should offer crisis response to children and their caregiver(s), as well as families at risk, to the extent that these services are covered under the Bureau for Medical Services (BMS) Children with Serious Emotional Disturbance Waiver (CSEDW).	The Vendor should describe how it will meet this specification. Note: Although not all populations in the specification are included in the scope for this procurement, the Vendor should demonstrate an understanding of the populations listed. For crisis services outside the Children with Serious Emotional Disturbance Waiver (CSEDW), the Department may carve in these services at a later date.
ND018	The Vendor should develop and implement a recruitment strategy for the following providers:	The Vendor should describe how it will meet this specification.
ND019	Federally Qualified Health Centers (FQHCs)	See the parent specification.

ND020	Rural Health Clinics (RHCs)	See the parent specification.
ND021	If the Vendor elects not to contract with Federally Qualified Health Centers (FQHCs) and/or Rural Health Clinics (RHCs), the Vendor should develop and implement a strategy to ensure that members in applicable populations can access these providers.	The Vendor should describe how it will meet this specification.
ND022	The Vendor should develop and implement a recruitment strategy for the following publicly supported providers:	The Vendor should describe how it will meet this specification.
ND023	Local Health Departments	See the parent specification.
ND024	Critical Access Hospitals	See the parent specification.
ND025	Primary Care Centers	See the parent specification.
ND026	School-Based Health Centers (SBHCs)	See the parent specification.
ND027	Right from the Start (RFTS) Providers	See the parent specification.
ND028	Bureau for Public Health (BPH) Laboratories	See the parent specification.
ND029	Children with Special Health Care Needs (CSHCN) Program	See the parent specification.
ND030	If the Vendor elects not to contract with the publicly supported providers, the Vendor should develop and implement a strategy to ensure all members have access to services.	The Vendor should describe how it will meet this specification.
ND031	The Vendor should develop and implement recruitment strategies for new or modified provider types.	The Vendor should describe how it will meet this specification.

Our goal and strategy are to build a comprehensive county- and region-specific, experienced, and high-quality network that offers provider selection, preserves existing community referral patterns, and ensures access to care for the underserved. When possible, Aetna is committed to using local providers; however, when local providers are not available, we will draw on our national expertise to deploy innovative alternative models, such as telemedicine services, innovative contracting strategies, and leveraging provider relationships through Aetna Medicaid organization health plans. We will continue to use our comprehensive contracting methodology, APMs, technology/telehealth services, and an ongoing level of engagement and diligence to continuously recruit providers and scale our provider network to meet the needs of our West Virginia members. We also employ enhanced recruiting and retention methods based on our level of engagement with providers.

[ND010] Continuous Network Development

Aetna's Provider Relations team is crucial in identifying needs to expand the network to increase timely availability for members across all provider types. Upon notification of a provider need, we immediately initiate recruitment efforts. These notifications may be received from a variety of sources, such as referrals from the integrated care team/medical management or other community agencies. Once notified, the Network team conducts outreach to providers in that area or specialty.

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. As depicted in **Figure 5.1-1,** our recruitment strategies are customized to different provider types.

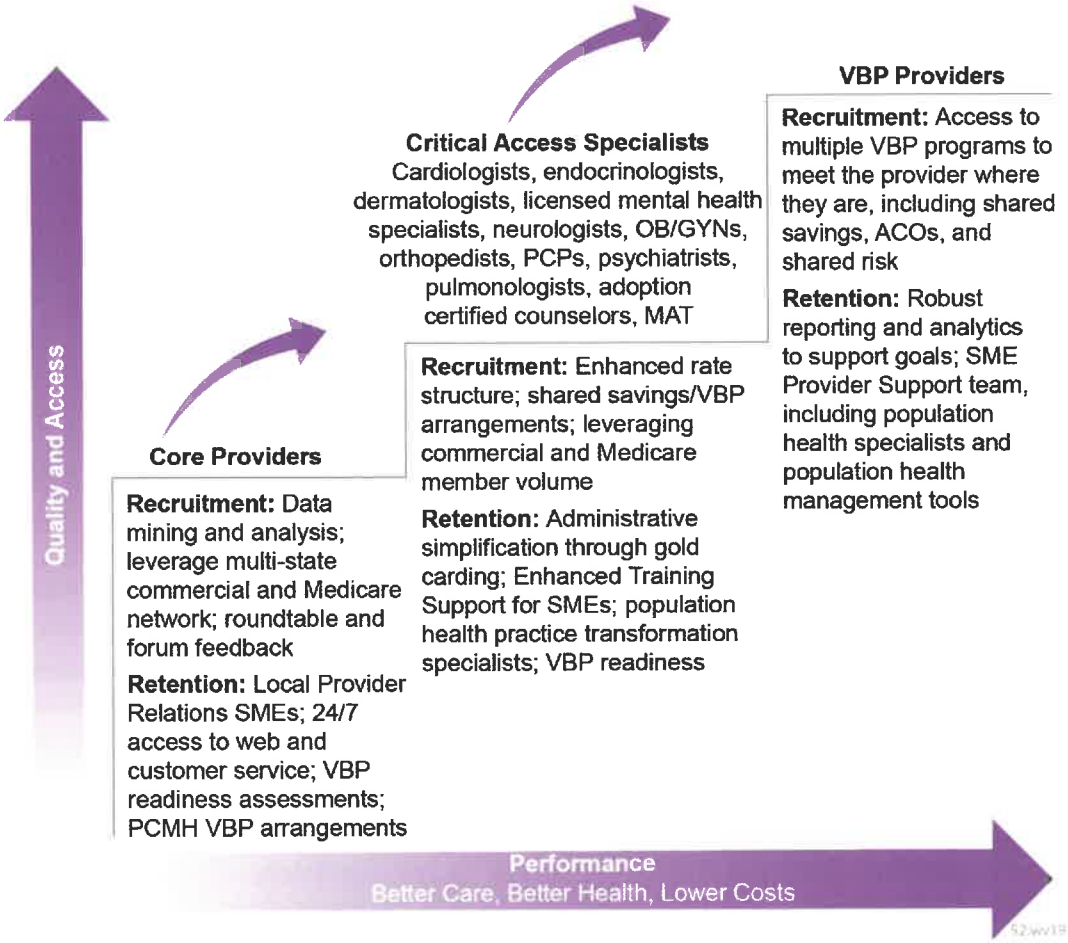

Figure 5.1-1: Recruitment and Retention Strategies by Provider Type
Aetna's provider recruitment and retention strategies are customized based on provider type.

Examples of specific strategies to recruit and retain providers that we will use in addressing the needs of children and youth under this program include the following:

- **Meeting with stakeholder focus groups through the Governance Roundtables to understand the availability and adequacy of care and perceived gaps in services**: We provide flexibility and choice through our community-based provider collaborations, resulting in optimal, compassionate care to members.
- **Enhanced provider competencies:** Aetna is in the process of implementing two enhanced provider competency programs that are specifically targeted to improve the delivery of services to at risk children and youth. These include a Trauma Informed Care Recognition Model and Training in Adoption Competency. As a part of the implementation of these two programs, Aetna will be offering incentives and will include indicators for recognized providers in our provider directory. Aetna has obtained approval to offer continuing education units (CEUs) for clinical providers who participate in TIC training and is in the process of obtaining approval for continuing medical education (CMEs) credits for TIC and is exploring CEU credits for TAC training.
  - **Providing TIC training:** Aetna has collaborated with the National Council on Behavioral Health to assess the impact of trauma on members. **Aetna has trained 85 percent of their staff on trauma-informed principles, with the goal of training 100 percent of staff prior to**

implementation of this contract. We are also working with the provider network in a yearlong collaborative to assess and develop standards for TIC for members.
  - **TAC:** C.A.S.E. has developed training for mental health providers on adoption competency. Their training model includes both a 72-hour in-home and classroom training as well as case consultation component, as well as less intensive 30-hour web-based training. **Aetna will collaborate with C.A.S.E. and our provider network to implement TAC-trained providers throughout the state.**
- **Identifying non-participating providers to improve accessibility:** Our Provider Relations team analyzes our commercial network to identify high-performing providers in addition to providers in existing groups that do not currently serve Medicaid members. We actively recruit these identified providers to join our provider network. Aetna recognizes the importance of developing relationships over time, by demonstrating our good-faith commitment to work with providers in meeting our members' needs. For example, we worked collaboratively with River Park as an out-of-network provider for nearly four years, before they joined our network.
- **Using the integrated care model:** Aetna uses a whole-person, integrated care approach to solve for the fragmented physical and behavioral health and community support systems that, when coordinated for members, leads to better health outcomes.
- **Simplified contracting using streamlined agreements**: Our contracts are fully compliant with State 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.
- **High-touch, personalized contacts:** We use face-to-face 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. Additionally, we work to minimize provider administrative burden and provide ease to access support through the following activities:
  - No requirement to submit paper or electronic referrals for services
  - A dedicated provider call center
  - Technical assistance and training related to Medicaid managed care claims submissions and the technical interfaces providers will have with Aetna
  - Online tools through the provider portal that make it easier for providers to interface with Aetna

A contracted West Virginia pediatric provider practice let us know the process for reporting PCP information on member ID cards would be easier if providers could fax in a request form. Aetna collaborated with the provider to develop a form that the provider completes and has the guardian sign. The provider faxes the completed form to Aetna, so we can update the PCP information. We are currently testing this new process with the pediatric provider and will roll it out as an alternative process to the rest of the network.

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 particular provider into a comprehensive and effective, innovative APM. Many high-quality providers find value-based arrangements an attractive means through which to join a network. 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.

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 (CMHCs), 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.

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 place emphasis on advancing providers through the APM continuum to categories 3 and 4, which include upside gainsharing, downside risk, and condition-specific population-based payments and other incentives. 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 recently added a new shared savings agreement with **University Physicians and Surgeons**.

Our unique approach with these providers increases improvement in the health of West Virginians through innovative, whole-person care, and well-coordinated systems of care addressing medical and non-medical drivers of health. We have collaborated with the provider community to advance the West Virginia health priority of implementing delivery system reforms to improve quality and outcomes and the reduction or elimination of health disparities through our innovative physician incentive plans.

Aetna plans to use the APM arrangements described in **Table 5.1-3**. 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, to work with them, give them support, and help them gain confidence to move to the next level of model for success.

Table 5.1-3: 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. National Committee for Quality Assurance (NCQA) certification is not required.	2A
Incentives for reporting Z codes	Allows providers to progress toward payment for reporting, while providing valuable information regarding a member's SDOH status.	2B
Training in Adoption Competency	Allows providers to demonstrate competency by undergoing training through C.A.S.E.	2B
PCMH with quality incentives	Allows rewarding for performance on specific quality measure targets and infrastructure payments to support transformation, as well as adoption of TIC.	2C
Shared savings arrangements	This all-upside arrangement allows practices to become familiar with the connection between cost and quality	3A

Type of Arrangement	Rationale for Selecting Model	HCP-LAN APM Framework Maturity Level
	performance and allows for sharing of cost savings after quality targets are met.	
Bundled payments	This is an up- and downside arrangement related to bundled payments for services and allows specialists to participate in value-based programming.	3B
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 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.

[ND016] Targeted Recruitment of Specialty Care Providers and Hospitals

Through our experience in developing Medicaid networks for child welfare programs, we understand that while many types of service providers are already included in our comprehensive network, an adequate supply of behavioral management specialists, therapists, child and adolescent psychiatrists, and family and peer support workers are needed. Although we will leverage our current network, we know it is not uncommon for the current providers to not offer the capacity and geo-access necessary to meet the needs of the covered population. Therefore, provider recruitment will be essential as early as possible. Prior to and upon award, Aetna we will complete a GeoAccess review of provider types to determine network needs and to develop contracting solutions. A network of telemedicine and telehealth providers will be a component of our network development plan, to the extent permitted under current West

Virginia laws and regulations. Aetna considers several factors when recruiting network providers for this specialty population, including the following:

- Clinical expertise
- Ability to accept new patients
- Potential for high-volume referrals
- Specialties that best meet member needs
- Geographic location: considering distance, travel time, means of transportation, and access for members with physical disabilities
- Expertise in working with the diverse needs of the Specialized Managed Care for Children and Youth program members

Aetna will also work with current providers of foster care, Safe at Home and other wraparound services, including, but not limited to, providers such as KVC and Necco. We are fully committed to collaborating with other providers serving these children, youth, and their families, including regional child welfare organizations, and other publicly supported providers.

We will also leverage strategies that have been successful in other states. Mercy Care, a Medicaid managed care plan administered by Aetna in Arizona, contracts with specialists using individualized scopes of work to accommodate the unique nature of services. The agreements are tailored to agreed-upon performance and outcome metrics to the specialty provider. For example, Arizona Rapid Response providers are utilized to provide priority clinical evaluations for the Department of Child Safety (DCS) for children in the custody of DCS or under in-home dependency investigations. The Rapid Response provider contracts include scopes of work that are tailored to the services provided, program requirements, and performance metrics, such as completion of evaluations within 24 hours for immediate dispatch and 72 hours for all other Rapid Response referrals, and referral of all eligible children for a full behavioral health assessment. We will use a similar approach to work collaboratively with our West Virginia providers to develop tailored performance metrics.

Expanding our Rural Network of Specialty Providers

Josh (not his real name), a 9-year-old boy, struggled with Generalized Anxiety disorder which was related to constant worry about his mother's health. Josh's mother suffered from a brain tumor and Josh has witnessed his mother experience seizures on multiple occasions. The anxiety that Josh experienced led to issues with school attendance as he did not want to leave his mother home alone as he constantly worried about her safety. In order to assist Josh with managing his anxiety, Josh was enrolled in animal-assisted therapy at a local equine therapy provider and was reacting positively to his treatment. The provider was identified as being out-of-network with Aetna, primarily due to the remote location of Josh's home. The Aetna prior authorization nurse reached out to the Aetna medical director regarding the member's need for continued treatment with his out-of-network provider. This request led to an approval for a benefit exception, which allowed Josh to continue with his much-needed equine therapy and prevented Josh from experiencing any further distress. Following this service approval, the Aetna prior authorization nurse continued to collaborate with Josh's therapist, who soon became an in-network equine therapist with Aetna.

Since 2004, Aetna has had an arrangement with the largest health system in the state, West Virginia University Health System, and our network currently includes 77 acute and behavioral health hospitals throughout West Virginia and the surrounding states. We will continue our monitoring and engagement activities to identify and conduct targeted outreach to non-contracted hospitals. As a part of our recruitment efforts, we will work with hospitals to identify potential APMs to facilitate contracting and support improving health outcomes for this the children and youth in the foster care and adoption assistance program. In addition to continuing to enhance hospital services in the state, Aetna will continue to leverage our relationships with border-state providers through Aetna Medicaid organization

health plans located in all five of West Virginia's border states. Out-of-state hospital providers that we currently utilize include Cincinnati Children's Hospital, University of Kentucky HealthCare, and Winchester Medical Center.

[ND017] Offering Crisis Response Services

Aetna understands the goal of supporting children with SED is by helping to keep them with their families, in their home with an integrated network of care to improve their health and behavioral health outcomes. We will provide families and other caregivers with education on access to all services, and care team members will assist in navigating those processes. Immediate crisis response is critical for all children and families but particularly the SED population. Aetna's team of highly qualified staff will guide families and caregivers through this process, which often begins with a call to the 24/7/365 toll-free behavioral health services line that initiates crisis stabilization services. The call line responders can directly connect to 911 emergency services, which can be dispatched at any time during the conversation if needed. Staff quickly ask questions that assess the current situation and help stratify risk levels to determine the best level of care and disposition with the safest outcome. During this triage process a family may be directed to a hospital emergency room, one of the 13 comprehensive behavioral health centers, or to specialized inpatient children's services at Chestnut Ridge, in Morgantown, or River Park, in Huntington, to link them to the most appropriate and least restrictive services based on the assessment during the call. While the goal is to keep the child at home it is necessary to be prepared for all levels of crisis and maintain partnerships and contracts with these West Virginia partners. Family members may also need support for themselves and may want to call 844-HELP-4WV, which offers a 24/7/365 call, chat, and text line that provides immediate help for any West Virginian struggling with an addiction or mental health issue. Aetna works with the team at First Choice Services, which offers recovery support and transportation services and will coordinate efforts, as necessary.

Care team members coordinate management of the crisis by receiving a case note immediately from call staff and follow-up occurs after crisis resolution. Care coordinators follow up with members within 24 hours of a behavioral health crisis intervention to address their additional needs. Aetna also contracts with two community behavioral health centers specifically for children's mobile crisis response services: FMRS Health Systems, which serves four southern West Virginia counties, and United Summit Center of West Virginia, serving 13 northern counties. The children's mobile crisis teams provide the following services:

- Conduct risk assessments, provide crisis interventions, connect the individual to ongoing behavioral health services or other community resources/supports, and engage peer and family services
- Provide crisis services of triage, assessment, and immediate stabilization of acute symptoms of mental illness, substance use, and emotional distress
- Make reasonable efforts to stabilize acute psychiatric or behavioral symptoms, evaluate treatment needs, and develop plans to meet the individual's needs
- When clinically indicated, shall assist and transport the individual to a more appropriate facility for further care

Following a mobile crisis intervention, Aetna then coordinates with FMRS and United Summit to provide intensive outpatient care with the family (foster) and child, to identify and assist the individual in utilizing community and family/support systems and accessing follow-up services to manage and/or prevent further behavioral health crisis experiences. Cases will also be reviewed by Aetna's behavioral health medical director. Additional SNS will offer a wraparound approach that will continue to support the family in a comprehensive manner.

[ND018 – ND030] FQHCs, RHCs, and Other Publicly Supported Providers

Aetna has an established robust network of publicly support providers including the following:

- All West Virginia FQHCs and RHCs **[ND019, ND020]**
- 45 local health departments (LHDs) **[ND023]**
- 25 critical access hospitals **[ND024]**
- 156 school-based health centers **[ND026]**
- 26 Right from the Start providers **[ND027]**

To meet the needs of the population we will obtain a list of the approved Children with Special Health Care Needs (CSHCN) providers Bureau for Public Health laboratories (BPH laboratories) and outreach to any of these providers or primary care centers that are not already in our network. We utilize the recruitment strategies detailed earlier in this section, including, but not limited to, individualized outreach and engagement through our locally based Provider Relations team and APMs, and by leveraging other local relationships. **[ND018, ND022, ND025, ND028, ND029]**

"I told the audience (at a National Conference in Washington D.C.) that Aetna Better Health of West Virginia is the best example of an MCO that collaborates with us effectively."

—-Donna Pauley-Wilson
Director of Nursing
Maternal Child and Family Health
(a CSHCN provider)

Aetna will fully comply with all contracting, payment, and service delivery requirements related to publicly supported providers, as detailed in the **Model Service Provider Agreement Section 3.4**, including, but not limited to, the following:

- **FQHC and RHC requirements: [ND019, ND020]** As stated, Aetna currently contracts with all West Virginia FQHCs and RHCs, and we will maintain compliance with the **Model Service Provider Agreement Section 3.4.1,** by:
  - Continuing to contract with as many FQHCs and RHCs as necessary to permit beneficiary access to participating FQHCs and RHCs without having to travel a significantly greater distance past a non-participating FQHC or RHC. We understand that contracts with individual physicians at FQHCs and RHCs do not suffice for to meet this requirement.
  - Continuing to meet the requirements to contract with FQHCs and RHCs in accordance with the time and distance standards for routinely used delivery sites as specified in the **Model Provider Services Agreement, Appendix K.** We understand that contracted FQHC or RHC that have no capacity to accept new patients will not satisfy these requirements, and that if we cannot satisfy the standard for FQHC and RHC access at any time during the contract, we must allow our Medicaid members to seek care from non-contracting FQHCs and RHCs and reimburse those providers at the Medicaid rate. **[ND021]**
  - Offering FQHCs and RHCs terms and conditions, including reimbursement, which are at least equal to those offered to other providers of comparable services. We will not sign exclusive contracts with any publicly supported providers that prevent the providers from signing contracts with other MCOs.
  - Updating payment rates to FQHCs and RHCs, upon Department notification of any changes to the FQHC/RHC reimbursement rates, to the effective date in the notification by the Department. We will load the new payment rate into our claims payment system with 30 calendar days of the notification. Aetna will pay the new rate for any claims not yet paid with a date of service on or after the effective date of change. If a claim has already been made paid, within state fiscal year 2020 with a date of service on or after the effective date of the rate change, we will reprocess the claim to reimburse at the new rate.
- **Local health departments: [ND023]** Aetna will contract with any LHD providing Medicaid services that complies with the terms and conditions of our provider contract and provider qualification and credentialing process. We will work with the LHDs to coordinate the provision of the services and to avoid duplication of services.

  - If one of our Medicaid members seeks serviced directly from a non-contracted LHD, Aetna will reimburse the LHD at the lesser of the health department's fee rate or the Medicaid fee rate. Core services provided by LHDs to our Medicaid managed care members that we will reimburse include the following: all sexually transmitted disease services including screening, diagnosis, and treatment; human immunodeficiency virus services including screening and diagnostic studies; tuberculosis services including screening, diagnosis, and treatment; and childhood immunizations.
  - We will obtain vaccines for childhood immunizations from the State Bureau for Public Health's Immunization Program. Any time a member seeks immunizations from a governmental public health entity, we will pay for such services at current Medicaid fee-for-service rates for administration costs only. Medically necessary services and non-vaccines for children (VFC) vaccines administered by governmental public health entities will be reimbursed for the cost of the vaccines. Aetna will encourage 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.
- **BPH laboratories: [ND028]** We will comply with requirements related to the use of BPH laboratories for certain cases (e.g., metabolic testing for newborns, rabies), requirements for BHP laboratories to perform tests, including those mentioned under core services, on MCO members for public health purposes. In addition, we will require all contracted laboratories who have 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. These services are usually funded by State or federal funds. However, whenever a service is not funded by other State or federal funds, Aetna will reimburse OLS for these services.

In the unlikely event that Aetna would elect not to contract with a publicly supported provider, when permitted, we would 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. **[ND021, ND030]**

[ND031] New or Modified Provider Types

Nationally, for more than 30 years, Aetna has been a leader in partnering with state Medicaid agencies to improve access to high-quality specialty and behavioral health care services. We have broadly developed and continue to carefully manage fully integrated health plans and provider networks for our Medicaid and Medicare Advantage Dual-Eligible Special Needs Plans (D-SNP) health plans across the country. Given our experience in West Virginia and our knowledge of the needs/challenges facing children and youth in foster care or at risk for being involved in the foster care system, we are well-positioned to further deliver our provider network and practitioner solutions to accelerate the transformation of the health care and child welfare systems in West Virginia

Mercy Care, a health plan administered by Aetna in Arizona, has developed an extensive specialty provider network to support populations like those t will be served in the Specialized Manage Care for Children and Youth program, including children and youth in Arizona's foster care system. Mercy Care's provider network is designed to encompass and coordinate a comprehensive set of services available through traditional and non-traditional specialty service providers. Examples of specialty services providers available to Mercy Care members include the following:

- **In-home and community-based services:** These services are offered in varying intensity levels, and are designed to assist in keeping children and families together, support families with children that are at risk of being placed out of home, or have frequent use of crisis services, hospitals, or are involved with juvenile justice. In-home and community-based services providers also include adult and youth peer support providers who are individuals with experience receiving behavioral health or services through one of the child-serving systems, respectively, and who have complete State-approved certification training.
- **Parent services:** A variety of specialty providers are contracted to offer a range of services to parents and other family supports, which are aimed at improving outcomes for children and maintaining children in their home environment, through parental education, counseling, and supportive services. Providers of parent services include counselors experienced in facilitating group discussions, using role-play techniques, and providing parents with training on topics such as TIC, Active Parenting, Mental Health First Aid, self-care for the caregiver, and navigating the child welfare and juvenile justice systems. Parent and family support providers, who are individuals with personal experience raising a child with behavior health and involved in one or more of the child-serving systems, are also utilized to assist and support families in navigating the system.
- **Phase-of-life services:** These services are designed to meet the needs of children and youth based on various developmental stages. Examples of specialty providers used for phase-of-life services include non-licensed individuals acting under the supervision of independently license behavioral health professionals, who are trained to provide education and training to transitional age youth (age 16 to 18+) on topics such as job preparedness, independent living skills, and college preparation, as well as to provide employment support.
- **Sexually maladaptive behaviors:** Specialty providers experienced and knowledgeable in therapeutic interventions, such as cognitive treatment intervention and Multisystemic Therapy for Youth with Problem Sexual Behaviors, are available to provide services designed to address sexually maladaptive behaviors. These specialty providers include providers who are knowledgeable in family-centered treatment modalities to facilitate family preservation or reunification when appropriate.

Plan Coordinates with State Agency for Improved Service Delivery

Mercy Care, in collaboration with the Arizona Department of Children Service (DCS), initiated a comprehensive and coordinated approach to improve the child welfare behavioral health penetration rate. As a result, they have sustained improvements in service delivery for this vulnerable population, as demonstrated by an increased penetration rate from 39 percent in 2014 to a stabilized rate of 78 percent since 2017, indicating a penetration improvement of 100 percent.

This increased penetration rate was achieved through the review of several data points, which include the following: identifying DCS-involved youth who were not active in behavioral health treatment; identifying eligible youth in shelters and group homes to verify whether they were engaged in behavioral health services; and reviewing the DCS list of youth removed from homes to verify whether a rapid response assessment had been completed and monitoring ongoing services. Based on this monitoring, Mercy Care conducts focused outreach and engagement, such as offering caregivers and youth an intake appointment with a local behavioral health provider; outreaching to direct providers at shelters and group homes to facilitate access to services; outreaching to children and families that did not receive a rapid response and assessment; and following up if we identify ongoing services are not being accessed.

Through this collaborative approach Mercy Care and DCS feel confident that children who are placed in child welfare are connected to behavioral health services and receive ongoing trauma-informed services and supports to help them through their family's journey while they are involved in child welfare.

- **Stabilization services:** There are a range of stabilization services that are supported through contracts with several different specialty providers. These include child crisis hospital teams, crisis response for youth that are dually diagnosed, inpatient children behavioral health facilities, and outpatient peer parent and family support service providers.
- **Substance use disorder treatment:** Specialty child and youth substance abuse providers include providers who are knowledgeable and experienced treatment approaches, such as Adolescent and Community Reinforcement Approach, Multisystemic Therapy, and Functional Family Therapy.

Mercy Care has been successful in developing and growing these services using community and provider collaborations and ongoing efforts to support innovative services programs and practices that are supported by flexible contracting strategies. As described, these specialty provider contracts include scopes of work that are tailored to the services and the populations being served by each provider and include provider-specific performance metrics and outcomes goals, including standards and requirements. Mercy Care routinely monitors provider performance against the agreed-upon metrics, which allows for early detection of concerns to avoid significant issues.

We understand that needs of West Virginia's children and families involved in the foster care system and adoption assistance program are unique and that the rural of nature of the state presents challenges that are specific to West Virginia. Our approach to leveraging the strategies that were effective in Arizona will be to assess and modify the strategies to be responsive to West Virginia's needs. For example, strategies for recruitment in West Virginia may include collaborating with current providers to develop new services and/or supporting providers in recruiting or training current staff in additional treatment modalities. Through our network monitoring and Governance Roundtable model, we will continually assess opportunities to develop and contract with new and modified provider types, as needed to meet the needs of the children in this program.

Pharmacy Network

ND036	The Vendor should ensure that the contracted network has a suitable range of pharmaceutical therapies to meet member needs, including, but not limited to, the following:	The Vendor should provide a general description of how it would meet these specifications, if pharmacy benefits are carved in at a future date.
ND037	Availability of compounds	See the parent specification.
ND038	Availability of specialty drug pharmacies	See the parent specification.
ND039	The Vendor should make additional outreach efforts to the following types of pharmacies:	The Vendor should provide a general description of how it would meet these specifications, if pharmacy benefits are carved in at a future date.
ND040	High volume	See the parent specification.
ND041	Rural	See the parent specification.
ND042	Public health entities administering the Vaccines for Children (VFC) program	See the parent specification.
ND043	The Vendor should ensure that pharmacy services are available to members in a timely manner, including, but not limited to, nights and weekends.	The Vendor should provide a general description of how it would meet this specification, if pharmacy benefits are carved in at a future date.

Aetna, in collaboration with our pharmacy benefit management (PBM) subcontractor, CaremarkPCS, will ensure that our contracted pharmacy network composition, services, and management are in compliance with the **West Virginia Department of Health and Human Resources Bureau for Medical Services Provider Manual Chapter 518, Pharmacy Services**, and State requirements. CaremarkPCS understands and is experienced in serving the West Virginia Medicaid population and program, as they were Aetna's pharmacy subcontractor from 2013 to 2017 under our Medicaid managed care contract.

Our network has sufficient range of pharmacy products and services, and access to prescription medications, to meet our children and youth population's needs, including, but not limited to the provision of U.S. Food and Drug Administration (FDA)-approved manufactured prescription medication products, compounds, home infusion, and specialty medication products. Our robust network is composed of retail pharmacies (e.g., chain, independent), and specialty pharmacies, as well as pharmacies that support specific members' needs such as home infusion and long-term care services. The network pharmacies that service our West Virginia Medicaid members hold a current permit from the West Virginia State Board of Pharmacy (BOP) and adhere to all State and federal regulations. Pharmacies located out-of-state and filling prescriptions for West Virginia Medicaid members are licensed by the state in which they are located. Pharmacies located out-of-state and shipping or mailing prescriptions into West Virginia are licensed by the state in which they are located and hold a permit from the West Virginia Board of Pharmacy.

Aetna's Established and Comprehensive West Virginia Pharmacy Network

Aetna has reviewed the West Virginia State Medicaid registered pharmacy provider list and identified that CaremarkPCS currently has contracts with 97.4 percent of the 755 active pharmacy providers listed. Through this already established, comprehensive network of pharmacy providers, Aetna will be able to meet member pharmaceutical product and service needs upon award of the contract, including offering a suitable range of pharmaceutical therapies and services as detailed in **Table 5.1-4 [ND036, ND039]**

Table 5.1-4: Access to Pharmaceutical Therapies and Services

Pharmacy Type	Number of Currently Contracted Pharmacies	Specific Services Offered: % of current network pharmacies offering service [ND037]
Retail (independent and chain)	673	99.4% e-prescribe, 21% compounds, 22% home delivery
Specialty Drug Pharmacy [ND038]	12	100% e-prescribe, 20% compounds, 100% home delivery
Home Infusion	3	100% e-prescribe, 100% home delivery
Long-term Care	40	100 % e-prescribe, 39% compounds, 71% home delivery
Other (Clinic, Health Center, DME)	14	100% e-prescribe, 39% compounds

Our pharmacy network adequately services members residing in urban, rural, and suburban counties and ZIP codes within the state of West Virginia. The current network includes pharmacies located in all 55 West Virginia counties. **[ND043]** Based on the current network of contracted West Virginia Medicaid pharmacies, if pharmacy services were to be carved in, Aetna is positioned to make sure that pharmacy services are available to members in a timely manner and include access to services on nights and weekends, as well as including 24-hour pharmacies and pharmacies that are open seven days a week. To further support member access to needed medications, 24 percent of our network pharmacies offer home delivery and mailing services. These services are available, as permitted by the State, and enhance accessibility for members in rural communities and others who may have difficulty accessing pharmacy prescription products and services due to physical limitations or disabilities. **[ND041]**

At implementation, Aetna will identify an initial list of high-volume pharmacy providers for children and youth enrolled in the foster care and adoption assistance program. This initial identification will be based on historic utilization data for the covered population, which we will request from the State. Based on the

current network, including 97.4 percent of West Virginia-enrolled pharmacies, we anticipate the current network will include many if not all high-volume pharmacies for this population. If, however, we find members in the Specialist Managed Care for Children and Youth program are using high-volume pharmacies not currently contracted, we will work with CaremarkPCS to recruit and contract with those pharmacy providers. Additionally, if our pharmacy director is contacted by a pharmacy provider that wants to provide services to our members in the future, the director will forward the pharmacy's information to CaremarkPCS to reach out to the pharmacy, and make sure the pharmacy understands it must enroll with the West Virginia State Medicaid program. As a part of our continuous network development and monitoring strategy, our pharmacy director will work with CaremarkPCS to monitor utilization data and trends to identify pharmacy providers of concern and report any concerning findings to the Caremark PCS network team for investigation and resolution. Our monitoring process ensures our members have access to quality pharmacy providers. **[ND040]**

Aetna currently contracts with 44 public health entities statewide, which represent 90 percent of the public health entities that are administering the VFC program. We are actively recruiting the public health entities with which we do not currently hold contracts and will continue to work with these providers to further expand our network. Additionally, we know that the public health departments contract with pediatricians to further improve accessibility and utilization of services under the VFC program. Our current network includes 250 pediatricians across the state, who participate in the VFC program. Our network meets the accessibility standards for travel time/distance and ratio for all members served under our current Medicaid contract. **[ND042]**

Aetna's Approach to Ongoing Pharmacy Network Accessibility and Choice

As stated previously, Aetna's approach to network development is based on a strategy of ongoing monitoring and recruitment, so our members have access to a network that offers enhanced choice, accessibility, and responds to changing needs of the member. Through our longstanding partnership with CaremarkPCS, we have established effective communication processes that support ongoing collaboration and coordination of pharmacy network recruitment and network strategies. Throughout the duration of this contract, Aetna will work with CaremarkPCS to monitor data from a variety of sources, including, but not limited to, pharmacy utilization, member grievance and appeals, care management, and State agency and stakeholder feedback, to identify opportunities to improve the quality of the products and services provided by our pharmacy network. **[ND036, ND039]**

Provider Selection, Credentialing, and Re-credentialing

ND044	The Vendor should establish and implement a provider re-credentialing cycle for physical health and behavioral health providers.	1) The Vendor should describe the proposed provider re-credentialing cycle. 2) The Vendor should indicate if this cycle would be different for pharmacy providers, if pharmacy benefits are carved in at a future date.

Aetna has established and implemented 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, 42 CFR 438.610, and 42 CFR 455, Subpart B. To join our Aetna network, providers are required to meet credentialing standards as described in the **Model Service Provider Agreement Section 3.1,** be eligible to be enroll in the West Virginia Medicaid program, and meet the Medicaid provider enrollment requirements set for in applicable West Virginia regulations and the applicable Medicaid policy and procedure manual.

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 credential 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 the Children's Health Insurance Program (CHIP), as required by 42 CFR 438.610. Aetna 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 will submit monthly reports to the Department with the names, National Provider Identifiers (NPIs), and Employer Identification Number or Medicaid ID 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, corrective action plans, 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, such as not accepting the provider in the network or requiring that the provider implement corrective actions to address the identified issue and avoid future reoccurrence. Aetna 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, the process includes the following:

- Procedures for initial credentialing
- Procedures for re-credentialing at least every three years, recertifying, and/or reappointment of providers
- Processes for receiving advice from contracting health care professionals with respect to criteria for credentialing and re-credentialing of individual health care professionals
- 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: Aetna has 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.

Aetna does 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. As an NCQA-accredited 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 assure the State that we will continue to meet all requirements, including those included in the **Model Service Provider Agreement Section 3.1**. 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 after the Aetna National Quality Management and Measurement department's credentialing process and provide approval of all of Aetna's credentialed providers. We routinely monitor provider performance and compliance, including monthly provider sanction screening, and complaints and quality issues, and take appropriate action.

Aetna conducts credentialing or re-credentialing for all 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, selected criteria are verified (State license, medical schools, training, and board certification) 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 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 (OIG) 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

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 a National Provider Identification 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 5.1-5**.

Table 5.1-5: 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.	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 is collected through our quality management structure. This information 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 CVO.

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 Section 3.1**.

Criteria for PCPs, OBGYNs, and other specialists: Aetna conducts an onsite visit of PCPs and OB/GYN 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 its dental network to SKYGEN, our dental benefit administrator. As a part of our oversight of SKYGEN, 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'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

Pharmacy Credentialing and Re-credentialing

Aetna's PBM, CaremarkPCS, will be responsible for performing credentialing and re-credentialing of the pharmacy network on behalf of Aetna, if the pharmacy benefit is carved in. CaremarkPCS has and will maintain policies and procedures to support compliance with applicable State and federal requirements. Each pharmacy applicant requesting membership in the network must have specific credentials and meet specific contractual standards, including, but not limited to, the following:

- Active membership in the National Council for Prescription Drug Programs and compliance with Healthcare Insurance Portability and Accountability Act regulations (e.g., NPI Number, etc.)
- Appropriate state licensure
- A valid DEA number at time of enrollment
- Affordable Care Act-compliant
- Evidence that all prescriptions are dispensed as dictated by applicable State laws
- The ability to meet all the contractual and professional obligations for participation in a network, including the following:
  - Mandatory requirements for electronic transmission of claims
  - Submission of usual and customary charges
  - Submission of accurate claims data
  - Evaluation of concurrent drug utilization review alerts, along with other online claims processing messaging
  - Compliance with contract and maximum allowable cost pricing

  - Valid tax ID number
- Proof of insurance and compliance with malpractice liability requirements
- Submission of the pharmacy's customary service levels (e.g., delivery services, language accommodations, emergency hours).

To contract with CaremarkPCS, an independent retail pharmacy must complete all pages of the membership enrollment form and comply with all data and licensing requirements. The membership enrollment form includes the pharmacy's demographic and ownership information. In addition, the following documentation must be returned by the pharmacy:

- A signed provider contract
- A completed provider service levels form
- A copy of the state provider license and DEA certificate
- A copy of the liability insurance policy

To enroll a new chain store, CaremarkPCS must receive a request from the chain headquarters. We do not require hard copies of insurance policy, and state license certificates for members of a chain pharmacy upon enrollment. The chain headquarters is responsible for ensuring that each store has this information.

Re-credentialing Criteria

Our re-credentialing process is completed every other year through a survey questionnaire sent to network pharmacies requesting that each targeted pharmacy verify the data we have on file for that pharmacy. A sample of data fields include (not all inclusive) the following: pharmacy name, address, phone, fax, e-prescribing participation, additional services offered, and licensure.

Data on the returned survey are entered into a database and compared to the current data on file. Once the comparison has been completed, changes are loaded to the master pharmacy database.

Excluded Provider Review

During the pre-enrollment process, and on a monthly basis, we perform all required § 455.436 federal database and some state reviews for excluded providers. If we learn from this review about a CVS Health network pharmacy that is not in good standing with the OIG, we terminate that pharmacy's membership in all our networks. In addition, we frequently contact state board of pharmacy websites and personnel to verify pharmacy status when it appears that a given pharmacy may be under review by a regulatory body.

Provider Contracting and Oversight

Aetna continues to contract with 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 RFP upon contract award.

Aetna understands the importance of the State mainstreaming of Medicaid beneficiaries into the broader health delivery system and include 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 closing their panels to Medicaid members without prior notification and consent by Aenta. 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.

Aetna requires participating providers to sign an executed contract or letter of agreement between Aetna and themselves following negotiations. Once a contract is executed, our Network department provides 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. 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. Claims are adjudicated appropriately based on the data loaded into our claims processing system.

Oversight and Monitoring of Provider Compliance

In addition to our formal credentialing, re-credentialing, and contracting processes, we have established a variety of mechanism to assess provider contract compliance and identify potential noncompliance. These include the following:

- 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

- Reviewing notifications received from the Department

If a potential concern is identified through the processes detailed previously, 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.

Provider Corrective Action and Termination

Aetna makes every effort to ensure that our relationships are strong enough with our providers to resolve issues as they may 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 rely upon. We know that at-risk children have experienced significant disruptions in their lives and preserving continuity of service providers is high priority. We will make every effort to avoid further disruptions and provider continuity and consistency is service providers. Consistency in service 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.

Termination due to noncompliance: Aetna maintains policies and procedures regarding the termination of providers and provides delegated oversight of all network activities. Our process includes quickly identifying and reporting changes in the provider network to the Department, including voluntary or involuntary provider/practitioner terminations. If the provider materially breaches the terms of their provider contract, and fails to timely and adequately cure such breach, Aetna may, in its discretion, terminate the provider agreement in accordance with the terms of such agreement. We will also terminate providers from the network, or modify their provider agreement, if directed by the Department, when it determines that such termination or modification is in the best interest of the membership and State.

Aetna monitors our network for, and will immediately terminate provider from the network, if we identify any of the following:

- The provider engages in an activity that violates any law or regulation and results in suspension, termination, or exclusion from the Medicare, Medicaid, or CHIP program
- The provider's license, certification, or accreditation is terminated, revoked, or suspended
- The provider has medical staff privileges at any hospital terminated, revoked, or suspended
- The provider engages in behavior that is a danger to the health, safety, or welfare of members

Termination or loss of a provider: Aetna maintains policies and procedures that outline how we would respond to the termination or loss of a provider, which address the notification process for the Department and members, identification of transition activities and methods to ensure continuity of care, processes, and tools to analyze the impact to network adequacy and access, and strategies for addressing identified deficiencies.

If a provider were to be terminated or leave the network, our executive leadership would be immediately convened to identify whether, based on the circumstance of the termination, it would be appropriate to outreach to the provider to continue negotiations around the provider's participation, or if the circumstances present a significant ethical, safety, compliance, or other risk. For providers that are initiating the contract termination, we will initiate a provider exit survey. Information collected from the provider exit survey will be used to improve our provider retention and recruitment processes.

In the event of a provider termination we will notify the Department via email within three business days of the termination. Our process for notifying the Department of provider contract terminations meets State requirements, 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 National Provider Identifier, Medicaid ID, entity name, and provider type
- 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 a part of our termination process, we conduct provider surveys, which are used to help inform our provider retention and recruitment strategies. As required, we will obtain prior approval of the survey tool from the Department and will provide survey results upon request.

Aetna's processes and policies make certain members are notified in a timely manner and that members have continued access to covered services in the event a provider is terminated. 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 will provide members with notice within 30 days of any provider termination. As applicable, the notice will include the following:

- If the provider was a PCP, information about selecting or being auto-assigned to a new PCP and how we will assist the member to transition care to the newly assigned PCP
- If the provider was a specialist, information about how we will assist the member to transition care to another specialist

Our member transition process includes a coordinated, cross-departmental response, facilitated by daily or weekly status reports and updates provided to our plan leadership. The transition plan includes the following:

- Identifying affected members through data and reports from care management and utilization management
- Identifying priority members, such as those in currently in an inpatient setting, scheduled to have surgery, in the middle of care (e.g., pregnant, receiving chemotherapy), 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 GeoAccess reports to determine geographic impact and implement targeted strategies to identify and contract with other providers, including the use of SCAs, and the use of telehealth, as necessary, to maintain compliance with network adequacy standards
- Initiate a clear communication protocol between care management and provider relations to make information regarding identified network needs through targeted member outreach and individual care plans, and network development activities occur in real time to respond to identified member needs.

Transition activities and methods for ensuring continuity of care: Aetna allows members 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 12 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.

If a member is receiving an active course of treatment or care at the time, we terminate a provider's participation in the network. We may arrange for the continuity of care through the current active treatment period with the same provider if there is not a quality of care or licensure or credentialing issue, regardless of the provider's network status. The extension will continue for 90 days or through transition of authorized care. We realize the importance of communicating with members quickly and with the appropriate supporting steps to facilitate continual care for those impacted by a provider termination; therefore, our timely and effective communication is critical.

Assessing impact to network adequacy and identifying deficiencies: Our leadership and local provider relations representatives have established strong relationships with our providers. As a result, we know if our providers are encountering barriers or challenges that may impact their continued participation in our network and proactively work with the providers to avoid terminations. We would simultaneously review GeoAccess reports and other data to assess the impact should a provider be terminated or leave the network and develop a plan to address any identified network gaps.

6. Provider Services

The Vendor should refer to the relevant specifications located in ***Appendix 1: Detailed Specifications*** (based on the categorization within Column E: Subject Matter Area) and pertinent narrative in ***Section 4: Project Specifications*** in this RFP, and then describe its approach to Provider Services below. The Vendor's narrative response should not exceed 30 pages.

At Aetna, fostering a positive and collaborative provider experience is in our DNA. Our innovative solutions and flexible approach to integrated care management provide unique opportunities for improved health outcomes that meet and exceed State expectations. We bring to West Virginia our national expertise and experience to enhance coordination of care and access to services, including physical health, behavioral health, dental care, and socially necessary services (SNS). Our dedication to be a cooperative, responsive, and innovative partner to State agencies, members, member families and fictive kin, providers, community-based organizations, and other stakeholders defines us as a loyal organization driving the statewide mission to ensure access to and improve delivery of high-quality, cost-effective health care services. Through our collaborative relationships with the National Council for Behavioral Health and the Center for Adoption Support and Education, we will continue to identify and support our providers in implementing new strategies and best practices for treating children and youth in this vulnerable population.

Through our 23 years of working in West Virginia, we have developed a deep understanding of West Virginia providers. Our Provider Relations team engages with providers through a variety of mechanisms that are designed to provide and promote collaborative communications. Aetna's comprehensive provider services functions include all services and tasks, including, but not limited to, the following requirements contained in the **Model Service Provider Agreement Section 3.6.1**:

- Assisting providers with questions concerning member eligibility status
- Assisting providers with plan prior authorization and referral procedures
- Assisting providers with claims payment procedures
- Handling provider complaints
- Providing and encouraging training to providers to promote sensitivity to the special needs of children and youth in the foster care system, adoption assistance program, and those receiving SNS
- Educating providers on the program, including coordination and integration of services, and program and service requirements
- Educating providers on our written policies on the False Claims Act, including policies and procedures for detecting and preventing waste, fraud, and abuse

In addition to, and as part of providing, the required functions for the Specialized Managed Care for Children and Youth program, Aetna's provider services functions will be tailored to further support unique needs of providers in serving the covered population. We will leverage our knowledge of West Virginia and our experience working with children in foster care and other high needs youth who are currently enrolled with Aetna, and leverage effective practices from our national experts, to support ongoing identification and implementation of initiatives to better support and respond to our providers. These initiatives will initially include, but not be limited to, the following:

- Provider training to aid in navigating systems and delivering services in a manner that is responsive to the unique needs of the children and families including training on trauma-informed care (TIC), in partnership with the National Council for Behavioral Health, and Training in Adoption Competency model offered by the Center for Adoption Support and Education
- Establishing provider representation in our Governance Round Tables. We will initiate local, regional, and statewide Governance Round Tables actively working to integrate allied systems and governmental

branches to facilitate a common understanding of family and community networks, and best practices in family safety, healing, and health. These include systems such as the courts, behavioral health, physical health, education, child and family welfare, and other managed care organizations (MCOs) as needed.
- Offering targeted supports to key providers, including SNS and other non-traditional providers, such as navigating managed care systems and coordination with physical and behavioral health providers
- Expanding our innovative contracting strategies through targeted incentives and emerging compensation models more lucrative for providers who adopt evidence-based practices and time-tested clinical approaches to care management for at-risk children and youth
- Streamlining processes and promoting digital tools to reduce administrative burden

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 West Virginia Department of Health and Human Resources (the Department). Our staff is in communities across the state to ensure strong and collaborative provider relationships. We will support coordination with local community groups, SNS providers, and publicly supported providers. Aetna's highly trained and experienced provider relations staff have over 100 combined years of West Virginia Medicaid experience.

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

Aetna's provider relations staff orientation and initial training begins before we hire, to select employees with appropriate experience, training, education, and direct provider relationships that demonstrate effective provider relationship management. Upon hire, our initial phase provides new staff with foundational information including the following: Aetna's organization and internal operations, an overview of West Virginia's Medicaid program, an overview of the Department and its policies and procedures, Centers for Medicare & Medicaid Services requirements, cultural competency and health literacy, quality of care, Americans with Disabilities Act (ADA), fraud, waste, and abuse (FWA), compliance, code of conduct, privacy, Lean Six Sigma, systems navigation, and contractual, State, and federal requirements specific to individual job functions. Our provider relations staff will also receive training specific to West Virginia's Foster Care, Adoption Assistance, and SNS providers and members, including, but not limited to, information on covered services and regional availability of such services, service and program requirements, and strategies to support providers in meeting member needs.

Aetna exceeds the current call center standards. For the last 18 months, our West Virginia provider call center has had an average speed of answer of 12.8 seconds and an abandonment rate of .5 percent, falling well below the required State threshold of 30 seconds for average speed of answer and less than 5% abandonment rate.

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 Section 3.6.1.** Our provider call center is managed and operated by highly trained staff members who, as a part of implementation, will receive additional training on the West Virginia Specialized Managed Care for Children and Youth program and educated on the unique needs of West Virginia medical, behavioral health, and SNS providers. This additional training will help ensure our 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 to provide guidance and education specific to individual provider types, including significant traditional and non-traditional providers, and SNS providers.

Our call center availability and performance exceed the requirements outlined in the **Model Service Provider Agreement Section 3.6.1**. Our call center is available from 8:30 a.m. to 5:30 p.m., Monday through Friday. After regular business hours the line will be answered by an automated system that advises callers of the operating hours and provides instructions on alternative methods to verify member enrollment. Providers can access our provider web portal, our interactive voice response (IVR) capabilities, or speak with our staff 24/7/365 to verify member eligibility and benefits information, as well as to request authorization information. 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 secured website (https://www.aetnabetterhealth.com/westvirginia/login). Our IVR capabilities also allow providers to access claims information, auto-fax explanation of benefits/remits, check prior authorization status, and access frequently asked questions. Aetna has also established a direct line for contracted providers call for a peer-to-peer discussion related to authorization denials.

Provider Training

PS001	The Vendor should provide initial (during implementation) and ongoing training for existing providers.	1) The Vendor should explain the proposed process, schedule, and content for providing ongoing training to existing providers. 2) The Vendor should provide an overall summary of training topics for existing providers.
PS002	The Vendor should provide initial and ongoing training targeted to new providers.	1) The Vendor should explain the proposed process and schedule for providing ongoing training to new providers. 2) The Vendor should provide an overall summary of training topics for new providers.
PS003	The Vendor should provide training on mandated reporters to support applicable State Code, as defined by the Department.	The Vendor should describe how it will meet this specification.
PS004	The Vendor should coordinate with the member's primary care provider (PCP) and behavioral health provider, for applicable populations, to ensure each provider has access to the most up-to-date medical records.	The Vendor should describe how it will meet this specification.
PS013	The Vendor should educate primary care providers (PCPs) on their responsibility to coordinate a member's overall health, for applicable populations.	The Vendor should describe how it will meet this specification.
PS014	The Vendor should conduct outreach to all specialists regarding the importance of encouraging members with complex needs to seek primary care services, for applicable populations.	The Vendor should describe how it will meet this specification.
PS015	The Vendor should educate and provide guidance to primary care providers (PCPs) on coordinating physical health services and ensuring that the PCP coordinates the member's medical health services, as appropriate, with behavioral health and/or socially necessary services (SNS), for applicable populations.	The Vendor should describe how it will meet this specification.
PS016	The Vendor should educate primary care providers (PCPs) about the importance of dental screenings to ensure appropriate referrals to dental providers, including, but not limited to, training PCPs to verify that beginning at six (6) months after the first tooth erupts or by 12 months of age (as part of the Early and Periodic Screening, Diagnosis, and Treatment [EPSDT] process), the member should be referred to dental providers, for applicable populations.	The Vendor should describe how it will meet this specification.

PS017	The Vendor should educate and monitor primary care providers (PCPs) regarding administration of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, for applicable populations.	The Vendor should describe how it will meet this specification.
PS018	The Vendor should educate providers about the ability to request out-of-network referrals.	The Vendor should describe how it will meet this specification.
PS020	The Vendor should educate primary and specialty care physicians about foster care members and members with complex needs, including, but not limited to, the following:	The Vendor should provide a detailed description of how it will meet this specification.
PS021	Opportunities for standing referrals	See the parent specification.
PS022	Opportunities for specialists to serve as primary care providers (PCPs)	See the parent specification.
PS023	Availability of disease management	See the parent specification.

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 West Virginia Specialized Managed Care for Children and Youth provider training program will build upon our current training program and be designed to aid providers in meeting this population's unique needs, while minimizing provider burden. Aetna's provider relations director will be responsible for developing and maintaining the West Virginia Foster Care, Adoption Assistance, and SNS Training and Education Plan. The provider relations director will participate in the Governance Round Table meetings to improve communication and support inclusion of stakeholder feedback and collaboration related to the provider training program. The Governance Round Table model provides a flexible structure for facilitating local, regional, and state-level round tables, including a training committee. These round tables are designed to include a broad scope of divergent perspectives and voices, including but not limited to, youth and parent partners; State agencies such as the Department and Bureau for Children and Families (BCF); providers, representatives from courts, juvenile justice and law enforcement; education professionals; community organizations and advocacy groups; and other private and public entities involved in supporting at-risk children and youth.

[PS001 – PS003, PS014, PS020 – PS023] New and Existing Provider Training

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. We will focus our ongoing West Virginia Foster Care, Adoption Assistance, and SNS provider training initiatives to support providers as they evolve their practices to better meet the unique needs of these children, youth, and their families and other supports, and to improve system coordination.

Under our current West Virginia Medicaid contract, Aetna has established several activities, which we will leverage to engage our providers when they initially contract with us and on an ongoing basis. Our formal initial engagement and orientation practices, which will be continued for newly contracted providers, includes sending our welcome packet, initial provider training, and one-to-one support and education provided by our local-based provider relations staff. Our welcome packet is designed to convey important information quickly and in a functional, easy-to-follow format. It includes information about how to attend our provider training orientations and information and instructions on how to access our provider manual and portal, as well as key contact information. The welcome packet also includes a welcome letter, orientation schedule, identification of and contact information for their assigned provider relations consultant, copy of the provider contract, and provider portal enrollment forms. 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 Foster Care, Adoption Assistance, and SNS, as well as training on requirements for providing health

care services and behavioral health care services to West Virginia members, as outlined in **Table 6.1-1** In addition to being invited to the regional forums on Specialized Managed Care Children and Youth and SNS, described later in this section, Aetna's existing providers will have access to training and educational materials through our established quarterly provider training update process and email notifications. These trainings will focus on making sure our existing providers have a variety of mechanisms through which they can receive training on the specific requirements and expectations of this program, as well as the unique needs of the children and youth being served. **[PS001]**

We will continue to offer all new providers orientation training within 30 days of a provider joining the network. New providers will receive our standard provider orientation training, as well as orientation trainings, on the Specialized Managed Care for Children and Youth and SNS programs, as described in **Table 6.1-1**. Materials are sent directly to new providers and reviewed during either an onsite or webinar-based meeting. Training and education materials and toolkits will, at a minimum, be available to providers through a variety of resources including live and pre-recorded internet-based training, regional provider forums, individual provider onsite training and telephonic outreach, email and fax blasts, and provider notices. During the implementation of this contract, we will utilize these outreach mechanisms to provide training on the Specialized Managed Care for Children and Youth Program and SNS to our current network of providers, and to outreach and train new providers. This outreach will include regional provider forums that will be available to all providers and include targeted outreach and engagement with new providers including those who have historically contracted with BCF but not participated in Medicaid. A recording of the regional provider forum presentations will also be available online, for providers who are not able to attend in person or wish to review portions of the presentation. **[PS002]**

All providers will be offered ongoing training through a variety of mechanisms, including but not limited to, quarterly provider webinars, provider forums, one-on-one meetings. A description of new and ongoing training topics is also contained in **Table 6.1-1.**

Table 6.1-1: Initial 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 Quarterly 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: a West Virginia Medicaid overview; Provider Relations and Member Services functions and contact information; the provider website, secure provider portal and provider manual; covered services including physical health and behavioral health services, and dental care, medication coverage and prior authorization, medical prior authorization, authorization timelines and medical necessity; claims processing including clearinghouse, clean claims, claim submission; FWA; provider communications; member rights and responsibilities, access and availability standards, cultural sensitive standards, non-discrimination and reasonable accommodations for members with disabilities; medical record standards; appeal and grievance; and Healthcare Effectiveness Data and Information Set (HEDIS).

Training Topic	Provider Audience	Training Description/Topics Included
West Virginia Foster Care, Adoption Assistance, and SNS Orientation	New and Existing Providers	The West Virginia Specialized Care for Children and Youth new provider orientation educates providers on program goals and desired outcomes, as well as program requirements. Topics will, at a minimum, include the following: roles and responsibilities of the provider, the Department, BCF, local child protective services (CPS) workers, members, foster care and adoptive parents, and how Aetna coordinates and collaborates with these agencies; Family First Prevention Services Act, and other federally mandated services and programs impacting covered West Virginians; covered medical, behavioral, and SNS services and the provider's responsibilities for providing and/or coordinating such services, with a special emphasis on areas that vary from Mountain Health Trust (MHT) and West Virginia Health Bridge (HB) Medicaid coverage and commercial coverage rules; aging out process, and support available through Aetna; and continuity of care training will emphasize Healthcare Insurance Portability and Accountability Act (HIPAA) requirements supporting compliant sharing of member health information.
Requirements for Providing Physical and Behavioral Health Care Services and Dental Care to West Virginia Members	New and Existing Providers	**[PS020]** The purpose of this training will be to make sure providers serving West Virginia Foster Care, Adoption Assistance, and SNS programs understand specific requirements applicable to this population. Training topics will at a minimum include the following: medical consent requirements; **[PS003]** mandatory reporter requirements to support State code (with an emphasis on the increased risk of reportable events such as abuse for this population); **[PS022]**circumstances when specialty providers may serve as PCPs; required timelines for services and assessments; ASAM® Criteria, application of the criteria in the assessment and level of care processes, and State oversight and monitoring process; **[PS021]**opportunities for standing referrals; **[PS014]** methods for, and the importance of, encouraging members with complex needs to seek PCP services; specific medical information required for children in foster care; appropriate utilization of psychotropic medications; evidence-based behavioral health treatment interventions and specific behavioral and physical health needs of the Foster Care and Adoption Assistance populations; **[PS023]** availability of disease management; dental care; trauma-informed care; child and adolescent needs and strengths; crisis intervention services; high-fidelity wraparound approach; impact of Adverse Childhood Experiences (ACEs); neonatal abstinence syndrome (NAS); the effect of abuse and neglect on the developing brain, the effect of intrauterine assault, fetal alcohol syndrome, shaken baby syndrome and substance-exposed infants; and screening for and identification of trauma, and behavioral health and substance use disorders; Care Coordination teams for West Virginia members and how to access the care coordinator; and performance measures and health outcomes.

Training Topic	Provider Audience	Training Description/Topics Included
New and Ongoing Provider Training[1]		
Quarterly Training Updates	New and Existing Providers	Quarterly 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 application of ASAM® (American Society of Addiction Medicine) Criteria in the assessment and level of care processes, as well as changes in policies and requirements.
Foster Care Behavioral Health Navigation Forum	New and Existing Providers	This will be a monthly forum for foster, adoptive, kinship, and group home caregivers to learn about the behavioral health services available to children and youth in foster and adoptive care.
Foster, Adoptive, and Kinship Training Series	New and Existing Providers	This will be on ongoing quarterly training series that initially covers an overview of TIC and evolves to address topics identified by through the Governance Board and other stakeholder feedback. Examples of topics that may offered include the following: TIC: Working with Children with Crisis; TIC: Compassion Fatigue and Caregiver Self-care; TIC: Supporting Children in Congregate Care; and TIC for Children with Fetal Alcohol Syndrome and Substance Exposure.
Child and Family Advisory Partnership (CFAP) Community Forum	New and Existing Providers	These forums will be used to connect foster, adoptive, kinship, and group home caregivers to what is happening in the local behavioral health community and offer an opportunity to talk directly with providers. Attendees will be encouraged to share ideas on how to improve the delivery of care to members, their families, and supports.
Training for Youth Transitioning	New and Existing Providers	This will be an ongoing development of training and support tools that assist West Virginia providers in meeting the needs of youth transitioning through the foster care system. This will also include support and training for BCF staff in working with providers to meet the specialized needs of youth who are struggling with placement stability. Training will include such topics as understanding the behavioral health support that can be offered for youth and how to reach out to obtain services and supports through our Care Coordination teams.

[1] Aetna Better Health of West Virginia leverages the best practices from Mercy Care, an Arizona Medicaid MCO administered by Aetna, and will collaborate with the Department, BCF and other appropriate agencies to modify and adopt the following successful training materials for the Specialized Managed Care for Children and Youth project.

Training Topic	Provider Audience	Training Description/Topics Included
Sex Trafficking 101	New and Existing Providers	Aetna will work with West Virginia's law enforcement to develop and offer training on human trafficking, including training on meeting the complex behavioral health and support needs of this population. This is a best practice evidenced at Mercy Care, a Medicaid managed care organization administered by Aetna in Arizona[2]. Mercy Care implemented a similar initiative and has provided training to foster/adoptive/kinship caregivers, Department of Child Safety (DCS) group home providers, law enforcement, family advocacy centers, hospitals, DCS staff, behavioral health providers, judges, court staff, juvenile probation, attorneys, and others. These trainings have significantly supported the referral of youth as indicated by the increase of referrals from participants of the trainings.
LGBTQ Cultural Competency	New and Existing Providers	Aetna understands there is a disproportionate degree of lesbian, gay, bisexual, trans/transgender, intersex and other sexuality, sex, and gender diverse (LGBTQ) youth represented in the foster care system. To best address the needs of LGBTQ members in foster care, care coordinators, providers, foster parents, and fictive kin will need training and experience working with this population in order to have a robust understanding of the cultural values and practices within the community. This training will be designed to make sure providers are trained and demonstrate skills to serve the 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.

Our Foster Care, Adoption Assistance, and SNS Training and Education Plan will be a living document, that changes to respond to system changes, provider needs, and other training deemed necessary by the Department. In addition to the trainings identified in **Table 6.1-1,** we will collaborate with the Department, BCF, and local CPS workers to identify additional training topics such as the following: infant, child, and adolescent development; the impact of foster care on families and children; managing significant behavioral and psychiatric disorders in cooperation with mental health professionals, State agencies, the child, and navigating their policies and procedures; working closely with health care coordinators; adoption competency; and ACE(s) awareness such as family-based sexual trauma competency. Through our Governance Round Table model, we will continue to collaborate and obtain feedback from across the program to identify and respond to additional training needs, including provider training designed to make sure providers have the right tools to work with children, their parents and fictive kin clinically, operationally, and administratively.

The provider relations director will be responsible for developing and submitting the Provider Training Manual and Training Plan as required by the Department, as well as developing instructional design/curriculum based on knowledge of State systems and assessment of community training needs and outcomes. In developing the Provider Training Manual, Training Plan, and curriculum, the director will work with and obtain recommendations through the Governance Round Tables, and through collaboration with key State

[2] Mercy Care is not a subsidiary of Aetna Inc. but is managed by Aetna's Medicaid organization.

agencies, such as the Department, BCF, Bureau for Medical Services (BMS), and Bureau for Behavioral Health (BBH). Additionally, the provider relations director will identify necessary competencies and associated training needs to support implementation of new models of care, services, and to address identified gaps in training and incorporating provider identified training needs. The provider relations director will be a key participant in internal and external implementation meetings, and will be 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. Ongoing provider training needs will be identified through a variety of sources including, but not limited to, surveys, regional provider forums, feedback from onsite visits and other individual provider communication channels, as well as town hall listening sessions with providers as part of implementation. Provider sessions will reoccur with program or staffing changes and will include frequently used out-of-state and border state providers.

Aetna will submit our intial provider education and training approach within 150 calendar days of the operational start date and will submit a final version of the materials within five days from receipt of any required edits or changes identified by the Department. On an ongoing basis, we will submit our Provider Training Manual and Training Plan, including topics, schedule and languages spoken, to the Department for initial review and approval at least 30 calendar days prior to any scheduled trainings and as updated thereafter. We welcome the Department at any of the training sessions specific to this contract.

Continuous provider engagement, training, and collaboration is a cornerstone of our processes and critical to achieving improved member experience and health outcomes. We will routinely notify providers of policy and program changes in a timely manner through provider notices and the quarterly updated training program. Supplemental trainings will be available upon request or if a provider is identified as needing more direction and guidance through member, provider, or quality improvement committees, or as requested by the Department. Aetna will continue to engage and educate our providers through, but not limited to, following mechanisms:

- **Provider individualized contacts:** Our provider relations staff conducts monthly calls with most hospitals and meets with high-volume providers at least annually, although many are visited quarterly. We offer ad hoc trainings on topics such as basic billing, and provider reorientations via internal or external request.
- **Provider scorecards:** We will utilize provider scorecards to allow appropriate trending and provide feedback to address areas of opportunity.
- **Training webinars:** We have a provider education plan that includes monthly new provider training, and quarterly updated training for existing providers. Supplemental trainings are offered and hosted via webinars. 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 to the provider and when staff turnover occurs.
- **Email/Fax blasts:** We notify providers of policy and program changes through email/fax blasts that are sent as frequently as needed, and provider relations staff follow up to reiterate and confirm providers received the information and address any questions.

We also participate in in several provider associations and host regional provider forums, through which we offer providers updates and instructions on a variety of issues, changes, and initiatives. We will participate in industry-specific provider councils as requested by the Department and are prepared to offer trainings and other informational presentations to additional industry-specific provider councils and organizations. Through these formal committees, workgroups, or other forums we also solicit a broad range of feedback and perspectives from across our network. The committees and workgroups include the following:

- **Aetna's Regional Provider Forums:** Aetna is the only current MCO in West Virginia that hosts our own provider workshops, including six regionally located workshops conducted annually. We design the workshops to facilitate interaction with providers across the state and meet providers where they are. The workshops address a variety of key topics and include staff from across the Aetna organization, such as claims and utilization management (UM). We will welcome SNS providers to join these Regional Provider Forums, and will include topics specific to foster care, adoption assistance, SNS, TIC, and Training in Adoption Competency. Through the Governance Round Table model, we will identify transition age youth, foster parent representatives, and State agencies to present on unique needs, challenges, and barriers in navigating the system and accessing services that are designed to meet the needs of this population.

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.

- **Regular Joint Operating Committee (JOC) meetings:** Aetna has established monthly meetings with hospitals and large physician groups to address emerging issues and identify opportunities to improve their provider experience. These meetings currently include biweekly meetings with CAMC Health System and West Virginia University, and are being established for University Health Associates.
- **Provider association meetings:** We participate in several monthly 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.

Through our ongoing engagement with providers, we learned that home health providers were experiencing difficulties with payments when initial visits occurred over a weekend, due to an inability to obtain authorization prior to service delivery. As a result, we added a code to our system that allows these services to be billed without a prior authorization.

We understand the importance of offering an effective training program, including mechanisms to obtain provider and stakeholder feedback. We will leverage and expand upon our established practice to support the system transition, and will engage in ongoing collaboration with the State, providers, key stakeholders, and partners to make sure our training program evolves to meet the changing needs.

[PS020] Developing Enhanced Provider Competencies to Support Foster and Adoption Assistance Children, Youth, and Families

Children and youth receiving services through foster care and adoption assistance have unique needs that are best meet with providers who understand the full scope of complexities and have developed specific competencies in delivering services in a responsive manner. Developing these competencies requires a commitment from providers to go beyond basic training and education, to implement changes in the practices over time. Aetna is committed to supporting West Virginia providers in developing these competencies through our Trauma Informed Care Recognition Model and supporting provider implementation of the Center for Adoption Support and Education (C.A.S.E.) Training in Adoption Competency model (TAC). Through these initiatives we will work to create a network of providers that is equipped to provider foster care and adoption assistance for children and youth with whole-person care that is tailored to their unique needs.

Trauma-informed Care

Aetna is committed to leading the state in capacity-building of a network of providers trained in the delivery of trauma informed care in the State. Our goal is to have 100 percent of the providers who serve Specialized Managed Care for Children and Youth members adopt the TIC model. To achieve this goal, we will conduct

ongoing provider outreach and engagement and will offer a comprehensive Training and Coaching Plan informed by experts including the Department and BCF among other community leaders. Aetna will provide multiple orientations to providers on the new model before beginning a baseline assessment of the provider's gaps and needs, as a part of our TIC Recognition Model. An example of our training agenda is depicted in **Figure 6.1-1**.

NATIONAL COUNCIL

Jeff Richardson, MBA, LCSW-C, Board Chair
Linda Rosenberg, MSW, President and CEO

ACEs are Not Destiny
Aetna Medicaid Organization
Health Plan Provider Network
Trauma-informed Care Foundational Training

In Partnership with
the National Council for Behavioral Health

8:00–8:30	Staff sign-in/coffee
8:30–9:00	Welcome and Introductions
9:00–10:30	Overview of Trauma, its Impact, and Effects Understanding ACEs – Adverse Childhood Experiences
10:30–10:45	Break
10:45–12:00	Trauma and the Human Stress Response Trauma and Addictions
12:00–1:00	Lunch
1:00–2:30	Becoming a Trauma-informed Organization SAMHSA Principles: 7 Domains of Trauma-informed Care Infusing Trauma-informed Concepts into Daily Work
2:30–2:45	Break
2:45–4:00	Compassion in Our Work and World
4:00–4:30	Next Steps Evaluation

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Figure 6.1-1: Aetna's Trauma-informed Care Training Agenda

Aetna is the only managed care organization that has partnered with the National Council for Behavioral Health in West Virginia to offer our providers training on TIC, in support of our goal to have 100 percent of our contracted providers adopt the TIC model.

We meet providers where they are, conducting the National Council for Behavioral Health's Organizational Self-Assessment: Adoption of Trauma-Informed Care Practice[3] to assist individual practitioners and provider organizations to understand their knowledge and capacity in trauma-informed care and design a program to assist them in their development of trauma-informed practice. As a part of our overall Provider Quality Rating System (PQRS) and efforts to assist members in selecting providers, our provider directory will include an indicator to identify providers who have adopted TIC, including the level of adoption, as described in **Table 6.1-2.**

We assist providers to move along the continuum from being trauma aware to being trauma-transformed. Becoming a trauma-informed organization requires committing to organizational transformation over a period of years. To facilitate this transformation, we have adopted a Trauma Information Care Recognition Model with six levels to identify providers at different stages of development and to recognize progress over time. Our proprietary Trauma-Informed Provider Organization Audit Tool that includes the following domains:

- Respecting member voice and choice
- Staff beliefs, attitudes, and behaviors
- Commitment of leadership to TIC
- Disclosure readiness
- Staff well-being
- Staff knowledge and skills in TIC
- Hospitality to diversity.

Table 6.1-2: Levels of Trauma-informed Care

Level	Description
Trauma Aware 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. Both clinical and non-clinical staff describe this as "a good place to work." Members describe this is "a good place to come for care" expressed as feelings of safety, trust in clinical and non-clinical staff, being listened to, and being welcomed and respected.
Trauma Aware Level 2: Enhancing Routine Clinical Practice	• Individual practitioners have integrated Level 1 knowledge into routine clinical practice using evidence-based tools. "I'm doing the clinical work I've always done and have added clinical tools that address trauma and SDOH to my routine toolbox." • Provider organizations promote trauma-informed primary prevention as a routine practice for all members, analogous to childhood vaccinations, flu shots, etc. Routine clinical care includes the following: – Member education about how to thrive and flourish, build resiliency, enhance protective factors, and minimize the risks of trauma – Assessment and inclusion of SDOH as standard elements of a person's treatment/recovery plan

[3] National Council for Behavioral Health, "Organizational Self-Assessment: Adopting of Trauma-Informed Care Practice," https://www.nationalcouncildocs.net/wp-content/uploads/2014/01/OSA-FINAL_2.pdf: accessed June 1, 2019

Level	Description
Trauma Informed Level 3: Basic Trauma Informed Care	• Individual practitioners expand routine clinical practice by integrating treatments, services, and supports that explicitly address trauma. The scope of practice is expanded by either of the following: – Adding qualifications in evidence-based and/or promising trauma-specific treatments, services and supports – Integrating Level 2 practices into serving populations at high risk of trauma, people with complex needs, and/or marginalized populations • 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. They have identified resources to respond to a person's immediate and ongoing needs, including, but not limited to, trauma-specific services. They collaborate with trauma-informed Level 3 individual practitioners. Current Joint Commission standards for accreditation for behavioral health require use of a trauma screening tool during the admission process.
Trauma Informed Level 4: Advanced-Trauma Informed Care	• Individual practitioners include considerations of complex trauma and SDOH within routine clinical practice, using a biopsychosocial model of care that integrates physical and behavioral health. • Provider organizations are Trauma-Informed Center of Excellence (COE) for at least one high-risk/rising-risk population, marginalized population, or for people with complex needs. COEs are provider organizations that offer state-of-the-art and innovative treatments, services and supports for people with complex needs. They may focus on improving health outcomes for a well-defined population, develop and implement practices and clinical pathways that may be adopted as clinical standards of care, and are often referral consultation centers, embedded within a larger system of care. There is close collaboration with trauma-informed (Level 3-4) individual practitioners.
Trauma Transformed Level 5: Close/Full Collaboration in a Merged Practice	Provider organizations include trauma-informed (Level 3-4) individual practitioners on inter-disciplinary 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 (SAMHSA) Integrated Care Level 5 or 6[4].
Trauma Transformed Level 6: Trauma Informed System of Care	Provider organizations do the following: • Collaborate across sectors to meet the complex needs of people they serve within a larger community context • 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 • Bridge 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.

[4] Substance Abuse and Mental Health Services Administration, "A Standard Framework for Levels of Integrated Healthcare and Update Throughout the Document," https://www.integration.samhsa.gov/integrated-care-models/A_Standard_Framework_for_Levels_of_Integrated_Healthcare.pdf: accessed June 19, 2019

Training in Adoption Competency Model

Research shows that adoptive parents have extreme difficulty finding mental health providers that understand the unique and complex needs of their families. A 2011 survey of 1,100 adoptive parents by the North American Council on Adoptable Children found that 43 percent indicated that they could not find needed services; 39 percent responded that providers don't understand adoption; 25 percent noted that appropriate services don't exist in their community; and 21 percent indicated they don't know how to find post-adoption services.[5]

Aetna is committed to improving these statistics and helping West Virginia children and parents thrive by committing resources and aggressive attention to this community. Because adoptive parents are likely not actively involved with the child welfare system and are often suffering in silence, Aetna will partner with the State to do outreach to all families receiving adoption and guardianship assistance payments and invite them to partner with our care teams and provide all services available to participants based on their requests and their levels of need. Moreover, we recognize that youth in foster care and those aging out have the same needs for adoption/attachment focused mental health services. The American Academy of Pediatrics, Healthy Foster Care America Initiative identifies mental and behavioral health as the greatest unmet health need for children and youth in foster care. Yet few mental health providers receive graduate level training in the complex needs these families present.

We understand we have significant work to do to expand the provider network with the expertise needed to meet the complex needs of this population. C.A.S.E. is the only organization in the country with California Evidenced-Based Clearinghouse for Child Welfare status to train mental health providers in adoption competency. To date, C.A.S.E. has trained more than 1,700 clinicians in their Training in Adoption Competency model, however, none of these providers are in West Virginia. Aetna will work our provider network to develop this competency throughout the state and improve the delivery of services to children enrolled in this program.

Aetna is working to develop a formal partnership with C.A.S.E. to support the delivery of TAC to mental health providers throughout West Virginia. The training includes 72 hours of in-home and classroom training as well as a case consultation component. Additionally, C.A.S.E. has a new, less intensive yet still significant 30-hour web-based trainings program that will be available fall 2019. While this curriculum is offered at no cost to mental health providers, Aetna will partner with C.A.S.E. to provide implementation support to ensure that mental health providers are made aware of the training, and we will provide a financial incentive for them to complete the training and be listed as adoption-competent providers. This curriculum will be especially important to expand the network much more quickly and will also allow us to reach providers in rural areas that may have difficulty accessing the full TAC training.

To further support the development of TAC-certified and training providers, Aetna is working to obtain approval for continuing education units (CEUs) for clinical staff, as well as continue medical education credits (CMEs). Aetna will also offer a one-time financial incentive to those who complete the certification process and deliver mental health services to both foster and adopted youth and families. Additionally, as a part of our overall PQRS, our provider directory will identify providers who have completed the certification process, as well as those who have completed the web-based training.

[PS004, PS013, PS015 – PS018] Education and Training for Primary Care Providers

PCPs are a core component of ensuring members receive critical core services and that care is provided in a coordinated, whole-person model. In addition to the trainings outlined previously in this section, Aetna will provide PCPs with additional training to help ensure PCPs understand these responsibilities

[5] North American Council on Adoptable Children, "Post-Adoption Needs Survey Offers Direction for Continued Advocacy Efforts," https://www.nacac.org/resource/post-adoption-survey-direction-advocacy-efforts/: accessed July 26, 2019

and how to access support and information from Aetna to further enhance compliance with applicable requirements and deliver high-quality services to our members. We will also send PCP routine reminders regarding these topics and will conduct individualized follow-up when requested or identified through monitoring of data, record reviews, complaints, and other mechanisms. The additional PCP training and education will, at a minimum, include required training on coordination of care, EPSDT requirements and monitoring, and requesting out-of-network referrals. We will specifically outreach to PCPs, with an emphasis on PCPs assigned to Specialized Medicaid Children and Youth members, to encourage and incentivize participation in the Trauma Informed Care training and recognition model.

[PS013, PS015] Coordination of Care

Our PCP training on coordination of care will specifically focus on the role of the PCP in coordination of overall care to members, including physical health specialists, behavioral health providers, and SNS services, for applicable populations. The training will include an overview of covered Medicaid and SNS services and identify best practices for coordinating member care. Due to the complex social and health factors frequently experienced by these children and youth, the PCP training will be designed to address the broad scope of member needs, and support our members receiving individualized, whole-person services. This broad approach will include the following: educating PCPs on the spectrum of behavioral health treatments and services, including intensive interventions—both in home and facility based—for children with serious emotional disturbances; and coordinating with non-traditional providers, member's fictive kin, local department case managers, and community supports, to address the full array of factors impacting our members. We will also educate providers on resources and supports available through Aetna, including our locally based clinical care teams, member and provider relations call lines, and provider manual and online resources, which can be used to assist in identify and connect members to needed resources, services, and supports. These resources will include written material, available through the provider website and secure portal, which include key contacts, information, eligibility requirements, and requirements related to services for children in foster care, such as circumstances where BCF representative consent is required. Monitoring of provider compliance with care coordination will be addressed through our quality management program.

In conjunction with the care coordination training, we will also offer PCPs and their staff, training on the use of FamilyConnect, Aetna's shared electronic health record that serves as the single source of truth of youth and their circles of support. As a part of this training, we will educate providers on Aetna's role in supporting the coordination of care, including access to up-to-date member records for physical and behavioral health providers through FamilyConnect. FamilyConnect will contain copies of current and prior assessments and care plans, as well as the Medical Passport, a tool utilized by foster parents, relatives, fictive kin, and other caregivers to document appointments and medical histories for children and youth in the foster care system. PCPs will receive training on how to access and navigate FamilyConnect, which is available through our secured provider portal. **[PS004]**

[PS017] EPSDT Services

EPSDT services are fundamental to identifying developmental, physical, and behavioral issues. While EPSDT services are critical for all children in Medicaid, children involved in the foster care system and adoption assistance programs are at higher risk for experiencing trauma and other social determinates of health risk, and for missing key screenings. As a key first step to making sure these especially vulnerable children receive all necessary EPSDT services, members and their guardians, are made aware of their rights under the federal regulations governing the provider of EPSDT services, and providers are trained on our expectations for compliance by PCPs. This includes information about the West Virginia EPSDT Periodicity Schedule and educating providers on requirements that PCPs must perform oral health assessments, evaluations, prophylaxis, and oral hygiene counseling. We also educate providers on

referring members to dental care; conducting routine physical examinations; screening for developmental delay through the fifth year; screening for autism spectrum disorder; conducting 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, 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.

We know that children in foster care and at-risk youth are more likely to miss appointments due to a variety of factors, including changes in member placements, member unwillingness and/or hesitation to receive services, and transportation challenges. As a part of this training, we will include information on solutions to improve member participation and reduce no-show/missed appointments. These strategies include, but are not limited to, coordination with the member's Aetna care coordinator, to outreach to the member and their guardian to provider supports and assist with resolving barriers to member care.

The training will also inform practitioners on how Aetna monitors providers for compliance through our monthly and quarterly analysis of EPSDT screening and well-visit rates. This routine monitoring is used to help identify strategies that are working well and provides insights into areas for improvement. Aetna's clinical care teams review gaps in care and are responsible for conducting outreach to parents, caregivers, and legal guardians of members ages 0 to 20. We track EPSDT requirements and HEDIS measures and utilize the data to generate reports and to identify any early deficiencies. Some tools used include care alerts (which identify high-and medium-risk members who are delinquent), priority lists, quarterly measures, and feedback EPSDT practice profiles, tracking phone calls conducted (automated and direct), and face-to-face contacts. We share pediatric measure with the network and practices quarterly for quality improvement purposes. These EPSDT Profiles are generated for each provider or practices and include items such as well-visit rates and well-visit components.

[PS016] Education and Guidance on Dental Screenings and Referrals

Aetna will also provide specific training to PCPs regarding the importance of dental screenings and the appropriate referral process to dental providers. Training materials related to dental EPSDT services will include input from our dental director to make sure materials are accurate and consistent with training and education offered by SKYGEN, our dental subcontractor. SKYGEN is currently conducting a statewide training for all West Virginia dental providers in its network, to provide education and training to dental providers on requirements related to dental screenings and services. In addition to this current training, SKYGEN actively promotes family involvement in using dental home EPSDT services. SKYGEN helps to promote their goal of making sure children receive age-appropriate comprehensive dental services, through member education and outreach materials. Materials that will be used for the Special Managed Care for Children and Youth program include proactive outreach through calls and mailings, as well as tip sheets for distribution at PCP and other provider offices, local service agencies, health clinics, and other community-based health care locations. The training will also provide an overview of SKYGEN and Aetna's integrated care management program, through which EPSDT-eligible members, parents, foster care parents, and legal guardians will be notified of dental EPSDT services.

[PS018] Requesting Out-of-Network Referrals

In addition to our training on EPSDT services, we will also provide education and training regarding the ability and process for providers to request out-of-network services. We know that EPSDT screenings for high-needs populations, including children involved in the foster care and adoption assistance populations, may result in identification of needs for specialty providers or circumstances that are more

likely to require access to out-of-network providers. This training will offer providers information on Aetna's policies and practices related to out-of-network referrals, including the following:

- **Emergency services:** Aetna makes sure members have access to emergency care 24/7/365, at the nearest facility available, regardless of the emergency room's (ER) provider participation status. We will educate providers on the increased utilization of emergency services that result from higher rates of chronic disease, co-occurring physical and behavioral disorders, as well as barriers stemming from SDOH, adverse childhood events, and trauma.
- **Non-emergency services:** Aetna will authorize out-of-network services in situations where we are unable to provide medically necessary, covered services, within our network of contracted practitioners and providers. Prior authorization for these out-of-network services includes a review to determine whether the services are medical necessary and verification that the services cannot be performed by a network provider. If it determined that medically necessary services are available through network provider, our care management staff will work with the provider and member to access an in-network provider. If medically necessary services are not available in-network, the out-of-network provider will be invited to join our network, or if necessary, we will enter into a single-case agreement.

Figure 6.1-2: Aetna Presenting the All-Star Award to CAMC Health System
Aetna currently recognizes providers through our Quality All Star Program, which recognizes providers who achieve high-quality HEDIS scores.

The training will also address Aetna's role in in coordinating services in a timely manner with out-of-network practitioners/providers, a description of the type of information we will provide to the member to be able to arrange the service, and our processes for confirming that members do not incur any additional cost for seeking these services from an out-of-network practitioner or provider.

Provider Quality Rating System

PS005	The Vendor should establish a quality rating system for its contracted providers and disseminate this information to help members make informed choices about their care.	The Vendor should describe how it will meet this specification, including an approach to establishing quality ratings and how the Vendor will disseminate the information.

Aetna will establish quality ratings for its contracted providers and the information will be available to our members through our provider directory, which is available on our website, to help members make informed choices about their care. Our member services staff will also be trained on the PQRS, and provider directory flags to identify providers with additional competencies in TIC and TAC and can provide guidance regarding this information to members calling for assistance with selecting providers. Member education will also be provided through the Member Handbook. As a part of the implementation of the PQRS and additional competencies indicators, we will provide educational materials to our current providers. New providers will receive information and education regarding the PQRS and additional competencies flags through the new provide education program.

Quality rating based on HEDIS: Aetna has an established Aetna Quality All Star Program that highlights overall performance of those providers who achieve high quality HEDIS scores, which we will utilize for our Provider Quality Rating System (PQRS). This PQRS will offer transparency in the provider selection process and be designed to celebrate PCPs that demonstrate high-quality clinical performance. The top-scoring practices receive the Aetna Quality All Star Award, such as CAMC Health System as shown in **Figure 6.1-2**. The practices will be designated in the online provider directory, they receive preferential member assignment, and visibility to other providers for peer recognition. In choosing an Aetna Quality All Star, members, and their caregivers, legal guardians, and kin fictive, know they are getting a provider that has been identified as offering high quality services to West Virginians. The goal is to facilitate family choice of the best provider for each member. Criteria for the program include HEDIS reporting measures, such as children and adolescents' access to PCPs.

Enhanced competencies indicators: In addition to identifying providers with demonstrated high-quality clinical performance, we are also updating our provider directory to identify Trauma Informed Care Recognized providers, including the level of TIC adoption obtained. As we work with West Virginia providers to implement the TAC model, we will include another provider directory indicator to assist members and their families identify providers who have completed training on the TAC model.

We will continue to work collaboratively with the State and West Virginia providers to identify and assess additional opportunities to further recognize and feature providers with demonstrated high-quality services and the ability to meet the unique needs of members in the Specialized Managed Care for Children and Youth program.

Provider Manual

PS006	The Vendor should distribute provider manuals according to set timeframes and methods of delivery.	The Vendor should describe how it will meet this specification, including proposed timeframes and methods of delivery.

Aetna has, and will maintain a provider manual that includes applicable specialty manuals for all network providers and will be updated to include SNS. We will distribute the provider manual according to the timeframes and methods of delivery established by the Department. We include information on how to access the provider manual online in our welcome packet, to make sure providers have access within five days of inclusion in our network. We also make a hard copy of the provider manual available to providers, upon request. Aetna will continue to submit our provider manual, including any provided by a subcontractor for direct services, and any updates, to the Department for approval.

Our provider manual is designed to serve as a resource for providers to make sure providers have access to a broad range of information and guidance on Aetna's administrative processes. The type of information communicated via the provider manual includes, but is not limited to, information on how to directly contact various Aetna departments, an overview of our model of care, a description of administrative process, provider responsibilities and requirements, and claims submission and payment. Our current provider manual includes all required topics, including the following:

- A description of Medicaid covered and non-covered services, including EPSDT services
- A description of PCPs' responsibilities, including the following:
  - Maintain continuity of member's health care by serving as the primary care provider
  - Provide 247/365 access
  - Make referrals for specialty care and other medically necessary covered services, both in-network and out-of-network, consistent with the MCO's utilization management policies
  - Maintain a current medical record for the member, including documentation of all services provided by the PCP, as well as specialty or referral services
  - Adhere to EPSDT Periodicity Schedule for members under age 21

  - Follow MCO-established procedures for coordination of in-network and out-of-network services for Medicaid members
- State operating business hours and phone numbers for the Provider Relations department
- Explain to providers how to resolve questions concerning member eligibility
- Explain Aetna's referral process
- Explain how providers are to submit a clean claim, including a complete listing of all required information, including claims coding and processing guidelines for the applicable provider type
- Encourage training to promote sensitivity to the special needs of the population
- Educate providers regarding MHT and HB program differences
- Explain that when there are program or service site changes, the notification of changes will be provided at least 30 days before the intended effective date
- Outline provider requirement to inform members of costs for non-covered services prior to rendering such services
- Explain provider requirements to treat all information obtained through the performance of the services included in provider contract as confidential information to the extent that confidential treatment is provided under State and federal laws, rules, and regulations
- Explain Aetna's provider complaint and appeal processes, which must comply with contract requirements, 42 CFR 438.414, and be the same for all providers
- Explain requirement and process for provider reporting and return of overpayments
- Describe provider reporting requirements

As a part of our implementation of the Specialized Managed Care for Children and Youth contract, we will review and update our provider manual to address any program specific requirements and information. These updates will include, but not be limited to, the following information:

- A description of the program goals and desired outcomes, and roles and responsibilities related to coordination with the Department, BCF, local CPS workers, members, foster care, and adoptive parents
- How Aetna coordinates and collaborates with the above identified agencies and stakeholders.
- Family First Prevention Services Act, and other federally mandated services and programs impacting covered West Virginians
- Covered medical, behavioral, and SNS services and the provider's responsibilities for providing and/or coordinating such services, as well as any program-specific prior authorization protocols
- Care Coordination teams for West Virginia members and how to access the care coordinator
- Key service delivery requirements, such as medical consent requirements; mandatory reporter requirements to support State code; circumstances when specialty providers may serve as PCPs; required timelines for services and assessments; ASAM Criteria, application of the criteria in the assessment and level of care processes, and State oversight and monitoring process; opportunities for standing referrals; methods for, and the importance of, encouraging members with complex needs to seek PCP services; specific medical information required for children in foster care; availability of disease management; dental care; TIC; child and adolescent needs and strengths; crisis intervention services; high-fidelity wraparound approach; impact of ACEs; and screening for and identification of trauma, and behavioral health and substance use disorders
- Our Provider Quality Rating System and identification of TIC Recognized and TAC-trained providers

We recognize there are unique challenges and requirements, as well as nuances in the administration of SNS. Through our contract with KEPRO, we will maintain an SNS Provider Manual. This separate manual will be designed to proactively eliminate ambiguity and confusion about SNS by providing clear guidance on specific requirements including, but not limited to, prior authorization requirements, utilization management procedures, and the continuum of services. We will collaborate with BCF and

KEPRO to make sure all necessary information is included, and to identify any key areas to include in SNS provider communications as a part of the distribution of the manual and during contract implementation and ongoing updates. The provider manual will be available online, and upon request will be made available to providers in hard copy.

Additionally, in collaboration with KEPRO, we will continue to develop/provide educational training and technical assistance to all stakeholders identified by BMS regarding policy, services available, service delivery models, and the various types of services other than SNS available. Specifically, providers and workers will be kept apprised of service issues, the authorization process, as well as training on any new Utilization Management Guidelines approved by BMS. New providers will continue to receive provider orientation within 60 days and have their first retrospective review within six months of their company's initial authorization. The specific training for parents and foster parents as providers will continue to cover enrollment, registration, referral, authorization requests, and invoicing.

Provider Website and Secure Portal

PS024	The Vendor should provide a publicly accessible, secure website with information targeted to providers.	The Vendor should describe how it will leverage its website to help meet the needs of providers.
PS025	The Vendor should provide a secure portal—accessible by providers, Department caseworkers, and other stakeholders as permitted by the Department—that allows these stakeholders to log in and access information as permitted by the Department, including, but not limited to, the following:	The Vendor should describe how it will leverage its website to help meet the needs of providers, Department caseworkers, and other stakeholders as permitted by the Department. Note: The Medicaid fiscal agent will provide member eligibility information.
PS026	Medical records	See the parent specification.
PS027	Authorization status	See the parent specification.
PS028	Confirmation of services previously provided to avoid duplication	See the parent specification.

Aetna has an established, publicly accessible, secure website with information targeted to providers, which is available at https://www.aetnabetterhealth.com/westvirginia/providers/. The site includes webpages specifically designated for providers, which offers easy-to-use access to current program information, as well as provider-specific information. Information available on the provider website includes contact information for our call centers and hotlines, including the provider call center; searchable provider manual and provider directory; current and clearly defined prior authorization requirements; pharmacy preferred drug list (PDL) and pharmacy conditions for coverage and utilization limits; information on member rights and responsibilities; provider updates such as 'What's New' updates; and links to other websites including, but not limited to, the Department and BCF. As part of our implementation process, we will be adding a foster care component to this public- facing website. The foster care component of our website will include education information related to working with foster care children, the Specialized Managed Care for Children and Youth program, and other informational materials. **[PS024]**

Aetna's secure web-based provider portal offers providers access to the portal through secure single sign-on functionality that improves efficiencies for providers and offers complete accessibility to provider and member data and reports. We recognize that access to member information is particularly critical for providers who are treating children and youth in this population, because children may often time present for an appointment with no medical history, especially after a change in placement or following a recent revocation of parental rights. To further support timely access to information and coordination of care, Aetna will also provide access to the secure provider portal to Department caseworkers and other stakeholders, consistent with applicable federal and State privacy security laws, regulations, and standards. Our system is designed to support a variety of user roles, and we will collaborate with the

Department to assess and identify user roles and needs, to support compliance with role-based permissions. An example of our current secure provider portal screens is depicted in **Figure 6.1-3**. **[PS025]**

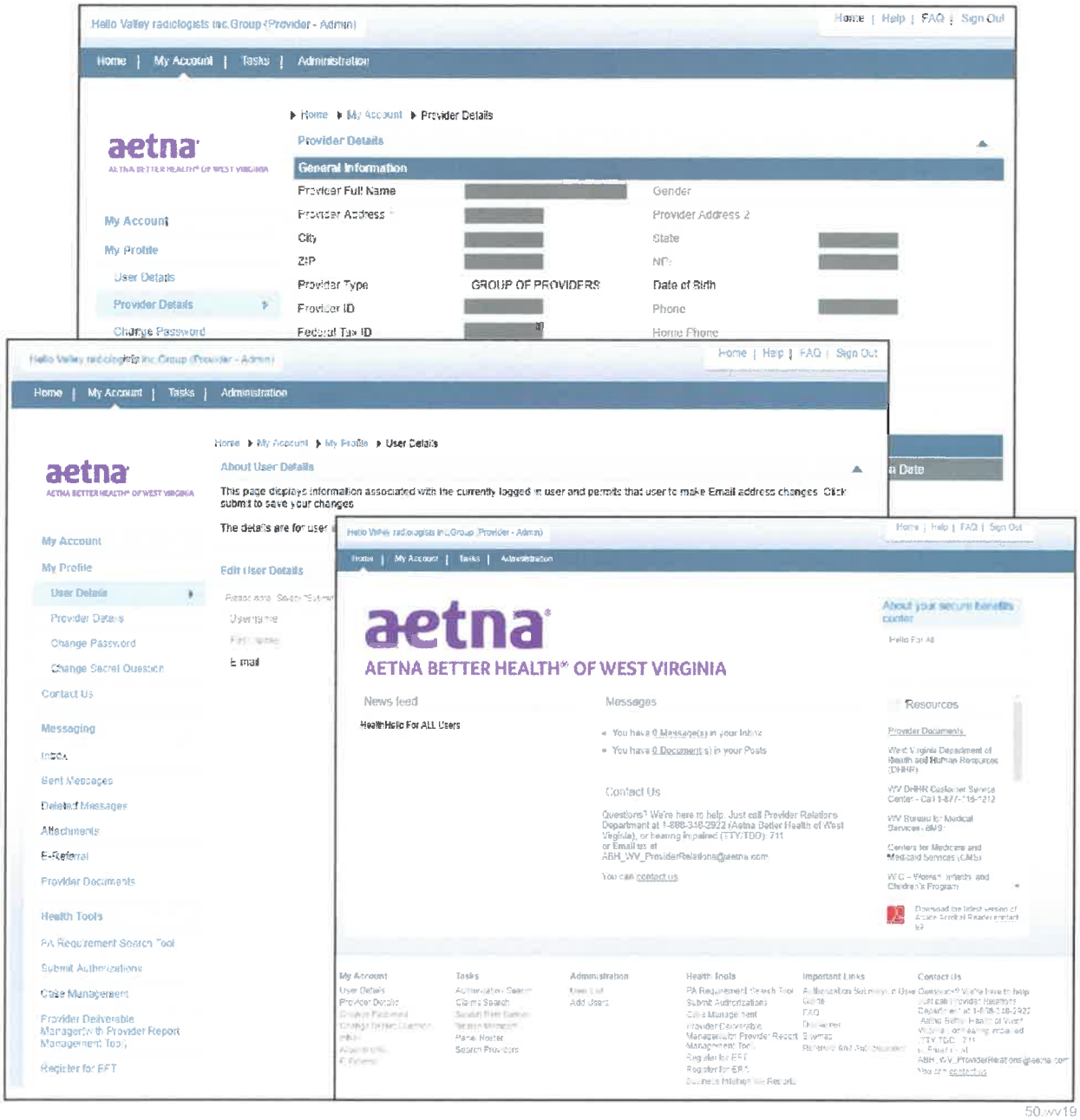

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Figure 6.1-3: Examples of Aetna's Secure Provider Portal
Our secure provider portal is designed to make information available for our providers in an easily accessible manner and at the provider's convenience.

Our web-based platform allows us to communicate member health care information directly with providers in real time, including the following:

- Member identification (ID) cards and panel roster

- 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, or submission/service dates, and allows for review of prior authorization requirement by specific procedures or service groups and show details on codes and any noted prior authorization exception information **[PS027]**
- The ability to 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 grievances.
- Access provider training materials and the provider manual
- To submit inquiries through the provider portal

We continually review and identify opportunities to improve the functionality and ease of use on our provider portal and respond to changing program needs. As required by this RFP, the West Virginia secure provider portal will be specifically improved to include the following:

- **Member records:** We will provide access to our care management system to providers and Department caseworkers, which contains a single sign-on functionality. **[PS026]**
- **Authorization status:** As described previously, our current provider portal allows providers to look up the current status of authorizations. We are currently in the process of reviewing and planning enhancements to our current portal functionality, including improvements to our online authorization request system to better support the ability for providers to submit supporting documentation **[PS027]**
- **Confirmation of services previously provided to avoid duplication**: Providers can currently confirm whether services have been provided previously either by reviewing their claims data through the provider portal or by calling our Member Services department. We will continue to make this information available to providers. Aetna, through our subcontractor KEPRO, also will make SNS service data available to providers and Department caseworkers and other stakeholders as identified by the Department. **[PS028]**

We are aware of the new requirements regarding electronic authorizations, under HB2351, and will comply with these changes. We are currently are in the process of reviewing and planning enhancements to our current portal functionality through integrating with the Availity web portal, a provider web portal that supports multiple MCOs' data. These future enhancements will offer providers a more robust set of provider self-service tools and information, including, but not limited to, the following: one-stop shopping for providers to access their data across multiple MCOs if they have an account with Availity; improvements to the 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 webpage, 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 representative or our provider call center. Providers can also register for the portal through our website. Additional information regarding the portal is available through the navigation guide on our website.

Supporting the use of Electronic Prescribing

PS019	The Vendor should support e-Prescribing functions.	The Vendor should provide a general description of how it would meet this specification, if pharmacy benefits are carved in at a future date.

To ensure efficient and safe access to covered medications, the Aetna-CaremarkPCS pharmacy network supports the use of electronic prescribing (e-prescribe) tools. Review of pharmacies in the Aetna-

Caremark PCS pharmacy network that will service West Virginia Medicaid members, shows that 99.4 percent of retail pharmacies, and 100 percent of specialty, home infusion, and other pharmacy types, support e-prescribe.

The Aetna website provides access for our providers to our e-prescribing tool through a web link. Our e-prescribe tool allows the prescriber to see the preferred drug status, therapeutic alternatives, and clinical criteria on the selected medication (i.e., prior authorization, step therapy, quantity limits). Nationally evidenced, electronic prescribing has proven to be a safer and more efficient way of communicating prescriptions between providers and pharmacies. Our e-prescribe tool, which is widely used by our prescribers, improves prescribing efficiency and safety. Currently, Aetna Medicaid prescribers send 67.4 percent of prescriptions to our pharmacies via e-prescribe. For prescribers servicing our behavioral health and Children's Health Insurance Program plans, e-prescribe rates currently average 78 percent.

Claims Acceptance and Payment

PS007	The Vendor should accept and pay claims on time for physical and behavioral health services, as defined by the Service Provider Agreement (SPA).	The Vendor should describe how it will meet this specification. The response should include, but is not limited to: •A breakdown of turnaround times for paper vs. electronic data interchange (EDI) claims •Claim turnaround report for each of the past 12 months, indicating the percentage of total claims that are clean, and the percentage of clean claims processed within 30 days, and within 90 days

Aetna. fully understands and supports the requirements of the West Virginia Medicaid program as well as the needs of its members and providers, as we have been successfully operating within the state for over 23 years. Under the direction of our claims payment director, we will accept and pay claims on time for physical and behavioral health services, in compliance with State and program requirements, including requirements defined in the **Model Service Provider Agreement, including, but not limited to, section 3.7.**

Through transparent communication, responsible stewardship, and collaboration with the Department, we have continuously improved our systems to be in alignment with the Department's requirements. Our claims processing system is highly customizable and flexible, which has allowed us to configure our systems in accordance with West Virginia's fee schedules, covered services, and provider manual requirements as well as respond quickly to the needs of the Department when off-cycle updates occur in health plan advisories, information bulletins, and ad hoc requests

Aetna's Claims Adjudication Process and Capabilities

We are committed to continuously meeting and exceeding the Department's requirement to pay clean claims within 30 days of receipt. We understand the needs of our providers and that not all provider practices are the same. Therefore, while we strongly encourage our providers to electronically file their claims, we accept claims submitted in both electronic and paper form. 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 [EDI] claims, Medicaid ID registration, etc.) are easily accessed through the provider portal on our website and through our local Provider Relations team.

Year to date, Aetna's West Virginia Average Days to Payment is 9 days for EDI and 13 days for paper claims.

We process and reimburse providers' claims in accordance with the Department's prompt payment standards. Timely and accurate payments reduce provider abrasion and increases provider satisfaction. Aetna is proficient in handling large numbers of claims through continual monitoring to meet and exceed various State requirements. For example, year-to-date **through June 30, 2019, our total Medicaid claims processed was 28.7 million. For West Virginia specifically, the total Medicaid claims processed was 1.4 million with an 87.5 percent auto-adjudication rate**. Readmissions, unclean claims, coordination of benefits claims submitted via paper with a paper explanation of benefits, claims that require the review of medical records, as well as claims that required an authorization that is not an exact match, are pended for manual adjudication. When reimbursing medical and pharmacy provider claims, Aetna follows the requirements stated in 42 C.F.R. 447.46, and the timely claims payment requirements of 42 C.F.R. 447.45 unless the Department issues other specific requirements. When receiving, transmitting, and processing data, we use ASC X12 standards, comply with reporting requirements, and capacity standards that expand as needed to accommodate enrollment or program changes. **Figure 6.1-4** shows the flow of claims from receipt to payment in three phases: origination, adjudication, and post-adjudication.

Aetna's 12-month rolling electronic claims (EDI) submission rate was 93%.

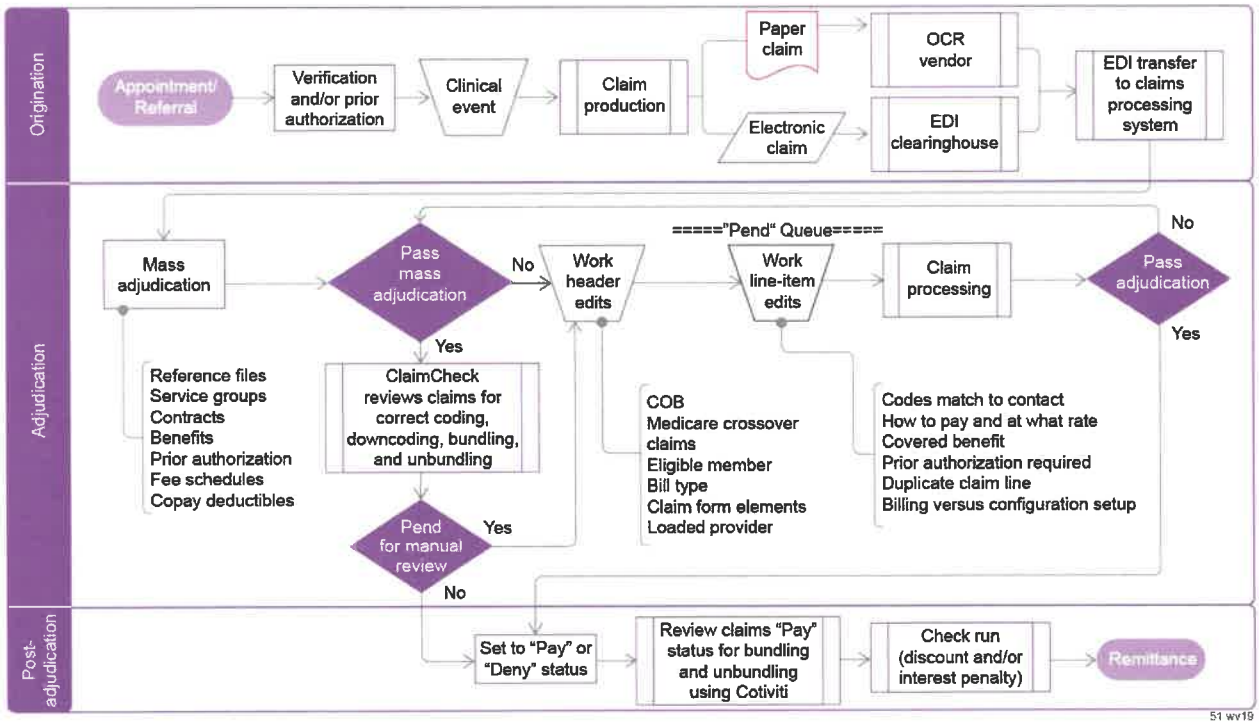

Figure 6.1-4: Life of a Claim

Our end-to-end claims processing workflow ensures timely and accurate payment

Our provider and subcontractor payment process is configured to adhere to all West Virginia and federal prompt pay guidelines. If a claim is paid beyond those guidelines, applicable interest is automatically calculated and paid. Through feedback and surveys, we monitor satisfaction with our claims process. To avoid any increase in administration costs and to avoid provider burden through incorrect claim payment or inappropriate claim denial, we bring a best-in-class claims payment and process that minimizes incorrect payments or inappropriate denials. Aetna confirms that our claims processing and management

information system meets and will continue to meet the Medicaid managed care requirements, and we will maintain compliance throughout the term of the contract. This will be accomplished through our compliant, rules-based information processing system.

Aetna has processes to accurately and timely load new provider contracts, provider demographic information, changes in provider contract terms, updated prior authorization requirements, and changes to the provider directory into our claims adjudication system in accordance with all requisite timelines. We load the West Virginia provider files daily. Provider data validation happens immediately upon submission to confirm the provider is enrolled in the West Virginia Medicaid program in support of the Department's program integrity requirements. If the provider is not enrolled, the claim is denied and returned to the provider advising the reason for the denial. These actions ensure accurate claim payment and encounter submissions.

Claim adjudication edits are configured within the claims processing system to validate the accuracy and completeness of data allowing for the seamless submission of encounters. The system has over 400 business rules in addition to standard configuration payment rules that our Configuration Standards Reimbursement Administration department configures to enforce policies and procedures. Examples include the following:

- **Benefits package variations:** The system automatically analyzes CPT, revenue, and HCPCS codes to determine whether specific services are covered under the contract or under benefit rules. If services are not covered, the system automatically denies the respective claim line with the appropriate HIPAA remittance remark on the recipient explanation of medical benefits.
- **Data accuracy:** The system is continually updated based on the most current code sets available (HCPCS, revenue, CPT, national drug code, ICD codes) by year. As new codes are added, terminated, or changed, we update the codes, so the system is always in compliance with HIPAA standards. If a network provider bills a code that has been terminated, the system denies the claim line and advises the provider the code is invalid via remittance advice.
- **Adherence to prior authorization requirements:** The system is configured to enforce the supporting documentation requirements of certain services. In addition, it can configure prior authorization by code, provider type, and place of service. Claim edit rules are set to validate the claim against the network provider, member, dates of service, services rendered, and units authorized. We have, and will continue, coordinate with UM to make modifications to support service requirements specific to this population.
- **Adherence to State-specific requirements:** The system is configured to enforce the rules and requirements set forth by the State of West Virginia such as timely filing and procedure code validity.
- **Provider qualifications:** Provider files are configured by specialty and category of service. This allows for the enforcement of categories of service and provider type on claims validation. Certain procedures can only be performed by select network provider types. For example, the system will not permit the processing of a claim for in-office heart surgery by a podiatrist. Cotiviti Healthcare (Cotiviti), an industry leader for front-end automation of correct-coding and medical-policy decisions, lends additional support, reviewing any claim line set to 'Pay' for billing appropriateness by specialty. The system 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 with a valid Medicaid identification, and is an active provider for the date of service.
- **Eligibility and enrollment:** The system validates the date of service against the member's enrollment segment to determine if they were eligible on that date. If not, the system denies the claim using the appropriate HIPAA-approved remittance comment.

- **Duplicate billing logic:** The system uses a robust set of edits to determine duplication of services (e.g., same member, same date, same network provider, same service, or any combination of these criteria). This logic protects against payment for services rendered by the same physician.

Other claims processing edits and tools used to maximize accuracy throughout the adjudication process include ClaimCheck® edits. ClaimCheck is a comprehensive code auditing solution based on guidelines such as CPT, HCPCS, American Medical Association (AMA), Centers for Medicare & Medicaid Services (CMS), CMS National Correct Coding Initiative Program (NCCI)/Medically Unlikely Edits (MUE), and ICD-10-CM. These guidelines support the claims processing system by applying expert industry edits from a provider recognized knowledge base to analyze claims for accuracy and consistency with relevant policies and procedures. 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-10 CM, NCCI IOM Manuals (internet-only), AMA, HCPCS, and national and local coverage determinations as well as health plan policies. The system uses algorithms to detect potential claims up-coding with follow-up procedures for chart audits as appropriate. **Table 6.1-3** includes examples.

Table 6.1-3: 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.
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.
Procedure code guidelines	Aetna follows the AMA CPT-4 book and CMS HCPCS book 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 AMA CPT book, this vaccination must be reported in addition to the vaccine and toxoid code(s).

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 for Medicaid 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. Contracted providers, who have a claim denied in whole or in part, are also notified of applicable appeal and grievance rights, which are addressed through our established provider grievance and appeals process.

Policies and Procedures to Meet Performance Standards and Prompt Pay Requirements for all Provider Types

Our claims 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. All Aetna Medicaid Administrators LLC policies are reviewed at least annually (within 12 calendar months of last reviewed/revised date). Policies may be updated more frequently if there are changes to the contract, federal, State, or other regulatory requirements, or Aetna business processes. All policy updates are reviewed by the Aetna Medicaid Policy Committee and require approval from Aetna Medicaid Administrators, chief operating officer, and chief medical officer prior to being published. Specific policies are as follows:

- **2000.05 Data Entry:** Documents processes used to facilitate timely and accurate data 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
- **2000.20 Claims Submission:** The purpose of the claims submission policy is to make sure paper or 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.
- **2000.30 Non-Contracted 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 CMS regulations, Department, and health plan standards
- **2100.15 Claims Inventory Management:** The Claim Inventory Management policy confirms proper inventory control for timely claims payment
- **3900.30 Reporting and Return of Overpayments:** Documents process for reporting and returning overpayments to the State
- **6200.10 Provider Claim Payment and Data Completeness:** Document requirements and standards for claims payment and data completeness

Monitoring Claims Receipts

We use a suite of automated tools and scheduled and ad hoc reports to monitor claim receipts, including the following:

- **Pended claims tool and reports:** Includes 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 the Claims team; if it is aging, the manager can assign out as soon as it 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 State requirements are being met.

These reports are used to distribute and manage claims through resolution. If any of the inventory management reports indicate a less than favorable trend, corrective action steps are taken 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, and if necessary, all Operations. Additionally, any systematic intervention opportunities by Information Technology to enhance claim processing are investigated and executed in collaboration with our claim payment director.

West Virginia-specific Strategies to Address Potential Provider Payment Issues

Our claims payment system will be analyzed to determine what additional editing needs to be configured in support of the State-specific requirements of this program. This will enable us to address any potential provider payment issues and provide billing education. Partnering with providers to support the smooth transition of this population and to ensure timely reimbursement is a top priority.

Underpayments, Overpayments, Pre-and Post-claims Editing Policies

Underpayment and overpayment recoveries: Our established policies and procedures help ensure that we and our subcontractors follow established benchmarks that help us proactively manage and analyze prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the State as required by 42 C.F.R. 447.46 and 42 C.F.R. 447.45. Additionally, all recovery of overpayments and underpayments will be administered in accordance with West Virginia requirements. We coordinate over- or underpayment reimbursement with the Department to ensure payment recovery is accurately reflected 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.

Provider Billing Education

The Provider Relations team implements innovative approaches using technology and reporting to provide targeted training to our provider community and improve the provider experience. The Provider Relations team uses on-demand reporting and analytics to help 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 facilitate timely claims payment for the provider. Risk adjustment training includes defining risk adjustment; its goals, risk scores, how they are calculated, and their impact on revenue; and how coding and encounter reporting are critical components of risk adjustment. Aetna also reacts to trends in claims denials.

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 regionally based provider forums where we invite guest speakers to present on best practices, system initiatives, and other topics relevant to serving West Virginia members. Information on claims edits is shared with providers.

Providers are also furnished with toll-free numbers to contact our provider or claims inquiry and research call centers; they have a direct number to reach their designated provider relations representative. They may also use email, secured web portal, fax, or mail.

West Virginia Claims Processing Performance

We are committed to continuing to meet and exceed the Department's goals for claims submission and adjudication to payment timeliness. We accomplish this through focused claims inventory and workflow management practices, data monitoring and analysis, and management oversight. 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. **During the last 12 months Aetna's average turnaround time for EDI claims is 8 days, and our average turnaround time for paper claims is 13** days. In support of these requirements, we generate a weekly payment cycles for medical claim payments. **Table 6.1-4** list our consistently high-performance data and compliance with timely processing with 30-day claims payment requirements for the last 12 months.

Table 6.1-4: West Virginia Claims Performance for the Past 12 Months

Month	Days to Pay		30 Days		90 Days	
	EDI 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
Jun-19	8	13	166,878	99.74	167,316	100.00
May-19	8	12	167,622	99.53	168,389	99.99
Apr-19	8	13	181,596	99.39	182,615	99.95
Mar-19	8	13	217,825	99.25	219,450	99.99
Feb-19	8	14	183,785	99.35	184,964	99.98
Jan-19	9	14	184,845	99.06	186,586	99.99
Dec-18	9	13	186,188	99.01	188,044	100.00
Nov-18	8	11	172,479	98.79	174,592	100.00
Oct-18	8	14	157,558	98.93	159,252	100.00
Sep-18	8	15	222,739	99.24	224,418	99.99
Aug-18	8	12	164,560	98.87	166,322	99.83
Jul-18	8	13	160,112	98.62	162,356	100.00

Guidelines for Approving Out-of-Network Provider Claims

PS008	The Vendor should establish and implement guidelines to approve out-of-network provider claims for physical health and behavioral health services--including, but not limited to, hospitals--on an ongoing basis (after the 90-day exemption timeframe).	1) The Vendor should describe how it will meet this specification. 2) The Vendor should state whether it will reimburse these providers using the Medicaid fee schedule(s) or an alternate fee schedule.

Aetna will comply with the requirements to allow adequate, timely, and medically necessary covered services through a non-participating provider as required by the State, through our claims processing system described previously. In situations where medical necessary services are provided by a non-participating provider, we will either contract with that provider or allow the member to seek services from that non-participating provider using a single-case agreement. Our Provider Relations team engages and encourages non-participating providers to join by conducting telephonic engagement and in-person visits to the provider's office to discuss becoming a contracted provider.

As required by the **Model Service Provider Agreement Section 3.7.3** we will pay clean claims submitted by out-of-network providers within 30-days of submission when the claims are for the following: medical emergency services; family planning and sexually transmitted diseases services; prior authorized services; or when retro-authorization meeting medical necessity has been granted due to the nature of the service. Our out-of-network reimbursement rate for non-emergency services is 80 percent of the Medicaid fee schedule.

For our members that have complex medical needs and are under the specialty care of a non-participating provider for the entire episode of care (e.g., rare forms of cancer), the care coordinator coordinates care with the non-participating providers and engages the Utilization Management department to review and authorize services according to the member's care plan. A member being treated for a behavioral health disorder with a non-participating provider follows the same transition plan. Members, and their parents, legal guardians, fictive kin, and child welfare case managers are educated about how to access out-of-network services through the member handbook, our member services staff, and care management staff. The care coordinator collaborates with the provider, ensuring appropriate care, until we can assist our member by transferring care to an in-network provider or the existing provider contracts to our network.

Review Process for Payment of Emergency Services

PS009	The Vendor should establish and implement a review process for payments for emergency services for applicable populations, including, but not limited to, the following:	1) The Vendor should describe how it will meet this specification. 2) If algorithms are used to evaluate pended claims, the Vendor should describe how it will ensure that the "prudent layperson" standard is upheld.
PS010	Which types of claims are automatically paid	See the parent specification.
PS011	Which types of claims are automatically pended	See the parent specification.
PS012	Evaluation of pended claims for payment, upholding the "prudent layperson" standard	See the parent specification.

Aetna never requires prior authorization for emergency care and automatically pays claims for emergency services that conform to claims submission requirements. [PS010]

Aetna's established process for review of emergency services follows the prudent layperson standard; our payments are based on the member's symptoms, not on the final diagnosis. Aetna provides and reimburses ER and post-stabilization services across 16 states in which we currently operate Medicaid programs. **[PS009]** Additionally, we adhere to the following guidelines regarding ER services in West Virginia:

- Aetna does not limit what constitutes an emergency medical condition based on lists of diagnoses or symptoms. Furthermore, our emergency and post-stabilization services do not require prior authorization.
- Aetna also pays for follow-up screening and treatment services necessary to diagnose or stabilize the member as needed to treat the member appropriately.

Consistent with our standard claims review process, if we identify an ER provider as an outlier in consistently billing higher level codes, we may pend the claims and request documentation to verify the level of code billed. As stated, decisions to pend ER claims are not based on member symptoms or diagnosis, but solely on a provider being identified as an outlier when compared to expected service levels billed. Records are reviewed by our medical staff to verify whether the documentation supports the level of service billed. If we determine the records support a lower level of service, we will notify the provider and process the claim at rate for the appropriate level of service. Claims are reviewed and released for payment within the required turnaround times. **[PS011]**

As stated previously, Aetna follows the prudent layperson standard when paying claims for emergency services and limits the pending of emergency claims to those situations where a provider is identified as an outlier in billing services with higher levels of codes than other similar providers. The review of these pended claims is for the purpose of assessing whether the provider's overall billing practices are consistent with applicable service code requirements. **[PS012]**

7. QUALITY

The Vendor should refer to the business specifications located in ***Appendix 1: Detailed Specifications*** (based on the categorization within Column E: Subject Matter Area) and pertinent narrative in ***Section 4: Project Specifications*** in this RFP, and then describe its approach to Quality below. The Vendor's narrative response should not exceed 60 pages.

Aetna's superior quality outcomes and value-based arrangements support West Virginia's goals while demonstrating a commitment to providing an optimal member and provider experience. We achieve quality management excellence through our innovative solutions and flexible approach to integrated care management to improve health outcomes that meet and exceed State expectations.

Quality Assurance and Performance Improvement Program

QU005	The Vendor should administer a Quality Assurance and Performance Improvement (QAPI) Program.	The Vendor should describe how it will meet this specification.

Aetna brings the full complement of our local and national quality improvement infrastructure to provide a comprehensive quality approach across the entire continuum of care services for West Virginia. **We are the only National Committee for Quality Assurance (NCQA) Commendable-accredited Medicaid organization in West Virginia, a ranking we have maintained since 2016**. We have achieved high-quality outcomes by working in the State for many years and focusing on our local communities. We are West Virginians, which empowers us to make a significant impact in communities across the state to address social determinants of health (SDOH) for the most vulnerable children and youth. Aetna has strong connections with local providers and communities; through our Care Connection team (CCT) care management model, we will have staff throughout the state that understand children and youth in the child welfare system and individuals receiving adoption assistance and the differences in the communities where they live. Aetna's Quality Assurance and Performance Improvement (QAPI) program helps to support the State's goals by monitoring and enhancing our quality of care and coordination of care and access to services, including physical health (PH), behavioral health (BH), dental care, and socially necessary services (SNS).

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 **Model Service Provider Agreement Section 7, 42 C.F.R. 438.330**, and NCQA accreditation standards. Aetna's QAPI is designed to continuously improve and monitor the medical care, member safety, BH services, and delivery of services to members and their caregivers, including ongoing assessment of program standards to determine the quality, accessibility, availability, and appropriateness of care. A key focus of our quality program is improving the member's biological, psychological, and social well-being with an emphasis on quality of care and the non-clinical aspects of all services. Where the member's condition is not amenable to improvement, our goal is to implement measures to assist the member to live safely in the least restrictive setting. Incorporating the continuous quality improvement (CQI) concept, our quality program is comprehensive and integrated across the entire continuum of care to deliver needed supports and services in the most integrated, appropriate, and cost-effective way possible to enhance coordination of care and access to services, including PH, BH, dental care, and SNS.

The quality management (QM) 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 our quality scores exceeding our competitors. We maintain health information systems that collect, analyze, and report data to meet all contractual requirements. Our quality program includes a robust structure of oversight committees with

members from across the health plan, as well as from the provider network representing the communities we serve.

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 member, family, practitioner, and provider satisfaction across the various settings of care within the delivery system. Through our QAPI program, we ensure the services provided to children and youth in the foster care system and individuals receiving adoption assistance conform to the standards and requirements of regulatory and accrediting agencies, including the West Virginia Bureau for Medical Services (BMS) and NCQA. The purpose of the QAPI program is to establish standards and criteria and provide processes, procedures, and structures to review and monitor the care and service delivered, including accessibility, availability, and continuity of care. We have an established program that includes a comprehensive quality approach across the entire continuum of care services. This approach allows us to reduce fragmentation of care and has allowed us to promote key improvement activities across our organization and provider network to help our members.

QAPI Program Goals and Objectives

Aetna strives to achieve the following primary goals to help improve health and social outcomes for our members and the impacts on families:

- Implement a QM program that effectively promotes and builds quality into the organizational structure and processes of the health plan
- Conduct continual monitoring and assessment of member care and services striving to provide health care and services to health plan members to ensure appropriate medical practice standards and the needs of our members and health care professionals
- Identify and analyze opportunities for improvement with careful implementation of actions and follow-up
- Encourage member safety across the organization and network of providers
- Maintain compliance with local, State, and federal regulatory requirements and accreditation standards

"One of the most ubiquitous and significant ways that Charleston Area Medical Center (CAMC) has experienced improvement in quality scores is through collaboration with payers in the marketplace. Aetna is an efficacious partner in many of the quality initiatives that CAMC has begun through its clinically integrated network, West Virginia Health Network (WVHN). Over the past year, providers that have joined WVHN have seen an increase in their HEDIS scores and decrease in care gaps through these joint efforts."

—Michelle Coon
President, CAMC Health Network

Our quality management director is a West Virginia native and a registered nurse with extensive experience guiding QM programs in the Mountain State, including accountability to ensure that the local QM program adheres to all external quality review and accreditation requirements while meeting the needs of our most vulnerable children and youth population. **Our quality management director has over 30 years of QM experience and has been directly accountable for the quality program in West Virginia since 2014.**

Aetna integrates quality management and performance improvement processes into all departments, with each department responsible for selected processes, functions, and monitoring activities. Staff members perform monitoring activities as a part of routine operations and report results to the proper internal departments, committees, or external agencies as required. Every Aetna functional area is accountable for quality outcomes—this focus across our organization has helped our quality performance exceed our competitors.

Organization Structure and Administration

A formal committee structure allows for oversight of the QAPI program and for the flow of information to and from the board of directors as depicted in **Figure 7.1-1**. The committee members integrate Aetna medical functions, operations departments, network, and members into the QM program through their participation on one or more committees, overlapping membership and leadership responsibilities, and integrated reporting requirements.

Figure 7.1-1: QAPI Committee Structure

Aetna's comprehensive quality committee structure directs organization-wide CQI initiatives.

Board of Directors

Our local board of directors has ultimate accountability for the West Virginia QAPI program and related processes, activities, and systems. This includes responsibility for implementing systems and processes for monitoring and evaluating the care and services members receive through the health delivery network. They review and approve the proposed annual QAPI work plan and updates, program description, and evaluation.

Quality Management Oversight Bodies and Schedule of QM Activities

The local West Virginia QM department provides the administrative support for the coordination of committee meetings, meeting preparations, and follow-up activities. The Quality Management Oversight Committee (QMOC) provides executive oversight of quality activities and their integration across the plan through its receipt and review of reports and minutes from the committees. **Table 7.1-1** provides a description of the Aetna local and national QM committees.

Table 7.1-1: QAPI Committees and Schedule of Activities

QAPI Committees	Description	Meeting Frequency
West Virginia-based Committees		
Quality Management Oversight Committee	Chaired by the chief executive officer (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 and among delegated organizations and network providers.	Six times per year

QAPI Committees	Description	Meeting Frequency
Quality Management/Utilization Management (QM/UM) Committee	Chaired by the chief medical officer (CMO)/medical director with cross-functional representation and network providers, including primary care providers (PCPs)/medical homes, specialists, pediatrics, obstetrics/gynecology (OB/GYN), and BH; advises and makes recommendations to the CMO/medical director on matters pertaining to the quality of care and service provided to members, including the oversight of the QAPI and UM.	10 times per year
Delegation Oversight Committee	Chaired by the director of quality management with cross-functional representation; advises and makes recommendations to QMOC about delegated relationships.	Quarterly
Complaint Committee	Chaired by the complaint and appeals supervisor and reviews issues of expression of dissatisfaction by members, practitioners, or providers.	Monthly
Service Improvement Committee (SIC)	Chaired by the director of operations with cross-functional representation; advises and makes recommendations to the QMOC and/or Aetna management about customer (member and practitioner/provider) issues.	Monthly
Appeals 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 members or providers.	Weekly
Member Advisory Committee	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, including health education and other member materials.	Quarterly
Compliance Committee	Chaired by the compliance officer with cross-functional representation; 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 policies.	Monthly
Aetna National Committees		
Credentialing and Performance Committee (CPC)	Composed of participating practitioners of various specialties who are all voting members, as facilitated by the Aetna regional medical director; responsible for credentialing and re-credentialing individual practitioners who deliver services to members. This committee is also 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 members. This committee reports to the QM/UM Committee at least quarterly.	At least every 45 days
Aetna Practitioner Appeals Committee (Subcommittee to the CPC)	Facilitated by an Aetna medical director; conducts professional review hearings of providers who appeal decisions made by the CPC involving professional competence or conduct of the provider; consists of providers appointed on an ad hoc basis by the CPC. The committee reports through CPC and to the QMOC.	As needed
Aetna Quality Oversight Committee	Chaired by the Aetna medical director or designee; conducts the credentialing/re-credentialing of facilities/organizational providers/vendors and the review of facilities/organizational providers/vendors potential quality of care issues and complaints.	10 times per year

We integrate a governance model with responsibilities and accountabilities of top-level management and the board of directors. A formal committee structure allows for oversight of the QAPI program and for the flow of information to and from the board of directors. The committee members integrate Aetna medical functions, operations departments, network, and members into the QM program through their participation on one or more committees, overlapping membership and leadership responsibilities, and integrated reporting requirements. Aetna takes part in all quality meetings as requested by the 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 documentation.

Quality Management Department

Under the direction of the CMO/medical director, the QM department administers Aetna's QAPI and provides administrative support for the health plan committees. The CMO/medical director reviews the reports and information and submits to the appropriate committees and State agencies. **The department is well staffed with an experienced team that is knowledgeable of the State's communities** and includes a director of quality management, Healthcare Effectiveness and Data Information Set (HEDIS) project manager and coordinators, accreditation project manager, prevention and wellness outreach staff, and QM nurses. The QM departmental staff maintains documents, medical records, and research documents in a safe, confidential, and protected manner. The department responsibilities include, but are not limited to, the following:

- Daily coordination and support of QM processes and monitoring activities to promote enhanced coordination of care, access to services, and seamless care for members
- Coordination with Care Management, UM, and other Aetna departments to carry out quality and performance improvement activities
- Partnering with the Aetna Medicaid organization's national QM team in the review of information related to potential quality of care issues
- Performance improvement projects
- Monitoring performance rates for all performance measures
- Documentation of quality management and performance improvement activities (e.g., reports, correspondence, minutes) and reports to the appropriate committees
- 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 activities involved in the preparation of the annual QAPI evaluation
- Coordination of member satisfaction surveys including the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and the annual BH member satisfaction survey to promote tailoring flexible programs to meet member needs
- EQRO coordination

The QM department coordinates evaluation and follow-up on contacts from members and their caregivers/guardians, practitioners, providers, State or regulatory agencies, or other referral sources. It is the central area for receiving and responding to potential quality and/or risk management and compliance issues. Quality management and performance improvement activities are part of a fundamental Aetna focus on ensuring members' needs are met and systemic issues are modified to improve health and social outcomes for youth and impacts on families. The department's role in initiating and coordinating communications about the program is critical in linking the parties involved (members, 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.

Quality Strategies and Approach

QU017	The Vendor should monitor quality improvement strategies with measurements including, but not limited to, the following:	The Vendor should describe in detail how it will meet this specification.
QU018	Access to care	See the parent specification.
QU019	Demand for services	See the parent specification.
QU020	Quality of care	See the parent specification.
QU021	Health outcomes	See the parent specification.
QU023	The Vendor should analyze utilization data to monitor quality improvement strategies.	The Vendor should describe in detail how it will meet this specification.
QU024	The Vendor should collect and analyze quality measures at a set frequency.	The Vendor should describe how it will meet this specification.
QU025	The Vendor should report annually to the Department on its activities related to access to care, according to the Service Provider Agreement (SPA).	The Vendor should describe how it will meet this specification.
QU057	The Vendor should establish and implement ongoing quality monitoring activities to ensure quality for members and compliance with program requirements.	The Vendor should describe how it will meet this specification.
QU058	The Vendor should periodically enhance ongoing quality monitoring activities to ensure quality for members and compliance with program requirements.	1) The Vendor should describe how it will meet this specification. 2) The Vendor should describe when it will perform quality initiative monitoring activities."

In addition to the daily oversight of our QM department, Aetna evaluates QM effectiveness monthly, quarterly, and annually through the quality committees. The scope, goals, objectives, structure, staffing, and responsibilities of the QAPI program are modified based on our analyses, as well as changes to the contract and accreditation standards. Aetna leadership, providers, members, and/or member agency representatives, community agencies, and multiple departments work together as a team to improve our organization's performance. Our innovative CQI approach encompasses an extensive array of activities, involving providers, members, their families/caregivers, and the day-to-day operations teams in our efforts. It ensures year over-year review of all standing or innovative QAPI program elements and frequent modifications to the program in support of a Plan-Do-Study-Act (PDSA) framework. PDSA guides our approach to developing, testing, and implementing changes as part of Aetna QAPI program and performance improvement projects (PIPs). We use the PDSA cycle and perform multiple analyses, including root-cause analysis, flow and run charting, Ishikawa diagrams, Pareto charts, and the Five Whys. We create driver diagrams to show areas for potential improvement and take actions as guided by our QM/UM Committee. Using the QAPI components, Aetna maintains a robust quality program through the following:

- Our committee structure promotes clinical and quality leadership engagement in public health issue discussions in the State, allowing Aetna to leverage experience across different Medicaid states to collaborate successfully with the Department to support State goals
- Using data-driven, objective, and rigorous measurement to support an outcomes-based continuous quality improvement process
- Having a structure in place to identify and remove barriers by which to address unmet member or provider needs and monitoring the effectiveness of improvement programs, including evaluation of member and provider surveys
- Monitoring provider performance to support a network that demonstrates understanding and ability to address health needs of diverse member needs while supplying accessible, high-quality care and integrated services, and to support our value-based payment programs to drive high-value care
- Promoting equity through reduction or elimination of health disparities and regularly stratifying and reporting upon health outcomes to develop interventions that improve quality disparities based on

differences such as age, race, ethnicity, sex, primary language, geography, special needs, and key population groups.

Our PIPs include those selected by the State and internally chosen through the QAPI program. As outlined in **Section 7.2.1 of the Model Service Provider Agreement**, our PIPs include both **clinical and non-clinical** areas of focus. Examples of our PIPs for dental services for children and adolescents and postpartum visits are included in this section.

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. Our rate of annual dental visits for children age 2 to 21 years in 2017 (61.04 percent) revealed an opportunity for improvement. Our approach to targeting this area for action included efforts by many team members within Aetna's various departments to look for opportunities within their daily scope of activity to focus on this issue. Our Care Management team members address gaps in care as they work with children and adolescents in various levels of care management. Our QM department's data analytics 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 practitioner offices in these lower-performing areas in order to host dental clinics, where our Aetna children and adolescents were outreached for attendance to the dental well-clinic day. 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 7.1-2**. 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 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 member outreach, our dental visit rate has steadily increased from 61 percent in 2017 to 64 percent in 2019.

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 QM team evaluated various cultural and disparity factors that may be affecting this postpartum visit rate. It was identified that a significant number of our postpartum members who did not keep a postpartum appointment also had an opioid disorder. Identification of this trend presented an opportunity to engage the Care Management team for member outreach and assessment. Aetna embedded obstetrics case 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 members in their communities to assist with postpartum care planning. The substance use disorder (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. **These outreach efforts have contributed to improvement in the**

Figure 7.1-2: Dental Visit
Ariel (not her real name) is happy with her Aetna backpack full of goodies during the children's dental event at Williamson Health and Wellness Center.

postpartum visit from 60.83 percent in 2017 to 63.50 percent in 2018.

[QU057] Establishing and Implementing Ongoing Quality Monitoring Activities

Aetna maintains a QM program that provides the foundation and resources to ensure that high-quality and cost-effective services are provided to our members. The program involves the participation of the board of directors, management, practitioners, and multiple departments working together as a team to improve our organization's performance. Aetna designed the program to meet or exceed State and federal regulatory requirements, Centers for Medicare & Medicaid Services (CMS), NCQA, and Aetna requirements. The Aetna quality program provides a formal process, through the robust committee structure, to systematically monitor and objectively evaluate the company's quality, efficiency, and effectiveness. Through this structure, Aetna formally assesses information through our established QAPI structure and processes, including review of historic and current performance data. We produce monthly reports showing aggregate performance rates, predictive rates, and encounter data to identify members needing care or outreach.

An example of our current quality monitoring is related to our inpatient (IP) alerts. Aetna tracks when our member is being discharged from an IP setting to help ensure appropriate continuity of care. The process requires Aetna to outreach the member and/or caregiver/guardian within three business days of discharge to complete necessary questionnaires (such as the health risk assessment and post-discharge questionnaire) to assess the need for care management services (if not already enrolled in the care management program). If we are unsuccessful in reaching the member and family, we try to obtain alternative contact information from all the available sources (e.g., last PCP office visited, last pharmacy visited, etc.). Once we are able to reach the member and/or caregiver, we ascertain the reason behind the IP admission, potential underlying health and social factors that may have led to the admission, and medications prescribed during or after the admission, and we assess the need for referrals to specialists or support services. In addition, during our post-discharge outreach, we help to ensure appointments are set for follow-up and that discharge instructions are provided and understood by the member and their families. We also assess for any specific dietary needs and make certain they can obtain proper nutrition.

As an **NCQA-accredited organization at the Commendable level**, our approach encompasses an extensive array of strategic solutions to improve the experience of our members and the care delivered by our providers. Understanding and acting on data is foundational to improving members' health outcomes, ensuring gaps in care closure, and decreasing health care costs. This approach is reflected in our recent collaboration with the New River Health Association to provide annual eye screening for members with diabetes or pre-diabetes who live in medically underserved areas.

[QU058] Approach to Periodically Enhancing Quality Monitoring Activities

Aetna conducts an **annual evaluation** of the QAPI program to assess the overall effectiveness of our quality improvement program and CQI. 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. It also addresses barriers from the previous year, identifies barriers encountered during the calendar year that were evaluated, includes data trends, and provides Aetna with the opportunity to make changes to the QM program for the upcoming year. In addition, **we incorporate changes or enhancements to these monitoring activities as identified throughout the year** through several monitoring activities, including our PIPs. Theses evaluations include all aspects of the QAPI program to determine the extent and effectiveness of improvements in the quality of care and services.

Opportunities for improvement identified in the evaluation or articulated by the Department or other key stakeholders drive the development of the goals and objectives. The QM department is responsible for

preparing the annual evaluation, identifying new or necessary changes and enhancements to our monitoring activities, and submitting for review and approval to the QM/UM Committee, QMOC, and the board of directors. Examples include the recent 2019 medical record documentation audit, which revealed steady improvement in the evidence in the medical record of communication/discharge summaries regarding emergency care and hospitalizations. These results improved from 76 percent in 2017 to 87 percent in 2018 to 93 percent in 2019. Education of our providers regarding the importance of documentation of communication/discharge summary information has been effective in improving compliance with this important aspect of medical record documentation, which contributes to safety of clinical care.

As a result of the 2018 annual evaluation, Aetna added resources to certain state regions to enhance monitoring activities. Continuity and coordination of health care and our continued monitoring of the communities and its provider networks drove these initiatives and remediation of potential gaps through the following activities:

- Addition of a **SUD specialist** in each of the CCTs
- Increased resources devoted to the southern region of the state to address the medical, BH, and social needs identified in this region to increase ongoing monitoring and interventions efforts
- Development of a streamlined annual notification to practitioners of key regulatory requirements, addition of a second member newsletter, and redesign of the member handbook

As one example of our continuous monitoring and enhancements, using our results and analysis from our 2018 provider satisfaction survey, we discovered a need for improved coordination between BH and PH providers. To improve our processes and understanding of communication barriers between providers, we added three behavioral providers to the QM/UM Committee and adopted the CCT model to improve coordination.

Aetna's QM and UM programs systematically measure and analyze performance data and work to improve the overall quality and safety of clinical care and quality of service provided to our members; these members include our children with special health care needs, those involved in the foster care system and adoption assistance, and those transitioning out of foster care. Throughout the year, Aetna uses multiple data sources to provide real-time information on progress towards our targets on a monthly and quarterly basis. We use this data to periodically enhance and update current quality monitoring activities.

[QU017] Monitoring Quality Improvement Strategies

Each year an evaluation reviews all aspects of the medical management programs, emphasizing demonstrated improvements in the quality of care and services provided to members as well as opportunities for improvement. The annual QM/UM program evaluation includes the following:

- A description of completed and ongoing QM activities that address quality and safety of clinical care and quality of service
- Trending of measures to assess performance in the quality and safety of clinical care and quality of service
- Consideration of member and practitioner experience with medical management programs
- An analysis and evaluation of the overall effectiveness of the QM and medical management programs and of progress towards influencing network-wide safe clinical practices

For all areas where goals are not met, a root cause or barrier analysis is conducted to identify the underlying reason(s). This information is used to determine changes or restructuring of the QM and/or UM programs as necessary. One key area of focus for Aetna has been monitoring of well care metrics for children. The HEDIS 2017 results indicated opportunities for improvement in well-child visits and childhood immunizations. We conducted a root-cause analysis, which revealed specific geographic areas

within the state where compliance with screening recommendations appeared to be lower. Aetna targeted practices in these areas and collaborated with specific providers and federally qualified health centers (FQHCs) to conduct well-visit clinics. We also utilized the Ted E. Bear, M.D.℠ Cub Club to focus attention on the importance of childhood immunizations. **Table 7.1-2** demonstrates the **significant improvements in well-care visits**.

Table 7.1-2: Monitoring Well-care Visits

Well Child Measures	2017		2018	
	Result	Goal Met	Result	Goal Met
Well-child visit ages 15 months to 6 years	63.68%	No	72.99%	Exceeded
Well-child visit ages 3 to 6 years	71.93%	No	75.91%	Exceeded
Childhood immunizations—combo 10	24.53%	No	36.50%	Exceeded

As an NCQA **Commendable**-accredited organization, we have demonstrated our commitment to CQI. Examples of our successful CQI initiatives include the following:

- Compliance related to seven-day post-discharge follow-up demonstrated year-over-year data improvements from 30.32 percent in 2017 to 32.17 percent compliance in 2018
- Monitoring of metabolic measures on children prescribed antipsychotic medications demonstrated a **significant improvement** of 19.52 percent points in compliance between 2016 and 2018
- Collaborating with Feeding America organizations to hold mobile food pantry events in identified food deserts throughout the state over the entire year as part of our larger strategy to engage community organizations; improve member health and social outcomes; and promote key areas identified by our QM analysis for each region/community such as well-child checkups, immunization schedules, and dental checkup information

CQI Activities Implemented to Increase Compliance with BH Post-discharge Follow-up

- Providing gift cards to members who complete their follow-up visit within seven days
- Care coordinators located at key provider offices
- Telephonic outreach by Care Management team to address barriers, assist in making BH follow-up appointments, and provide referrals

In addition to special analyses and programs, a variety of standard mechanisms are used to address Aetna objectives and goals as explained in **Table 7.1-3**.

Table 7.1-3: Aetna Quality Monitoring Strategies

Areas of Focus	Monitoring Strategies
Access to Care **[QU018]**	• Conduct annual population assessment analysis to promote equitable access to care and services by identifying and affecting reduction of racial and ethnic and regional disparities in health care outcomes that could negatively impact quality health care • Annually evaluate and generate accessibility and availability analyses on the network and implement corrective action if necessary • Conduct annual continuity and coordination of care evaluations • Evaluate regular credentialing and re-credentialing reports • Monitor the practitioner and provider network's capacity to accommodate the membership while considering the diverse needs of the member population, including BH and special health care as well as specific language or cultural needs and preferences

Demand for Services **[QU019]**	• Maintain mechanisms for reviewing the entire range of care delivery systems, including all demographic groups, care settings, and services available to the member • Use enrollment metrics to provide annual reports that include all demographic groups, care settings, and services available to the member • Use utilization of service categories • Identify and evaluate quality and risk issues • Implement follow-up measures and action plans to resolve issues and prevent recurrences • Monitor actions for continued effectiveness • Implement rapid response process (i.e., Rapid Response team meetings)
Potential Quality of Care (PQOC) **[QU020]**	• Promote optimum care and service and identify issues related to provider and member quality of care • Monitor outpatient and inpatient services to identify deviations from standard of care/service • Perform ongoing off-cycle quality of care and quality of services reviews • Manage quality and risk management referrals • 12 months trending all referrals for individual practitioners/facilities/organizational providers; referred to Credentialing Committee for evaluation • Monthly evaluation in overall case trends for the prior three years • Grievance and appeals monitoring for PQOC • Over- and under-utilization • Member satisfaction
Health Outcomes **[QU021]**	• Measure effectiveness of the population health strategy and implement interventions to improve performance • Conduct an annual population health management effectiveness analysis • Identify opportunities to improve health care outcomes for children and youth in the foster care system and individuals receiving adoption assistance • Maintain and/or improve HEDIS annual scores for targeted measures • Identify and act on opportunities for improvement • Monitor the effectiveness of initiatives

[QU023] Using Utilization Data to Monitor Quality Improvement

Understanding utilization rates is foundational to improving enrollee health outcomes, ensuring closing gaps in care, and decreasing health care costs. Aetna formally assesses utilization rates through our QM/UM Committee, including review of historic and current performance data for over-utilization of low-value care and under-utilization of high-value care. We produce monthly reports showing aggregate performance rates, predictive rates, and encounter data to identify enrollees needing care or outreach. Hotspot drilled-down reports show enrollee characteristics, race, ethnicity, specific gaps by area, SDOH, and other variables to identify need for intervention based on region. We use the PDSA cycle and perform multiple analyses, including root-cause analysis, flow and run charting, Ishikawa diagrams, Pareto charts, and the Five Whys, and take actions as guided by our QM/UM Committee.

As directed by the CMO/medical director, PH and BH medical directors provide oversight of Aetna's clinical functions including QM, UM, and care management. The medical directors provide clinical leadership for the QM/UM Committee, conduct medical necessity reviews, conduct peer-to-peer reviews, and provide mentoring and clinical leadership for the integrated care management program to improve utilization and quality outcomes.

Aetna uses utilization data to identify specific patterns of higher utilization by county for children and youth so that outreach can occur. Once specific geographic areas are identified with higher emergency room (ER) utilization, the CCT members in that county are empowered to quickly address unique needs that may be present in that geographical region. Having our CCT members physically located in each region—with many of them onsite at local facilities—greatly enhances our ability for rapid response to potential care and/or service issues with our children and youth.

An example of how Aetna uses utilization management data to track trend quality improvement over time is our monitoring of ER visits related to our alternative payment model (APM) arrangements. The data shown below in **Figure 7.1-3** demonstrates a year-over-year improvement in the reduction of ER visits for one of our APM providers.

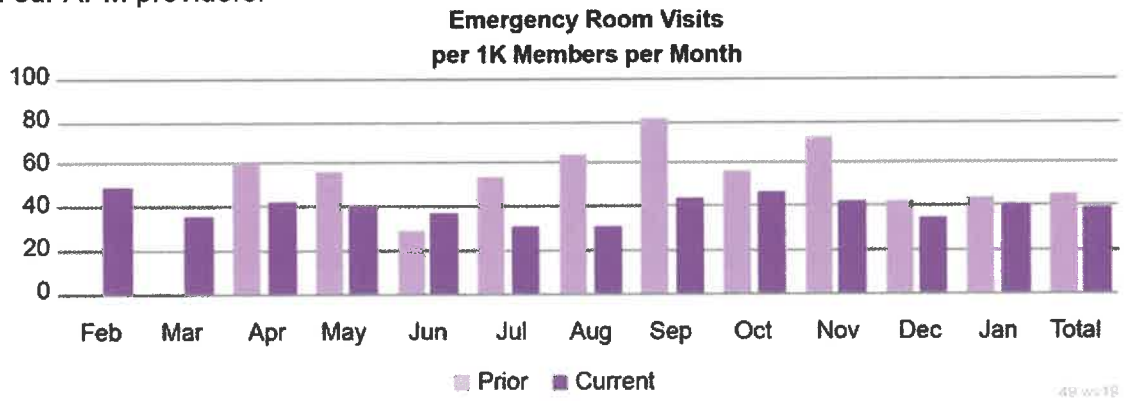

Figure 7.1-3: UM Data Demonstrating ER Visit Trends
Aetna uses UM data to track and trend ER visits for our providers in APM arrangements.

[QU024] Collecting and Analyzing Quality Measures
The QM/UM Committee reviews trends in quality and utilization management measures and outcomes and reviews utilization issues (cases) requested by the CMO/medical director and identifies opportunities to improve the care and services provided to members and recommend solutions. This committee also manages and provides direction on clinical quality improvement initiatives, such as HEDIS results, PIPs, study results, satisfaction survey findings, and general information related to programs, systems, and processes. **Table 7.1-4** includes a list of analyses and reports Aetna utilizes to monitor and evaluate the QM and UM activities.

Table 7.1-4: Quality Improvement Measures and Frequency

Quality Improvement Measure	Description	Frequency
Analysis of member complaints and appeals	Monitoring of the volume and types of member complaints and appeals including a drill-down by specific category to identify trends and monitoring of turnaround times	Quarterly
Assessment of member experience	Comprehensive analysis of multiple indicators of member experience, including member complaints and appeals and satisfaction survey data	Annual
CAHPS analysis	Analysis of the results of the adult and child member satisfaction surveys, including year-over-year comparison to identify trends	Annual
Clinical practice guideline/preventive service guideline review and update	Review of current clinical practice guidelines and preventive health guidelines to ensure adherence to the latest recommendations from national sources	At least annually or more frequently if guidelines are updated by national sources

Quality Improvement Measure	Description	Frequency
Continuity and coordination of medical care	Analysis of data on member movement between practitioners and across settings to evaluate continuity and coordination of medical care services	Annual
Continuity and coordination between medical care and BH care	Analysis of data about opportunities for improved collaboration between medical care practitioners and BH care practitioners	Annual
HEDIS 2018 Work Plan	Work plan outlining initiatives targeting improvements in various clinical performance measures	Annual
Language services	Analysis of member requests for translation services to ensure that member needs are met	Annual
Medical record documentation audit report	Analysis of practitioner medical records to ensure compliance with recommendations for proper medical record documentation and confidentiality practices	Annual
Membership profile/population assessment	Analysis of entire member population characteristics including age bands, racial/ethnic considerations, SDOH, geographical variations, high-volume diagnoses, and other characteristics of our membership	Annual
Network adequacy	Comprehensive assessment of all measurements of accessibility and availability of care, including the number and geographic distribution of practitioners, appointment accessibility, and requests for and utilization of out-of-network services	Annual
Performance Improvement Projects	Assessment of clinical performance in various areas pertinent to the member population	Quarterly
Potential Quality of Care	Identification, investigation, and tracking of potential or actual quality of care concerns	Quarterly

[QU025] Report Access to Care Activities Annually to the Department

Aetna helps to ensure access to timely and appropriate services, as outlined in **Section 3.1.2 of the Model Service Provider Agreement**. This includes maintaining a panel of primary care providers from which the members may select a personal primary care provider.

Aetna monitors practitioner accessibility and availability on an ongoing basis to maintain the network in accordance with established standards for reasonable geographical location, ratio of practitioners to members, hours of operation, appointment availability, and coverage for emergency care and after-hours services. Monitoring activities include practitioner surveys, onsite visits, evaluation of member satisfaction surveys, evaluation of concern/complaint, and/or appeal reports, evaluation of practitioner to member ratios, and monitoring of closed primary care practitioner panels. Upon identification of deficiencies, Aetna works with providers and practitioners to develop corrective action plans followed by reassessment for compliance. The Aetna QMOC and the board of directors review accessibility and availability data and reports at a minimum of six times per year.

QM and provider services staff work together to monitor the availability of practitioners and the accessibility of medical and BH services. QM staff assists provider services staff in developing benchmarks for availability and accessibility measures that meet network standards, analyzing data collected in the monitoring process, and preparation of information for the QMOC. If the reported data

indicate the need for an action plan or additional studies, QM will assist in developing tools and reporting results and outcomes to the QMOC and board of directors.

Activities Related to Access to Care

Through the 2018 UM/QM program evaluation, our assessment of network availability data revealed 100 percent compliance with geographic availability goals for family practice/general practice, pediatrics, and nurse practitioners; in addition, appointment accessibility data for PCPs and high-volume/high-impact practitioners revealed that all standards were met. In addition, our assessment of network availability data revealed 100 percent compliance with geographic availability goals for all types of BH practitioners (both prescribers and non-prescribers); during the study period, there were **no member complaints or appeals related to BH care accessibility**.

Our interdisciplinary care coordinators, part of CCTs, act as a resource for both members and all participants of the West Virginia child welfare system of care, including community organizations, family support, and foster care providers. This step helps to coordinate collaborative services and promotes access and continuity of care. Our local and community-based team has a knowledgeable team of social workers, registered nurses, and counselors who have a wide variety of expertise, including experience caring for youth (sometimes lived experience), and who are fully trained to assess a comprehensive profile of each member. We utilize our locally placed CCTs, which include our care coordinators, to help identify gaps in care for our child and adolescent population, which in turn helps improve local access to much-needed PH and BH services and other SNS.

We ensure that our care coordinators understand the impact of Adverse Childhood Experiences (ACEs) and the importance of creating an environment of safety that does not cause re-traumatization. We apply **trauma-informed care (TIC) standards** and our training emphasizes the roles and responsibilities of the Department and other children's services agencies and those of foster parents in making decisions on behalf of children in foster care and the adoption assistance programs.

Aetna's goal is ensuring development and ongoing management of a comprehensive primary, specialty, and BH provider network of qualified and clinically advanced care providers, trained to work with this target population, so each member receives the very best in health care services. We deeply value and depend on our provider relationships to create programs and practices that are fair and simple to implement so that providers can stay focused on what they do best: providing high-quality care to their patients. We have learned that developing and maintaining **an all-inclusive integrated care network** requires continuous assessment of network gaps, ongoing efforts to recruit and maintain providers—including those trained in trauma-informed care—and innovative solutions to improve access and quality of services to our members and their families. An example of this type of activity is when we identified, through GeoAccess® reports, that Mingo County lacked adequate provider network accessibility. We reached out and initiated a contract with Logan Mingo Area Mental Health to assist in meeting the BH needs of the community, including children in the target population and their caregivers. In addition, Aetna identified gaps in the SUD provider network and implemented a **rapid expansion of SUD providers statewide**.

With the addition of Logan Mingo Area Mental Health, Aetna has secured contracts with 12 of 13 community comprehensive BH providers established under State authority. In response to the need for SUD services, Aetna was able to expand the network by contracting with an additional 8 residential providers, increasing total bed capacity to 648.

Aetna's Provider Services department is responsible for monitoring the practitioner/provider network to confirm that a sufficient number and types of primary care practitioners and specialty physicians, dentists, and ancillary services are available to meet members' medical and BH needs. Aetna meets weekly to review issues related to grievance and appeals, which includes access to care issues.

Our Member Services department monitors member telephone access to Aetna services. The Member Services department also monitors the system call-tracking module and/or manual documentation to identify trends in member complaints and appeals about the timeliness of appointments and after-hours access to practitioners. Aetna evaluates data obtained against performance standards, and when indicated, implements interventions for improvement. Continual monitoring of improvements provides data to determine whether the interventions are effective and sustained over time.

Annually, Aetna performs a comprehensive analysis of our network adequacy for both non-behavioral and BH care to address identified opportunities for improvement. The approach used to assure that the plan maintains a practitioner and provider network sufficient in number, type, and geographic distribution to meet our non-behavioral and BH care access goals and includes the following:

- Measuring member satisfaction CAHPS surveys, BH member satisfaction surveys, and non-BH and BH care access-related complaints, grievances, and appeals
- Evaluating practitioner compliance with Aetna and State availability standards and accessibility to services standards
- Analyzing requests for and utilization of out-of-network services
- Identifying situations indicating a need for intervention
  - Working toward the resolution of barriers to accessing medical and BH care
  - Reducing the likelihood of overall network inadequacy as a result of inaccessible and/or unavailable practitioners

Aetna continually assesses our network and helps to ensure the network evolves to proactively meet identified needs through our ongoing network analysis. To assess and identify members' needs, we utilize a variety of internal reports and will use data and feedback from our system of care (SOC) staff and other internal departments, the governance board members, community organizations, and other system partners. Our strategy for monitoring provider network compliance uses a holistic approach to obtain a comprehensive view of system needs and potential network gaps and to identify network development opportunities to support system transformation. It is imperative that the network not only achieve adequacy, but also be user-friendly to our members in as close to real time as possible. Data and reports are reviewed on a daily, weekly, monthly, quarterly, and ad hoc basis, as described in **Table 7.1-5**.

Table 7.1-5: Network Monitoring Data and Reports

Reporting and Monitoring Activity	Data or Report Description	Frequency
GeoAccess reports	We review GeoAccess reports to measure compliance with the Department's access standard requirement for each ZIP code	Annually
PCP-to-member ratios	We review ratios by provider type to confirm availability of an adequate number of PCPs	Annually
Network adequacy	We review utilization data including prevalent conditions, single-case agreements, provider referral issues (availability of specialties), and the new and termed providers report to confirm sufficiency of the type and number of providers	Weekly
ER utilization dashboard	Continuous monitoring is performed using operational dashboards that measure and trend members' utilization, including ER care. These dashboards allow us to identify opportunities to enhance our network by location, disease state, and members' type.	Daily

Reporting and Monitoring Activity	Data or Report Description	Frequency
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	Annually
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	Annually
Provider appointment availability fax surveys	We query providers on appointment availability and after-hours care	Annually
Member and provider appeal and grievance data	We review analysis and trending of appeal and grievance cases to identify potential availability or accessibility issues, perform root-cause analysis, and develop corrective action plans, if necessary	Quarterly
CAHPS survey	We review and analyze CAHPS survey results and create action plans for opportunities for improvement identified through the survey	Annually

When we identify a network gap or opportunity for enhancement, our Provider Services team formulates a plan to improve the network. The results of our monitoring efforts are reviewed by our Service Improvement Committee, which also monitors any action plans to make sure identified gaps are addressed. Our goal is to maintain a comprehensive network of traditional and non-traditional providers that demonstrate a pattern of practice that understands the unique needs of our members. We continually work to offer our members and their families the highest quality providers near where they live, work, and play. Our success is based on our demonstrated commitment to engage and collaborate with key stakeholders, community organizations, providers, members, and their families.

Aetna will help to ensure the monitoring our networks of providers to assess compliance with meeting the current Department standards for timeliness, including the following:

- Emergency cases must be seen immediately or referred to an emergency facility
- Urgent cases must be seen within 48 hours
- Routine cases other than clinical preventive services must be seen within 21 calendar days (exceptions are permitted at specific times when PCP capacity is temporarily limited)
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services must be scheduled in accordance to EPSDT guidelines and the EPSDT Periodicity Schedule
- An initial prenatal care visit must be scheduled within 14 calendar days of the date on which the woman is found to be pregnant

Process for Continuous Network Improvement and Ensuring Provider Compliance with Availability and Appointment Requirements

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. SOC staff, including the child and adult SOC administrators, will meet routinely with the network director and provider services liaison to review network adequacy data, identify opportunities for network enhancement and growth, and review the status of the recruitment plan.

Aetna will implement steps to support compliance with required time, distance, and appointment wait time standards as outlined in **Section 3.1.2 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. In addition to contract requirements and performance metrics, through our financial incentives program, we

may also offer enhanced payment for those offering after-hours and weekend. Aetna monitors its providers regularly to determine compliance with these requirements. 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 QM program structure. Standards for wait times and appointments, disability access, competency, expertise, cultural sensitivity, and hours of operation are communicated through the provider manual, during site visits, and in training documents.

In addition to our standard monitoring activities, we will monitor compliance with contract requirements through our integrated SOC model to support members and providers. In instances where members are not able to make appointments with the appropriate provider, Aetna care coordinators and member services representatives will step in, facilitate the request, and even make the appointment if necessary. In addition, if a provider is attempting to assist a member with getting an appointment with another provider, provider services staff will assist in obtaining the appointment so that the members can receive the care they need in a timely manner. We will also provide intensive wraparound services, as appropriate, that are designed to support the members staying in their community.

Steps Taken with Providers Not Meeting Contractual Access Standards

Aetna monitors our providers' compliance with access standards through tracking inquiries and complaints. Whether or not the member lodges a complaint, the representative will log the issue in the call-tracking system. QM and provider services staff members also conduct annual provider access and availability surveys to confirm that individual providers are meeting contract standards for appointment availability and after-hours access.

Our QM and Provider Services teams monitor provider performance against established goals to assess their progress. When we identify providers who are not meeting access standards, we reeducate them regarding requirements and work with them to determine obstacles to compliance and how to overcome those obstacles and a corrective action plan may be implemented. If the provider is unable to meet the contractual requirement after these steps, this information is taken to the QMOC for review and possible termination from the network.

Approach to Meeting Access Standards When Care Cannot Be Accessed in the Network

We continually monitor and assess the adequacy of our network and work collaboratively with external stakeholders and State agencies to anticipate care needs to make sure members have access to needed services. **If a member cannot access a hospital, PCP, or other specialist, then the network is not adequate (usable) for that member, regardless of whether our network technically meets the Department's definition of adequate.**

Aetna will comply with the requirements to allow adequate, timely, and medically necessary covered services through a non-participating provider if our participating providers are unable to provide these services on a timely basis. If a qualified provider is available outside of the network for a specialized, medically necessary covered service (such as in a bordering state), we will either contract with that provider or allow the members to seek services from that non-participating provider using a single case agreement. Our Provider Services team engages and encourages non-participating providers to join by conducting telephonic engagement and in person visits to the provider's office to discuss becoming a contracted provider.

For our members with complex medical needs and who are under the specialty care of a non-participating provider for the entire episode of care (e.g., rare forms of cancer), the care coordinator works with the non-participating providers and engages the UM department to review and authorize services according to the members' care plan. A member being treated for a BH disorder with a non-participating provider follows the same transition plan. Members are educated about how to access out-

of-network services through the member handbook, our member services staff, and care management staff. The Care Management department collaborates with the provider, ensuring appropriate care, until we can assist our members by transferring care to an in-network provider or the existing provider contracts to our network.

Addressing Quality of Care Concerns

QU032	The Vendor should follow a process to address quality issues, including, but not limited to, the following:	The Vendor should describe in detail how it will meet these specifications.
QU033	What steps will be taken	See the parent specification.
QU034	Who is responsible for addressing issues	See the parent specification.
QU035	Timeframes for resolution	See the parent specification.

[QU032] Addressing Quality Issues

Aetna identifies, investigates, and monitors potential adverse events looking for trends and potential quality and safety issues. A potential quality of care (PQOC) concern is defined as a concern raised to the health plan by anyone internal or external that requires investigation as to whether the competence or professional conduct of an individual network practitioner, facility, or ancillary provider adversely effects or could adversely affect the health or welfare of a member.

[QU033] Steps Taken

Aetna's integrated quality review process helps to ensure that issues involving quality of care or service, safety, complaints, or other areas of dissatisfaction are systematically evaluated. Aetna requires any employee who perceives a potential quality, risk management, or safety issue to refer the issue to the QM department. A referral may originate in any Aetna department. The referring department staff documents the issue on a PQOC concerns investigations form and forwards it to the centralized PQOC team for evaluation. QM nurses will review and may assign it to a different functional area within the organization to review and address the needs as indicated (i.e., complaint and appeals). The centralized PQOC team will document and track potential quality of care issues in the PQOC business applications system. The case is then sent to the appropriate clinician to review and make recommendations.

As an example, in 2018, the health plan received and investigated 29 PQOC cases. All cases were reviewed to identify any trends related to individual practitioners or facilities. Of critical importance is a review of any case involving children or adolescents. It was noted that three of the cases in 2018 were related to BH care for adolescents. The Aetna behavioral health medical director reviewed all three cases. In one of the case investigations, Aetna contacted Child Protective Services to inform them of potential safety concerns related to the child involved. Only one of the cases reviewed was determined to be a quality of care issue and it was related to care in a BH care facility. A formal response was requested from this facility and the response was presented to the Quality Oversight Committee and accepted. This facility has been flagged as a 'track and trend' to monitor closely for any further issues.

[QU034] Who is Responsible for Addressing Quality of Care Concerns

The CMO/medical director or designated medical director oversees the peer review investigation of issues referred in accordance with the quality review process that includes the following:

- 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 practitioner's contract is terminated, suspended, or limited due to quality of care issues
- Development and implementation of corrective action plans as necessary
- Providing Fair Hearing rights to practitioners

Aetna has experience with and will continue to comply with **Section 7.3 of the Model Service Provider Agreement** outlining the written policies and procedures for taking appropriate remedial action whenever inappropriate or substandard services are furnished, or services that should have been furnished were not, including 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

Actions taken by the committee include peer-to-peer discussion, practitioner corrective action plan, financial penalties, suspension of privileges, termination of contract, and other follow-up determined necessary by peer review. **PQOC data is aggregated monthly** and reported to the QM/UM Committee and QMOC. If the termination results in a material change in the network, Aetna supplies written notice to the Department and other applicable regulatory bodies or agencies.

Information resulting from PQOC activities is incorporated into the QAPI and used in re-credentialing, re-contracting, and evaluation of provider performance. Aetna's QAPI activities are coordinated with other performance monitoring activities, including utilization management, risk management, and resolution and monitoring of members complaints and grievances. QAPI activities are linked to other management functions within Aetna, such as network changes, benefits redesign, medical management systems, practice feedback to providers, and member education and treatment services.

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 member. Our 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 corrective action plan with a description of the timeframe for improvement; evidence of education, counseling, and development of policies and procedures; monitoring and trending of data; limitation or discontinuation of the practitioner/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 practitioner credentials as well as other quality issues.

The QM department coordinates peer review activities although they may require the participation of Medical Management, Provider Services, or other departments. Aetna may request external consultants with special expertise (e.g., oral surgery, cardiology, oncology) to participate in peer review activities, if applicable. The peer review process adheres to Aetna policies. Applicable State and federal laws govern the peer review process and contain immunity and confidentiality provisions that protect the peer review process. Aetna keeps all peer review documents safe, protected, and confidential.

Fair Hearing Appeal Process

The right of appeal is available to practitioners/providers whose participation in the Aetna network was limited or terminated for a reason based on the quality of the care or services provided. Aetna policy describes appealable actions that include the restriction, reduction, suspension, or termination of a contract under specific circumstances. The appeal process adheres to federal and State laws and regulations and Aetna-approved policies including the requirement for the health plan to report actions that result in suspension or termination of a practitioner/provider's contract. The Aetna Practitioner Appeal Committee conducts the appeal process. Practitioners receive reports of final decisions upon completion of due process actions. The committee tracks and trends all decisions.

Member Complaints and Appeals

The member complaint and appeals process includes the review of member concerns and their resolution in a satisfactory and timely manner. The appeals process addresses denied claims or other services relative to a member's benefits. The process provides a member the opportunity to attend a meeting before the Appeals Committee for review and final determination.

The complaint and grievance supervisor in collaboration with the Member Services and Provider Services departments is responsible for informing and educating members and practitioners about a member's right to file a complaint or appeal or request a Fair Hearing and for assisting members in filing a complaint or appeal or in requesting a Fair Hearing.

The Provider Services department gives each practitioner information about the member complaint, appeal, and Fair Hearing process at the time they enter a contract with Aetna as well as through a variety of other sources, including the provider manual and on the Aetna website.

Members receive information about the complaint, appeal, and Fair Hearing process in the member handbook and in notice of action letters issued in conjunction with the utilization review process. The complaint and grievance supervisor works collaboratively with the CMO/medical director or designated physician and the QM, Medical Management, Member Services, and Provider Relations departments to facilitate the resolution of all complaints and appeals.

[QU035] Timeframes for Resolution

Aetna makes certain member satisfaction is addressed in a timely manner and in accordance with **Section 4.8.1 of the Model Service Provider Agreement**. Members will have 30 calendar days from the date of the notice of action to file an appeal, and Aetna will respond to the appeal within 30 calendar days from the day the appeal is received. For complaints and grievances, members will receive a response within 30 calendar days from the date the complaint is received. Standard resolution and notice of appeals occur following the timeframes established by the Department and will be extended up to 14 calendar days if the member requests or if it is shown that additional information is necessary and that the delay is in the interest of the member. In addition, for Fair Hearings members must request the hearing no later than 120 calendar days from the date of the decision. The State will hear the member's case and decide within 90 calendar days of the request for a State Fair Hearing.

Using Data to Identify Barriers for Individuals with Special Needs

QU026	The Vendor should use data to identify barriers to care for individuals with special healthcare needs, including, but not limited to, the following data collection methods:	The Vendor should describe in detail how it will meet these specifications.
QU027	Focus groups	See the parent specification.
QU028	Surveys	See the parent specification.
QU029	"Secret shopper calls"	See the parent specification.
QU030	Aggregate utilization monitoring	See the parent specification.

QU044	The Vendor should use data to identify access barriers for members with special needs, including, but not limited to, the following data:	The Vendor should describe in detail how it will meet these specifications.
QU045	Complaints and grievances	See the parent specification.
QU046	Primary care provider (PCP) change requests	See the parent specification.
QU047	Out-of-network referrals	See the parent specification.
QU048	Emergency room (ER) usage	See the parent specification.

[QU026] Using Data to Identify Barriers to Care for Individuals with Special Health Care Needs

At Aetna, 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 members that may fall into this category through high utilization and other applicable factors. For children identified with special health care needs, including those involved in the foster care system or adoption assistance, a care coordinator is assigned to assist and support the individual and their family in addressing potential barriers to care. Aetna has experience implementing complex care management programs that proactively identifies members for whom intensive management goals would include improving quality of care and assisting CSHCN to reach their optimum level of wellness and/or palliative comfort. The care coordinator also assists the family by coordinating care and ensuring that all necessary services, including SNS, are made available. 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 members 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 GeoAccess 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 member input (such as member surveys, focus groups, and our Member Advisory Committee) to assist in identifying any potential barriers that children with special health care needs may experience.

[QU027] Using Focus Groups to Identify Barriers to Care for Individuals with Special Needs

Focus Group Topics

- Access
- Service delivery
- Gaps in support systems
- Engagement with system staff
- Cultural competency
- Consumer knowledge of services and supports

Although we communicate with and assist individual members on a regular basis, we recognize the power of hearing firsthand stories from individuals who have been directly involved in the foster care and adoption assistance systems, outside of our direct member interactions. The Member Advisory Committee assists in this process by soliciting member feedback and opinions regarding issues related to access and the quality of care and services provided to members as well as potential programs, activities, and educational materials. Our SOC administrators, specifically the child SOC and recovery and resiliency SOC administrators, will coordinate multiple member-focused coalitions that will include members and their families and caregivers. We will engage the families and caregivers of CSHCN through focus groups on a monthly basis, as outlined in **Section 12.6 of the Model Service Provider Agreement**. We will use these opportunities to hear from those impacted by the foster care system firsthand and develop collaborative solutions that address the unique situations facing this population. We currently meet with

the Bureau of Child and Families (BCF) on a monthly basis, where we can collaborate and discuss potential topics for focus groups related to CSHCN to make certain useful information is collected. These interactions can also help Aetna identify ways to advance the Family First Prevention Services Act across the state and help to ensure the collection of information useful to us and our key stakeholders, such as BCF.

Aetna will conduct at least 12 focus groups throughout the year with youth, families, and foster and adoptive parents that reside in the community and utilize socially necessary services. The focus groups will be used as an opportunity to provide the Department with feedback on where services are being most impactful, so programmatic changes can be made to improve the overall health of the program.

[QU028] Using Member Satisfaction Surveys to Identify Barriers to Care for Individuals with Special Needs

Aetna uses the CAHPS survey tool to collect information about consumer-reported experiences with health care. The survey measures how well the health plan is meeting members' expectations, which Aetna uses to identify areas of opportunity for improvement to improve the quality of care and service provided to members. We provide survey results to both members and practitioners to promote ongoing continuous quality improvement.

The QM department, as part of the QM/UM program evaluation, will conduct retrospective reviews to compare satisfaction ratings for the special needs population as compared to the aggregate scores. Aetna regularly tracks and monitors accessibility of services, and with the identification of special needs population, via the Department's enrollment information identifying children with special health care needs. The CAHPS survey captures data related to appointment availability, which will be used to identify and address and barriers to care for children with special needs. At implementation, Aetna will expand our surveys to include use of the CAHPS survey item set for children with chronic conditions (CCC). We have experience using the CAHPS item set for the CCC survey and will be implementing this targeted survey to identify barriers to care for individuals with special needs. This version of the CAHPS survey expands beyond the standard CAHPS child survey to assess areas related to health providers, including contacting schools or daycare centers 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.

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 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.

[QU029] Using Secret Shopper Calls to Identify Barriers to Care

Aetna has experience with conducting secret shopper calls to identify barriers to care. We will use this approach to specifically target providers serving the CSHCN population. We will use our quarterly panel and claim reports to identify providers who meet a set threshold volume to conduct secret shopper calls. The calls will be conducted at a set frequency throughout the year. The provider relations director (or designee) will facilitate secret shopper calls to practitioners that currently treat our CSHCN members to ensure that appointment availability exists for routine, urgent care, and follow-up visits as required by the contract. These calls will be conducted by members of our West Virginia-based provider relations staff and the results will be included in our annual Availability of Network Practitioners report.

In addition, Aetna's Provider Relations department conducts an annual provider fax survey to all providers who have been in the network for at least six months. A part of this survey focuses on the provider's accessibility and availability of appointments. Aetna will add questions specially related to accessible services for children identified with special and complex health care needs. In addition, for new network primary care practice sites, Aetna conducts an onsite initial credentialing visit, during which the Provider Relations department inquires about accessibility and availability of appointments. For providers serving children with special needs, additional target population-specific survey questions will be included and addressed during this initial onsite visit to help ensure accessibility and availability standards are being met. Providers not meeting standards receive education. Additional follow-up is provided after education to ensure required processes have been implemented. If the provider is still not meeting standards, our contracting team will reach out to the provider for a response. Results are reported to the SIC, and any further action, up to possible termination, will be taken.

[QU030] Using Aggregate Utilization Data to Identify Barriers to Care for Individuals with Special Needs

Aetna uses multiple data sources to monitor appropriate health care utilization. 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 individuals with special needs. Some UM metrics tracked and used to identify barriers to care include average length of stay for both BH and PH, total readmission rates, and acute BH and PH bed days. Aetna's network director will be responsible for identifying network gaps and opportunities for improving and monitoring to make sure identified needs are promptly acted upon. SOC staff, including the child and adult SOC administrators, will meet routinely with the network director and provider services liaison to review network adequacy data, identify opportunities for network enhancement and growth, and review the status of the recruitment plan. An example of how we use aggregate data is through our APM arrangement monitoring. We found a substantial decrease in membership ER utilization per 1,000 in University Physicians and Surgeons (also known as 'Marshall') and CAMC, demonstrating a positive impact in two of our APM providers.

Aetna annually evaluates member and practitioner experiences related to various aspects of the UM process and identifies opportunities to improve experience through targeted initiatives. The analysis utilizes member CAHPS, practitioner/practice survey results, and complaints and appeals.

We have an extensive suite of UM dashboards and reports with near real-time data to monitor appropriate utilization of services and cost-efficiencies. Aetna uses the following data sources:

- **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 members' 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 divert members to those services when possible. This provides for a region-specific, targeted approach to ER diversion. We use our own care coordinators and engage PCPs, health homes within in the community, and facilities with high ER utilization to participate in discharge planning and to educate members about these other services available in their local community in lieu of the ER Additionally, we monitor care management metrics regularly and use data from the ER utilization dashboard to deploy care coordinators for member outreach during or immediately following an ER visit.
- **UM performance dashboards:** We developed and use a suite of UM dashboards to monitor data reports. We use the UM performance dashboards to identify high utilizers and engage care

coordinators to outreach the members for immediate intervention, such as dashboards on the following:
  - Readmissions
  - Observations versus one- to two-day stays
  - ER utilization by facility, level billed, and primary system chief complaint
  - Neonatal intensive care unit (NICU) admission patterns
  - Medical claims trends
  - Authorization trends
  - Inpatient performance to target trends
- **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.
- **Gaps-in-care reporting** as both an internal and external tool to address under-utilized services. As a health plan, we are evaluating gaps in care daily every time we interact with a member. 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 members 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 a member needs specific outreach or resources in completing their care.

[QU044] Using Data to Identify Access to Care Barriers for Individuals with Special Needs
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 members' 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 needs.

Aetna's network director will be responsible for identifying network gaps and opportunities for improving and monitoring to make sure identified needs are promptly acted upon. SOC staff, including the child and adult SOC administrators, will meet routinely with the network director and provider services liaison to review network adequacy data, identify opportunities for network enhancement and growth, and review the status of the recruitment plan. In instances where members 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. In addition, if a provider is attempting to assist a member with getting an appointment with another provider, provider services staff will assist in obtaining the appointment so that the member can receive the care they need in a timely manner.

Aetna will implement steps to support compliance with required time, distance, and appointment wait time standards as outlined in **Section 3.1.2 of the Model Service Provider Agreement**. 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 QM program and committee structure.

Children with special health care needs, as defined by the State, will be flagged in the internal Aetna data system based on the assigned tier of care management. Most children involved in the foster care system will fall into this category. A care management tier will be assigned based on the outcome of the front-end assessment process, including administration of the health risk assessment. Once flagged, monitoring as it relates to complaints and grievances, PCP change requests, out-of-network referral, and ER utilization, will be tracked for this target population.

For providers not meeting contractual requirements, the following steps are taken:

- Providers not meeting the contractual requirements receive education regarding appointment accessibility standards.
- Additional follow-up is provided after education to ensure the required processes have been implemented.
- If the provider is still not meeting standards, our Provider Relations team will reach out directly to the provider for a response.

[QU045] Tracking and Trending Complaints and Grievances for Individuals with Special Needs

Through our robust committee structure, Aetna has national experience with, and will locally implement, a process in which we review trends related to children with special health care needs, including those involved in the foster care system and adoption assistance programs. We will review, on a quarterly basis, our grievance and appeals report in the local SIC to identify trends related to barriers to care for these populations. We will compare these rates to the general children and adolescent populations across the year. When trends are identified, the committees will take action to help ensure these issues are addressed promptly and directly with the providers through education and possible corrective action plans. In 2018, there were a total of 105 member complaints received by Aetna. None of the complaints received were related to access to care.

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 the CSHCN populations to help ensure timely response to issues. Appeals and grievances files are maintained in a secure manner, as required to protect members' privacy and confidentiality rights, and are accessible to the Department, its designee, or CMS upon request. We retain appeal and grievance files for the longer of 10 years following the final decision, or 5 years from the date of the expiration or termination of this contract.

We capture this documentation both to meet the State and federal requirements, and because it allows us to maintain and track all cases from origination through resolution/decision. Our system contains a standard suite of reports and queries by case type of complaint, appeals, grievance, or State Fair Hearing that we utilized to track cases throughout the process. To support the accuracy and integrity our appeal and grievance data and reporting, Aetna has programmed its appeal and grievance 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 appeal and grievance supervisor uses 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. 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 report run in calendar days. All follow-up actions such as members' 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.

[QU046] Tracking Members Requesting Changes in Primary Care Providers for Individuals with Special Needs

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 the CSHCN population. When members or their caregivers and guardians request to change their PCP, the Member Services team selects the appropriate reason code for the change and 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 the CSHCN population 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 to identify and correct any network adequacy concerns. If we identify a potential quality of care 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. In addition, we continually monitor terminated PCPs, and for CSHCN we transfer members to appropriate PCP to help ensure continuum of care.

[QU047] Tracking Barriers for Out of Network Referrals for Individuals with Special Needs

Aetna's overall goal within this process is to assure that members, including those identified as CSHCN, receive continuity of care. Occasionally, a member is referred to an out-of-network provider/practitioner because of special circumstances, specific qualifications of the out-of-network provider/practitioner, or because of a pre-existing relationship with an out-of-network provider/practitioner. We track barriers not only through our claims, but through our GeoAccess and drill-down reports. These additional reports assist in identifying trends for out-of-network referrals in certain regions and allow us to engage additional providers in the area to initiate contracts within our network. An example of how we remedied an identified gap in care identified is in the Eastern Panhandle area. We discovered there was no inpatient BH facility for children ranging in age from 5 to 14 years, and so we outreached and initiated a contract with an inpatient facility meeting this need: the Alice C. Tyler Village of Childhelp East, located in Lignum, Virginia.

[QU048] Tracking Access to Emergency Room Use for Individuals with Special Needs

Medicaid members, including CSHCN, tend to visit the ER more often than non-Medicaid members because they often have higher rates of chronic disease and more co-occurring PH and BH disorders. In addition, these members have barriers stemming from social determinants of health. We will help the CSHCN population 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. 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.

Members with special health care needs who seek non-emergent care in an ER are not 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 members 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 members through the following process.

- Care coordinators access informatics reports that identify members with special health care needs (flagged in our internal data management system) who have utilized ER services

- Care coordinators outreach to CSHCN members to educate them on ER use and when it is appropriate to use the ER versus urgent care or PCP/specialty provider and give information on the 24-hour Health Information line (Nurse Line)
- Care coordinators identify barriers that prevent these members from receiving care in their medical home or outpatient specialist office, such as transportation, work schedules, or social support. Care coordinators work with members and their guardians to reduce and/or remove the barriers. If a member and/or their guardian agree, we refer them to the appropriate Care Management team for ongoing support and assistance with removing barriers if not already enrolled in care management.
- Care coordinators discuss the member benefits and potential consequences for non-emergency services provided in the ER
- Care coordinators identify practice trends that affect members' ability to receive care in a medical home setting

Effective Use of HEDIS Measures

QU006	The Vendor should use Healthcare Effectiveness Data and Information Set (HEDIS) scores to assess its programs' and policies' impacts on West Virginia's youth and families.	The Vendor should describe how it will meet this specification.
QU007	The Vendor should use measures beyond Healthcare Effectiveness Data and Information Set (HEDIS) scores to assess its programs' and policies' impacts on West Virginia's youth and families.	The Vendor should describe proposed measures beyond traditional Healthcare Effectiveness Data and Information Set (HEDIS).
QU008	The Vendor should report measures to the Department according to the requirements in the Service Provider Agreement (SPA), including, but not limited to, the following:	The Vendor should describe how it will meet this specification.
QU009	Healthcare Effectiveness Data and Information Set (HEDIS) scores	See the parent specification.
QU010	Measures that go beyond traditional Healthcare Effectiveness Data and Information Set (HEDIS) scores	See the parent specification.

Aetna uses HEDIS and other performance indicators to assess our program and policy impact on West Virginia's youth and families **[QU006].** We have 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. Aetna has demonstrated superior HEDIS scoring, especially in those measures related to care of children and youth. **Table 7.1-6** depicts examples of our **HEDIS scores above the national average.**

Table 7.1-6: Aetna 2018 HEDIS Scores Above National Average

Measure	National Average	HEDIS 2018
Adolescent Well Care	52.96%	58.39%
Annual Dental Visit—Total	54.22%	63.06%
Appropriate Testing for Pharyngitis	78.29%	79.33%
Asthma Medication Ratio 12 to 18 years	63.38%	64.04%
Asthma Medication Ratio 5 to 11 years	72.38%	73.60%
Follow-Up Care for Children Prescribed ADHD Medication – Continuation and Maintenance Phase	54.95%	75.83%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	44.63%	61.38%
Immunizations for Adolescents—Combo 1	77.63%	86.62%

Measure	National Average	HEDIS 2018
Medication Management for People with Asthma 12 to 18 years	29.97%	33.10%
Medication Management for People with Asthma 5 to 11 years	31.20%	40.28%
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Total	34.64%	47.65%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (*lower rate is better)	2.39%	1.15%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI% Total	72.59%	72.99%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Total	67.08%	77.13%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Total	60.58%	71.05%
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 months	94.65%	98.28%
Children and Adolescents' Access to Primary Care Practitioners—25 months to 6 years	86.62%	92.43%
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 years	90.00%	96.28%
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 years	88.57%	94.73%

At the close of each review cycle, our contracted NCQA auditor validates our HEDIS data files. Our CEO confirms that Aetna maintains the resources and functions necessary to support HEDIS or other performance measurement activities. The CEO designates the CMO/medical director to direct the initiatives and see that they conform to State, federal, local, and Aetna Medicaid organization mandates. Under the CMO/medical director's direction, HEDIS activities and interventions are carried out by the West Virginia QM department with support from the national Aetna team. Improving HEDIS and other performance indicator rates are a company-wide endeavor, with operating responsibilities shared by departments designated by the CEO.

All departments involved in HEDIS or other performance measurement activities comply with federal, State, and local privacy regulations during review and/or transport of medical records and information. 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 and submits to the CMO/medical director and leadership for review.

[QU007] Measures Beyond HEDIS to Assess Program and Policy Impact on West Virginia's Youth and Families

Aetna recognizes that having a meaningful impact on the health outcomes of West Virginia members goes beyond improving performance on these traditional HEDIS scores. Our approach to supporting children and families is immediate family engagement emphasizing primary prevention and early intervention. Aetna's transformative vision drives our model for enhanced care coordination and service

integration supporting children and youth in foster care, which in turn supports the State's goal to help reduce the number of children removed from the home through increased family-centered care that provides necessary and coordinated services to all members of the family. This approach drives our SOC model incorporating our whole-person, whole-family approach to physical, behavioral, and social well-being. We reach beyond ensuring access to quality health care by focusing on complete healing and resiliency for children and their families. In alignment with West Virginia State goals, we implement delivery system reforms to improve quality and outcomes. We closely monitor that our care management, care coordination, and utilization management services and policies align to our person-centered model of care to promote the best possible outcomes for West Virginia members and their circle of support.

At Aetna, outcomes are measured at all levels of care, management, and leadership. When desired outcomes are not achieved, corrections are made quickly. Aetna proposes to use measures beyond HEDIS that assess the outcomes related to care management, care coordination, and utilization management. These measures will help to ensure the clinical models of care have a meaningful impact on the health outcomes of members and their families.

Care Management Services and Policies

The **Charting the LifeCourse™ framework** focuses on serving members and families in concert with their circle of support. Children and youth involved in the foster care system may not have birth families actively participating in their care. By using the framework and engaging additional informal supports, these children and youth are surrounded by individuals invested in their overall quality of life. This framework creates and documents a single care plan that addresses much more than covered services and paid/unpaid support. The care plan also addresses the members' likes and dislikes, gaps in care, and life goals and objectives that promote self-efficacy and personal satisfaction, living in the community of their preference, and participating in socially rewarding life activities. The LifeCourse framework focuses on the member's circle of support and assists them to identify what they need to be successful. We address all challenges by engaging the child's circle of support, including biological parents, adoptive parents, relatives, foster parents, or other caring adults in a collective approach to family safety, healing, and thriving. We are committed to improving outcomes for members and their families and have added APM arrangements to contractually incentivize recommended outcome measures. All adopted measures will be incorporated into our **Aetna Foster Care Toolkit** and distributed to applicable providers with supplemental education and technical assistance.

Aetna's tiered care management approach moves through the continuum from low risk (general population) to high risk—our most intensive care management for the most vulnerable members with biopsychosocial complexities. The model identifies people at risk of high cost and/or high utilization in the future by using medical, behavioral, laboratory, dental, and pharmacy diagnoses and claims data, and the likelihood of integrated care management making an impact. The risk rankings feed directly into our electronic care management platform to identify and prioritize members for outreach into intensive or supportive care management as well as those who would benefit from chronic condition management. Our care coordinators act as the **single point of contact** for the members, family, and entire circle of support, resulting in less system confusion, more connection to high-quality services and supports, and increased satisfaction.

At case closure, we ensure a successful transition including oversight and planning related to housing, nutrition, education, and employment (if applicable), whether it is to biological, kinship care, adoptive, or foster parents. Post-case closure, we remain available for assistance and continue to track the child's outcomes. In Aetna's experience, most children involved in the foster care system will remain eligible for Medicaid benefits, creating the need for effective health care access as well as transitions to stable

housing, employment or employment training, and/or educational services. **Table 7.1-7** outlines our recommended measures to determine if care management is having a meaningful impact on the health outcomes of members and their families.

Table 7.1-7 Recommended Measures for Care Management

Recommended Care Management Measure	Description
Percent of individuals who move to lower care management tiers	Based on the support of the care coordinator and circle of support, individuals will move from higher risk tiers to lower risk tiers.
Rate of grievances and complaints	Having a single point of contact for issue resolution will result in fewer grievances and complaints.
Rate of adverse outcomes/potential quality of care concerns	The dedicated care coordinator will work to understand the family's needs, connect them with high-quality evidenced based treatment in their community, and be the first point of contact to resolve any issues or barriers.
Results from the CAHPS adult and child survey and the foster care-specific satisfaction surveys for youth and circle of support	Close communication and coordination with the dedicated care coordinator will result in high rates of satisfaction as gathered from the CAHPS adult and child survey, as well as from our foster care-specific satisfaction survey for youth and their circle of support.
Percent of children/youth that stay engaged with services past age 18	The care coordinator will build a relationship with the children/youth and family to encourage ongoing participation in services past age 18.
Percent of children completing EPSDT appointments per the recommended schedule	Care coordinators provide education and reminders to parents/caregivers to increase compliance with EPSDT well-child visits with referrals to and follow-up with specialists for any concerns about developmental milestones.
Percent of early warning indicators, including screening positive for ACEs, sleep problems, and developmental anomalies	Care coordinators screen for and address ACEs, anomalies in growth/development, sleep problems, and social emotional disorders.
Percent of at-risk youth connected to evidence-based SUD services	Based on screening and assessment for SUD, the care coordinator will secure linkages to treatment resulting in more youth being identified and engaged in SUD care.

Care Coordination Services and Policies

Aetna employs the SOC approach for care coordination to reduce fragmentation, with the goal of helping members experience a seamless process while obtaining specialized services available from different funding streams, programs, and plans. Our SOC model is driven by the Aetna care coordinator providing care coordination through convening, advocating, supporting, and connecting youth and families to resources and supports including relatives, friends, community members, and new relationships. We leverage and maximize supports and services beyond PH and BH needs; we work with the child and family to identify other areas of interest and activities that bring them joy and connect them with matching community resources to build resiliency.

Aetna is committed to supporting the **members and their caregivers as the lead voice in the care planning process**. The members and their family identify individuals in their circle of support, including family members, caregivers, representatives, or other important people in their lives who will join the care team for the purposes of ongoing gathering of assessment information and development of a single care

plan. We have discussions about the services and supports they need, as well as finding opportunities for balance and incorporating joy and play.

Children and youth enrolled in Aetna may experience high rates of ACEs, often resulting in challenges with mood regulation, attachment, behavioral control, and other areas of diminished functioning. They are often misdiagnosed or have multiple diagnoses (at times conflicting) and are prescribed psychotropic medications when they have untreated trauma. We engage psychiatrists trained to understand the role of ACEs and trauma to evaluate and review medications and adjust accordingly as well as connect the members to trauma-informed care treatment to avoid misdiagnoses and inappropriate prescribing.

We are West Virginians, which empowers us to make a significant impact in communities across the State to address SDOH for the most vulnerable children and youth of West Virginia. 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. In addition, we believe that by supporting our members in addressing their SDOH, we can help support their families with prevention of re-entry or initial entry into the foster care systems. With our integrated care model and focus on SDOH, we believe we can help improve health and social outcomes for youth and impacts on families. Engaging the youth's circle of support leads to greater understanding of the family's financial situation in this process as it impacts their access to quality housing, nutrition, transportation, and numerous other factors in creating and sustaining a healthy life. Our focus centers on providing access to care and social determinant resources, supporting kinship care whenever possible over foster care. We believe relatives are the preferred source of care for children who must be removed from their birth parents as kinship care maintains familial connections for the child. **Table 7.1-8** outlines our recommended measures to determine if care coordination is having a meaningful impact on the health outcomes of our members. We will coordinate with BCF to identify and assisting in tracking the following measures as it relates to our care coordination efforts. Our CCTs will help to ensure care coordination activities are well documented through the child's comprehensive and centralized care plan, created in collaboration with other professionals involved in treatment and the child's circle of support.

Table 7.1-8: Recommended Measures for Care Coordination

Recommended Care Coordination Measure	Description
Percent of care plans that include community engagement activities	Many of these children and families live in cultural and social isolation. Connection with community and activities increases the likelihood of healthy behaviors and outcomes. Our care coordinators encourage activities the child and family might like including sports, music, and cultural or faith-based events.
Rate of improvement in quality of life indicators	In collaboration with the Harvard Lee Kum Sheung Center for Health and Happiness, Aetna has embraced that measurement of quality of life includes a combination of objective well-being measures (education, physical and built environment, community, and economy), and subjective well-being measures (psychological, social, and spiritual). Our care coordination services and policies connect members and their circle of support to both types of resources to improve health outcomes and overall quality of life.
Percent of school-based measures, including attendance, grades, high school graduation rate, and absenteeism	With increased support and connection to the school and school-based services, we expect a positive impact on attendance, reports from school, progression in grades, high school graduation rates, and absenteeism.

Recommended Care Coordination Measure	Description
Social determinants of health (e.g. physical activity, consumption of healthy foods, pro-social activities, etc.)	Health is measured based on environmental factors, including but not limited to increased access to healthy foods, regular exercise, time with family and friends, and the overall reduction in toxic stress.
Behavioral health challenges (mental health and substance use) including crisis and inpatient stays	The care coordinator works closely with all involved providers including mental health and substance abuse to decrease crisis and inpatient stays.
Number of children placed in out of home care/residential/detention	The care coordinator works closely with the child, family, providers, and community resources to ensure all needs are met, resulting in decreased number of children placed outside the home.
Length of stay in out of home care, residential, and detention	When the members require out of home care, residential, or detention, the care coordinator works closely with the child, family, providers, and community resources to ensure all needs will be met upon discharge, resulting in reduced lengths of stay.
Rates of incidence of arrest, status offenses, detention, and incarceration	With close care coordination between all involved parties and support for the members and family, we expect lower rates of arrest, status offenses, detention, and incarceration.

Utilization Management Services and Policies

Aetna's UM program will coordinate and pay for whole-person care for our members and families in the most appropriate setting. We identify, evaluate, manage, and improve clinical care and services through our UM services and policies. As directed by the CMO/medical director, PH and BH medical directors provide oversight of Aetna's clinical functions including QM, UM, care management, and credentialing. The medical directors provide clinical leadership for the QM/UM Committee, conduct medical necessity reviews, conduct peer-to-peer reviews, and provide mentoring and clinical leadership for the integrated care management program. We will have policies in place to make sure that members are not denied important services for long-term safety, stability, and normal development.

Our staffing includes qualified health professionals who **live in West Virginia with active West Virginia professional licenses** with applicable experience and training. This enables the team to be familiar with resources/services specific to their area and allows for relationship building with providers/practitioners in the area, resulting in increased continuity of care and engagement with members. Our care coordinators and utilization managers are assigned to cases until resolution; they conduct daily rounds to continually stay informed of the member's and families' needs. **Table 7.1-9** outlines our recommended measures to determine if utilization management is having a meaningful impact on the health outcomes of members.

Table 7.1-9 Recommended Measures for Utilization Management

Recommended Utilization Management Measure	Description
Rate of inappropriate denials/overturn on appeals	Aetna recognizes that the care team and circle of support promote what is best for the members and family. Aetna will collaborate with the care team and communicate directly with providers, including peer-to-peer discussions.

Recommended Utilization Management Measure	Description
Percent compliance with authorization timelines	We complete service authorization requests timely and efficiently in compliance with established NCQA turnaround timeframes and the requirements indicated in **42 CFR 438.210(d).**
Rates of ER utilization, hospital readmission, length of stay, and NICU admissions	We use nine UM dashboards, which provide data reports on readmissions, observations versus one-to-two-day stays, ER utilization, NICU admission patterns, outpatient urine drug testing patterns, medical claims trends, authorization trends, outpatient utilization trends, and inpatient performance targets. Through these reports, we can identify and engage high utilizers into lower levels of care.
Rates of gaps in care	We evaluate gaps in care every time we interact with a member. This allows us the opportunity to not only encourage needed care but also assist in getting the members to the visit. We share gap in care reports with our network providers and work with them to assess members' needs in closing gaps in care.
Drug over- and under-utilization patterns	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.

[QU008] Reporting HEDIS Measures and Beyond to the Department According to the Service Provider Agreement

Aetna measures and reports performance on HEDIS indicators to the Department annually and measures that go beyond HEDIS scores are/will be reported. Our health information systems use data collection methods that allow for reporting of data analytics specific to health outcomes and metrics. The methods include trending of measures and performance to show both positive and negative trends. Our population assessment provides details on data to allow for predictive analytics on members' behavior, as well as stratification of members conditions. Aetna utilizes sophisticated internal tools, technology infrastructure, and databases as described in **Table 7.1-10** to identify, analyze, track, and improve quality and performance metrics beyond traditional HEDIS scores to determine that our care management, care coordination, and utilization management services and policies are having a meaningful impact on the health outcomes of our members.

Table 7.1-10: Internal Aetna Tools and Technology Infrastructure

Data Source Type	Description
Claims management system	Collection of medical claims for inpatient, outpatient, and professional services
HEDIS- and NCQA-certified data platform	For generation of annual HEDIS and non-standard HEDIS rates, and creation of monthly trend reports and provider gap in care lists
Surveys/assessments	Annual and post-call member and provider surveys to measure their satisfaction and experience with our programs and services, social determinants, and care needs
Medical record audits	Provider adherence to medical record, HEDIS standards, and clinical practice guidelines

Grievances and appeals data platform	Collection and tracking of member 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

[QU009] Reporting on HEDIS Scores

Aetna's performance is measured annually based on HEDIS or other performance indicators that are mandated by the State regulator or specified in contract agreements. Aetna will comply with the standard in **Section 6.11.6 of the Service Provider Agreement.** The CEO is responsible for confirming that Aetna maintains the resources and functions necessary to support HEDIS or other performance measurement activities. The CEO designates the CMO/medical director to direct the initiatives and see that they conform to State, federal, local, and Aetna Medicaid organization mandates. Under the CMO/medical director's direction, HEDIS activities and interventions are carried out by Aetna's QM department. Improving HEDIS or other performance indicator rates are a company-wide endeavor, with operating responsibilities shared by departments designated by the CEO.

The Aetna QM department has the following responsibilities:

- Review and oversight of data collection, document review, inter-rater reliability assessments, and measurement reporting
- Participation on the EQRO oversight team, as applicable, to coordinate review and attestation of data integrity and preliminary and results by the Aetna CEO, CMO, and HEDIS manager

Any Aetna department involved in HEDIS or other performance measurement activities will comply with federal, State, and local privacy regulations during review and/or transport of medical records and information. Analysis and comparison of performance results to national benchmarks provides the basis for the design and implementation of appropriate interventions. The Aetna QAPI work plan incorporates HEDIS activities and performance measurement goals. If Aetna does not meet targeted goals, the QM department will develop a corrective action plan and submit to the CMO/medical director and Aetna administration for review.

[QU010] Measures Beyond HEDIS scores

In addition to meeting the reporting requirements for the Department regarding HEDIS measures, Aetna will also report on child quality measures relevant to the **Model Service Provider Agreement** covered services following the technical specifications provided by CMS, as outlined in **Section 6.11.7 and Appendix E of the Model Service Provider Agreement.** Please refer to **Table 7.1-11** for National Core Health Care Quality Measures Reporting.

Table 7.1-11: National Core Health Care Quality Measures for Children

Health Care Quality Measure	
Primary Care Access and Preventive Care	
• Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index Assessment for Children/Adolescents (WCC-CH) • Chlamydia Screening in Women Ages 16–20 (CHL-CH) • Childhood Immunization Status (CIS-CH) • Immunizations for Adolescents (IMA-CH) • Well-Child Visits in the First 15 Months of Life (W15-CH)	• Screening for Depression and Follow-Up Plan: Ages 12–17 (CDF-CH) • Adolescent Well-Care Visits (AWC-CH) • Children and Adolescents' Access to Primary Care Practitioners (CAP-CH) • Developmental Screening in the First Three Years of Life (DEV-CH)

Maternal and Perinatal Health	
• Pediatric Central Line-Associated Bloodstream Infections (CLABSI-CH) • Audiological Diagnosis No Later Than 3 Months of Age (AUD-CH) • Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)	• Contraceptive Care—All Women Ages 15–20 (CCW-CH) • PC-02: Cesarean Birth (PC02-CH) • Live Births Weighing Less Than 2,500 Grams (LBW-CH) • Contraceptive Care—Postpartum Women Ages 15–20 (CCP-CH)
Care of Acute and Chronic Conditions	
Asthma Medication Ratio: Ages 5–18 (AMR-CH)	Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)
Behavioral Health Care	
• Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH) • Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH) • Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH) Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)	• Follow-Up After Hospitalization for Mental Illness: Ages 6–17 (FUH-CH) • Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)
Dental and Oral Health Services	
CAHPS Health Plan Survey 5.0H—Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH)	Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)

Data-driven Clinical Initiatives that Yield Improvements in Clinical Care

QU036	The Vendor should initiate data-driven clinical initiatives that yield improvements in clinical care for applicable populations.	The Vendor should describe: 1) Data-driven clinical initiatives that the Vendor initiated within the past 24 months that have yielded improvement in clinical care. 2) Statistically significant improvements generated by these clinical initiatives.

Aetna is committed to maintaining a member-focused, innovative, and adaptable managed care system as evident by our successful NCQA accreditation efforts. Examples of our data-driven clinician initiatives in the past 24 months include well-child care and dental visits.

Data-driven Clinical Initiatives in Past 24 Months

Aetna has purposefully selected the following two clinical initiatives as examples within the past 24 months that have yielded measurable improvement in clinical care for a managed care population comparable to the population of children and youth in the foster care system and individuals receiving adoption assistance.

Our QM staff attends the well-visit clinic days to meet with children and families and give them their $25 gift card for completing the well-visit examination.

Clinical Initiative One: Improvement in Well-Child Care for Children Ages Three to Six Years

Aetna works to improve member health status through prevention and wellness activities. Prevention and wellness initiatives are based on Aetna's strategic plan, population assessments, prior year activity results, identified gaps in care, and care management goals. Monthly monitoring of screening rates

revealed an opportunity for improvement in the percentage of children ages 3 to 6 years who received a comprehensive well-child examination. The QM team analyzed the data by geographic region and identified specific areas with higher numbers of members in this age group who had not received recommended services and collaborated with network practitioners and FQHCs in these areas to conduct well-visit clinic days specifically for Aetna members. Key aspects of the well-visit drives include the following:

- Targeted outreach to parents/guardians of children in each geographic location to inform them of the availability of the well-visit clinic days at their practitioner office and assist them in scheduling an appointment (transportation is arranged as needed)
- Member services staff also attend the well-visit clinic days to offer face-to-face assistance to members and families with general health care needs, such as requesting a new ID card
- Care management staff also attends the well-visit clinic days to offer additional assistance that may be needed by any of the families with children with special needs

In addition to the well-visit clinic days, Aetna also utilizes additional approaches to reaching members to encourage well-visit examinations, including the following:

- Texting campaigns specifically targeting families with a child due for a well-visit exam
- Quarterly outreach to practitioners with gaps-in-care lists showing members in their practice who are due for an examination
- Aetna's Ted E. Bear, M.D. Cub Club, which includes regular outreach to families with children up to age 13 years. Cub Club activities include special offers to complete healthy activities to earn fun prizes. These healthy activities include well-visits, dental visits, immunizations, and general healthy behaviors such as getting adequate sleep and exercise.

Goals for initiatives are determined using national standards (e.g., HEDIS) and/or performance thresholds with analysis of data to evaluate the effectiveness of the prevention and wellness activities. Analysis of the year-over-year data revealed that the interventions had been successful in resulting in improvement in the well-child visits and childhood immunization as depicted in **Table 7.1-12.**

Table 7.1-12: Monitoring Well Care Visits

Well Child Measures	2017		2018	
	Result	Goal Met	Result	Goal Met
Well child visit ages 15 months to 6 years	63.68%	No	72.99%	Exceeded
Well child visit ages 3 to 6 years	71.93%	No	75.91%	Exceeded
Childhood immunizations—combo 10	24.53%	No	36.50%	Exceeded

Clinical Initiative Two: Improvement in Annual Dental Visits

The 2014 *Burden of Oral Disease in West Virginia Report* indicates West Virginia children had significant experience with tooth decay. Tooth decay is largely preventable and childhood years are the perfect time for preventive dental care. Analysis of Aetna's dental visit rates revealed opportunity for improvement. Root-cause analysis revealed that the children in the Supplemental Security Income (SSI) population tended to have higher compliance across all reporting periods. This may indicate that these children are being referred to dental or oral health providers during evaluation, diagnosis, and treatment of other complex health conditions. Similarly, the presence of speech/language and developmental disorder diagnoses appears to demonstrate a correlation to higher dental visit compliance rates, perhaps as a result of being referred for dental care during assessment and evaluation of the speech, language, and/or developmental conditions. Dental visit rates for children in the Temporary Assistance for Needy

Families (TANF) population appeared to trend lower than the SSI population. Aetna outlined various member and practitioner initiatives in order to positively impact dental screening rates, including the following seen in **Table 7.1-13**.

Table 7.1-13: Member and Practitioner Initiatives

Initiative	Description
Member Initiatives	
Dental wellness community events/clinics	Collaboration with dental providers at FQHCs and dental clinics to host dental clinics for Aetna members. Members attending the well-visit clinic receive $25 gift card at the conclusion of their visit.
Back-to-school events	Aetna participates in back-to-school events to distribute dental kits and reinforce the importance of dental well visits.
Relationship with Head Start	Aetna collaborates with community schools to hold dental events during the school year where local dental providers perform dental visits. In 2018, five Head Start events were held in Raleigh, Mercer, McDowell, Monroe, and Wyoming counties.
Ted E. Bear, M.D. Cub Club	The Cub Club is a wellness club for members age 13 and under. The Cub Club includes seasonal challenges such as the Dental Challenge, where children are encouraged to practice good daily dental habits. Members/guardians track activities on a monthly calendar. At the completion of the challenge, members receive a dental kit including a toothbrush, toothpaste, and dental floss.
Member outreach by telephone	Monthly gaps-in-care reports are used to identify members in need of a dental visit. Telephonic outreach calls are made throughout the year by QM and Member Services staff to all members age 2-20 years needing a dental visit. Care coordinators also remind members of needed screening during their member outreach. In 2018, there were a total of 507 successful dental visit member reminder calls.
Provider Initiatives	
Provider training webinars	QM staff collaborate with Provider Relations team to deliver training webinars, which include education on the importance of dental screening visits. All provider types, including PCPs, specialists, FQHCs/rural health clinics (RHCs), health departments, and ancillary providers, are invited to the webinars.
High-volume practitioner incentives	Incentives offered to high-volume practitioner sites for improvements in their dental HEDIS rates

Goals for initiatives are determined using national standards (e.g., HEDIS) and/or performance thresholds with analysis of data to evaluate the effectiveness of the prevention and wellness activities. Analysis of the year-over-year data revealed that the interventions had been successful in resulting in statistically **significant and sustained improvement in annual dental visits from 2017 (61.04 percent) and 2018 (63.06 percent) to 2019 (64.18 percent).**

Collecting, Monitoring, and Reporting Member Satisfaction Measures

QU022	Member satisfaction	See the parent specification. Parent Specification: The Vendor should monitor quality improvement strategies with measurements including, but not limited to, the following:
QU037	The Vendor should establish and collect member satisfaction measures following the implementation date.	1) The Vendor should provide proposed member satisfaction measures.

		2) The Vendor should describe past Vendor efforts to assess member satisfaction.

Aetna assesses member and family experience through various methods, including the administration of the CAHPS survey and the Aetna Behavioral Health Member Satisfaction Survey, as well as by evaluation of member complaint and appeal information. CAHPS surveys include questions related to a range of health care services at multiple levels of the delivery system as depicted in **Table 7.1-14**, such as **Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Health Plan Customer Service, Health Promotion and Education, and Coordination of Care.** 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 showed the CAHPS survey questions indicated most members were satisfied with their ability to get needed care, tests, or treatment. Following the implementation date, Aetna will be adopting the CAHPS CCC version to help ensure CSHCN and their families are receiving appropriate care and are satisfied with services. This version is specifically geared to the target population and will allow us to more efficiently identify trends in member satisfaction. Proposed new questions for this CAHPS CCC version would include member satisfaction measures related to their ability to get counseling for the child's emotional, developmental, and behavioral problems; satisfaction with ability to get help from the child's provider in contacting the school/daycare; and level of satisfaction with socially necessary services provided.

Table 7.1-14: Aetna 2018 and 2019 CAHPS Results Meeting the 75th and 90th Percentiles Nationally

CAHPS Measure	2018 Rate and Percentile	2019 Rate and Percentile
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

Aetna uses CAHPS survey results to identify and investigate areas of member dissatisfaction, outline action steps to follow up on the survey findings and develop an action plan. The action plan includes implementation steps and a timeline for completion. Quarterly updates on the CAHPS action plan are forwarded to BMS as required by the contract in **Section 6.11.4 of the Model Service Provider Agreement**. 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.

Simplifying Administrative Processes

QU004	The Vendor should adopt strategies to simplify administrative procedures.	The Vendor should describe how it will meet this specification.

Aetna recognizes that it is essential to continually review our health plan processes to identify those that create unnecessary burdens on providers. End-to-end provider experience is critical to getting the best care

and outcomes for our enrollees. We are continually identifying and adopting strategies to simplify and streamline administrative procedures.

Our prior authorization process is fully automated and complies with all federal and State requirements. Our UM program description and written policies and procedures include processes, guidelines, review criteria, turnaround timeframes, and qualifications of health plan staff involved in UM processes. We complete service authorization requests timely and efficiently in compliance with established NCQA and State contract turnaround timeframes and the requirements indicated in 42 CFR and 438.210(d).

As part of the service request requirements, requesting providers supply pertinent information such as appropriate medical records. Upon receipt, UM staff reviews the request and then applies the hierarchy of appropriate medical necessity guidelines and evaluates the individual member's circumstances. UM staff first review respective the member's information in their electronic platforms and may outreach to the requesting provider or care coordinator to obtain additional information to support the request for services. Our CMO/medical director or delegate is available for consultations with staff regarding prior authorization, retrospective review, and concurrent review issues. Aetna understands the challenges members and their families in rural areas of the State may experience accessing care and engages the use of telehealth when possible to resolve any gaps in care. We do not require any stricter prior authorization requirements for services provided through telehealth than if the services were provided in person.

Aetna uses integrated systems and interdepartmental processes to coordinate services for members. The UM business application system allows departments to share members and provider information, coordinate procedures such as discharge planning, transition a member from an institutional setting back into the community, authorize post-hospital services, and follow up on complex cases or emergency room care. Aetna's UM business application system also provides the authorization number and effective dates for authorization to participating providers and as applicable non-participating providers. Aetna's UM business application system stores and reports the time and dates all service authorization requests received, decisions made regarding the service requests, clinical data to support the decisions, and timeframes for notification of providers and members of decisions.

A medical director with appropriate clinical expertise in treating the applicable member's medical or BH condition is the only staff within UM that has the authority to deny a service authorization request.

Another way Aetna simplifies the administrative process is through our newborn enrollment process, where we make sure our newborns can receive services immediately. We identify newborns through our enrollment manager application so we can manage their care immediately until they are enrolled. We supply the Department with the newborn enrollment report that lists newborns so they can add them to the 834-file for enrollment. Our enrollment manager application utilizes proprietary member matching rules to ensure file records (including newborns) are accurately matched to existing records in our system when processing 834-files.

We understand that not all providers are familiar with managed care practices, and we employ multiple innovations and automation designed to minimize their administrative burden and enhance provider experience, including the following:

- Conducting a comprehensive annual review of services requiring prior authorization to improve members' access to services and reduce provider burden
- Supporting a dedicated provider services line 8:30 a.m. to 5 p.m. weekdays, except holidays, for assistance
- Providing a toll-free fax line, fax blasts, and direct provider communication regarding prior authorization process changes
- Providing provider education at Aetna forums and site visits

Oversight and Monitoring of Providers and Subcontractors

QU002	The Vendor should share best practice methods or programs with physical and BH providers and should provide identified best practice methods or programs to the Department for consideration in sharing with socially necessary services (SNS) providers.	The Vendor should describe how it will meet this specification, as well as any other ways it would actively work with network providers to ensure accountability and improvement in the quality of care provided. The Vendor should describe which best practice methods it employs to its provider network.
QU003	The Vendor should take action against physical and BH providers that demonstrate unacceptable performance and should share identified socially necessary services (SNS) provider performance deficiencies with the Department.	1) The Vendor should describe the standards it uses to assess provider performance. 2) The Vendor should describe how it will meet this specification, as well as any other ways they would actively work with network providers to ensure accountability and improvement in the quality of care provided.
QU043	The Vendor should monitor and reinforce primary care provider (PCP) compliance with program requirements for applicable populations.	1) The Vendor should describe how it will meet this specification, in general. 2) The Vendor should describe specifically how it will meet this specification for program requirements including, but not limited to, 24-hour coverage, appointment scheduling, and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) periodicity standards.
QU049	The Vendor should use reports/data from subcontractor(s), as applicable, to ensure appropriate subcontractor oversight and the following member-related outcomes:	The Vendor should describe how it will meet these specifications.
QU050	Access to care	See the parent specification.
QU051	Member satisfaction	See the parent specification.
QU052	Continuity of care	See the parent specification.
QU053	The Vendor should run data at a set frequency to identify which members in applicable populations have not received primary care services.	The Vendor should describe: 1) Types of data the Vendor will use to determine which members have/have not received primary care services 2) Any other mechanisms the Vendor will use to determine which members have/have not received primary care services
QU054	The Vendor should contact members within a set timeframe after identifying which members in applicable populations have not received primary care services.	The Vendor should describe how it will meet these specifications.
QU055	The Vendor should contact the member's primary care provider (PCP) within a set timeframe after identifying that a member has not received primary care services, for applicable populations.	See the parent specification.
QU056	The Vendor should analyze and synthesize reports on data about members in applicable populations who have not received primary care services.	The Vendor should describe how it will meet these specifications.

Compliance monitoring is a health plan-wide endeavor, and 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, our members, and our participating providers. These committees perform day-to-day oversight activities for internal monitoring of operations.

Aetna performs ongoing monitoring of subcontractor performance, including meeting with subcontractors on a weekly, monthly, or quarterly basis, depending on the subcontractor. 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 corrective action plans 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 accounted for.

Local oversight: The 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 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.

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

Delegation oversight activities are formally monitored as a component of the QAPI program. Audit reports of delegated activities and corrective action plans (CAPs), if applicable, are submitted to the appropriate oversight committee (e.g., 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 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.

[QU049] Using Data from Subcontracts to Ensure Appropriate Oversight

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 has a comprehensive set of policies and procedures to manage the delegation of responsibility for any delegated program function. We understand all processes required for effective oversight of subcontractor performance, and we are successful at conducting these activities as part of our daily business. We have extensive experience with subcontractor oversight, including

with selecting subcontractors and ongoing monitoring of subcontractor performance. By leveraging this experience, we ensure the successful completion of all delegated functions under the West Virginia Medicaid program.

Aetna Better Health's local Delegation Oversight Committee requires all subcontractors to report various measures the committee to ensure comprehensive oversight of its subcontractors. The following is an example of data sources used to monitor subcontractor performance and ensure that they are meeting all contractual responsibilities as they provide service to our members:

- **Customer service call data:** Data from each subcontractor is tracked on a monthly basis 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:** Reported at least quarterly to the local Delegation Oversight Committee. This includes reporting on requests for out-of-network services, which is a key indicator of the subcontractor's ability to adequately provide needed services.
- **Provider appointment surveys:** Reported at least annually by each subcontractor, as applicable
- **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. This monitoring would allow for early identification of any apparent trends in denials of service so that these patterns could be promptly addressed with the subcontractor

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. These audits include review of associated policies and procedures and file audits, where applicable. The local Delegation Oversight Committee reviews the audit tools to help ensure that local contract-required service-level and metric requirements are included. 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. If audit results reveal an issue with the vendor's compliance with the service level agreement, the frequency of our monitoring activities will increase accordingly.

[QU050] Using Subcontractor Data to Monitor Outcomes Related to Access to Care

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. In order to monitor subcontract 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. There is also an annual GeoAccess review performed and reviewed to help ensure that our vendors meet the 30-mile criteria meeting the access to care standards. The data collected is reviewed during the quarterly oversight Joint Operation Committee meetings. 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. Given our well-established relationship with our vendors, access to care standards has always been met and exceeded. If access to care issues arise, it would result in contract remediation up to contract termination.

[QU051] Using Subcontractor Data to Monitor Outcomes Related to Member Satisfaction

All subcontractors are required to send member complaints to Aetna for resolution. Each case is discussed individually in Joint Operating Committee (JOC) meetings. Increases and trends in complaints

are brought to the Service Improvement Committee for discussion and possible corrective action. Upon award, Aetna will review and capture this information for children and youth in the foster care system and individuals receiving adoption assistance.

[QU052] 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 the 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 subcontract 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 will be addressed through an action plan implemented at that time.

[QU003] Taking Action Against Providers Demonstrating Unacceptable Performance

The QM and provider services staff work together to monitor network practitioner and provider performance, including SNS providers. QM staff assists provider services staff in developing measurable objectives to evaluate provider performance; analyzing data collected in the monitoring process; and preparing information for the QMOC. If the reported data indicate 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 member safety issues, makes recommendations to the 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 members. 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 practitioners 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 practitioners 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.

Aetna will administer retrospective reviews of SNS services in two ways. First, UM guidelines will be used to retroactively review SNS service requests. Second, after the prior authorization, KEPRO will implement a retroactive review of provider documentation practices and UM processes. KEPRO will review service invoices presented by the provider and utilize a random sample of authorizations. The provider's credentialing information will also be evaluated while onsite for the retroactive review. Each SNS provider will be reviewed within three years of the term of the BCF agreement with the provider. Additional reviews may be warranted based on the scores from the past review period being under 80 percent. Providers must score at least 80 percent during their retrospective review for each service

reviewed. Providers failing to meet 80 percent will be placed on a probation period for each respective service failing to meet that threshold. The KEPRO reviewer will provide a written notice that the probation period is in effect. At the end of the probation period, KEPRO will conduct another assessment. If the provider continues to score less than 80 percent for that service, KEPRO will recommend to BCF the service be closed for that provider and the provider should no longer be eligible for referrals for that service. If the provider scores a zero on any safety related service during any review, the service will be automatically closed for the provider.

[QU002] Sharing Best Practice Methods and Programs

Aetna engages members and their supports where they are to achieve the highest level of health, independence, dignity, and self-management needed to have greater control of their lives and experience the life they envision for themselves. **In alignment with national best practices for PH and BH, we focus on the strengths, preferences, abilities, and aspirations of a person rather than making decisions that are based on impairments and disabilities.** For providers participating in our APM programming, we employ a multi-channel approach to share best practices on an ongoing basis. We share and communicate best practice methods and programs with our providers through a variety of forums, including but not limited to the following:

- Face-to-face visits by members of the Provider Relations and QM teams
- Provider collaborative for trauma-informed care
- Bulletin updates via fax blasts
- APM teams working directly with providers on practice incentives based on evidence-based practices and outcomes
- Co-location in facilities; working with providers on education directly
- Guest lectures at association meetings
- Dental letters for opioid prescribing (we reviewed prescribing patterns and identified outliers and sent them letters with information on best prescribing practices)
- Peer-to-peer calls

Aetna has developed an integrated and highly participatory approach to plan implementation and support. The selection of highly participatory methodologies for support of members, providers, and partners is intended to provide the ability to have a responsive system to member needs, which builds on the best evidence available for providing effective PH and BH services. Based up retrospective reviews, meeting discussions, and Aetna focus group findings, best practices will be identified and shared with SNS providers through the KEPRO web portal, provider onsite reviews, and provider trainings.

Aetna will share best practice methods and coordination with the Department through a direct relationship and will include the Department in key roles with the training collaborative. This design provides an opportunity to individualize support and implementation to local and regional levels across West Virginia where there may be unique needs. The participation by Department representatives in the core model training will provide direct and frequent interaction between members, providers, and partners with Department staff, ensuring opportunities for direct insight into the impact of Aetna implementation and operation.

Best Practices Shared with Our Provider Network

Examples of best practices shared with our provider network include our neonatal abstinence syndrome program, flu vaccinations, diabetic dental practices, and diabetic-asthma project with community health workers. We share best practices with our provider network by working directly with the provider offices. We provide education, training, technical assistance, and toolkits to deploy best practices and break patterns of non-compliance.

Best Practice Methods/Programs for Consideration with Socially Necessary Service Providers

Aetna's transformative vision drives our model for enhanced care coordination and service integration supporting the children and youth in the foster care system and individuals receiving adoption assistance populations. Collaborative relationships are at the center of Aetna's approach to serving the West Virginia children's population. Aetna selected a nationally award-winning model called **Collaborative Family Engagement** as a framework and methodology to strengthening and sustaining a partnership with the Bureau of Child and Families staff and leadership. Collaborative Family Engagement is one of the first in the nation to approach building a collaborative effort to bring a health system and child welfare system together to support and strengthen the safety of children and the well-being of families. This will be a unique approach to build a collaborative effort to stand a health system and child protection system shoulder-to-shoulder in supporting and strengthening the safety of children and the well-being of families.

Aetna recommends using an SOC approach that provides **evidence-based, trauma-informed care treatment and recovery services**. Aetna has learned that many child and adolescent members have had trauma in their lives and are best served to receive all aspects of their care from a trauma-informed perspective, including from Aetna staff and our provider network. According to Dr. Allison Sampson-Jackson of Integration Solutions[1], the impact of an ACEs score of 0 compared to an ACEs score of 4 results in a 357 percent increase in likelihood that the individual will experience depression. In addition, there has been a 46 percent increase in the number of children and youth in the custody of the state between 2014 and 2017.[2] Aetna understands that trauma is often a part of our members' history and has incorporated a trauma-informed system of care into its integrated care delivery model. We know that adult outcomes associated with ACEs include increased risk for heart disease, diabetes, obesity, cancer, intimate partner violence, depression, smoking, substance abuse, and early death. Aetna's SOC includes trauma-informed care trained care coordinators and a network of providers that includes providers providing trauma-informed care services. Where there are gaps in the network, Aetna provides training for providers to ensure at-risk youth have access to trauma-informed care services. We meet members and those who support them where they are on their journey.

Our **interdisciplinary care coordinators,** who are part of **CCTs**, act as a resource for both members and all participants of the West Virginia child welfare system of care, including community organizations, family support, and foster care providers. This step helps to coordinate collaborative services and promotes access and continuity of care. Our local and community-based team has a knowledgeable team of social workers, registered nurses, and counselors who have a wide variety of expertise, including experience caring for youth (sometimes with lived experience); they are fully trained to assess a comprehensive profile of each member. We ensure that our care coordinators understand the impact of ACEs and the importance of creating an environment of safety that does not cause re-traumatization. We apply trauma-informed care standards, and our training emphasizes the roles and responsibilities of the Department and other children's services agencies and those of foster parents in making decisions on behalf of children in foster care.

In addition, the Aetna team is trained in advanced coursework on trauma-informed care, **Mental Health First Aid**, and the fundamentals of development, including age-appropriate and stress-related behaviors, adolescent substance use, and permanency training. We have trained approximately 2,500 staff in the principles of trauma-informed care across the Aetna Medicaid organization since 2018. Some of the topics include the following:

- Defining trauma

[1] Samples, Jeremiah, "West Virginia's Child Welfare Crisis: A Path Forward," West Virginia Department of Health and Human Resources (2018): accessed August 2, 2019; http://wvahc.org/wp-content/uploads/Prez-on-Child-Welfare-1.pdf.
[2] Ibid.

- Prevalence and impact of trauma and ACEs
- 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
- Application for staff and members

Aetna looks forward to collaborating with the Department to ensure children involved in the foster care system or have been identified as having complex special health care needs are screened for adverse childhood experiences and BH needs and are connected to providers using trauma-informed treatment practices. We are committed to offering Mental Health First Aid and trauma-informed care training to our providers and community-based partners.

[QU043] Monitoring and Reinforcing PCP Compliance

Aetna's commitment to serving as a good steward of West Virginia resources is demonstrated by our monitoring and oversight processes, including daily departmental operational meetings, daily cross-function operational oversight meetings at the executive leadership level, provider and network escalation processes, and PCP oversight processes. We take seriously our obligation to understand and comply with the unique requirements set forth by the Department and will collaborate with the Department and other key stakeholders to monitor and measure our progress in meeting performance objectives. Aetna conducts the following monitoring activities related to PCPs:

- Accessibility analysis
- Availability analysis
- Medical record reviews
- Gaps in care
- Readmission
- ER utilization
- Inpatient utilization
- Pharmacy spend
- Medical cost
- Severity ER 1 visit

In 2018, the practitioner appointment accessibility fax survey results revealed that 99 percent of practices met the appointment standard for new patient initial visits, existing patient follow-up visits, and urgent care appointments to Aetna members with 100 percent of PCP respondents able to provide after-hours coverage. **All PCP practitioners had after-hour coverage available**. In addition, as part of the initial credentialing process in 2018, Provider Relations representatives conducted office site visits of 13 primary care practice sites. This site visit included a review of the practitioner's appointment schedule to evaluate appointment accessibility and to determine if the health plan's appointment accessibility standards were being met. **All these practitioners met or exceeded the appointment accessibility standards.**

Monitoring and Reinforcing 24-hour Coverage

We currently monitor and reinforce 24-hour coverage for the PCP through our internal QM process. Prior to contracting, PCPs must include information on their credentialing application outlining how they meet this requirement. In addition, this requirement is reviewed again during the initial onsite credentialing visit. To monitor the 24-hour coverage on an ongoing basis, the provider must respond on our annual survey how they are meeting this requirement. If Aetna determines a PCP is noncompliant with the 24-hour coverage requirement at initial application, then the PCP is not permitted to join our network. We will provide education to PCPs on the requirements if deficiencies are noted at any time throughout the monitoring process. If a deficiency is noted, the provider has 60 days to address it; if they are unable to, the provider deficiency is reported to the Service Improvement Committee for review and possible termination of contract.

Monitoring and Reinforcing Appointment Scheduling

Our process for monitoring and reinforcing appointment scheduling for PCPs is similar to that of the 24-hour coverage requirement. At the time of initial application, we verify the potential provider meets the contract standard of timeliness and availability of appointments. We monitor ongoing compliance with this standard via our annual provider survey; if deficiencies related to appointment scheduling are noted, we meet with the provider to give education on the requirements. Providers then have 60 days to address the deficiency. If the provider still fails to comply with the requirement, the QM/UM Committee will review and determine additional corrective actions that may be warranted, including potentially terminating the provider's contract. In addition to the annual appointment availability analysis, we also monitor our complaint and grievance data to identify potential concerns with appointment accessibility. Every member complaint is reviewed by our Complaint Committee to ensure that the issue was resolved satisfactorily with the member/caregiver/guardian. Any complaints regarding appointment scheduling would be handled by direct outreach to the provider by the Member Services team. In any situations where there would be a trend in member complaints (defined as three or more complaints) regarding appointment accessibility, there would be direct outreach by the Provider Relations representative to the provider to address the issue.

Monitoring and Reinforcing EPSDT Periodicity Standards

Aetna will monitor and reinforce 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 CCTs review gaps in care and set task reminders for follow-up visits for the following: children age five and under with no screening; targeting children and youth with special health care needs with delinquent screenings; and conducting outreach to parents and caregivers of members ages 0 to 20 with delinquent well-visit exams or screenings on the importance of well-visit exams, screenings, and following EPSDT schedules. EPSDT requirements and related HEDIS measures are tracked and the data is utilized to generate reports and identify any early deficiencies. Some tools used include care alerts (which identify high- and medium-risk members who are delinquent), priority lists, quarterly measures and feedback, EPSDT practice profile, tracking phone calls conducted (automated and direct), and face-to-face contacts. The pediatric measures are shared with the network and practices quarterly for quality improvement purposes. The EPSDT profile for each provider or practice is generated and includes items such as well-visit rates and well-visit components.

[QU053] Using Data to Identify Members Who Have Not Received Primary Care Services

Aetna will track data related to youth entering into the foster care system in addition to monitoring the required 90-day follow-up, as required in **Section 2.2 of the Model Service Provider Agreement**. Members in this target population will be flagged in our internal data management system based on the enrollment file sent to us by the State. On a monthly basis, we will use this flag to run claims reports to identify which members in the target population have not received primary care services. This data can also be used to determine if a member may be going to another physician or urgent care for these services, so they can be re-directed to their PCP or assigned to the new PCP of attribution.

We are currently exploring the utilization of West Virginia Health Information Network (WVHIN) to assist in providing data for providers treating foster care youth. This data will be retrieved from WVHIN on a regular basis to help us identify, in a timely manner, members who have not been seen by their PCP within the set timeframes. In the case of lags in claims data, we will be able to pull data from the WVHIN to help proactively address noncompliance.

[QU054] Contacting Members Who Have Not Received Primary Care Services

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Figure 7.1-4 Aetna Well-visit Event
These well-child event participants are sporting smiles and showing off their Aetna gift bags after their checkups at Teays Pediatrics in July 2019.

Aetna believes in a proactive approach to ensuring members receive PCP services in a timely manner. When we receive the monthly enrollment file from the State, members are flagged in our system to receive a welcome text and outreach from a Care Management staff member within 24 to 48 hours. All youth entering the foster care system are assigned to the Care Management team and are stratified into one of three tiers, depending on severity of issues. Tier 1 members (lowest level of severity) receive at least a quarterly outreach call from the Care Management team along with at least one interdisciplinary care team meeting per quarter. Tier 2 and Tier 3 members receive more intensive outreach depending on the situation. All these outreaches by the Care Management team provide additional opportunities for the member and/or caregiver to be reminded of the importance of receiving timely primary care services. Care Management staff verify PCP assignment, inquire about most recent visits, encourage necessary well-child visits, and confirm that members have access to a complete and up-to-date list of network and SNS providers. If the member or caregiver is not reached during the initial outreach call, a letter will be sent containing information related to services and a reminder to make their PCP appointments. In addition, the members identified as not having received timely primary care services are included in any community well-visit events at local primary care sites, as depicted in **Figure 7.1-4.** The QM team makes direct member outreach telephone calls to these members to invite them to schedule a visit with the PCP during the wellness event.

[QU055] Contacting PCPs for Members Identified as Not Receiving Primary Care Services

Aetna helps to ensure that PCPs are aware of their assigned panel and will send each contracted provider a panel report within five days of the end of the month. Within these notifications, the members will be identified separately if they are involved in the foster care system and/or identified as CSHCN. We will also inform the provider of the access to this report via our web-based provider portal. To proactively notify and make certain PCPs are aware of the access and reporting guidelines for these populations, our provider relations staff will provide them with informational fliers, along with monthly provider trainings for provider office managers. For members that are identified as not having received the required PCP services, we will send out monthly letters notifying the PCP of which members are overdue for an ESPDT visit or other well-child follow-up.

[QU056] Reports about Members Who Have Not Received Primary Care Services

Aetna currently utilizes aggregate claims data related to PCP services to help identify members that may be missing critical appointments and screenings. On a quarterly basis, we currently generate reports for 100 percent of our PCPs to identify any children and youth in their practice who are overdue for their wellness appointments. The reports include the names and contact information of all children and youth who are in need of services. The QM team also uses this information in order to pinpoint provider offices for direct outreach and an offer to conduct a well-visit clinic drive at their facility. We work collaboratively with our Care Management department to conduct necessary outreach to the member and their families and caregivers who have not been seen by their PCP. The outreach by Care Management will include

conversations surrounding barriers to accessing care. The Care Management team will support the family in acquiring necessary supports to ensure access.

Developing and Updating Clinical Practice Guidelines

QU031	The Vendor should develop, update, and disseminate clinical guidelines to participating providers.	The Vendor should describe how it will meet this specification.

Aetna is committed to supporting providers in the adoption of clinical practice guidelines (CPGs) to measure, evaluate, and start best-practice interventions to provide the best care possible to our members. Aetna reviews adopted CPGs and preventive service guidelines every two years and when new scientific evidence or national standards are published by recognized sources prior to the two-year review date. We use national policies and processes for adopting and updating CPGs and preventive health guidelines from nationally recognized sources and in compliance with **42 CFR 438.236** and NCQA standards. Our quality management director brings all guidelines to our QM/UM Committee for review, input, and adoption. Modifications to the guidelines are made by consensus with each CPG being formally approved by our QMOC, with guidelines updated at least every two years.

Aetna uses evidence-based clinical practice and preventive health guidelines from nationally recognized sources, which serve as our standard of care. We adopt and maintain clinical guidelines for informational purposes for medical as well as BH conditions to promote consistent application of evidence-based treatment methodologies.

A physician-based committee at the national level reviews the guidelines at the national level; they are then presented to our local QM/UM Committee for review and approval. Following this committee's approval, the guidelines go to our QMOC for final review and adoption. See **Table 7.1-15** for examples of current CPGs[3] adopted in April 2019.

Table 7.1-15: Examples of Aetna's Clinical Practice Guidelines

Clinical Practice Guideline	Description
Alcohol abuse	National Institute on Alcohol Abuse and Alcoholism, Helping Patients Who Drink Too Much: a Clinician's Guide, 2005 Edition
Asthma	National Heart, Lung and Blood Institute-Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma Full Report, 2007
Attention-deficit/ hyperactivity disorder (ADHD)	American Academy of Pediatrics: Diagnosis, Evaluation, and Treatment of ADHD in Children and Adolescents, October 2011
Diabetes	American Diabetes Association Standards of Medical Care in Diabetes, 2019
Major depressive disorder	American Psychiatric Association Guideline for the Treatment of Patients with Major Depressive Disorder, Third Edition, October 2010
Opioids for chronic pain	Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain
Prenatal services	The American College of Obstetricians and Gynecologists Guidelines for Perinatal Care, Seventh Edition, October 2012 American Academy of Family Physicians, Prenatal, 2017
Tobacco cessation	Centers for Disease Control and Prevention Cessation Materials for State Tobacco Control Programs: multiple guidelines

[3] Aetna Better Health of West Virginia, "Clinical Practice Guidelines," (2019): accessed August 3, 2019; https://www.aetnabetterhealth.com/westvirginia/assets/pdf/providers/2019%20ABHWV%20CPGs%20for%20Web.pdf.

Aetna selects nationally recognized CPGs based on scientific evidence, national standards, and expert consensus. We encourage provider participation in the selection and adoption of the CPGs through our QM/UM and QMOC Committees, as well as through our regular regional JOCs. If we do not have a corresponding specialist to the topic within our network, we obtain the opinion of an expert out of network. We make modifications to the guidelines to incorporate input from providers as approved through the QM/UM Committee and QMOC.

We support **widespread dissemination of CPGs** to our providers through the website, web portal, provider manual, onsite visits, trainings, and fax blasts. In addition, members and their caregivers or guardians can contact the Member Services department at any time to request a hard copy of the CPGs. We will help to ensure providers receive up-to-date information on CPGs and will send out email blasts notifying them of any changes made. Provider relations staff will also inform their assigned providers of changes that occur to the CPGs. Staff is available to provide explanation to members in a culturally and linguistically appropriate manner.

In addition, CPGs and preventive health guidelines are shared with our PH and BH practitioners during the provider workshops held throughout the state, on provider webinars held quarterly for all new practitioners joining the network, and on our provider website. Best practices are shared quarterly with our regulator at the time of our PIP updates and annually during the external quality review.

Provider Profiling

QU038	The Vendor should profile the quality of care delivered by network providers, including, but not limited to, the following:	1) The Vendor should describe its practice of profiling the quality of care delivered by network providers. 2) The Vendor should provide the methodology for determining which and how many providers will be profiled."
QU039	Primary care providers (PCPs)	See the parent specification.
QU040	High-volume specialists	See the parent specification.
QU041	Hospitals	See the parent specification.
QU042	Other acute care providers	See the parent specification.

[QU038] Approach to Provider Profiling for Quality of Care Delivered

Our systems will run comprehensive provider profiling reporting that is unique to our network providers. The provider profiling report will be used to educate PCPs, hospitals, high-volume specialists, and other acute care providers about their practice patterns and their overall performance relative to their peers. We use key quality and efficiency indicators and use these reports to collaborate with providers in identifying opportunities to improve member experience. A key benefit is that reporting may be broken out by individual provider. The providers can trend their data, track gap in care activity, and capture actionable data for improving outcomes. With the roll-up of the data from provider reports and HEDIS activity, Aetna proposes delivering semiannual updates to the Department on APM activity and outcomes to allow for claims data to process and provide accurate updates on the metrics. Aetna will comply with the format prescribed by the Department to include status, progress, successes, and challenges. We will work with the Department to use the findings to identify additional opportunities for improvement.

Aetna uses various data points to develop practitioner profiles to monitor practitioner practice patterns along with members' health outcomes to identify opportunities for improvement. The objectives and goals of practitioner profiles are as follows:

- Identify practitioner utilization patterns that vary significantly from peer network practitioner groups
- Identify trends and address through practitioner outreach
- Provide information to network practitioners about their practice patterns
- Provide information for use as a component of quality management oversight

- Provide information for use as a component of practitioner incentive compensation
- Share objective, reliable, and meaningful data to providers in order to foster closer working relationships

Provider profile reports are generated by the Aetna Medicaid organization's APM Informatics team. The APM regional manager shares the results quarterly with the QM, Medical Management, and Operations teams at the health plan, and then it is shared with providers. Full explanation to providers is given, and our preference is to sit down and meet with the provider to discuss results and collaborate with them to identify areas of improvement. Aetna will provide support for providers to help support their patients and our members.

The CMO or designated medical director is responsible for accessing the profile interface quarterly to review identified practitioners' utilization patterns, trends, and costs during the previous year. These reports are shared with the provider, and if a profile reflects practices that do not further Aetna's health care mission, e.g., low performance of HEDIS measures, the CMO/medical director will request that the practitioner develop a CAP.

The provider profile report also monitors member satisfaction using data from complaints and appeals as well as administrative quality through compliance with access requirements. We format provider profiles to allow comparative feedback for individual practitioners compared to established targets, State or national benchmarks, their practices or groups, organizations, geographically relative peers, or the overall performance of the provider network. For groups and organizations, the profile provides a summary of all affiliated practitioners' performances. We furnish all reports in Health Insurance Portability and Accountability Act-compliant electronic and hardcopy formats depending on provider requests.

Each provider profile report contains the following at a minimum:

- **Coding tool:** Defines the performance metrics and provides detailed information on service coding used on claims to obtain credit for metric-related service provisions
- **Performance profile:** An Excel spreadsheet text report for each practitioner or provider group listing the metrics, member denominator, and numerator counts, current period performance for each metric, target(s) for the metric, and the provider's progress in achieving an award for performance for each target
- **Member intervention list:** A list of attributable members for each metric such as well visits, immunizations, and other screenings, with demographic information identifying members still in need of care or services; this intervention list facilitates outreach and registry used to promote member compliance and garner better performance outcomes for both the provider and members

Methodology for Determining Providers to Be Profiled

To address clinical quality, we will create profile reports for PCPs with 50 or more unique child/youth members, as well as acute care providers, hospitals, targeted BH providers, and our high-volume specialists with at least 10 full episodes of care over the reporting period, with a goal of providers who service up to 85 percent of the population. We will leverage the existing experience and best practice profiling process within our commercial and Medicare lines of business to develop effective reporting in West Virginia for implementation at contract go-live with a flexible approach to adapt the content and frequency as we learn about the needs of the population.

[QU039, QU042] Profiling PCP and Other Acute Care Providers

For the purposes of profiling, we have defined other acute providers to include health departments and free clinics but will adapt to further clarifications as provided by the State. Our PCP and other acute care provider profile report may include but is not limited to the following measures:

- Lead screening for children

- Follow-up care for kids prescribed ADHD medications
- Well-child visits at 15 and 30 months
- Children/adolescent access to primary care services
- Antidepressant medication management: effective acute phase treatment and effective continuation phase treatment (HEDIS)
- Diabetes control: HbA1c <8 percent (HEDIS) or absence of an HbA1c screen
- Cervical cancer screening (HEDIS)
- Appropriate medications for members with asthma (HEDIS)
- Potentially preventable emergency room visits; potentially preventable admissions
- Emergency room utilization and hospital readmissions

[QU040] Profiling High Volume Specialists

Aetna will identify specialists serving a high volume of children and youth as determined by claims spend in the foster care system and individuals receiving adoption assistance through claim volume data. We will also look at those high-volume specialists with at least 10 full episodes of care. The analysis will include re-admission rate, ER visit rate, and an analysis of selected appropriate HEDIS measures for the target population. For example, in profiling a high-volume endocrinologist, we will look at their population of individuals living with diabetes and review their HgA1c, ER visits, and inpatient rate. We will blindly compare high-volume specialists against their peers to demonstrate how they perform compared to their peers.

[QU041] Profiling Hospitals

Aetna will use metrics, such as 7- and 30-day post-discharge PCP visit follow-up, potentially preventable hospital admissions, and low-acuity emergency room visits to profile our network hospitals that are seeing a high volume of children and youth in the foster care system and individuals receiving adoption assistance. As with our high-volume specialists, we will report on these metrics and provide the hospitals with a report profiling their performance as compared to their peers. Aetna believes that this process will encourage the facilities to put operating procedures in place to help ensure discharging patients have a PCP office scheduled to assess and monitor medication, help to ensure adequate supports are in place post-discharge, and make sure the medical home is intact. We recognize the need to support this collaboration between the discharge staff along with the PCP, especially for members in rural areas. We believe that this process adds support to members in rural settings and gives accountability to us and the hospital to make certain a high quality of care is provided to our shared members.

Review of Profile Data

As part of our QAPI program, our QM/UM Committee will identify provider profile indicators based on their relevance to the applicable population(s), establish benchmarks, assess the results of provider profiles, monitor provider progress on CAPs, and develop quality improvement initiatives as needed. Aetna will notify all providers on the selected indicators and methodologies used to generate performance scores at the beginning of each reporting period.

Sample Quality Profile Reports

Network PCPs and acute care providers providing services to members will receive performance reports similar to the ones currently used for Aetna members. Unlike similar tools in the market, the provider profile report will contain a member list of needed care or services for each indicator, so providers can address all known gaps in care when patients are in the office or for use in provider/member outreach. We will continue to refine the tool, especially requesting regular feedback from providers to make it more user-friendly, and we will offer interactive formats for easier accessibility on computers and mobile devices.

Rationale for Selecting Performance Measures in Sample Report

We will select specific measures in the profile report because they relate to a high volume of the eligible population of children and youth in the foster care system and individuals receiving adoption assistance, as well as measures that are important to the State, which allows us to produce meaningful data for providers. These measures will be consistent with our goal of promoting preventive care to help keep our members healthy and will align with the Department's goals. We plan to include measures that provide data to support point-of-care clinical decision-making as well as tracking and monitoring overall quality, population health, and chronic service coordination efforts.

Proposed Frequency of Report Distribution

We will generate the profile reports quarterly with our provider services representatives, meeting with these providers in their offices on a biannual basis to share the profile reports and answer questions and mitigate issues or problems; educate them on Medicaid managed care, billing, prior authorization requirements, and specific issues facing their members; and verify demographic and roster information, appointment availability, and compliance with Americans with Disabilities Act and Aetna's cultural competency requirements. Representatives will provide education on any topic pertinent to the provider and help them to understand their performance in relation to the defined measures and their standing among their peers. Our provider profiling expands beyond traditional physician-based providers and includes facilities and home and community supports and services. Ad hoc profiles will be created as needed throughout the year based on performance indicators. All providers who meet eligibility requirements for program participation will receive profile reports. Reports will be distributed by mail, fax, and in real-time through the provider web portal. We will review the report in the QMOC to address its effectiveness and determine what is working and what needs to be improved and plan to incorporate provider feedback to improve the tool continuously.

Advance Payment Models

QU001	The Vendor should reward physical and BH providers that adhere to the quality or performance standards of the Department.	The Vendor should describe how it will meet this specification, as well as any other ways they would actively work with network providers to ensure accountability and improvement in the quality of care provided.
QU011	The Vendor should use alternative payment structures for those providers over which the Vendor has direct contract oversight--including, but not limited to, provider incentives and/or overcoming limitations of diagnosis-driven eligibility--for the percentage of provider contracts identified in the Service Provider Agreement (SPA) to increase healthcare quality and efficiency through collaboration and innovation to improve access to comprehensive healthcare.	The Vendor should describe: 1) A plan for alternative payment structures 2) Mechanics by which incentive payments to providers to improve quality of care would be made 3) Quality metrics that would be required for provider incentives and shared savings
QU012	For those providers over which the Vendor has direct contract oversight, the Vendor should identify and incorporate into alternative payment structures opportunities including, but not limited to, the following:	The Vendor should describe how it will meet this specification.
QU013	Cost savings	See the parent specification.
QU014	Reductions in inappropriate utilization of services, including, but not limited to, inappropriate admissions and readmissions	See the parent specification.
QU015	The Vendor should design and implement payment models with network providers (over which the Vendor has direct contract oversight) that tie reimbursement to measurable outcomes and ensure appropriate care is delivered in the most appropriate place and time.	The Vendor should describe how it will meet this specification.
QU016	The Vendor should report annually to the Department on its activities related to alternative payment structures for those	See the parent specification.

	providers over which the Vendor has direct contract oversight, according to the Service Provider Agreement (SPA).	

Aetna recognizes the importance of moving from a payment system that rewards volume to a reimbursement strategy that promotes positive outcomes and efficient use of resources. Aetna demonstrates its commitment to using innovative payment models as a mechanism to deliver needed supports and services in the most integrated, appropriate, and cost-effective way possible.

[QU011] Alternative Payment Models to Increase Quality and Improve Access

Aetna has instituted a physician incentive plan contracting initiative within our value-based purchasing program, Aetna Better Value. 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 place emphasis on advancing providers through the APM continuum to Categories 3 and 4, which include upside gainsharing, downside risk, and condition-specific population-based payments and other incentives. 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 recently added a new shared savings agreement with **University Physicians and Surgeons** (also known as 'Marshall').

Aetna's goals for APM implementation and development align with the State's goals over the length of the contract. As a result, our models are flexible, and metrics can be modified to ensure we meet objectives. Aetna is fully committed to collaboration with the Department and other vendors in developing and implementing an APM in West Virginia. The Aetna enterprise has developed over 1,900 arrangements of all types within the HCP-LAN APM continuum and over 7 million members in various APM arrangements across all lines of business. Through Aetna Better Value, our Medicaid suite of APM solutions, our physician incentive strategy supports delivery system reform and practice transformation Aetna has been highly successful building on a national record of success in payment reform. As providers evolve along the HCP-LAN APM continuum, we link more provider payments and incentives to value and realize improved quality, reduced costs, and increased member satisfaction and engagement. We also leverage our national and West Virginia commercial and Medicare enrollment to encourage providers delivering care to all product lines to accept physician incentive plans.

Provider Incentives

Our physician incentive plans are data-driven, based upon improvement opportunities identified via an analysis of claims, quality outcomes, SDOH, public health, and disparities data for each provider and model type. These physician incentive plans align with the HCP-LAN APM framework of 2A, 2B, 2C, 3, and 4 with direct linkage to the provider-specific and applicable quality performance measures. Aetna's physician incentive plan approach includes primary care and specialty care (including BH and hospital-based care) and expands into other treatment venues, such as community mental health centers, FQHCs, RHCs, and non-traditional providers. Our unique approach with these providers increases improvement in the health of West Virginians through innovative, whole-person care and well-coordinated systems of care addressing medical and non-medical drivers of health. We have collaborated with the provider community to advance the West Virginia health priority of implementing delivery system reforms to improve quality and outcomes and the reduction or elimination of health disparities through our innovative physician incentive plans.

Aetna focuses on the following provider incentives:

- **Provider well-child incentive:** Well child gaps-in-care lists are sent to the PCP on record quarterly. These lists include our members ages 3 through 6 and 12 through 21 years of age who have not had a well-child visit in the prior 12-month period. Each quarter, a query is run to identify any qualifying well-child claims. Claims are then matched to the members identified on the gaps-in-care lists sent to the offices. A well-child claim is considered qualifying if it is billed with an appropriate ICD-10 or CPT code and is performed by a provider with a primary care specialty. Incentives are paid at $25 per member. An incentive is only payable one time per year. Payment goes to the PCP on record to whom the letter was sent or at the group level for that office. If another provider/practice performs the service, no incentive is paid.
- **Provider postpartum incentive:** Postpartum letters are sent every two weeks to the last OB/GYN seen by the member and include all deliveries from the prior two-week period. Each quarter, a query is run to identify any qualifying postpartum claims. The first qualifying claim received is paid to the rendering provider/practice. Postpartum claims are considered qualifying if they occurred in the 21- to 56-day period after delivery and were billed with a CPT code of 59430. Incentives are paid at $75 per member.
- **Provider diabetic retinal eye (DRE) exam incentive:** DRE gaps-in-care lists are sent to the PCP of record quarterly. These lists include our members age 18 years and older with diabetes who have not had a dilated eye exam in the prior 12-month period. Each quarter, a query is run to identify any qualifying eye claims. Claims are then matched to the members identified on the gaps-in-care lists sent to the offices. A dilated eye exam claim is considered qualifying if it is billed with an appropriate ICD-10 or CPT code and is interpreted by an eye care professional. Incentives are paid at $25 per member. An incentive is only payable one time per year. Payment goes to PCP of record to whom the letter was sent or at the group level for that office.
- **Provider high-volume incentive:** HEDIS measures selected for the high-volume incentive are determined once the HEDIS rates for the year have been finalized. The top 20 high-volume providers are identified for each of the measures. Targets are set based on current goals. Providers can earn between a range of financial award amounts per measure depending on which target is met.

Overcoming Limitations of Diagnosis Driven Eligibility

Aetna wants all members to be eligible to participate in our provider APM arrangement; therefore, we do not use diagnosis-driven eligibility. We enter into APM arrangements that serve the entire population as well as those with specific diagnoses and will have both general and specific reporting to support these APM arrangements. We currently have APM agreements to cover the wide range population, as well as some agreements for specialized providers, including those treating children involved in the foster care system.

[QU012 – QU014] Using APM Agreements to Enhance Cost Savings and Reducing Inappropriate Admissions

Aetna was an early adopter and leader in APMs and has successfully entered into APM arrangements across the country, including over 500 national APM arrangements and one million members in an APM arrangement across our entire enterprise. All our APM strategies address reduction in ER utilization and hospital readmissions. We also include cost and utilization metrics in certain arrangements such as shared savings where there is risk. We understand the importance of clearly defining metrics for providers, specifying what is included and not included in our agreements. Our medical loss ratio serves as a total cost of care metric. Additionally, we have measures depending on provider specialty type, as well as traditional and significant transitional provider types. Aetna intends to enter into APM agreements with a variety of providers intending to encourage and reward effective utilization management and

quality of care. Aetna will comply with provider reimbursement requirements as outlined in **Section 3.7 of the Service Provider Agreement.**

We believe that all APM arrangements are put in place with the **overall goal of reducing costs while increasing quality of care delivered to our members**. Examples of our current APM arrangements in West Virginia include pay for quality (2C), PCMH (2A), shared savings (3A), and population-based payments (4B). Aetna plans to use the APM arrangements described in **Table 7.1-16.** 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, but rather to work with them, give them support, and help them gain confidence to move to the next level of model for success.

Table 7.1-16: 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
Incentives for reporting Z-codes	Allows providers to progress towards payment for reporting while providing valuable information regarding a member's SDOH status.	2B
PCMH with quality incentives	Allows rewarding for performance on specific quality measure targets as well as infrastructure payments to support transformation.	2C
Training in adoption competency	Allows providers to demonstrate competency by undergoing training.	2B
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 specialists to participate in value-based programming.	3B
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

Tracking of Costs and Improvement in Health Outcomes through APM Arrangements

The APM team works closely with the Finance team to ensure the efficacy of the APM arrangement and interventions are not only improving health outcomes but are financially sustainable. We track APM performance through not only provider profiling, but internal activities such as risk adjustment. This activity is done monthly, and interventions are implemented if there is a negative trend emerging.

Specific methods that will be used to determine the effectiveness of the APM models include the following:

- Review of provider scorecards on quality and cost metrics by the QM and Finance departments
- Trending reports that are reviewed by the quality strategy group within the JOCs as well as the QM/UM Committee
- Continual feedback between Aetna and APM providers to guide changes within the APM program to maximize quality and cost outcomes in the quality strategy meetings within the JOCs

We maintain close relationships with our providers and assist them to review metrics and develop strategies for improvement. Additionally, our provider services representatives meet with providers to address specific data trends in our JOCs as well as during onsite provider visits. All providers can make data requests as well. We have learned through our experience implementing APM programs that we need to set reasonable and attainable performance targets, including measures of access, outcomes, quality of care, and saving. APM arrangements must be data-driven, based upon improvement opportunities via an analysis of claims, quality outcomes, SDOH, public health, and disparities data for each provider and model type.

We provide our APM providers with regular data, weekly census, and quality metrics.

If an unusual utilization trend is related to the member's practices, we engage Care Management to assess if the members have the services and supports in place to meet their PH, BH, and SDOH, and help to resolve any barriers. We educate members on appropriate utilizations of ER services and provide tools for effective self-management.

Identifying and Reducing Inappropriate Utilization of Services through APM Arrangements

Physicians play a pivotal role in improving quality, reducing costs and potentially preventable events, and ensuring efficient and effective use of health care resources. Aetna helps providers achieve these goals by developing financial models that reward physicians for quality and appropriate service utilization. Our pay-for-quality (P4Q) program is designed to acknowledge and reward Medicaid providers with high clinical quality performance outcomes. The model utilizes a framework of PCPs with at least 100 assigned members. Providers must achieve certain **metrics to be eligible for payment**, including ER rate per 1,000, plan all cause readmission, readmission rates (TANF and Affordable Care Act), and ambulatory emergency department (AMBED-ED) visit rate.

[QU015] Tying Reimbursement to Measurable Outcomes and Appropriate Care

We aligned our profiling measures with our APM programming to incentivize the activities of the providers. Our P4Q program, which is part of our APM program, is an established program designed to acknowledge and reward Medicaid providers with high clinical quality performance outcomes. This model uses a framework of PCPs with at least 100 assigned members. Providers must achieve certain metric targets to be eligible for payment.

In 2017, the Aetna Medicaid organization plans rewarded providers in all states with nearly $1 billion in quality payments.

Aetna supports all providers that are interested in a stepwise approach from fee-for-service (FFS) payments and succeed through APM. We have a vast amount of experience helping providers become more successful, both with increasing member satisfaction through better quality health care guided by our APM programs as well as with helping them increase their practice and fiscal goals.

By giving providers the tools in each of these programs to help them be successful and building from a well-established network, Aetna will augment with our value-based experience and embrace supporting providers as they transition into value-based care/reimbursement. One of the results of this effort is that

members will enjoy **better health outcomes**. These payment models begin as departure from the traditional FFS infrastructure and do so from least to most complex. This allows innovation in provider payment to promote the State's strategy to incorporate performance and quality initiatives in delivery models. The following **Figure 7.1-5** illustrates our progressive array of payment model approaches.

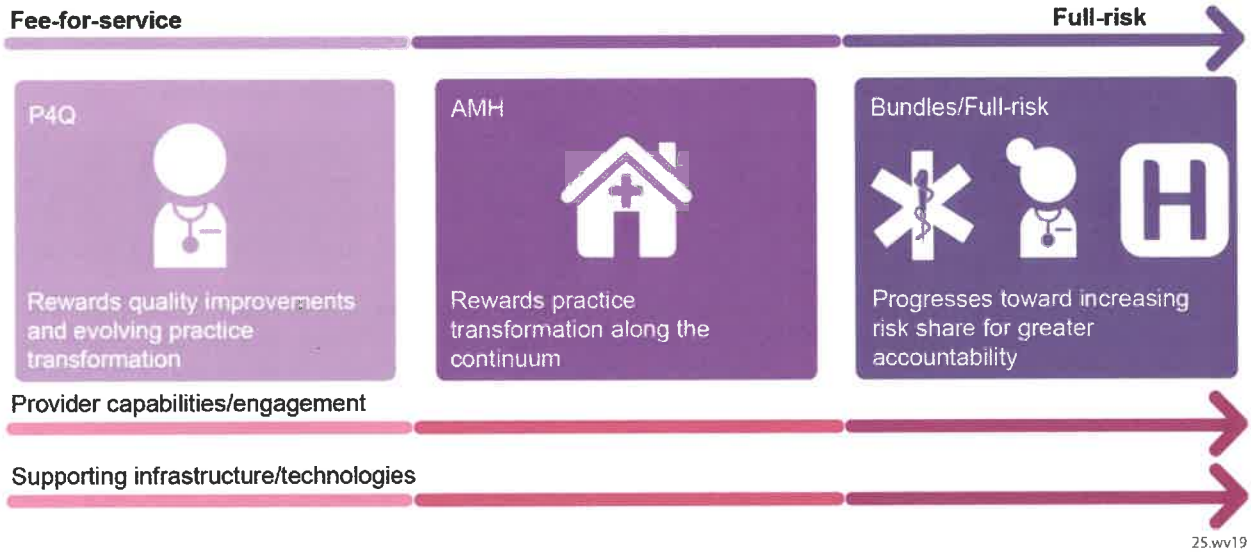

Figure 7.1-5: Volume-to-value Continuum

Our volume-to-value graphic expresses the steps providers can take to earn rewards from a payment model that incrementally moves from a fee-for-service to a full-risk arrangement.

Pay for quality: An annual bonus program related to quality metrics for providers that do not immediately qualify for our APM programs; it rewards providers for achieving improved performance on a broad spectrum of HEDIS and utilization metrics for their Aetna member panel. We have had success implementing pay-for-quality programs of different sizes from small to large in many of our Medicaid health plans, such as New Jersey, Florida, and Pennsylvania.

PCMHs/advanced medical homes (AMHs): Our PCMHs/AMHs are service delivery models for providers whose patients (our members) are best served by a medical home or who have complex needs and require an integrated BH/PH home. PCMHs/AMHs help to address the complex health needs of the entire community through a highly coordinated system of care, including comprehensive primary care, specialty care, acute care, BH integration, and the community. We understand the unique needs of youth involved in the foster care system and adoption assistance population; therefore, if the child and their caregivers choose to stay with their current PCMH/AMH, **we commit to using single case agreements to help ensure continuity of care**. Our PCMHs/AMHs are supported with the following APM arrangements, and they currently leverage this model in 12 health plans administered by the Aetna Medicaid organization including Arizona[4], Florida, Illinois, Kentucky, Louisiana, Michigan, New Jersey, Ohio, Pennsylvania, Texas, Virginia, and West Virginia:

- FFS payments with a per-member-per-month (PMPM) care coordination payment and incentives/penalties based on clinical process measures
- A PMPM payment covering both services and coordination with clinical outcomes measures

[4] Mercy Care is not a subsidiary of Aetna Inc. but is managed by Aetna's Medicaid organization.

Shared savings: Built on the FFS architecture, our shared savings arrangements include an opportunity for providers to earn incentives based on the costs of the services they provide compared to a benchmark. Providers must qualify to earn shared savings incentives by achieving clinical quality outcomes objectives. These arrangements are for practices serving a larger portion of our Medicaid members and who possess the skills and infrastructure necessary to manage the population and accept financial risk. This is different from traditional delivery; while there is an FFS underpinning to begin, the provider and managed care organization then transition into shared savings gleaned from effective management of the population. This could include a proportional gain sharing that ranges from a 30 to 70 percent split depending on the metrics and amount of risk undertaken. For example, from 2017 to 2018, our New Jersey plan achieved improvements showing the real impact of value pay structures, including a 10.26 percentage-point improvement in adolescent well care, a 21.50 percentage point improvement in lead screening for children, and a 22.70 percentage point improvement in well-child visits 3 to 6 years.

Episodic/bundled payments: Aetna has experience with episodic payment arrangements within our commercial line of business. We currently have bundled payment arrangements with several providers for defined services for an episode of care such as a hip or knee replacement or conditions such as diabetes and asthma and set a single fee to be paid to all the providers involved. Bundled payment rates are determined based on the costs expected for a particular treatment, as well as costs for any preventable complications that may arise. Challenges associated with episodes include the associated infrastructure required to administer episode payments. Episodic payment initiatives provide an opportunity to drive best practices and encourage better engagement and coordination across providers.

"Children's Mercy Pediatric Care Network collaborated with Aetna beginning in 2012 to serve more than 70,000 Medicaid children in western Missouri. This relationship leveraged the strengths of both organizations in an accountable care model with improved health outcomes for children and a simplified provider experience."

—Bob Finuf, Vice President, Children's Mercy Hospital and Executive Director, Children's Mercy Pediatric Care Network

Full risk: We successfully implemented a risk arrangement with Children's Mercy Integrated Care Solutions, a large integrated pediatric provider located in Missouri, in a 4B comprehensive population. Our several years of experience with this provider in the model will allow us to leverage this contracting structure seamlessly in West Virginia over time. These types of arrangement may include fully capitated arrangements for total population management and moves the furthest away from FFS payment. This is proving to be an effective, results-oriented model. For example, this joint provider/plan effort has achieved success for our members, most recently with a 27 percent reduction in ER visits. Other results included the following:

- **Patient satisfaction:** Top scores produced from the annual patient satisfaction survey scored a 5, rating an average of 79.3 percent of the time for patient access, 76.5 percent for communication, 88.1 percent for whole-person care, and 85.8 percent for self-management (measures included clinic hours, building appearance, and ability to be seen, among others).
- **Care management and disease management:** In 2015, utilization management process as a source for care management referrals decreased from 54 percent of referrals in 2016 to 35 percent in 2017. At the same time, referrals from providers increased from 6 percent of referrals to 15 percent and referrals originating from claims and encounter data increased from 1 percent to 11 percent of referrals.

Measurable Outcomes

Aetna drives improvements in health outcomes through its APM arrangements; we collaborate with providers to identify quality metrics that are both meaningful to their member population and state goals, and represent benchmarks supported by professionally endorsed entities such as the National Quality Forum, NCQA, and CMS. Each strategy within the APM programming improves quality, with specific quality measures tied to the

payment. We recognize the critical importance of aligning incentives for our network providers to what the Department has defined as their overall program goals. We strive to find the right balance between simplicity of collection and meaningfulness of the measures. In 2018, seven out of eight children's measures met or exceed the plan performance goal. Quality and outcome measures that Aetna has realized to date and expects to continue from our APM collaboration with various stakeholders are described in **Table 7.1-17.**

Table 7.1-17: HEDIS Measures 2016-2018

Measure Name	HEDIS 2018	HEDIS 2017	HEDIS 2016
Adolescent well-care visits (AWC)	58.39%	55.90%	39.86%
Adolescent immunization (combo 1)	86.62%	85.14%	83.90%
Childhood immunizations (combo 10)	36.50%	24.53%	33.73%
Annual dental visits (total rate)	63.06%	61.04%	58.95%
Well-child three to six years	75.91%	71.93%	72.13%

APM arrangements will be designed to reflect both health plan and the State plan priorities. These are sensitive PH and BH conditions affecting the members. Including these in our APM arrangements will allow for greater impact with activities, interventions, and resources being made available from both the health plan and the provider groups.

[QU016] Reporting on Activities Related to Alternative Payment Models

Aetna will comply with **Section 3.7.10.2 of the Model Service Provider Agreement**, and report, using the APM Reporting Template, on the following activities at a minimum of annually. The report will include the following components:

- A thorough description of Aetna's APM initiatives
- Goals and outcome measures for the contract year
- Description of monitoring activities to occur throughout the year
- Evaluation of the effectiveness of the previous year's initiatives
- Summary of lessons learned and any implemented changes
- Description of the most significant barriers
- Plans for the upcoming contract year

[QU001] Rewarding Physical and Behavioral Health Providers

Through our **APM arrangements**, we incentivize and reward both PH and BH providers. Our goal is to enhance quality of care through arrangements, such as pay for performance and shared savings. Aetna maintains a robust quality program by monitoring provider performance to support a network that demonstrates understanding, accountability, and ability to address health needs of members while supplying accessible, high-quality care and services, and supporting value-based payment programs to drive high-value care. We **actively work with network providers** to understand their needs to be successful in achieving rewards and incentives; we listen and develop processes and tools to support them, including reducing administrative burden and altering our reporting formats to make them more actionable. **Our Aetna Quality All Star Program** highlights overall performance of those providers who achieve high-quality HEDIS scores. As we continue to celebrate our top-performing providers, we focus on leveraging their performance outcomes by sharing best practices during webinar trainings and other forums.

8. 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 5 pages.

Aetna has supported our fellow West Virginians since 1996[1] by providing Medicaid services that address the specific needs of our communities. During our 23-year history with the State, we have administered benefits and services to West Virginia's most vulnerable populations in all 55 counties. Nationally, we serve thousands of children in the child welfare system.

Our goals for West Virginia's children and youth population include, but are not limited to, enhancing quality of care, incorporating a comprehensive quality approach across the entire continuum of care services, and delivering needed supports and services in the most integrated, appropriate, and cost-effective way possible.

Value-added Services

Aetna's Medicaid experience across the country indicates the health and well-being of our members is enhanced by their ability to access services and supports not covered by Medicaid. These value-added services, together with covered services, aim to improve the well-being and quality of life for our members and promote individual and family self-sufficiency, recovery, and resiliency.

Aetna's suite of innovative value-added services is designed to support State goals while demonstrating a commitment to providing an optimal member experience. To achieve this member-centric approach that sustains long-term growth, we have moved away from the old model of giving multiple retail gift cards to try and impact short-term behavior change. Instead, we developed unique solutions to help members address their individual social determinant and health needs. As such, we believe these value-added services are a critical component of the overall program and will provide another path that leads to our members achieving optimal health and well-being. Aetna commits to providing all the value-added services proposed in this response for the entire term of the initial contract and for any extensions, if applicable.

Table 8.1-1 provides the description, eligibility criteria, and limits and restrictions of each of our value-added services.

[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 was 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.

Table 8.1-1: Aetna's Value-added Services

Value-added Service	Description, Eligibility Criteria, Limits and Restrictions
Afterschool Programs	Afterschool programs boost academic performance, promote physical health, and provide a safe, structured environment for the children of working parents. Our members can join a participating afterschool program of their choice and receive $50 annually toward the cost of membership. Qualifying members can request participation through their care manager, member services, or community outreach. **Eligibility Criteria:** Members statewide ages 5 to 18 who are enrolled in school. **Limits and Restrictions:** $50 per year. Parents or custodial/legal guardians are required to give consent.
Asthma Care Program	This program offers one-on-one education with asthma benefits coupled with scholarships to Camp Catch Your Breath. Each member who enrolls in the asthma care program will receive a peak flow meter. **Eligibility Criteria:** Members statewide with an asthma diagnosis. **Limits and Restrictions:** One camp scholarship per year and one peak flow meter per member.
Birthday in a Box	Members receive a gift box on their birthday that includes a toy that focuses on their development needs, a sweet treat, and stationery to draw or color on. **Eligibility Criteria:** Members statewide categorized as medically complex. **Limits and Restrictions:** One birthday box per member per year.
Connections for Life	Children and youth in the child welfare system, especially those in high-poverty areas, often lack the digital technology necessary to establish and maintain vital social connections, participate in school, find a job, and access resources. This program bridges the digital disparity faced by these vulnerable members and empowers them to stay connected and engaged with their world. Eligible members receive a free tablet and laptop, education and training around technology literacy, and help connecting to key local and national resources. This program leverages the resources of iFoster, a national nonprofit whose mission is to ensure that every child growing up outside their biological home has the resources and opportunities they need to become successful, independent adults. These tools enable our members to connect to iFoster's online portal, which provides access to resources vital to sustaining their connections. The portal is a one-stop online assistive aid, which a transition-age foster youth can access 24/7/365 from any internet connection. It provides access to hundreds of free and discounted products and services that help with school, work, and life, and is personalized based on their individual needs. Resources are complemented with learning tools to arm youth with the useful How Do I knowledge they need to transition to independence and self-directed multimedia trainings, which teach critical life skills and provide certificates in digital literacy and internet safety, soft skills development, and independent living. Additionally, a digital locker designed to store all their vital documents enhances the online suite of tools available in each youth's personalized iFoster portal account. The portal is supported by iFoster team members (who are also former foster youth) who provide live navigation help via phone, text, and email to help clear barriers.

Value-added Service	Description, Eligibility Criteria, Limits and Restrictions
	Tablets for Youth Youth in the child welfare system often cannot afford a steady connection to the internet, which results in significant isolation from their support circle and puts them at risk of not being able to contact loved ones and emergency services when needed. Aetna will provide a tablet, available through iFoster's portal, to eligible members ages 13 to 17. **Eligibility Criteria:** Members statewide ages 13 to 17 not placed in a pre-adoptive or adoptive home. **Limits and Restrictions:** One tablet per member.
	Laptops The lack of access to a computer in today's world is a significant social and vocational barrier that cuts off those impacted from opportunities in school and in the workforce. Those in the child welfare system are disproportionately impacted by this inequity and often lack the resources and knowledge to make a change. To help bridge this digital divide, iFoster will provide eligible members with a durable and long-battery-life laptop preloaded with a lifetime free subscription to Microsoft Office designed specifically by Microsoft, Intel, and Computer Design and Integration with the foster population in mind. **Eligibility Criteria:** Members statewide 18 years of age and older are eligible for a laptop. **Limits and Restrictions:** One laptop for members ages 18 and older.
Diabetes Program	This program consists of several benefits delivered to members to support them on their journey to improved health. Members who enroll and complete HgA1c testing receive a free glucometer and food journal to track HgA1c levels and eating habits. Members ages 7 to 15 can also receive a scholarship to Camp Kno Koma, access to routine teeth cleaning, and a dental hygiene kit that includes a toothbrush, toothpaste, and dental floss. Aetna will engage with the member via text messaging to provide diabetes-related education. **Eligibility Criteria:** Diabetic members statewide. **Limits and Restrictions:** One scholarship and hygiene kit per year; one glucometer and journal per member.
Essential Needs Duffle Bags	Children in the child welfare system often lack basic personal care necessities and a way to carry the few belongings they have. Aetna will provide duffle bags filled with essential hygiene and other personal care supplies. The non-branded bags are organized by age group and gender. All bags include a blanket, toothbrush, toothpaste, and a hairbrush. Youth members receive body wash, shampoo, conditioner, a bib, a stuffed animal, and a 4-inch stress ball. Teens receive shampoo, conditioner, body wash, deodorant, a journal, adult coloring books, pens/pencils, a fidget spinner, and a stress ball. **Eligibility Criteria:** Members statewide who are newly entering the child welfare system or who are not placed in a pre-adoptive or adoptive home. **Limits and Restrictions:** Limited to one duffle bag per member.

Value-added Service	Description, Eligibility Criteria, Limits and Restrictions
High School Equivalency Diploma	Aetna provides an online prep course offered through Covcel. Members can attend a physical prep class (offered statewide) or sign up for a well-respected online GED-TASC prep course. Once the member passes the Covcel GED-TASC online prep course and the TASC test they will receive the State of West Virginia High School Equivalency diploma. **Eligibility Criteria:** Members statewide who are 16 years of age and older where remaining in the school of origin is not in their best interest are eligible upon recommendation by the Child Welfare Agency. **Limits and Restrictions:** Members ages 16 to 17 require guardian consent and must have permission from their school district and cannot be registered in another school program.
Keep Kids Safe (Opioid Lockbox Program)	Keep Kids Safe is a part of Aetna's national campaign to fight the opioid crisis. This harm reduction intervention is used to support safety by providing 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. **Eligibility Criteria:** Legal or custodial guardians of members statewide who are prescribed a narcotic and have children in their home. **Limits and Restrictions:** One lockbox per household.
Legal Services, Clinics, and Education	The lack of access to timely and tailored legal assistance is a significant barrier for foster children and their families and perpetuates a cycle of disparity. Our members will have access to a dedicated attorney and paralegal though Legal Aid of West Virginia (LAWV), which aims to disrupt the cycle of returning people to the unhealthy conditions that would otherwise bring them back to the clinic or hospital. The attorney and paralegal will provide civil legal services to help stabilize the lives of our members and their caregivers. Benefits include legal services to all members and their families, including the following: • Establishing permanent custodial relationships through representation in adoption, guardianship, or custody proceedings • Increasing income supports for families, including navigating issues with government benefits or child support • Removing barriers to employment by providing assistance with expungement and driver's license issues • Increasing access to education by assisting with school enrollment issues and obtaining services to help children while in school • Preventing homelessness and increasing access to safe, affordable housing • Free statewide legal clinics **Eligibility Criteria:** All members statewide and their biological family members. **Limits and Restrictions:** Legal representation in adoption, guardianship, or custody proceedings; family law cases (e.g., divorce, custody, or child support); domestic violence protective order cases; evictions; poor housing (habitability) cases; expungement cases; help reinstating a driver's license; Social Security disability or Supplemental Security Income terminations or reductions; food stamps, Medicaid, low-income energy assistance, Temporary Assistance for Needy Families and other government benefits cases; Individualized Education Program cases; power of attorney issues; and bankruptcy.

Value-added Service	Description, Eligibility Criteria, Limits and Restrictions
Maternity Matters Program	This preventive health program for pregnant members and new mothers includes incentives to reduce premature births and to support healthy prenatal and postnatal behaviors. The funds earned are provided through a single reloadable Maternity Matters card and are available to use toward maternity and baby supplies, such as wipes, nursing supplies, diapers, formula, bottles, and pack-n-plays/cribettes.
	$25 Initial Prenatal Visit Reward Pregnant members can earn $25 for completing their initial prenatal visit. **Eligibility Criteria:** Pregnant members statewide. **Limits and Restrictions:** One per pregnancy.
	$10 Subsequent Prenatal Visit Reward Pregnant members can earn an additional $10 for each subsequent prenatal visit. **Eligibility Criteria:** Pregnant members statewide. **Limits and Restrictions:** $100 maximum per pregnancy.
	$25 Postpartum Reward New mothers can earn $25 after completion of one postpartum appointment within 21 to 56 days after giving birth. **Eligibility Criteria:** New mothers statewide. **Limits and Restrictions:** Appointment must occur 21 to 56 days after giving birth.
	Adult Preventative Dental Program Offers up to two checkups during pregnancy and dental hygiene kit (toothbrush, toothpaste, and floss). **Eligibility Criteria:** Pregnant members statewide 21 years of age and older. **Limits and Restrictions:** Up to two preventive dental checkups per pregnancy.
Ted E. Bear, M.D.℠ Cub Club	Children's club for members 13 years of age and under to promote healthy habits and lifestyle. Each quarter, enrolled members are encouraged to complete a project/task to improve their overall health and hygiene such as teeth brushing, exercise, etc. Once completed, members receive a reward such as a brushing kit, sports ball, etc. **Eligibility Criteria:** Members statewide 13 years of age and under. **Limits and Restrictions:** Members are limited to one gift per reward per quarter based on completed activities.
24/7 Health Information line	Our members can reach a licensed health care professional 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 others. Members get advice on what to do when they need health care, such as calling their physician or making an appointment. Members 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 members to make the best decision for their health-related matters. **Eligibility Criteria:** All members statewide. **Limits and Restrictions:** Not applicable.

Instructions for Completion of Appendix 1 - Detailed Specifications

1. The Vendor should self-score each requirement listed in the ***Capability Assessment*** column of *Tab 3 - Specification & Responses*, using only the values that appear in the drop-down list.
2. ***Capability Assessment*** values are outlined below:
    1. "Will Meet": Vendor agrees to specification.
    2. Will Not Meet": Vendor declines to meet the specification.
3. All specifications should contain one of the values identified above. Any specification without a ***Capability Assessment*** response value will be considered as "Will Not Meet."
4. In addition, the Vendor should provide the ***Attachment***, ***Section***, and ***Page Number(s)*** where its detailed narrative response for each specification resides, providing the Department with a crosswalk, ensuring that each specification is addressed. Be advised that the "Attachment" column has been pre-populated with the location that the Department anticipates the requirement response to reside; however, the Vendor may respond to a requirement in a different location. It is up to the Vendor to update the Attachment, Section, and Page Number(s) columns.
5. Please note that during implementation and in operations, the Department will have the right to review and approve the Vendor's approach to meeting all specifications, including, but not limited to, the Vendor's policies and procedures.
6. ***Hierarchy Level:*** The hierarchy level column defines relationships between parent and child specifications. The Department refers to parent specifications as specifications that rely on the content of a subset of related specifications (children) to fully define the scope of the requirement. The Department refers to child specifications as specifications that rely on additional context provided by a higher-level specification (parent) to fully define the scope of the specification. A hierarchy value of 1 denotes the highest-level specification. A hierarchy level 2 is a child to the nearest prior hierarchy level 1.
7. When included in a specification, the phrase "for applicable populations" is typically used to delineate between covered services provided for populations within the Vendor's MCO services versus ASO services. For example, the Vendor would not be expected to assign a member who is only eligible for SNS to a primary care provider (PCP) or ensure the member receives primary care services.

Tabs in this spreadsheet	
1. Worksheet Instructions	Instructions for completion of this RFP supplement.
2. Worksheet Information	This tab including information about the contents of this workbook.
3. Specification & Responses	Contains the specifications and all related data.
4. Code Values	Contains coded values for use in the specifications tab, and explanations as appropriate.

Columns on the Specifications & Responses Tab			
Section	**Column(s)**	**Description**	**Corresponding Code Values**
Specifications	*Spec ID #*	The unique ID of the specification.	N/A
	Specification Text	The text of the specification.	N/A
	Vendor Response Guidance	Information requested in the Vendor response to each specification. The Vendor is not limited to providing only the information requested in this column.	N/A
	Subject Matter Area	How the specification is categorized.	Specification Subject Matter Areas
Vendor Response	*Capability Assessment*	Vendor is expected to indicate its compliance with the specification using one of the supplied values.	Vendor Response - Capability Assessment
	Attachment	Vendor is expected to provide a reference to the appropriate attachment where more detailed information about the specification can be found. The expected attachment is identified for Vendor convenience.	Response Templates
	Section and Page Reference	Vendor is expected to provide a reference to the appropriate section and page number within the specified attachment where more detailed information about the specification can be found.	N/A

Specifi				Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
BA001	1	The Vendor should establish and implement authorization criteria for socially necessary services (SNS).	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	405
BA002	1	The Vendor should establish and implement a process for providers to request authorization for socially necessary services (SNS).	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	405 - 406
BA003	1	The Vendor should establish and implement a process to review authorization requests for socially necessary services (SNS).	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	406 - 407
BA004	1	The Vendor should apply utilization management guidelines to retroactively review socially necessary services (SNS).	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	407 - 408
BA005	1	The Vendor should coordinate socially necessary services (SNS) for the member and/or their family.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	408 - 409
BA006	1	The Vendor should verify the most appropriate provider of socially necessary services (SNS) is used to meet the member's needs.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	409 - 410
BA007	1	The Vendor should support the Department caseworker in the development of the member individualized service plan (ISP).	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	398 - 402
BA008	1	The Vendor should use family service plan (FSP) and individualized service plan (ISP) information, as applicable from the Department caseworker, to authorize socially necessary services (SNS).	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	410
BA009	1	The Vendor should establish medical necessity guidelines specific to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for applicable populations.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	411 - 412

Specifi				Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
BA010	1	The Vendor should establish processes specific to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services in all geographic areas, for applicable populations.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	412 - 413
BA011	1	The Vendor should develop and distribute materials to inform members, parents, and providers about the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, for applicable populations.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	413 - 415
BA012	1	The Vendor should use reports to monitor Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	415 - 416
BA013	1	The Vendor should work with caregivers and families to help track appointments members are scheduled for and may miss without further reminders or assistance.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	402 - 403
BA014	1	The Vendor should assist in rescheduling appointments and removing potential obstacles to care, including, but not limited to, transportation.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	403 - 404
BA015	1	The Vendor should develop and review utilization management guidelines for physical health and behavioral health services.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	417 - 418
BA016	1	The Vendor should apply utilization management guidelines to authorize payments or services for physical and behavioral health.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	420
BA017	1	The Vendor should apply utilization management guidelines to retroactively review payments or services for physical and behavioral health.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	420

Specifi				Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
BA018	1	The Vendor should help expedite the submission and return of service authorization data from providers.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	420 - 421
BA019	1	The Vendor should leverage a utilization management system with the ability to include text fields, including, but not limited to, the following:	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	478 - 479
BA020	2	Clinical notes	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	478 - 479
BA021	2	Inpatient requests	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	478 - 479
BA022	2	Review criteria	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	478 - 479
BA023	2	Case history	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	478 - 479
BA024	1	The Vendor should leverage a utilization management system with the ability to support claims payment for physical and behavioral health services by interfacing with other Vendor systems, as applicable, and Department enterprise systems, including, but not limited to, the following:	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	478 - 484
BA025	2	Medicaid Management Information System (MMIS)	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	485 - 486
BA026	2	Call Center	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	486 - 488
BA027	1	The Vendor should leverage a utilization management system with the ability to support inbound member and provider inquiries by interfacing with other Vendor systems, as applicable, and Department enterprise systems, including, but not limited to, the following:	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	483 - 484
BA028	2	Medicaid Management Information System (MMIS)	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	485 - 486
BA029	2	Call Center	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	486 - 488
BA030	1	The Vendor should establish interface(s) and conduct testing that meets all Department-specified interface requirements, including, but not limited to, the following:	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	488 - 490
BA031	2	Medicaid Management Information System (MMIS)	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	485 - 486, 488 - 489
BA032	2	Families and Children Tracking System (FACTS)	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	484 - 485, 488
BA033	2	Integrated Eligibility Solution (IES), when applicable	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	488 - 489

Specifi				Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
BA034	1	The Vendor should leverage a system with the ability to maintain case history.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	478 - 479
BA035	1	The Vendor should establish utilization management processes for members, including, but not limited to, the following:	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	421 - 422
BA036	2	Medical necessity review	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	421
BA037	2	Social necessity review	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	421 - 422
BA038	2	Approvals	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	422
BA039	2	Denials	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	422
BA040	1	The Vendor should operate utilization management monitoring activities in conjunction with fraud and abuse detection activities.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	437
BA041	1	The Vendor should prevent and detect fraud and abuse related to pharmacy services.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	438 - 440
BA042	1	The Vendor should modify its standard utilization management protocols when reviewing referral and treatment requests for members with special healthcare needs, including, but not limited to, the following:	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	422 - 423
BA043	2	Standing referrals	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	423
BA044	2	Expedited utilization review processes	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	423
BA045	1	The Vendor should establish condition-specific protocols or standards that will be used to manage members with special healthcare needs.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	424
BA046	1	The Vendor should update and share condition-specific protocols or standards with primary and specialty care providers.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	424
BA047	1	The Vendor should establish, implement, and update guidelines for the services or types of services that require prior authorization (PA) by the Vendor.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	424 - 425
BA048	1	The Vendor should establish, implement, and update guidelines for the services or types of services that can be approved by the member's primary care provider (PCP) for physical and behavioral health services.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	425

Specifi				Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
BA049	1	The Vendor should establish, implement, and update guidelines for the services or types of services to which the member can self-refer.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	425 - 426
BA050	1	The Vendor should establish and implement a required length of time for providers to request prior authorizations (PAs) for services.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	426
BA051	1	The Vendor should establish and implement levels of authority for prior authorizations (PAs).	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	426
BA052	1	The Vendor should provide prior authorization (PA) approval/denial letters to members, providers, and caseworkers, as appropriate.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	426 - 427
BA053	1	The Vendor should develop and use clinical guidelines for prior authorizations (PAs) for physical and behavioral health services.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	418 - 420
BA054	1	The Vendor should honor medical, behavioral health, pharmacy, and socially necessary services (SNS) authorization approvals from previous coverage during the transition period.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	432
BA055	1	The Vendor should notify providers and/or members regarding expiration of existing medical, pharmacy, and socially necessary services (SNS) authorizations.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	410
BA056	1	The Vendor should authorize out-of-network services, including, but not limited to, the following:	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	432 - 433
BA057	2	Emergency situations	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	432 - 433
BA058	2	Non-emergency situations, including, but not limited to, both medically necessary and non-medically-necessary services	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	433
BA059	1	The Vendor should grant members a standing referral to a specialist provider according to guidelines that the Vendor develops and the Department approves, including, but not limited to, the duration and/or number of visits usually granted or maximally allowed.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	433
BA060	1	The Vendor should develop and implement physical health and behavioral health guidelines for the extent to which a specialist provider may:	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	433 - 434

Specifi				Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
BA061	2	Admit patients for inpatient care	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	433
BA062	2	Choose the hospital of admission	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	433
BA063	2	Determine that the patient must remain hospitalized	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	434
BA064	2	Schedule or provide ancillary services, such as laboratory testing	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	434
BA065	2	Refer patients to sub-specialists or other providers	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	434
BA066	1	The Vendor should refer members to out-of-network providers using guidelines that the Vendor develops and the Department approves.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	434 - 435
BA067	1	The Vendor should establish and implement a process through which members and/or providers can request out-of-network referrals.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	435
BA068	1	The Vendor should ensure that information from non-network providers is shared with the member's primary care provider (PCP).	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	435
BA069	1	The Vendor should review and process medical referrals according to guidelines that the Vendor develops and the Department approves.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	435 - 436
BA070	1	The Vendor should develop and implement guidelines under which a member may continue an existing relationship with an out-of-network provider (or provider that leaves the Vendor's network) if it is considered to be in the best medical interest of the member, as determined by the member's primary care provider (PCP) and/or the Medical Director.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	436
BA071	1	The Vendor should perform ongoing monitoring of emergency room (ER) usage.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	427 - 428
BA072	1	The Vendor should apply the "prudent layperson" standard for all emergency room (ER) visits.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	429

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Spec ID #	Hierarchy Level	Specification Text	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
BA073	1	The Vendor should transition the member from an out-of-network provider to an appropriate in-network provider if the member is currently seeing a provider that does not participate in the network.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	436
BA074	1	The Vendor should assist in transferring necessary clinical information to the foster care member's new in-network physical health or behavioral health provider.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	436
BA075	1	The Vendor should inform members of their choices in Family Planning services, for applicable populations.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	441
BA076	1	The Vendor should facilitate timely payment for Family Planning services for in-network and out-of-network providers, for applicable populations.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	441
BA077	1	The Vendor should identify pregnant women at enrollment and on an ongoing basis.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	441 - 442
BA078	1	The Vendor should promote "early and often" prenatal care for women who are identified as being pregnant, for applicable populations.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	442 - 445
BA079	1	The Vendor should identify individuals with complex or serious medical conditions on an ongoing basis, for applicable populations.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	446
BA080	1	The Vendor should use information systems to identify members with special needs.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	446 - 447
BA081	1	The Vendor should use information systems to isolate data specific to eligibility category or diagnosis.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	446 - 447
BA082	1	The Vendor should ensure timely access to crisis stabilization services.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	448 - 451
BA083	1	The Vendor should manage pharmacy benefits, ensure contractual and regulatory compliance, and coordinate services.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	455 - 460
BA084	1	The Vendor should develop and implement prescription limits, including, but not limited to, limitations on brand name and generic prescriptions.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	460 - 462
BA085	1	The Vendor should identify and manage polypharmacy utilization.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	463 - 472

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Spec ID #	Hierarchy Level	Specification Text	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
BA086	1	The Vendor should monitor potential abuse or inappropriate utilization of controlled prescription medications.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	463 - 472
BA087	1	The Vendor should manage members with a history of prescription drug abuse, including, but not limited to, lock-in.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	470 - 472
BA088	1	The Vendor should ensure that primary care providers (PCPs) maintain information shared by behavioral health providers as to the outcome of behavioral health screenings and evaluations, including, but not limited to, in a patient's medical record.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	451 - 452
BA089	1	The Vendor should inform primary care providers (PCPs) about changes in a member's behavioral health, including, but not limited to:	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	452 - 453
BA090	2	Hospitalization	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	452
BA091	2	Emergency room (ER) usage	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	452
BA092	2	Change of medication	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	452
BA093	1	The Vendor should assist members in accessing additional services as a result of change in behavioral health status, including, but not limited to, the care coordinator's assistance in making appointments for members.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	453 - 454
BA094	1	The Vendor should provide dental services for individuals under 21 years of age as covered services in an amount, duration, and scope to achieve the purpose for which the services are furnished, for applicable populations.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	473 - 474
BA095	1	The Vendor should remind members of upcoming initial and periodic dental screenings, for applicable populations.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	474 - 475
BA096	1	The Vendor should make arrangements with inpatient and outpatient facilities for the provision of dental services to members with special needs, for applicable populations.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	475 - 476
BA097	1	The Vendor should monitor dental screening utilization on an ongoing basis, for applicable populations.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	476
BA098	1	The Vendor should intervene if a member has not had a dental screening in over one year, for applicable populations.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Benefit Administration	476 - 477

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Spec ID #	Hierarchy Level	Specification Text	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
CM001	1	The Vendor should coordinate continuity of care between healthcare providers, child welfare providers, behavioral health providers, and care coordinators with an integrated care plan for all children.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	495 - 501; 519 - 521, 523
CM002	1	The Vendor should share information required for continuity of care with the member and their family or caregiver(s).	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	539
CM003	1	The Vendor should provide training to ensure an integrated care plan is jointly developed and shared among the primary care provider (PCP) and/or specialist serving as a principal coordinating physician, and the child and caregiver(s).	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	500 - 501, 539
CM004	1	The Vendor should evaluate and report member progress in meeting goals identified in the individualized service plan (ISP).	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	528
CM005	1	The Vendor should collaborate with the Department's pharmacy program to help provide coordinated care for the member, including, but not limited to, those members accessing psychotropic medications, for applicable populations.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	529 - 530
CM006	1	The Vendor should establish and maintain patient-centered medical homes for its members (in applicable populations) in alignment with the American Academy of Pediatrics (AAP) guidelines in the Health Care Issues for Children and Adolescents in Foster Care and Kinship Care manual, including, but not limited to, the following:	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	540
CM007	2	The application process for providers	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	540 - 541
CM008	2	Assessment of whether foster care members can continue to receive healthcare in their medical home of origin, and if not, how best to establish and maintain new medical homes	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	541
CM009	2	Communication with members and/or their caregivers/families, as appropriate, about patient-centered medical homes for applicable populations	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	541
CM010	2	Annual reporting processes	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	541
CM011	1	The Vendor should collaborate with hospitals, psychiatric residential treatment facilities (PRTFs), residential providers, behavioral providers, and others on discharge planning needs of a member leaving an inpatient facility or changing levels of care.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	536 - 538

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Spec ID #	Hierarchy Level	Specification Text	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
CM012	1	The Vendor should collaborate with hospitals, psychiatric residential treatment facilities (PRTFs), residential providers, behavioral providers, and others to ensure outpatient services have been established prior to the member leaving an inpatient facility or changing levels of care.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	536 - 538
CM013	1	The Vendor should coordinate with the Department to ensure that all needed medication is available to the member after leaving an inpatient facility or changing levels of care.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	536 - 538
CM014	1	The Vendor should engage in the Individualized Care Planning process for foster care members.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	525
CM015	1	The Vendor should collaborate with caseworkers to support members experiencing home removals and changes in placement based on Department foster care requirements.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	534 - 535
CM016	1	The Vendor should collaborate with caseworkers to minimize the need for removals and changes in placement.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	534 - 535
CM017	1	The Vendor should identify and track new members with high physical or behavioral health needs to assure continuity of care, for applicable populations.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	521 - 522
CM018	1	The Vendor should monitor members' physical or behavioral health needs and respond to changes in acuity over time, for applicable populations.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	528
CM019	1	The Vendor should use telemedicine, telehealth, and telemonitoring services to improve quality and/or access to care.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	546 - 547
CM020	1	The Vendor should use internet and/or web-based services to improve quality and/or access to care.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	547
CM021	1	The Vendor should identify and implement opportunities to use video conferencing to improve quality and/or access to care.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	547 - 548
CM022	1	The Vendor should identify members for participation in Intensive Care Management (ICM) teams for individuals with one or more chronic conditions, for applicable populations.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	505 - 506
CM023	1	The Vendor should determine the composition of the Intensive Care Management (ICM) team for participating members, for applicable populations.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	507

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Spec ID #	Hierarchy Level	Specification Text	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
CM024	1	The Vendor should develop plans specific to each case for members participating in Intensive Care Management (ICM) teams, for applicable populations.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	525
CM025	1	The Vendor should conduct ongoing gap analyses to determine the types of services and resources not available in the State.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	548
CM026	1	The Vendor should work with the Department and community partners to increase capacity for those services and resources identified as not available in the State.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	548
CM027	1	The Vendor should leverage population health management risk stratification tools to support stratification of members into risk tiers for care coordination services.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	521 - 522
CM028	1	The Vendor should capture data related to social determinants of health, as defined by bodies including, but not limited to, the Centers for Disease Control and Prevention (CDC).	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	514 - 518, 521
CM029	1	The Vendor should incorporate data about social determinants of health into its care coordination services.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	514 - 518; 521, 525, 530 - 532
CM030	1	The Vendor should establish committees with family members, the member, providers, the care coordinator, and a Department lead to help develop the most appropriate care plans for the member.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	524 - 525
CM031	1	The Vendor should develop and implement access to care standards and methodology.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	548 - 549
CM032	1	The Vendor should develop and implement care guidelines for working with youth who may have been exposed to adverse childhood experiences (ACEs).	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	544 - 546
CM033	1	The Vendor should establish an organizational structure and treatment framework to recognize, understand, and respond to the effects of all types of trauma, per American Academy of Pediatrics (AAP) guidelines for a trauma-informed practice.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	542 - 544
CM034	1	The Vendor should facilitate coordination of care between primary care providers (PCPs) and children's dental providers for applicable populations, including, but not limited to, for children with special healthcare needs.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	524

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Spec ID #	Hierarchy Level	Specification Text	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
CM035	1	The Vendor should provide a care coordination model with stratified services for eligible members according to clinical, social, or other criteria.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	495 - 501, 505
CM036	1	The Vendor should screen members for stratification into care coordination services upon enrollment.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	514 - 518
CM037	1	The Vendor should monitor screening timelines for member care coordination stratification.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	501
CM038	1	The Vendor should assign members to an appropriate healthcare professional who is formally responsible for coordinating the member's overall healthcare, including, but not limited to, behavioral health, for applicable populations.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	518 - 519
CM039	1	The Vendor should use clinical, social, or other criteria to assign members to a care coordinator within a timeframe that the Department approves.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	518 - 519
CM040	1	The Vendor should develop education, member materials, and outreach strategies that are appropriate for adults and children and adhere to federal and State marketing regulations.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	549 - 550
CM041	1	The Vendor should identify opportunities on an ongoing basis for activities or linkages with West Virginia (WV) Children with Special Health Care Needs (Title V) program clinics, providers, or other professionals.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	531, 534

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Spec ID #	Hierarchy Level	Specification Text	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
CM042	1	The Vendor should perform screening, assessment, and/or utilization analysis to identify and provide services for members with special needs.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	514 - 518; 519 - 521
CM043	1	The Vendor should perform screening and assessment to identify and provide services for members with behavioral health needs.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	514 - 518; 519 - 521
CM044	1	The Vendor should complete health risk assessments that will be made available upon enrollment to members in applicable populations and/or their caregiver(s), including, but not limited to, assessments specific to members with special healthcare needs.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	514 - 518
CM045	1	The Vendor should provide targeted education programs and identify who will receive these programs.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	550 - 552
CM046	1	The Vendor should use specialized care coordinators for certain conditions, including, but not limited to, experienced pediatric or cardiac nurses and behavioral health specialists.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	518 - 519
CM047	1	The Vendor should develop and maintain qualifications and training for Vendor staff who will be involved in coordinating care.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	498 - 499

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CM048	1	The Vendor should develop and implement steps for care coordinators to establish relationships with their assigned members.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	495 - 501; 518-519
CM049	1	The Vendor should establish and implement guidelines for when care coordinators should have face-to-face contact with their assigned members, including, but not limited to, when requested by a Department worker.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	506, 528
CM050	1	The Vendor should develop and implement standards for how often the care coordinators will contact members after the initial care coordination contact, based on the member's acuity level.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	506 - 507, 528
CM051	1	The Vendor should collect statistics, according to a set frequency, on care coordinators' progress toward establishing relationships with members.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	495 - 501
CM052	1	The Vendor should monitor and evaluate care coordinators in regards to establishing relationships with members.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	501
CM053	1	The Vendor should identify members in need of treatment plans.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	523 - 525
CM054	1	The Vendor should develop, update, and use clinically appropriate treatment plans that address coordination of primary services, specialty services, ancillary services, community and social support, and/or carved-out services for members identified as having special healthcare needs, based on that member's needs.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	525, 528 - 529
CM055	1	The Vendor should share care plans with a member's primary care provider (PCP) at a set frequency.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	539

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CM056	1	The Vendor should share care plans with a member's primary care provider (PCP) outside of the established schedule according to guidelines developed by the Vendor and approved by the Department.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	539
CM057	1	The Vendor should track the completion of care plans.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	501
CM058	1	The Vendor should provide episodic and/or catastrophic care coordination interventions.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	535 - 536
CM059	1	The Vendor should identify providers that do not perform coordination activities and take action to improve coordination.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	528
CM060	1	The Vendor should coordinate services with community resources and social services for members in the area served by the Vendor, including, but not limited to, those with special healthcare needs.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Care Management	532 - 533
CS001	1	The Vendor should coordinate care across child-serving systems, including, but not limited to, the educational system, community services, and after-school programs.	Community/Stakeholder Engagement	Will Meet	Attachment E - Detailed Specifications Approach	Community Stakeholder Engagement	555 - 560
CS002	1	The Vendor should establish relationships with Child Protective Services (CPS) workers and coordinate the needs of the child to reduce duplication of services and improve access to service needs.	Community/Stakeholder Engagement	Will Meet	Attachment E - Detailed Specifications Approach	Community Stakeholder Engagement	561 - 562
CS003	1	The Vendor should establish relationships with child welfare workers in addition to Child Protective Services (CPS), including, but not limited to, workers who provide case management, case planning, and permanency planning while the child is in care.	Community/Stakeholder Engagement	Will Meet	Attachment E - Detailed Specifications Approach	Community Stakeholder Engagement	562 - 563
CS004	1	The Vendor should establish communications with the judicial system to help drive that the services being ordered for the child are in the child's best interest and most medically and/or socially appropriate.	Community/Stakeholder Engagement	Will Meet	Attachment E - Detailed Specifications Approach	Community Stakeholder Engagement	563 - 564
CS005	1	The Vendor should inform the court of alternative services that best meet the child's needs, as deemed appropriate by the Department.	Community/Stakeholder Engagement	Will Meet	Attachment E - Detailed Specifications Approach	Community Stakeholder Engagement	564

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CS006	1	The Vendor should establish relationships with applicable Department agencies and State advocacy groups, including, but not limited to, the following:	Community/Stakeholder Engagement	Will Meet	Attachment E - Detailed Specifications Approach	Community Stakeholder Engagement	565
CS007	2	Child advocacy centers (CACs)	Community/Stakeholder Engagement	Will Meet	Attachment E - Detailed Specifications Approach	Community Stakeholder Engagement	565 - 566
CS008	2	Court appointed special advocates (CASAs)	Community/Stakeholder Engagement	Will Meet	Attachment E - Detailed Specifications Approach	Community Stakeholder Engagement	566
CS009	2	The West Virginia Child Abuse Network, as defined by applicable State Code, as defined by the Department.	Community/Stakeholder Engagement	Will Meet	Attachment E - Detailed Specifications Approach	Community Stakeholder Engagement	566
CS010	1	The Vendor should establish communications with foster parents based on Department foster care guidelines.	Community/Stakeholder Engagement	Will Meet	Attachment E - Detailed Specifications Approach	Community Stakeholder Engagement	567
CS011	1	The Vendor should collaborate with the Bureau for Public Health (BPH) to increase the number of families enrolled in the West Virginia (WV) Home Visitation Program.	Community/Stakeholder Engagement	Will Meet	Attachment E - Detailed Specifications Approach	Community Stakeholder Engagement	567 - 568
CS012	1	The Vendor should engage community-based child welfare organizations to help provide family-centered treatment that goes beyond traditional medical care.	Community/Stakeholder Engagement	Will Meet	Attachment E - Detailed Specifications Approach	Community Stakeholder Engagement	568
CS013	1	The Vendor should provide initial (during implementation) and ongoing training for advocates and other stakeholders.	Community/Stakeholder Engagement	Will Meet	Attachment E - Detailed Specifications Approach	Community Stakeholder Engagement	568 - 569
CS014	1	The Vendor should coordinate with child placement agencies to ensure each agency has access to the most up-to-date records, as appropriate.	Community/Stakeholder Engagement	Will Meet	Attachment E - Detailed Specifications Approach	Community Stakeholder Engagement	569 - 572
MS001	1	The Vendor should identify and reach out to members (or their caregiver or caseworker as appropriate) with the most immediate service needs leading up to and immediately following implementation of a program.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	595 - 604; 606 - 607
MS002	1	The Vendor should provide outreach and training on an ongoing basis to youth and young adults and their respective caregivers who are eligible for services.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	614

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MS003	1	The Vendor should collaborate with community partners to help design materials that best meet the needs of the populations being served.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	608 - 609
MS004	1	The Vendor should leverage information technology (IT) solutions to improve access to information, including, but not limited to, the following:	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	615 - 616; 626 - 627
MS005	2	Member health records (by the member, caregiver, and/or provider as appropriate)	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	615 - 616
MS006	2	Appeal processes	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	621 - 628
MS007	2	Other member rights and responsibilities	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	604 - 606, 615; 621 - 623
MS008	1	The Vendor should distribute an informational welcome packet to families impacted by the transition.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	595 -604
MS009	1	The Vendor should develop a community resource library, including, but not limited to, member handbooks, newsletters, and/or care coordinators.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	615 - 618
MS010	1	The Vendor should facilitate connecting members to community resources and social services.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	583 - 587
MS011	1	The Vendor should develop materials for members, including, but not limited to, members with special healthcare needs, in accordance with federal and State marketing regulations.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	608 - 615
MS012	1	The Vendor should consult with persons with disabilities and advocacy groups while developing materials for members with special healthcare needs.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	609, 613
MS013	1	The Vendor should use a methodology, including, but not limited to, claims history and proximity, to assign members in applicable populations to a primary care provider (PCP)	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	602 - 604
MS014	1	The Vendor should notify members in applicable populations of primary care provider (PCP) assignment.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	597 - 598, 603
MS015	1	The Vendor should educate members in applicable populations of the right to change primary care providers (PCPs).	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	603
MS016	1	The Vendor should conduct follow-up communications to ensure members in applicable populations are aware of the primary care provider (PCP) assignment.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	603
MS017	1	The Vendor should conduct outreach and transition planning efforts directed toward members with special healthcare needs.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	602 - 603; 606 - 607

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Spec ID #	Hierarchy Level	Specification Text	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
MS018	1	The Vendor should mail member handbooks on an ongoing basis, according to an established turnaround time, and including, but not limited to, the following:	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	599 - 600
MS019	2	Updates to the member handbook	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	600
MS020	2	Handbooks requested ad hoc by a member	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	599
MS021	1	The Vendor should provide enabling services--including, but not limited to, assistance with complaints and grievances--to members with physical or developmental disabilities.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	607 - 608; 615, 622, 624, 625
MS022	1	The Vendor should ensure the Contract Liaison/Medicaid Administrator monitors grievances--including, but not limited to, grievances related to subcontractors--for enabling services for members with physical or developmental disabilities.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	620 - 621
MS023	1	The Vendor should provide methods for members to contact the member services department, including, but not limited to, the following:	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	581 - 586
MS024	2	An emergency hotline	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	584 - 585
MS025	2	A toll-free number	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	582
MS026	1	The Vendor should transfer calls between the member services department and subcontractors for review, if applicable.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	583 - 584
MS027	1	The Vendor should educate members about the ability to request out-of-network referrals.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	604
MS028	1	The Vendor should educate member services representatives on the out-of-network referral process.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	604
MS029	1	The Vendor should train member services representatives on topics including, but not limited to, the following:	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	589 - 591
MS030	2	Serving members with disabilities and chronic conditions	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	590
MS031	2	The culture of disability	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	590
MS032	2	Resources available to members	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	591

Specifi				Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
MS033	1	The Vendor should, on an ongoing basis and at a set frequency, provide training to staff who perform outreach to members with special healthcare needs upon enrollment.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	590 - 591
MS034	1	The Vendor should use and report to the Department on customer service performance standards, including, but not limited to, the following:	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	587, 591 - 593, 626
MS035	2	Member-to-representative ratios	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	587
MS036	2	Call answering time, with a minimum of 83% of calls answered in 30 seconds	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	581, 591 - 592
MS037	2	Call abandonment rate not to exceed five percent (5%)	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	591-593
MS038	2	Single contact resolution	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	582 - 583, 592
MS039	2	Turnaround time for member requests	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	626
MS040	1	The Vendor should use warm transfer protocols for its member services and other applicable departments.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	582 - 583
MS041	1	The Vendor should establish and implement a 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. This process should include, but not be limited to, the following:	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	595 - 597
MS042	2	Member contact, including, but not limited to, welcome calls, welcome letters, and/or home visits	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	595 - 597, 606
MS043	2	Outreach to members who are difficult to contact, including, but not limited to, disabled members and members without telephones	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	596
MS044	2	Processing and issuing identification cards	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	597 - 599
MS045	2	Distributing member handbooks	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	599 - 601
MS046	1	The Vendor should distribute to members preferred drug list (PDL) and formulary changes affecting members' care.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	604

Specifi				Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
MS047	1	The Vendor should work with the State health exchange during the first six months of the contract to deliver to the Department an implementation plan for an electronic health record (EHR) system that serves as a health passport for members.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	615 - 616
MS048	1	The Vendor should provide a publicly accessible, secure website with information targeted to members that adheres to federal and State marketing regulations.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	615
MS049	1	The Vendor should provide a secure member portal that allows members to log in and access benefit information, including, but not limited to, the following:	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	615
MS050	2	Medical records	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	616
MS051	2	Authorization status	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Member Services	616
ND001	1	The Vendor should establish a statewide provider network containing providers that can provide a multi-disciplinary and comprehensive service array, either through their own practice or through collaboration with other providers.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	629 - 637
ND002	1	The Vendor should establish a statewide provider network that is accessible to children and their caregiver(s).	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	629 - 637, 638; 648 - 650
ND003	1	The Vendor should establish a statewide provider network that incorporates evidence-based best practices and interventions.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	638
ND004	1	The Vendor should establish a statewide provider network that provides for continuous communication with stakeholders.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	631 - 632, 638
ND005	1	The Vendor should establish a statewide provider network that has capacity in rural areas.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	632 - 634; 640 - 641
ND006	1	The Vendor should establish a statewide provider network that has capacity across specialty lines of physical health and behavioral health.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	632 - 634; 641 - 642
ND007	1	The Vendor should address deficiencies in the Essential Provider and Specialty Provider networks in relation to travel times and distances that may be experienced by a member.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	634 - 637
ND008	1	The Vendor should measure and regularly verify network compliance standards.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	647 - 648

Specifi				Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
ND009	1	The Vendor should take action if notified of inappropriate wait times before a member is seen by a provider.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	645 - 647
ND010	1	The Vendor should continue to build upon the provider network and credential new providers across the State for applicable populations.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	651 - 655
ND011	1	The Vendor should provide monthly reports to the Department on underserved areas of the State where the Vendor believes additional socially necessary services (SNS) providers should be permitted to enroll to address a gap in care.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	640 - 641
ND012	1	The Vendor, and/or any benefits management subcontractor(s), should monitor and evaluate ongoing access to services, including, but not limited to, the following:	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	645 - 646
ND013	2	Time/distance	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	645 - 646
ND014	2	Appointment timeliness, by provider type	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	645 - 646
ND015	1	The Vendor should ensure member access to covered services in areas where the provider network standards do not require a specialist.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	642 - 643
ND016	1	The Vendor should recruit specialty care providers and hospitals, for applicable populations.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	655 - 657
ND017	1	The Vendor should offer crisis response to children and their caregiver(s), as well as families at risk, to the extent that these services are covered under the Bureau for Medical Services (BMS) Children with Serious Emotional Disturbance Waiver (CSEDW).	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	657
ND018	1	The Vendor should develop and implement a recruitment strategy for the following providers:	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	657 - 659
ND019	2	Federally Qualified Health Centers (FQHCs)	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	657 - 659
ND020	2	Rural Health Clinics (RHCs)	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	657 - 659
ND021	1	If the Vendor elects not to contract with Federally Qualified Health Centers (FQHCs) and/or Rural Health Clinics (RHCs), the Vendor should develop and implement a strategy to ensure that members in applicable populations can access these providers.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	658, 659

Specifi				Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
ND022	1	The Vendor should develop and implement a recruitment strategy for the following publicly-supported providers:	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	657 - 659
ND023	2	Local Health Departments	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	658 - 659
ND024	2	Critical Access Hospitals	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	658
ND025	2	Primary Care Centers	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	658
ND026	2	School-Based Health Centers (SBHCs)	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	658
ND027	2	Right from the Start (RFTS) Providers	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	658
ND028	2	Bureau for Public Health (BPH) Laboratories	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	658 - 659
ND029	2	Children with Special Health Care Needs (CSHCN) Program	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	658
ND030	1	If the Vendor elects not to contract with the publicly supported providers, the Vendor should develop and implement a strategy to ensure all members have access to services.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	659
ND031	1	The Vendor should develop and implement recruitment strategies for new or modified provider types.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	659 - 661
ND032	1	The Vendor should establish and implement guidelines for which specialists will be able to serve as a primary care provider (PCP) for applicable populations, including, but not limited to:	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	645
ND033	2	The circumstances and process under which a member may select a specialist as his/her primary care provider (PCP)	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	645
ND034	2	Any managed care organization (MCO) approvals required	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	645
ND035	2	Any restrictions on the types of specialists that can serve as primary care providers (PCPs) for foster care members or other members with complex needs	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	645
ND036	1	The Vendor should ensure that the contracted network has a suitable range of pharmaceutical therapies to meet member needs, including, but not limited to, the following:	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	662 - 663
ND037	2	Availability of compounds	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	662
ND038	2	Availability of specialty drug pharmacies	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	662

Specifi				Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
ND039	1	The Vendor should make additional outreach efforts to the following types of pharmacies:	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	662 - 663
ND040	2	High volume	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	662 - 663
ND041	2	Rural	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	662
ND042	2	Public health entities administering the Vaccines for Children (VFC) program	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	663
ND043	1	The Vendor should ensure that pharmacy services are available to members in a timely manner, including, but not limited to, nights and weekends.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	662
ND044	1	The Vendor should establish and implement a provider re-credentialing cycle for physical health and behavioral health providers.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Network Development	663 - 670
PS001	1	The Vendor should provide initial (during implementation) and ongoing training for existing providers.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Provider Services	678 - 691
PS002	1	The Vendor should provide initial and ongoing training targeted to new providers.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Provider Services	678 - 684
PS003	1	The Vendor should provide training on mandated reporters to support applicable State Code, as defined by the Department.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Provider Services	678 - 684
PS004	1	The Vendor should coordinate with the member's primary care provider (PCP) and behavioral health provider, for applicable populations, to ensure each provider has access to the most up-to-date medical records.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Provider Services	688 - 691
PS005	1	The Vendor should establish a quality rating system for its contracted providers and disseminate this information to help members make informed choices about their care.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Provider Services	691 - 692
PS006	1	The Vendor should distribute provider manuals according to set timeframes and methods of delivery.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Provider Services	692 - 694

Specifi				Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
PS007	1	The Vendor should accept and pay claims on time for physical and behavioral health services, as defined by the Service Provider Agreement (SPA).	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Provider Services	697 - 703
PS008	1	The Vendor should establish and implement guidelines to approve out-of-network provider claims for physical health and behavioral health services--including, but not limited to, hospitals--on an ongoing basis (after the 90-day exemption timeframe).	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Provider Services	703 - 704
PS009	1	The Vendor should establish and implement a review process for payments for emergency services for applicable populations, including, but not limited to, the following:	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Provider Services	704
PS010	2	Which types of claims are automatically paid	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Provider Services	704
PS011	2	Which types of claims are automatically pended	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Provider Services	704
PS012	2	Evaluation of pended claims for payment, upholding the "prudent layperson" standard	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Provider Services	704
PS013	1	The Vendor should educate primary care providers (PCPs) on their responsibility to coordinate a member's overall health, for applicable populations.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Provider Services	688 - 691
PS014	1	The Vendor should conduct outreach to all specialists regarding the importance of encouraging members with complex needs to seek primary care services, for applicable populations.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Provider Services	678 - 684
PS015	1	The Vendor should educate and provide guidance to primary care providers (PCPs) on coordinating physical health services and ensuring that the PCP coordinates the member's medical health services, as appropriate, with behavioral health and/or socially necessary services (SNS), for applicable populations.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Provider Services	688 - 691

Specifi				Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
PS016	1	The Vendor should educate primary care providers (PCPs) about the importance of dental screenings to ensure appropriate referrals to dental providers, including, but not limited to, training PCPs to verify that beginning at six (6) months after the first tooth erupts or by 12 months of age (as part of the Early and Periodic Screening, Diagnosis, and Treatment [EPSDT] process), the member should be referred to dental providers, for applicable populations.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Provider Services	690
PS017	1	The Vendor should educate and monitor primary care providers (PCPs) regarding administration of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, for applicable populations.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Provider Services	689 - 690
PS018	1	The Vendor should educate providers about the ability to request out-of-network referrals.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Provider Services	690 - 691
PS019	1	The Vendor should support e-Prescribing functions.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Provider Services	697
PS020	1	The Vendor should educate primary and specialty care physicians about foster care members and members with complex needs, including, but not limited to, the following:	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Provider Services	678 - 688
PS021	2	Opportunities for standing referrals	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Provider Services	680
PS022	2	Opportunities for specialists to serve as primary care providers (PCPs)	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Provider Services	680
PS023	2	Availability of disease management	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Provider Services	680
PS024	1	The Vendor should provide a publicly accessible, secure website with information targeted to providers.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Provider Services	694
PS025	1	The Vendor should provide a secure portal--accessible by providers, Department caseworkers, and other stakeholders as permitted by the Department--that allows these stakeholders to log in and access information as permitted by the Department, including, but not limited to, the following:	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Provider Services	694 - 695
PS026	2	Medical records	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Provider Services	696
PS027	2	Authorization status	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Provider Services	696
PS028	2	Confirmation of services previously provided to avoid duplication	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Provider Services	696

Specifi				Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
QU001	1	The Vendor should reward physical and behavioral health providers that adhere to the quality or performance standards of the Department.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	764
QU002	1	The Vendor should share best practice methods or programs with physical and behavioral health providers, and should provide identified best practice methods or programs to the Department for consideration in sharing with socially necessary services (SNS) providers.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	748 - 750
QU003	1	The Vendor should take action against physical and behavioral health providers that demonstrate unacceptable performance, and should share identified socially necessary services (SNS) provider performance deficiencies with the Department.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	747 - 748
QU004	1	The Vendor should adopt strategies to simplify administrative procedures.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	742 - 743
QU005	1	The Vendor should administer a Quality Assurance and Performance Improvement (QAPI) Program.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	705 - 709
QU006	1	The Vendor should use Healthcare Effectiveness Data and Information Set (HEDIS) scores to assess its programs' and policies' impacts on West Virginia's youth and families.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	731 - 739
QU007	1	The Vendor should use measures beyond Healthcare Effectiveness Data and Information Set (HEDIS) scores to assess its programs' and policies' impacts on West Virginia's youth and families.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	732 - 737
QU008	1	The Vendor should report measures to the Department according to the requirements in the Service Provider Agreement (SPA), including, but not limited to, the following:	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	737 - 741
QU009	2	Healthcare Effectiveness Data and Information Set (HEDIS) scores	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	738
QU010	2	Measures that go beyond traditional Healthcare Effectiveness Data and Information Set (HEDIS) scores	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	738 - 739

Specifi				Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
QU011	1	The Vendor should use alternative payment structures for those providers over which the Vendor has direct contract oversight--including, but not limited to, provider incentives and/or overcoming limitations of diagnosis-driven eligibility--for the percentage of provider contracts identified in the Service Provider Agreement (SPA) to increase healthcare quality and efficiency through collaboration and innovation to improve access to comprehensive healthcare.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	758 - 759
QU012	1	For those providers over which the Vendor has direct contract oversight, the Vendor should identify and incorporate into alternative payment structures opportunities including, but not limited to, the following:	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	759 - 761
QU013	2	Cost savings	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	759 - 761
QU014	2	Reductions in inappropriate utilization of services, including, but not limited to, inappropriate admissions and readmissions	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	759 - 761
QU015	1	The Vendor should design and implement payment models with network providers (over which the Vendor has direct contract oversight) that tie reimbursement to measurable outcomes and ensure appropriate care is delivered in the most appropriate place and time.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	761 - 764
QU016	1	The Vendor should report annually to the Department on its activities related to alternative payment structures for those providers over which the Vendor has direct contract oversight, according to the Service Provider Agreement (SPA).	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	764
QU017	1	The Vendor should monitor quality improvement strategies with measurements including, but not limited to, the following:	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	713 - 715
QU018	2	Access to care	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	714
QU019	2	Demand for services	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	715
QU020	2	Quality of care	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	715
QU021	2	Health outcomes	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	715
QU022	2	Member satisfaction	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	741 - 742
QU023	1	The Vendor should analyze utilization data to monitor quality improvement strategies.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	715 - 716

Specifi				Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
QU024	1	The Vendor should collect and analyze quality measures at a set frequency.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	716 - 717
QU025	1	The Vendor should report annually to the Department on its activities related to access to care, according to the Service Provider Agreement (SPA).	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	717 - 722
QU026	1	The Vendor should use data to identify barriers to care for individuals with special healthcare needs, including, but not limited to, the following data collection methods:	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	725 - 728
QU027	2	Focus groups	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	725 - 726
QU028	2	Surveys	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	726
QU029	2	"Secret shopper calls"	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	726 - 727
QU030	2	Aggregate utilization monitoring	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	727 - 728
QU031	1	The Vendor should develop, update, and disseminate clinical guidelines to participating providers.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	753 - 754
QU032	1	The Vendor should follow a process to address quality issues, including, but not limited to, the following:	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	722 - 724
QU033	2	What steps will be taken	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	722
QU034	2	Who is responsible for addressing issues	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	722 - 724
QU035	2	Timeframes for resolution	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	724
QU036	1	The Vendor should initiate data-driven clinical initiatives that yield improvements in clinical care for applicable populations.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	739 - 741
QU037	1	The Vendor should establish and collect member satisfaction measures following the implementation date.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	741 - 742
QU038	1	The Vendor should profile the quality of care delivered by network providers, including, but not limited to, the following:	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	754 - 757
QU039	2	Primary care providers (PCPs)	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	755 - 756

Specifi				Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
QU040	2	High-volume specialists	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	756
QU041	2	Hospitals	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	756
QU042	2	Other acute care providers	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	755 - 756
QU043	1	The Vendor should monitor and reinforce primary care provider (PCP) compliance with program requirements for applicable populations.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	750 - 752
QU044	1	The Vendor should use data to identify access barriers for members with special needs, including, but not limited to, the following data:	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	728 - 731
QU045	2	Complaints and grievances	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	728
QU046	2	Primary care provider (PCP) change requests	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	730
QU047	2	Out-of-network referrals	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	730
QU048	2	Emergency room (ER) usage	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	730 - 731
QU049	1	The Vendor should use reports/data from subcontractor(s), as applicable, to ensure appropriate subcontractor oversight and the following member-related outcomes:	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	745 - 746
QU050	2	Access to care	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	746
QU051	2	Member satisfaction	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	746 - 747
QU052	2	Continuity of care	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	747
QU053	1	The Vendor should run data at a set frequency to identify which members in applicable populations have not received primary care services.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	751

Specifi				Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
QU054	1	The Vendor should contact members within a set timeframe after identifying which members in applicable populations have not received primary care services.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	752
QU055	1	The Vendor should contact the member's primary care provider (PCP) within a set timeframe after identifying that a member has not received primary care services, for applicable populations.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	752
QU056	1	The Vendor should analyze and synthesize reports on data about members in applicable populations who have not received primary care services.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	752
QU057	1	The Vendor should establish and implement ongoing quality monitoring activities to ensure quality for members and compliance with program requirements.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	712
QU058	1	The Vendor should periodically enhance ongoing quality monitoring activities to ensure quality for members and compliance with program requirements.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Quality	712 - 713

Vendors should not edit this worksheet.

Vendor Response - Capability Assessment	
Capability Assessment	**Description**
Will Meet	Specification will be met by the Vendor.
Will Not Meet	Specification will not be met by the Vendor.

Response Templates	
Response Template	**Description**
Attachment A	Cost Workbook
Attachment B	Vendor Qualifications and Experience
Attachment C	Project Organization and Staffing
Attachment D	Mandatory Requirements
Attachment E	Detailed Specifications Approach
Attachment F	Sample Case Scenario
Attachment G	Terms and Conditions Response Template

Specification Subject Matter Areas	
Abbreviation	**Subject Matter Area**
BA	Benefit Administration
CM	Care Management
CS	Community/Stakeholder Engagement
MS	Member Services
ND	Network Development
PS	Provider Services
QU	Quality

ATTACHMENT F: SAMPLE CASE SCENARIO

Instructions: A sample case scenario is described below. The Vendor should explain how they would care for the child using the question-and-response format provided beneath the scenario. The Vendor's response to Attachment F should not exceed 10 pages.

Case Scenario

Ben is six (6) years old. CPS has just conducted an evaluation of Ben's household and determined that based on parental substance abuse issues, Ben needs to be removed from the home and taken into State custody. Ben is currently placed in an emergency shelter while CPS staff work on placement options but will ultimately be placed with a kinship relative. Ben has had a history of needing various durable medical equipment (DME) supplies and behavioral health supports to help address his medical needs. The court has ordered socially necessary services to help Ben adapt to his new environment.

Please answer the questions below as to the Vendor's approach in helping Ben from the point of removal through placement and then ongoing.

Vendor Response

1. **Starting with the notification by the Department caseworker that Ben has been taken into custody, please describe your approach to communicating with all necessary stakeholders (Vendor should identify all parties to communicate with), identifying the spectrum of medical services needed and coordinating those services, and coordinating socially necessary services.**

REQUEST FOR PROPOSAL

Department of Health and Human Resources, RFP CRFP 0511 BMS 1900000001

As an experienced Medicaid managed care organization in West Virginia, Aetna understands the unique challenges of children and youth served in the Specialized Managed Care for Children and Youth program. We have undertaken a systemwide transformation to address the impact of physical, emotional, and social trauma and we extend this end-to-end process to implement a statewide, trauma-transformed, child and youth integrated system of care. In doing so, the system of care paradigm supports State goals to enhance coordination of care and access to services, reduce fragmentation, and improve communication among stakeholders through a whole-family approach driven by innovative, integrated care management solutions that provide opportunity for improved health outcomes. Our integrated care management approach moves the service paradigm from 'what's wrong with Ben and his family,' to a whole-family, strengths-based approach, and collaboratively empowers children, youth, and families by focusing on prevention, early intervention, and family preservation and reunification.

Ben's Circumstances and One Family's Opportunity

Ben is an extremely frightened 6-year-old boy, living in an unfamiliar emergency shelter with strangers, distant from his family. He has significant behavioral, physical, emotional, and social health needs that need to be addressed including a need for behavioral health (BH) services and durable medical equipment (DME) specifically, a nebulizer for his asthma. Ben was removed from his biological parents due to neglect secondary to opiate use. This event has been traumatizing for everyone in the family, and this family history has negatively impacted Ben's access to quality medical, behavioral, and socially necessary services. Ben's parents, Kerry and David, used opiates over a ten-month period during the school year, which negatively impacted their ability to supervise and care for Ben's needs. Medical, behavioral, and school appointments were missed, and Ben was left unsupervised for long periods of time. Ben started acting out angrily on the school playground, which led to a brief school suspension on one occasion. The school attempted to contact Kerry and David with no success. During the most recent episode of acting out, the school counselor elicited that Ben's parents are using medication and acting strange and forgetting about him, and filed a report resulting in the ensuring investigation with Child Protective Services (CPS).

Crisis Stabilization and Rapid Enrollment

Aetna's care coordinator, Josh, receives a call from a CPS worker named Simon whom he has worked with in the recent past. Simon informs Josh about Ben's removal and the circumstances surrounding the neglect and the parent's substance use. Josh and Simon are both worried about Ben's emotional needs and decide to **dispatch a regional, mobile crisis team** to the emergency shelter within at maximum, the next 24 hours. Josh makes an in-person visit at the shelter at the same time as the mobile crisis team to meet and assess Ben, imagining how frightening it must be for such a young boy to be away from his family. Josh is an experienced care coordinator who is a licensed social worker employed with Aetna for five years. He was previously employed with Mission West Virginia as a foster care recruitment educator. Josh is trained in **trauma-informed care and motivational interviewing.** Josh and the mobile crisis team carefully engage with Ben in order to not traumatize him any more than he already is. While comforting Ben and reassuring him, Josh meets with the emergency shelter staff, to assess the situation, and gather information necessary for the care team process. Specifically, Josh and the mobile crisis team provide the following services:

- Provide crisis interventions, and connect Ben to ongoing BH services and community resources
- Provide crisis services of triage assessment and **immediate stabilization** of his acute mental and emotional needs. Ben shares that he is worried about his family and feels lonely and upset. Tina, the shelter worker, has the best approach to soothing Ben, which she shares with Josh, and Josh invites Tina to be on Ben's interdisciplinary care team.
- Collect family history and parental engagement information including preferences for involvement
- Develop a comprehensive safety plan in collaboration with Ben, Simon, and the emergency shelter worker that includes **preventing future crisis and placement disruption**; the safety plan identifies who to contact during future emergencies, the type of care available, and how to access care

- Contact the family to learn about their involvement and concern; create an initial plan for engaging family and informal support system in safety planning, knowing comprehensive planning that includes extended family occurs after the crisis is stabilized

Because Ben is six years old, much of the initial interview and assessment was to develop a safe and trusting space and relationships for Ben to express himself freely, have a voice and choice, and develop relationships with adults that will love and care for him. Josh and Simon noticed Ben began to play with toys in the shelter, and was having fun, laughing with other kids. Once Ben's immediate needs are stabilized, Josh explains **peer support** services to Ben. Ben wants a mentor who can be like a big brother connecting with him on a level that Josh cannot. Josh links Ben with a peer support partner, named Tim, who immediately sets up time to visit after coordination with Simon and the emergency shelter worker. Tim is an adolescent boy who began volunteering as a mentor following attendance at Aetna's **Helping Each Other/Everyone Reach Out (HERO) workshop.** Tim is now working in a formal peer support role with an Aetna peer support provider. Tim is young at heart and enjoys spending time building Legos and simply listening to Ben.

Aetna in collaboration with KVC Health Systems sponsors and hosts HERO workshops for members who learn about the effects of trauma, how to build a supportive network, and participate in experiential activities that support resiliency. Family members and caregivers can attend to learn about the Family First Prevention Services Act and tips for strengthening their families. Our first workshop was July 19-20, 2019 in Charleston.

Josh and Simon coordinate, inviting Ben and his family to a meeting on the following day. Prior to the meeting, he thoroughly reviews all health record history and case information. Josh takes the time to engage and listen to the parents, as they are very upset and worried. Josh utilizes his empathic skills to guide assessment questions, build a rapport with Kerry and David, reassuring he is here to help strengthen the family, and develops a unified, family care plan. Josh finds that Ben was removed for neglect after CPS discovered Kerry and David were actively using opiates when Ben was at home. He also learns that Ben was having significant problems at school before the parents started abusing substances. They were working diligently to get Ben in for assessments right before they began using opiates, but then missed all the appointments. The school counselor had advised Kerry and David Ben may have attention-deficit/hyperactivity disorder (ADHD) and possibly, some learning disabilities. Ben would not sit still in class and when he became frustrated, he would yell and sometimes throw things. As Josh listens and takes notes, he realizes that Ben needs comprehensive BH and learning assessments. He immediately makes referrals, assuring adherence to the required 24-hour timeline.

1.	Starting with the notification by the department case worker that Ben has been taken into custody, please describe your approach to communicating with all necessary stakeholders (Vendor should identify all parties to communicate with), identifying the spectrum of medical services needed and coordinating those services, and coordinating socially necessary services

Communication that Supports Seamless Coordination of Care

Josh's role as the single point of contact responsible for oversight of care coordination is to assure near, real-time communication with Ben, the emergency shelter worker, Simon at CPS, crisis providers, outpatient physical, behavioral, dental, and social providers, Ben's family, and Ben's identified circle of support. Josh ensures that the parents are informed of the various options for services and supports and secures their approval with signatures on the appropriate release of information forms. Aetna's care management program is designed to support Josh's success through system level collaboration, regular and frequent contact, use of customized assessments, training based on nationally-accepted framework for foster children and children and youth involved in child welfare, access to an interdisciplinary team, and a comprehensive provider network supported by local community resource organizations. A safe trusting relationship is the team's primary initial goal for Ben.

Crisis Stabilization, Rapid Enrollment, and Related Communication

Ben was rapidly enrolled in Aetna's intensive care management program following notification from Simon that Ben was placed in emergency shelter. Immediately following the assessment at the emergency shelter, Josh confirms Ben's enrollment is processed and loaded in Aetna's electronic care management system within one business day of the CPS notification of Ben's removal. Josh reviews available information in the referral packet, schedules an in-person meeting with Simon to ask follow-up questions, asks about the family's needs, and gathers names and contact information as well as any other relative and family support information available. Josh reviews the mobile crisis team assessment, findings, and additional health information in **FamilyConnect**—Aetna's shared electronic health record that integrates data from Families and Children Tracking System (FACTS), the West Virginia Health Information Network (WVHIN), CPS, and provider and facility sources.

Aetna Technology Solutions that Promote Member Stability

FamilyConnect is Aetna's electronic health record technology solution for meaningful and complete electronic health records for each Aetna member involved with CPS. FamilyConnect is a single, electronic health record that integrates multiple data sources such as FACTS, WVHIN data including emergency room admission, discharge, and transfer data, and provider assessments and health records into one, single repository. FamilyConnect promotes actionable data that supports member stability—care coordinators, CPS, providers, guardians, families, caregivers, and other stakeholders can view information, allowing for a holistic view of each member's needs in near real time.

Josh's approach during his follow-up visits with Ben is to assume the need for **universal trauma precautions** due to his observations during the initial assessment and the high likelihood that Ben and his family have experienced more trauma and Adverse Childhood Experiences (ACEs) than he observed. Josh uses his training in trauma-informed care and motivational interviewing to guide his approach, assuring he communicates in developmentally appropriate language for a six-year-old and he interacts with Ben in a way that offers opportunities for building a trusting relationship. He listens compassionately to Ben, and validates his anger, sadness, fear, and experiences while assuring Ben he is here to help. Ben hugs Josh very tightly on a follow-up visit. It hurts Josh to walk away from Ben even though he made a point of **bringing Ben his favorite blanket and stuffed bear from his home.**

If there are existing psychotropic or other medications prescribed to Ben, Josh invites Aetna's **clinical pharmacist advisor** to be part of Ben's care team for urgent coordination of medications. The clinical pharmacist advisor would immediately address Ben's needs by researching Ben's pharmaceutical history and addressing any barriers to accessing medications that will be discussed with Ben's family and home staff. This includes coordination with the medical and BH providers, pharmacy, and parents or guardians to assure urgent delivery of existing prescription medications to the emergency shelter. The clinical pharmacist advisor remains part of Ben's Care Connection team (CCT), offering the same comprehensive coordination to caregivers in Ben's future placement. The clinical pharmacist advisor directly interacts with CPS, future caregivers, Kerry and David, the pharmacy, Aetna's internal pharmacy departments, and participates on Ben's care planning meetings. She documents her updates in **FamilyConnect.**

Securing Kinship Placement and Related Communication

Josh and Simon enlist the help of Kathy who is a skilled facilitator on **Family Search and Engagement (FSE).** Simon knows that the numerous people including Ben's relatives have moved out of the area due to the poverty and substance use risk in their original community. Extended family members began gradually dropping contact when they realized what was happening to Kerry and David. This has left Kerry and David without family support. Both Kerry and David agreed with the desire to reach out to family and re-engage. The FSE worker, Kathy, receives a list of extended family members from Josh after he met with Ben and his parents. Kathy also reviews Ben's record and referral packet after securing the necessary releases for the purpose of gleaning data points that will assist with online records searches. Kathy has phone numbers and

places of employment for Ben's grandfather and two sets of aunts and uncles. Kathy speaks with the parents to ensure that she ranks the order of the people that David and Kerry believe would support their recovery and who would step up to help with stabilization and respite. Kathy conducts online searches and phone calls. She locates 10 extended family members who are open to helping and who live in nearby communities, after they hear that David and Kerry are in substance use treatment and attending twelve step community meetings. They are relieved to learn that the family is receiving intensive treatment and community-based services. Based on feeling hopeful about Kerry and David's chances of maintaining recovery and being supported by Aetna, several agree to attend family care team meetings with four, in-person and six attending via Skype or by phone. Kathy expresses her gratitude, explains how the process will proceed, and that she will link them to Josh, who is Ben's care coordinator. Kathy encourages each extended family member to express concerns and not commit if they are not sure about what role they want to play in Ben's life, explaining the first meeting is for learning about FSE and getting to know each other. She is transparent about the goal of reunification with life-long connections to as many family members as possible. She explains how vital these connections will be in support of the family's preservation and wellness. She closes out each conversation with a commitment to attendance and a deep-felt expression of gratitude. Kathy, Josh, and Simon identify that Ben's grandparents would be the best fit for Ben's temporary kinship placement and work together to move Ben as quickly as possible out of the emergency shelter. Since Kathy is part of the care team, Josh assures her documentation is captured in Ben's electronic health record in FamilyConnect.

Aetna has selected a national award-winning framework for promoting and strengthening collaborative practice between child welfare professionals and community and family partners, called Collaborative Family Engagement (CFE). CFE is a cross-sector approach to reducing child welfare system fragmentation. Aetna will establish a governance roundtable model that includes the Department, Bureau for Children and Families (BCF), CPS, West Virginia Department of Corrections and Rehabilitation (WVDOCR), children, youth, families, foster families, and providers input into system development. As an extension of this model, Aetna is staffing four administrative positions at the health plan level to support collaboration, called system of care Administrators, whose responsibility is to implement CFE and enhance coordination of care.

Care Coordination and Related Communication in the Kinship Placement

Once Ben is moved to his grandparent's home, Josh contacts the grandparents to welcome them to the program and explain intensive care management services, including access to an interdisciplinary team of experts. He states he is their **single point of contact**—accessing other team participants when their expertise is needed and collaborating with other parts of the CPS system. Josh explains he would like to get to know the family and arranges a family meeting. He asks the grandparents for their preferred date, time, and location for scheduling, and explains what will happen in that first visit: he wants to know what happened to the family, as trained in trauma-informed care approaches, and states he will continue facilitation of assessments that began at the emergency shelter helping gather a comprehensive understanding of needs for the whole family.

At the scheduled visit, Josh captures all State-required assessments, Aetna assessments customized for children and youth involved in CPS, and the family's needs and capabilities. Josh continues sourcing information about health risk and needs, assuring full comprehension of Ben's history. He gathers additional perspectives about the family's crisis needs and updates the safety and care plan. If there were existing medications, he would confirm the grandparents receive those medications, explain the role of the clinical pharmacist advisor, and answer any questions they have. Josh spends one to one time with Ben, assuring his involvement and voice is included. Josh educates Ben about the program, using developmentally appropriate language and confirming Ben's understanding. He brings Ben an Aetna **Essential Needs Duffle Bag** filled with personal hygiene items such as a toothbrush, shampoo, a blanket, and other basic need items, an Aetna **value-added service** that promotes stability and continuity for our children and youth members removed from their homes. Josh reviews all contractually required items such as member rights,

grievances and appeals, and how to contact Aetna, including his direct contact information with the grandparents. He provides an **overview of care management**—how to access services and how eligibility works—and answers any questions the family has. Josh is trained in trauma-informed care, an approach that involves listening empathically **using guiding principles of safety, choice, collaboration, trustworthiness, and empowerment**. He listens compassionately and empathically to Ben and his grandparents as they describe their fears and numerous losses. Josh asks about the family's beliefs, needs, likes, dislikes, abilities, and struggles. All the while, Josh is noting the numerous strengths in each family member. He approaches the topic of the parents' opiate use and the removal gently, allowing each family member to share as trust is built. Josh describes the care planning process, and that care team meetings involve an interdisciplinary team comprised of Ben, grandparents, providers, school counselors, providers, and anyone else important to Ben's well-being: that is, their **circle of support.** Josh explains this is part of Aetna's **system of care model**; we focus on working together to address gaps and assure available resources using wraparound and Family Finding approaches. He explains that Ben's **voice**, and his family's voice, help the care team understand Ben's needs and prioritize care. Josh states Aetna's approach is **holistic and integrated**: all needs are addressed including his medical and psychological needs as well as helping Ben, needs of his grandparents, and coordinating care for Kerry and David.

> Aetna promotes the use of nationally accepted frameworks that meet the unique needs of children and youth involved in child welfare to guide our care management process. **Wraparound** care is a community-based approach that strengthens the family environment by addressing safety and family needs. **Charting the LifeCourse** framework is a best-in-class, family-centered approach based on the core belief that all people have a right to live, love, work, play, and pursue their life aspirations in meaningful ways. **Family Finding** is a model that offers trained facilitators strategies to locate and engage relatives of children in out-of-home placements.

Josh is trained extensively in foster care best practices, including **wraparound, Family Finding and the Charting the LifeCourse™[1] framework as well as the WV Child and Adolescent Needs and Strengths (CANS) assessment** to guide assessment and care planning. Josh explores goals that support what Ben and his family want for their lives through discussions about their hopes and dreams. Josh asks Ben to describe what it was like when life was good at home and in school. Ben is wary, and Josh uses his skills in **motivational interviewing** to elicit Ben's true feelings. Josh assures him that he is here to help Ben and his family all get better. He listens patiently as Ben describes his home, his parents and family life, how he misses everyone, and how badly he wants everyone to be better and back together. Ben talks about how his parents took good care of everyone not that long ago and he was playing with his friends. During the flow of asking informal questions, Josh uses the following evidence-based assessments mandated by the State and tailored to Ben's specific needs:

- WV CANS and CANS trauma screen;[2] health- and condition-specific issues including the PHQ-9[3]and ACES-Q[4] trauma assessment; Trauma Screening Questionnaire (TSQ)[5]
- Ben's clinical history, activities of daily living, social relationships and functional status

[1] University of Missouri Kansas City (UMKC) Institute for Human Development, Charting the LifeCourse™ Framework, UMKC: accessed July 2019; http://www.lifecoursetools.com/principles.
[2] The National Child Traumatic Stress Network (NCTSN), "NCTSN CANS Comprehensive Trauma Version," NCTSN, https://www.nctsn.org/measures/nctsn-cans-comprehensive-trauma-version-cans-trauma, accessed June 2019.
[3] American Psychological Association (APA), "Patient Health Questionnaire-PHQ9 and PHQ2," APA, 2019: accessed July 2019; https://www.apa.org/pi/about/publications/caregivers/practice-settings/assessment/tools/patient-health.
[4] American Academy of Pediatrics (AAP), "ACES screening tool for children and adolescents," AAP, https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/resilience/Pages/Clinical-Assessment-Tools.aspx, accessed July 2019.
[5] NCTSN, "Child Trauma Screening Questionnaire," NCTSN, https://www.nctsn.org/measures/child-trauma-screening-questionnaire, accessed August 2019.

- Level of cognitive functioning using the Pediatric Symptom Checklist (PSC-17)[6]
- Health literacy, psychosocial issues, and linguistic, cultural, and spiritual needs and preferences
- Visual and hearing status, needs, and preferences
- School-based performance and resources
- Informal family supports, family strengths and culture, family needs, and Ben's hopes, dreams, goals, and preferences

Josh uses the CCT meeting and the Wraparound Multiple Life Domain Planning process to assure full family involvement and collaboration. He addresses all gaps and barriers to care, identifying each as a documented need in the care plan. Josh uses the LifeCourse framework to solicit how the team can collaboratively address Ben's needs and facilitates discussions that promote identifying strengths and informal family and community support. As the single point of contact, he assures all updates are communicated and documented in FamilyConnect. Josh meets with Ben in-person at minimum as required per contract for intensive care management program enrollment and as often as change occurs. Josh uses language such as "what do things look like if you are at home and mom and dad are not acting strange," guiding the discussion so Ben can map out what his goal looks like in a more concrete way. Josh recognizes that he is assisting and teaching Ben to communicate his needs more effectively and links his skill development to the larger care management planning process. He reiterates whenever possible, that Ben has a voice that is important to the planning process by saying phrases such as "what you want is important and I am glad you shared that with me." He states that the first step is to work with everyone involved to help get Ben safely back to his parents' home, and the second step is to talk about what everyone is good at, and how that helps Ben move back home.

Communication with CPS

Josh's workstation is **embedded in Simon's CPS office**. He communicates daily with Simon, in-person and via email and text messaging when they are both in the field. Josh and Simon discussed what methods of communication they would use for urgent and emergent issues, and exchanged work cell phone numbers, using text and phone calls for urgent and crisis communication. Both Josh and Simon have access to FamilyConnect, a near, real-time view of provider assessments, findings, and other health communication and have developed a single care plan. Josh attends all the CPS multidisciplinary team meetings in-person and assures regular communication with Simon about the case plan. Josh assures case plan goals are thoroughly documented in the Aetna care plan and linked to services. Case plan goals are reviewed frequently and as mandated by contractual requirements. Josh assures Ben's care plan with related referrals for services and support updated as case plan goals change. This single care plan serves as the document to drive Bens integrated care plan.

Aetna will embed experienced care coordinators into BCF CPS office locations to enhance coordination of care. Aetna will collaborate with CPS to identify strategies to determine which office locations would benefit from this local partnership.

Coordination and Related Communication for School-based Services

Josh recognizes the importance of including and addressing Ben's behaviors of sometimes throwing things at school in the care planning process. He secures the appropriate releases of information and contacts the school counselor inviting her to the care management team. The grandparents ask why coordination is needed for the school counselor. Josh explains that it is **critical to understand the root cause** of Ben's behaviors, and to identify unmet school needs as well as academic strengths and positive connections with teachers and classmates, all of which inform the care plan. He assures the school counselor has opportunity in the care plan meeting to educate the team about her assessment, the need for special education services,

[6] W. Gardner and K. Kelleher, "Pediatric Symptom Checklist (PSC-17)," W. Gardner and K. Kelleher, 1999: accessed May 2019; https://www.prohealthmd.com/windhampediatrics-dev/wp-content/uploads/sites/25/2015/01/PSC-17.pdf.

and links **hope for a better future**. The care team identifies school behaviors and performance as a need in the care plan and solicits Ben's input about what he needs to be successful at school. The care management team decides Ben should be considered for an Individualized Education Program and the school counselor coordinates a referral and eligibility screening. Josh assures coordination of care with the school counselor, makes referrals, and secures authorizations for necessary services and supports such as one to one staff assistance during recess or physical education.

Sharing Medical Records and Maintenance of Ben's Individual Service (Care) Plan

To support continuity of care, Josh uses Aetna FamilyConnect, the shared electronic health record implemented in collaboration with CPS, WVHIN, and providers; it serves as the single source of truth for Ben and his circle of supports. Josh and providers share assessment, care plan, and updates in FamilyConnect as often as change occurs. Providers, Ben, his family, CPS, the neighbor/fictive relative, and parents can easily access and view information in FamilyConnect at any time **24/7/365** using Aetna's web-based portal or mobile application. FamilyConnect **integrates data from FACTS and WVHIN**, providing the care management team a near real-time, holistic view of Ben's unique needs. Josh is the single point of contact for Ben's care plan. He reviews the care plan with Ben, his parents, and the team at least monthly, making certain progress, barriers, and changes in needs and concerns are monitored and documented. The care plan is updated in FamilyConnect, the single, shared, electronic health record platform, any time there is a change in Ben's needs, as requested by Ben or his family, per contract requirements, and at minimum, annually. If there is a significant change, Josh conducts an in-person visit with Ben, his parents, grandparents and others involved to assure reassessment and updates to the care plan. Josh documents his interactions with the family, and team participants, in FamilyConnect, assuring the care plan is updated as change occurs. Josh facilitates updates to the plan during each team meeting as needed and the family receives updated copies of the plan to ensure they are reinforced for expressing their voice, choice and preferences.

Coordination of Medical Services

Josh has been extensively trained in the Specialized Managed Care for Children and Youth program, and he approaches Ben and his family's needs as urgent. He assures intensive, individualized care that promotes the family's greatest chance to be reunified, safely together in their home and local community while promoting treatment that effectively meets the whole family's needs. Josh uses a whole-person, integrated care framework to drive care management discussions about needs and related services. He monitors all referrals and related service authorizations. Josh connects Ben and his grandparents to the provider identified by Kerry and David, **assuring continuity of care**. New referrals are based on guardian and family needs and preferences and include primary care and dental care. Ben's primary care provider (PCP) is invited to participate on Ben's care team, and as an Aetna network provider, already has access to FamilyConnect. Josh moves quickly on creating new referrals, recognizing the need to stabilize chronic conditions and acute issues, and to adhere to all required timeframes for healthcare assessments. He completes follow-up making certain that comprehensive assessment for asthma and oversees timely access to nebulizer and other DME needs. This includes resolving any barriers to timely DME by coordinating with providers and completing follow-up discussions with the grandparents. He educates the grandparents about Early and Periodic Screening, Diagnostic and Treatment (EPSDT) assessments has occurred including dental, hearing, and developmental assessments are completed within 30 days and follow-up is completed in 90 days. He assures the grandparents understand the need for EPSDT and provides written communication such as brochures to assure understanding. He completes follow-up phone calls to verify Ben's attendance at EPSDT appointments within required timeframes. Josh communicates updates with the care management team, documenting all updates in **FamilyConnect**. The resulting assessments inform the care plan and future referrals and interventions necessary to ensure Ben is sufficiently assessed and treated, moving toward stabilization and optimal health.

Planning and Prioritizing Medical Services and Care

Josh and the CCT have prioritized Ben's needs and secured the following services as follows:

- Ongoing comprehensive assessment and referral that includes a referral to **FMRS Health Systems** Inc., an integrated, health home that offers the following services:
  - Primary care with a complete history and physical assessment in 24 hours with referrals for specialty services, EPSDT, and vaccinations; Josh assures PCP reassignment within required timeframes as contractually mandated and monitors that care occurred
  - Trauma-informed, behavioral health providers in Aetna's network that use evidence-based approaches tailored to Ben's needs such as **wraparound services to help the grandparents learn de-escalation techniques and trauma-informed play therapy to help Ben understand what happened to him**; this includes use of an iPad from Aetna that the grandparents can use to aid in continuity of care, health literacy/education, and communication with service providers
- Exploration and connection to appropriate educational support and school resources; the school counselor makes a referral for an IEP evaluation
- Exploration and development of Ben's circle of support inclusive of family reunification, re-establishing friendships, and the family's hopes and dreams; Kathy, Josh, and Simon identified grandparents as a kinship placement and moved Ben quickly to his grandparent's home
- Services and support for Ben's grandparents including kinship and behavior management support, education on opiate use disorders and recovery; Josh provides a referral to **West Virginia State University** for in-person and online grandparents-raising-children support groups, and to Nar-Anonymous Family 12 step program that supports the parents of a loved one who has a substance use disorder; Josh arranges for transportation as needed
- Ben's parents receive opiate treatment and supports including medication-assisted treatment (MAT) at Access Health, and as they enter recovery, training and support for effective parenting and life skills

Josh and all care coordinators have been trained in the tenets of the Families First Prevention and Services Act and the desire to keep families together and safe. Josh knows the need to build rapport with all family members and to address needs across multiple life domains not only for Ben, but also for his parents and the grandparents to guarantee the best outcome for Ben and the family. Josh supports Ben and his family to rebuild a meaningful life filled with purpose, achievement of dreams, and a sense of belonging. Using the Wraparound and LifeCourse framework, Josh recognizes that while Ben's family is fraught with several serious problems, Ben, his family, and his community are filled with inherent and learned strengths, and those are built into Ben's care plan. He elicits that when Ben was at his best, he had a lot of friends who admired his ability to be a good influence. He learns that Ben misses his school and neighborhood friends and enjoys spending time playing basketball. Josh asks how it's been going with his peer support specialist and assesses how Ben perceives and is building that relationship. Josh further explains about HERO workshops which is a weekend opportunity to play and learn, connect with others, and that his peer support specialist will be there as a teacher. Ben is interested, and Josh educates his grandparents about HERO opportunities to learn about the Family First model for strengthening families. He arranges transportation to and from the event. Whenever Ben or his family is overwhelmed or feeling hopeless, he reminds them of their hearts' desire to be together again, to feel well, and to be a whole family. Josh has observed that Ben continues to be afraid as observed by isolating and not yet having friends, and he understands that while trauma informed care is vital, so is time with their parents, time to play together, and room to be children in a loving family. Josh has a firm belief in the need to facilitate and ensure that Ben's family has a comprehensive plan of care that puts just as much importance on play and family time as it does on treatment and safety planning. As an example, Ben will calm down as a result of a positive behavior plan, time playing held by his grandparents. He will likely need all these strategies working in concert in order to feel safe again, to learn coping skills, and to eventually return home. Josh recognizes that Kerry and David need a recovery community and related support. Josh confirms Medicaid and intensive care management enrollment.

Planning and Prioritizing Socially Necessary Services

Josh is the single point of contact for coordinating SNS and assures all SNS planning and referrals occur in collaboration with the care management team. He utilizes the wraparound domain planning process driven by Ben and his family's voice and informed by legal, court, and guardian representatives to request appropriate SNS services. Services are based on Ben and his family's initial needs and ongoing needs. Josh completes all referrals and assures coordination with the Department, Simon, and Aetna's subcontractor, KEPRO, for authorizations. Josh shares information about Ben's assessments of unmet needs, strengths, and available resources and providers with KEPRO utilization management staff and provides updates during care planning meetings. He documents all needs, referrals, and authorizations in Ben's care plan in FamilyConnect. In consultation with the care planning team, Josh assesses the two most stabilizing interventions for Ben include visitation and relationship development with family, and BH support and services that address trauma. He has already referred Ben for BH services, and he secures authorization for safety services, respite, parenting skills training, and transportation to meet Ben and his family's initial needs. As Ben and the family progress through services, he uses updated needs identified in care planning meetings to secure additional SNS as appropriate. As progress occurs, Josh facilitates step down from SNS to family empowerment interventions, closing the loop from needing family services to family self-sufficiency.

Provider Education and Support that Promotes Effective Coordination of Care

Josh has the benefit of working in a statewide child welfare system that will be supported by Aetna's customized, governance structure for West Virginia and by Aetna's trauma-informed care transformation initiative. Aetna has supported a statewide **trauma informed care transformation**—which means understanding the effects of toxic stress and negative impact on health, especially for children and youth involved in CPS—and has a, year-long, training collaborative that is specifically designed to support **West Virginia providers and stakeholders on becoming trauma informed certified providers.** As trauma informed certified providers, they will learn how to screen and document trauma including ACEs, make appropriate referrals, provide evidence-based, trauma informed treatment, and be incentivized for quality driven outcomes. Aetna's approach begins with an organizational self-assessment that identifies providers with a history of trauma training, cultural competency training, and needs and gaps, and offers training and technical support that moves providers along the trauma informed transformation continuum resulting in a **trauma informed certification and credential** as a specialty provider. To date, we currently have three providers, Crittenton Services, FMRS Health Systems Inc., and KVC participating in our trauma informed transformation. Aetna's comprehensive provider support includes value-based arrangements, gaps-in-care reporting, and access to FamilyConnect. We have arranged value-based solutions via contracting with providers who offer medication-assisted treatment and offering incentives for extended after-hours availability and to increase appointment attendance. Aetna offers all providers gaps-in-care reports, allowing easy identification of members who needs immediate or ongoing follow-up for optimal health outcomes. Josh uses gaps-in-care reports to follow-up with providers and the family on EPSDT and other critical appointments for Ben and his siblings. Providers can access FamilyConnect allowing a full, 360-degree view of the member's health information history.

Family Reunification and Related Communication

Once Ben and his family feel confident and ready to handle life together again under one roof, Josh facilitates further planning for safe return home. Josh and the parents also understand that stressors will occur and that they need to ensure sustainability of their hard-won gains. Josh explores a variety of step-down services and supports that assist the family with ongoing insights and skill sets to ensure the family remains strong, healthy and safe. Josh knows from his training that children and families have a greater chance of optimal outcomes and a meaningful life if they live with purpose in their community. He asks Ben about his loneliness and distance from past friends. Ben is very tearful, and Josh uses his trauma-informed care skills to patiently sit with Ben as he elicits additional detail to assess for how this trauma has impacted Ben and validates his

experiences. As a result of Family Finding, Ben is reunited with two of his father's closest, neighborhood friends, who have numerous pets and who offer to have the entire family over to relax and enjoy the pets together. The family friends are a wonderful example of the transition from SNS to natural supports that will continue for the family long after system involvement.

Coordination and Communication to Address Social Determinants of Health

Josh knows his local community—he was born and raised there—including community resources such as food banks, local churches, and advocacy organizations. The care team identifies and connects Ben and his family based on their needs and preferences. He enrolls Ben's family in any federal programs they qualify for such as the Supplemental Nutrition Assistance Program, Special Supplemental Nutrition Program for Women, Infants, and Children, or housing support. Coordinated visitations are a critical need. Josh assures visitation coordination for the grandparents and parents, recognizing the vital role of including parents and grandparents in Ben's stability and recovery. Josh has collaborated with Simon at the onset of care management, and the talk daily in the CPS office, especially about social determinants of health (SDOH).

Josh and Simon know that Ben and his family have the greatest chance at reunification if they are kept together safely, and if their care plan is family-centered, holistic, includes the right SNS, and addresses SDOH needs. He learns through utilizing **wraparound, Family Finding, and LifeCourse** frameworks that Ben and his family did not often have enough clothes for him to wear. He searches referral in two places: Family Resource Network and elicits Simon's help to request help in the **CarePortal**. He locates a local church through CarePortal that can deliver clothes for a 6-year-old boy directly to the grandparents' home.

Aetna has entered a formal collaboration with Global Orphan Project and Celebrate Recovery to implement **CarePortal**, a community resource platform designed uniquely to meet foster, adoptive, and child-welfare involved children and youth needs. CPS case workers make direct referrals in CarePortal based on tenets in the Family First Prevention Services Act of supporting, connecting, and uniting families. Each referral is sent to three, local, closest, faith-based organizations for review, and the first to adequately respond deliver the items to the child or youth's family. Items include donations such as clothing, food, or transportation assistance.

Outcomes

Aetna's intensive care management, rapid enrollment, and immediate access to crisis stabilization services promotes the FFPSA tenets of prevention and early intervention and supports the State's achievement of reduced fragmentation and optimal health outcomes for Ben and his family. Ben and his family are experiencing stability, safety, recovery, and family wellness. Josh's efforts have connected Ben, his grandparents, and his parents to accessible, timely care:

- **Ben is thriving in the following life domains**:
  - He is enjoying school again has less acting out episodes, and plays happily with other children
  - His grandparents report he is calm, expresses himself, and appears happy when in their home, and when he is not calm, they use the crisis and safety plan, de-escalation techniques and reach out to identified extended family and support
  - He is actively participating in visits with his parents; his grandparents schedule and attend all of Ben's EPSDT and BH appointments
- The **grandparents have the support and resources they need** to provide care and welcome the opportunity to provide future respite for Kerry and David when the family is back together
- Ben's parents, **David and Kerry**, have maintained sobriety, completed all court orders for family reunification, and are surrounded by extended family and their newfound, recovery community; both parents have relapse prevention plans that anticipate stressors

Future strategies include continued care management and assurance of integrated services and support that result in family strengthening, helping Ben build a family network for life, his **forever family**.

ATTACHMENT G: TERMS AND CONDITIONS RESPONSE TEMPLATE

1. INSTRUCTIONS

The Vendor should review ***Attachment G: 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 G: 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.

Randy J. Hyun — 8/13/19

Printed Name / Signature of Authorized Personnel — Date

Proprietary

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)***
- ***Section 7: 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.

Randy J. Hyun — 8/13/19

Printed Name / Signature of Authorized Personnel — Date

If the Vendor is <u>not taking exceptions</u> to any of the State Customary Terms and Conditions, then the Vendor needs to provide a binding signature stipulating its acceptance of these documents.

Randy J. Hyun — 8/13/19

Printed Name / Signature of Authorized Personnel — Date

Proprietary

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 D: Mandatory Requirements (attached Microsoft Excel file, ***Attachment D – Mandatory Requirements)***
- Attachment B, 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 jurisdiction in any venue other than the applicable court (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.

Randy J. Hyun — 8/13/19

Printed Name / Signature of Authorized Personnel — Date

Proprietary

5. COMMERCIAL MATERIALS

The Vendor should list any commercial and proprietary materials it will deliver that are easily copied, such as Commercial Software, and in which the State will have less than full ownership ("Commercial Materials"). Generally, these will be from third parties and readily available in the open market. The Vendor need not list patented parts of equipment.

This requirement is not applicable to Aetna Better Health® of West Virginia's proposal for this bid.

Proprietary

6. EXCEPTIONS

The Vendor should indicate exceptions to the State's Terms and Conditions in this RFP. 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 interests of the State.

The terms and conditions of a Vendor's software license, maintenance support agreement, and service level agreement, if applicable, will be required for purposes of contract negotiations for this project. Failure to provide the applicable Vendor terms, if any, as part of the RFP response may result in rejection of the Vendor's Proposal.[1]

Instructions: Identify and explain any exceptions to the State's terms and conditions using the tables provided below, adding tables, as needed. If no changes are listed, the Vendor is indicating that no changes to the Terms and Conditions are proposed, and that the Vendor intends to accept them as written if the Vendor's Proposal is selected. Mandatory Requirements and Terms noted in this RFP are non-negotiable.

- The Vendor may add additional tables, as appropriate.
- Do not submit Vendor's Standard Terms and Contracting Provisions in lieu of stipulating exceptions below.
- Making revisions to State statutes and regulations is prohibited.
- The State has no obligation to accept any exception(s).

[1] This requirement is not applicable to Aetna Better Health® of West Virginia's proposal for this bid.

Proprietary

6.1 Exception #1 – <Insert Title of Provision>

Document Title (Reference Specific Contractual Document and Section in Which Exception is Taken)	Vendor's Explanation (Required for Any Rejection/Exception)	Vendor's Proposed Alternative Language (If Applicable) Cross-Reference to specific section of Vendor's Terms, If Any Provided As Part of the RFP Response
NOTES/COMMENTS: <FOR STATE USE ONLY>		

Proprietary

6.2 Exception #2 – <Insert Title of Provision>

Document Title (Reference Specific Contractual Document and Section in Which Exception is Taken)	Vendor's Explanation (Required for Any Rejection/Exception)	Vendor's Proposed Alternative Language (If Applicable) Cross-Reference to specific section of Vendor's Terms, If Any Provided As Part of the RFP Response
NOTES/COMMENTS: <FOR STATE USE ONLY>		

Proprietary

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

Aetna Office Addresses	
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 708101527	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

Aetna Office Addresses	
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.

Appendix B

Aetna Better Health® of West Virginia Certificate of Authority..... App B-3

Aetna Better Health® of West Virginia
NCQA Accreditation Certificate..... App B-7

Specialized Managed Care for Children and Youth Project
Organizational Chart ..... App B-11

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

Aetna Better Health® of West Virginia NCQA Accreditation 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

Medicaid HMO

an accreditation status of

ACCREDITED NCQA HEALTH PLAN COMMENDABLE

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

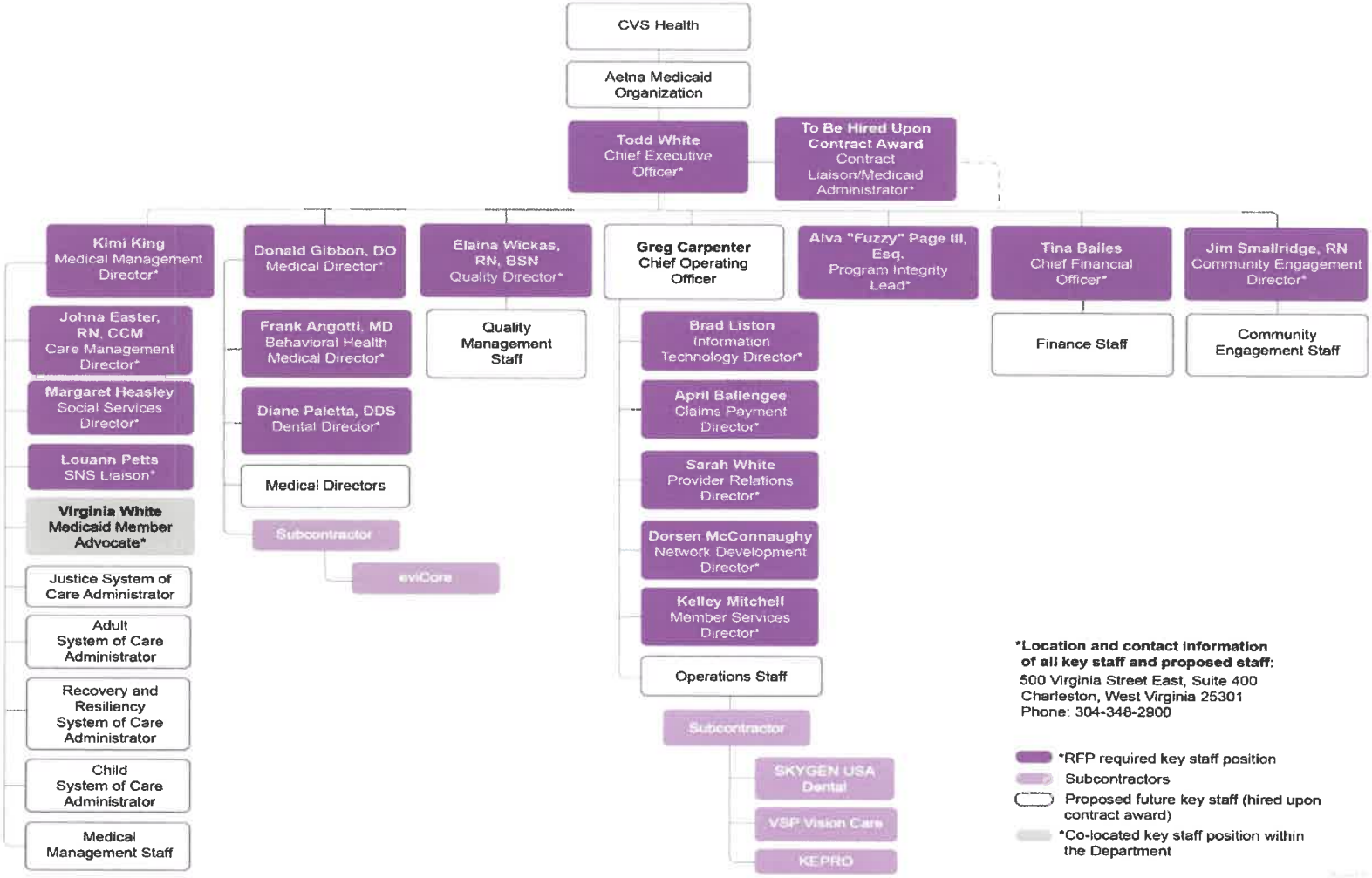
Margaret E. O'K
PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

October 18, 2016	*October 18, 2019*
DATE GRANTED	EXPIRATION DATE

Specialized Managed Care for Children and Youth
Project Organizational Chart

Specialized Managed Care for Children and Youth Project Organizational Chart



Regulatory Actions, Sanctions, and Other Compliance Actions

Regulatory Actions, Sanctions, and Other Compliance Actions

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
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

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	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
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

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	3/8/2018	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
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
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.

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	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.
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

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.	2/25/2019	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
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
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

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.	1/19/2018	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
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
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

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	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
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

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	10/30/2018	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
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

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	7/25/2018	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
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

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	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
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	Aetna Better Health of 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

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	10/20/2017	Reporting – encounter data	Sanction/Fine/Liquidated Damages	Refocus of priorities to contractual requirements	$373,469.17	Paid
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
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

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	8/10/2017	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
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

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	7/17/2017	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
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

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	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
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
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

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	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
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

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)/ MMP Product	9/28/2018	Other	Performance Measure Validation (PMV) audit which will look at the 2017 data for its MMP product. Final report issued on 12/12/18. Plan was found to be fully compliant	Re-educated staff on contractual requirements	$0	Closed
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
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

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)	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
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

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)	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
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

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)	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
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.
PA	Aetna Better Health	3/1/2018	DHS	Audit/Review	Refocus of priorities to contractual requirements	N/A	Final report pending

State	Contract/Program	Date of Action	Category	Description of Regulatory Actions	Plan of Correction	Monetary Sanction (if applicable)	Final Disposition
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
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.

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	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
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
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

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	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
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
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

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	8/14/2017	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
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

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.	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

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-21

AM Best rating for Aetna Better Health® of West Virginia ..... App D-35

Aetna Better Health® of West Virginia Capital Support Letter ..... App D-49

Dun and Bradstreet Rating for CVS Health

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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

Added to Portfolio: 01/31/2017

Endorsement: Diana.Fernandez@CVSHealt

Last View Date: 07/22/2019

Phone: 401-765-1500

Fax:

Web: www.cvshealth.com

Company Summary

SCORE BAR

PAYDEX® ↑	72	Paying 12 days past due
Commercial Credit Score Percentile ↓	57	Low to Moderate Risk of severe payment delinquency.
Financial Stress Score National Percentile ↓	44	Moderate Risk of severe financial stress.
D&B Viability Rating	1 3 A A	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

Portfolio Comparison

Portfolio Comparison : 3

Low Risk:1 ; High Risk:9

Data Depth Indicator

Data Depth Indicator : A

Predictive:A ; Descriptive:G

Company Profile:

A

Financial Data	Trade Payments	Company Size	Years in Business
Available	Available (3+Trade)	Large	Established

DETAILED TRADE RISK INSIGHT™

3 months from May-19 to Jul-19

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 **166** payment experiences reported from **60** companies.

D&B COMPANY OVERVIEW

This is a headquarters location

Do not confuse with subsidiaries with similar names.

Branch(es) or Division(s) exist	Gross Revenue	Chief Executive
Y	194579000000	LARRY J MERLO, PRES-CEO
Age (Year Started)	**Employees**	**History Status**
56 years (1963)	295000 (280 Here)	CLEAR
Net Worth	**Financing**	**Financial Condition**
58543000000	SECURED	FAIR
Stock Symbol	**SIC**	**Line of business**
CVS	5912 ,5961	Pharmacy health care services
NAICS		
446110		

PAYDEX® TREND CHART

STOCK PERFORMANCE

CVS 55.94 -0.57 ↓ (-1%)

Previous Close:	Volume:
56.5	5,480,915.00
Daily High:	Daily Low:
56.82	55.94
52-Week High:	52-Week Low:
82.16	51.73
P/E:	Market Cap:
N/A	72,671,212,074
EPS:	Div/Yield:
-0.47	3.58

FIRSTRAIN COMPANY NEWS Powered By FirstRain

Cvs Health Corp $CVS Technical Update Stock Traders Daily Jul 22, 2019
Google Inc.

CVS calls cops over Black woman?s voice tone Defender Network Jul 22, 2019
Google Inc.

CVS-Aetna Merger: AHF Urges Court to Stop the '800-pound Gorilla' Business Wire, Inc. Jul 21, 2019
Google Inc.

Court decision expected soon in CVS\Aetna merger Healthcare Finance News Jul 20, 2019
Google Inc.

CVS Health awards $2.9m in grants to free clinics Pharmacist.com Jul 19, 2019
Google Inc.

Clear Eyes, Target and OCuSOFT brands were among the latest eye ointment recalls caused by the same sterility concerns at Altaire Pharmaceuticals that caused Walmart, Walgreens and CVS store brands to be recalled. Napa Valley Register Jul 19, 2019
Google Inc.

Minnesota?s opioid epidemic requires collaborative solutions MinnPost Jul 19, 2019
Google Inc.

Clear/Cut Phocus Naturally Caffeinated

Sparkling Water Announcés National Availability At CVS Pharmacy New Kerala Jul 19, 2019
Google Inc.

Permalink to CVS Pharmacy names Murphy SVP, payer relations and managed care Chain Drug Review Jul 19, 2019
Google Inc.

CVS kicks off first trial of its home dialysis device FierceBiotech Jul 19, 2019
Google Inc.

16 Firms Going Ex-Dividend Next Week, Including CVS Health, Ford And Lowe?s Talk Markets Jul 19, 2019
Google Inc.

CVS Pharmacy names Kevin Murphy, Jr. to new leadership role Drug Store News Jul 19, 2019
Google Inc.

Patients are transforming from passive recipients of healthcare services to active participants in their own health (TGT, CVS, WMT) Stamford Advocate Jul 19, 2019
Google Inc.

CVS for Sale in Bogalusa, Louisiana listed by The Pharma Property Group Exclusively Market Watch Jul 18, 2019
Google Inc.

Owens Pharmacies in Red Bluff to move to CVS WN - WorldNews Jul 18, 2019
Google Inc.

CVS Health Eyes Home Dialysis Market With Telehealth Pilot Program mHealth Intelligence Jul 18, 2019
Google Inc.

CVS-Aetna merger will increase prescription drug costs for many U.S. PIRG Consumer Blog Jul 18, 2019
Google Inc.

Altaire Pharmaceuticals recalls eye care products sold at CVS Mandel Ngan/AFP/AFP/Getty Images Click On Detroit Jul 18, 2019
Google Inc.

Walgreens, CVS, and Walmart Lead the 25,000 Pharmacies Now Profiting From the 340B Program Drug Channels Jul 18, 2019
Google Inc.

CVS Health and the CVS Health Foundation Building Healthier Communities across the Country with Nearly $3 Million in New Grants to Free Clinics PR Newswire Jul 18, 2019
Google Inc.

CVS Health Applauds Expansion of Preventive Care Benefits for Health Savings Account Participants CVS Health Corporation Jul 17, 2019
Google Inc.

Independent downtown Farmington pharmacy competes with CVS metromode

Jul 17, 2019
Google Inc.

CVS launches clinical trial of new at-home dialysis care system that could be a game-changer ... WN - WorldNews Jul 17, 2019
Google Inc.

CVS moves into kidney dialysis market Beckers Hospital Review Jul 17, 2019
Google Inc.

Drug distributors down on opioid epidemic risk Seeking Alpha Jul 17, 2019
Google Inc.

Drugstore chain CVS developing home kidney dialysis device - CBS News CBS NEWS Jul 17, 2019
Google Inc.

CVS pushing into kidney dialysis with Segway inventor's help SFGate Jul 17, 2019
Google Inc.

CVS brand eye drops recalled because they may not be sterile TheIndyChannel.com Jul 17, 2019
Google Inc.

We compared beauty bargains at Dollar General and CVS ? and the dollar store came out on top Business Insider Malaysia Jul 17, 2019
Google Inc.

CVS Begins Trial for Home-Dialysis Device Toronto Star Jul 17, 2019
Google Inc.

CVS Health Announces Start of Clinical Trial for New Home Hemodialysis Device PR Newswire Jul 17, 2019
Google Inc.

Why the Justice Department Waved Through the CVS-Aetna Merger THE AMERICAN Prospect Jul 17, 2019
Google Inc.

Eyedrops sold at CVS recalled ArkLaTexHomepage.com Jul 17, 2019
Google Inc.

CONSUMER CATCH-UP: CVS recalls eyedrops, Apple warns of spoofed calls, and Tesla could become part of Walt Disney World ABC7 News Jul 16, 2019
Google Inc.

Right Now It Looks as If It Is Time for CVS Stock to Breakout Higher Daily Magazine Jul 16, 2019
Google Inc.

CVS is taking these eye drops off shelves over concerns the items aren't sterile enough 4029 News Jul 16, 2019
Google Inc.

Company recalls select eye drops, ointments at CVS News 12 Bronx Jul 16, 2019
Google Inc.

MIL-OSI USA: Teamsters Score Critical Legal Victory as First Step in Reversing

Rising Tide of Deadly Opioid Crisis
LiveNews NZ Jul 15, 2019
Google Inc.

PBMs poised to take back money they have already paid to Ohio pharmacists
Pharmacist.com Jul 15, 2019
Google Inc.

Nationwide eye drops recall now includes CVS KTVL CBS Channel 10 Jul 15, 2019
Google Inc.

Why CVS Health Stock Lost 17% Through the First Half of 2019 Motley Fool Jul 15, 2019
Google Inc.

Goodwipes brings V. Fresh wipes to CVS shelves Drug Store News Jul 15, 2019
Google Inc.

Baystreet.ca - CVS Health and Walgreens Soar BAYSTREET Jul 15, 2019
Google Inc.

CVS Stock Is a Buy as It Prepares to Take on Private Insurance Investor Place Jul 15, 2019
Google Inc.

CVS Health Eye Care Products Recalled
The Newtown Bee Jul 12, 2019
Google Inc.

CVS Declares Quarterly Dividend and Gets a Boost from Relaxed Rebate Policy CountingPips.Com Jul 12, 2019
Google Inc.

CVS Health Corp (CVS) To Go Ex-Dividend on July 24th MR Modern Readers Jul 12, 2019
Google Inc.

CVS brings MinuteClinic Video Visits to Connecticut Westfair Online Jul 12, 2019
Google Inc.

CVS Health (NYSE:CVS) Sees Unusually-High Trading Volume After Dividend Announcement Tech Know Bits Jul 12, 2019
Google Inc.

Rehmann Capital Advisory Group Reduces Position in CVS Health Corp (NYSE:CVS) Tech Know Bits Jul 11, 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	25	05/21/2019
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:

Portfolio Comparison
Compared to All US Businesses within the same MODEL SEGMENT:

- Model Segment : **Available Financial Data**
- Level of Risk: **Low Risk**
- Businesses ranked **3** within this model segment have a probability of becoming no longer viable: **0.2 %**

14 %

- Percentage of businesses ranked **3** with this model segment: **15** %
- 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.

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.

Company Profile:
Company Profile Details:

- Financial Data: **Available**
- Trade Payments: **Available: 3+Trade**
- Company Size: **Large: Employees:50+ or Sales: $500K+**
- Years in Business: **Established: 5+**

Financial Data	Trade Payments	Company Size	Years in Business
Available	Available: 3+Trade	Large	Established

CREDIT CAPACITY SUMMARY

This credit rating was assigned because of D&B's assessment of the company's creditworthiness. For more information, see the

D&B Rating Key

D&B Rating: 5A3	**Financial Strength:** 5A indicates 50 million and over	**Composite credit appraisal:** 3 is fair

The Rating was changed on March 8, 2019 because of changes in financial information, payment information, or other information about this business.

Number of Employees Total: 295,000 (280 here) (As of 31-Mar-19)	**Worth:** 58,543,000,000 (Up by 55.3% from last year) (As of 31-Mar-19) **Working Capital:** $1,234,000,000 (As of 31-Dec-18)

Payment Activity	**(based on 391 experiences)**
Average High Credit:	$544,128
Highest Credit:	$50,000,000
Total Highest Credit:	$145,311,350

Below is an overview of the company's rating history since 01-01-1991.

D&B Rating	Date Applied
5A3	03/08/2019
5A2	03/05/2019
5A3	09/26/2018
5A2	05/24/2001
5A3	04/23/1998
5A2	03/05/1996
5A1	01/01/1991

Note: The Worth amount in this section may have been adjusted by D&B to reflect typical deductions, such as certain intangible assets.

D&B CREDIT LIMIT RECOMMENDATION

Conservative credit Limit: 1,000,000

Aggressive credit Limit: 1,000,000

Risk category for this business: LOW

Risk category for this business: : LOW

The Credit Limit Recommendation (CLR) is intended to serve as a directional benchmark for all businesses within the same line of business or industry, and is not calculated based on any individual business. Thus, the CLR is intended to help guide the credit limit decision, and must be balanced in combination with other elements which reflect the individual company's size, financial strength, payment history, and credit worthiness, all of which can be derived from D&B reports.

Risk is assessed using D&Bs scoring methodology and is one factor used to create the recommended limits. See Help for details.

FINANCIAL STRESS CLASS SUMMARY

The Financial Stress Score predicts the likelihood of a firm ceasing business without paying all creditors in full, or reorganization or obtaining relief from creditors under state/federal law over the next 12 months. Scores were calculated using a statistically valid model derived from D&B's extensive data files.

The Financial Stress Class of 3 for this company shows that firms with this class had a failure rate of 0.24% (24 per 10,000), which is lower than the average of businesses in D & B's database

Financial Stress Class :

Financial Stress Class : 3

Low Risk:1 ; High Risk:5

Moderately lower than average risk of severe financial stress, such as a bankruptcy or going out of business with unpaid debt, over the next 12 months.

Probability of Failure:

- Risk of Severe Financial Stress for Businesses with this Class: **0.24**% (24 per 10,000)
- Financial Stress National Percentile : **44** (Highest Risk: 1; Lowest Risk: 100)

- Financial Stress Score : **1471** (Highest Risk: 1,001; Lowest Risk: 1,875)
- Average Risk of Severe Financial Stress for Businesses in D&B database: **0.48%** (48 per 10,000)

The Financial Stress Class of this business is based on the following factors:

- Low proportion of satisfactory payment experiences to total payment experiences.
- High proportion of slow payment experiences to total number of payment experiences.
- High proportion of past due balances to total amount owing.
- UCC Filings reported.
- High number of inquiries to D & B over last 12 months.

Financial Stress Percentile Trend:

Notes:

- The Financial Stress Class indicates that this firm shares some of the same business and financial characteristics of other companies with this classification. It does not mean the firm will necessarily experience financial stress.
- The Probability of Failure shows the percentage of firms in a given Class that discontinued operations over the past year with loss to creditors. The Probability of Failure - National Average represents the national failure rate and is provided for comparative purposes.
- The Financial Stress National Percentile reflects the relative ranking of a company among all scorable companies in D&B's file.
- The Financial Stress Score offers a more precise measure of the level of risk than the Class and Percentile. It is especially helpful to customers using a scorecard approach to determining overall business performance.

Norms	National %
This Business	44
Region: NORTHEAST	48
Industry: GENERAL RETAIL	49
Employee range: 500+	61
Years in Business: 26+	77

This Business has a Financial Stress Percentile that shows:

- Higher risk than other companies in the same region.
- Higher risk than other companies in the same industry.
- Higher risk than other companies in the same employee size range.
- Higher risk than other companies with a comparable number of years in business.

CREDIT SCORE SUMMARY

The Commercial Credit Score (CCS) predicts the likelihood of a business paying its bills in a severely delinquent manner (91 days or more past terms).

The Credit Score class of 3 for this company shows that 5.8% of firms with this class paid one or more bills severely delinquent, which is lower than the average of businesses in D & B's database.

Credit Score Class :

Credit Score Class : 3

Low Risk:1 ; High Risk:5

Moderate risk of severe payment delinquency over next 12 months.

Incidence of Delinquent Payment

- Among Companies with this Classification: **5.80%**
- Average compared to businesses in D&B's database: **10.20%**
- Credit Score Percentile : **57** (Highest Risk: 1; Lowest Risk: 100)
- Credit Score : **507** (Highest Risk: 101; Lowest Risk: 670)

The Credit Score Class of this business is based on the following factors:

- Proportion of slow payments in recent months
- Proportion of past due balances to total amount owing
- Total Liabilities to Net Worth influencing the score
- Evidence of open suits, liens, and judgments

Credit Score Class Percentile Trend:

Notes:

- The Commercial Credit Score Risk Class indicates that this firm shares some of the same business and financial characteristics of other companies with this classification. It does not mean the firm will necessarily experience severe delinquency.
- The Incidence of Delinquent Payment is the percentage of companies with this classification that were reported 91 days past due or more by creditors. The calculation of this value is based on D&B's trade payment database.
- The Commercial Credit Score percentile reflects the relative ranking of a firm among all scorable companies in D&B's file.
- The Commercial Credit Score offers a more precise measure of the level of risk than the Risk Class and Percentile. It is especially helpful to customers using a scorecard approach to determining overall business performance.

Norms	National %
This Business	57
Region: NORTHEAST	62
Industry: GENERAL RETAIL	49
Employee range:	UN
Years in Business: 26+	85

This business has a Credit Score Percentile that shows:

- Higher risk than other companies in the same region.
- Lower risk than other companies in the same industry.
- Higher risk than other companies with a comparable number of years in business.

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Customer's rights to use the Services are as described in the government contract signed between D&B and the Government

Under no circumstances will the Customer accessing the Services have greater rights in the Services provided hereunder than "Limited Rights" as that term is defined in FAR 52.227-14 (ALT II) and DFAR 252.227-7013(f) and "Restricted Rights" as that term is defined in FAR 52.227-14 (ALT III) and DFAR 252.227-7014(f), respectively.

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Dun and Bradstreet Rating for Coventry Health Care of West Virginia, Inc. dba Aetna Better Health® of West Virginia

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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 SINGLE (SUBSIDIARY)

Endorsement: Diana.Fernandez@CVSHealt

Type:

Phone: 304-348-2900

Fax:

Web: www.cvshealth.com

Company Summary

SCORE BAR

PAYDEX®

Commercial Credit Score Percentile	75	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 2 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 : 2

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	28 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 RI 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 **2** within this model segment have a probability of becoming no longer viable: **3 %**
- Percentage of businesses ranked **2** with this model segment: **16** %
- 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.

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.

Company Profile:

Company Profile Details:

- Financial Data:
- Trade Payments:
- Company Size: **null**
- Years in Business:

Subsidiary

CREDIT CAPACITY SUMMARY

This credit rating was assigned because of D&B's assessment of the company's creditworthiness. For more information, see the

D&B Rating Key

D&B Rating: --

The blank rating symbol should not be interpreted as indicating that credit should be denied. It simply means that the information available to D&B does not permit us to classify the company within our rating key and that further enquiry should be made before reaching a decision. Some reasons for using a "-" symbol include: deficit net worth, bankruptcy proceedings, insufficient payment information, or incomplete history information.

Number of Employees Total:

Payment Activity	**(based on 3 experiences)**
Highest Credit:	$50
Total Highest Credit:	$150

Below is an overview of the company's rating history since 02-13-2018.

D&B Rating	Date Applied
--	02/13/2018

D&B CREDIT LIMIT RECOMMENDATION

Risk category for this business: : LOW

Conservative credit Limit: 1,000

Aggressive credit Limit: 5,000

Risk category for this business: LOW

The Credit Limit Recommendation (CLR) is intended to serve as a directional benchmark for all businesses within the same line of business or industry, and is not calculated based on any individual business. Thus, the CLR is intended to help guide the credit limit decision, and must be balanced in combination with other elements which reflect the individual company's size, financial strength, payment history, and credit worthiness, all of which can be derived from D&B reports.

Risk is assessed using D&Bs scoring methodology and is one factor used to create the recommended limits. See Help for details.

FINANCIAL STRESS CLASS SUMMARY

The Financial Stress Score predicts the likelihood of a firm ceasing business without paying all creditors in full, or reorganization or obtaining relief from creditors under state/federal law over the next 12 months. Scores were calculated using a statistically valid model derived from D&B's extensive data files.

The Financial Stress Class of 3 for this company shows that firms with this class had a failure rate of 0.24% (24 per 10,000), which is lower than the average of businesses in D & B's database

Financial Stress Class :

Financial Stress Class : 3

Low Risk:1 ; High Risk:5

Moderately lower than average risk of severe financial stress, such as a bankruptcy or going out of business with unpaid debt, over the next 12 months.

Probability of Failure:

- Risk of Severe Financial Stress for Businesses with this Class: **0.24**% (24 per 10,000)
- Financial Stress National Percentile : **51** (Highest Risk: 1; Lowest Risk: 100)
- Financial Stress Score : **1478** (Highest Risk: 1,001; Lowest Risk: 1,875)
- Average Risk of Severe Financial Stress for Businesses in D&B database: **0.48**% (48 per 10,000)

The Financial Stress Class of this business is based on the following factors:

- Low proportion of satisfactory payment experiences to total payment experiences.

Financial Stress Percentile Trend:

Notes:

- The Financial Stress Class indicates that this firm shares some of the same business and financial characteristics of other companies with this classification. It does not mean the firm will necessarily experience financial stress.
- The Probability of Failure shows the percentage of firms in a given Class that discontinued operations over the past year with loss to creditors. The Probability of Failure - National Average represents the national failure rate and is provided for comparative purposes.
- The Financial Stress National Percentile reflects the relative ranking of a company among all scorable companies in D&B's file.
- The Financial Stress Score offers a more precise measure of the level of risk than the Class and Percentile. It is especially helpful to customers using a scorecard approach to determining overall business performance.

Norms	National %
This Business	51
Region: SOUTH ATLANTIC	48
Industry: HEALTH CARE SERVICES	58
Employee range:	UN
Years in Business: 26+	77

This Business has a Financial Stress Percentile that shows:

- Lower risk than other companies in the same region.
- Higher risk than other companies in the same industry.
- Higher risk than other companies with a comparable number of years in business.

CREDIT SCORE SUMMARY

The Commercial Credit Score (CCS) predicts the likelihood of a business paying its bills in a severely delinquent manner (91 days or more past terms).

The Credit Score class of 2 for this company shows that 2.5% of firms with this class paid one or more bills severely delinquent, which is lower than the average of businesses in D & B's database.

Credit Score Class :

Credit Score Class : 2

Low Risk:1 ; High Risk:5

Moderate risk of severe payment delinquency over next 12 months.

Incidence of Delinquent Payment

- Among Companies with this Classification: **2.50**%
- Average compared to businesses in D&B's database: **10.20**%
- Credit Score Percentile : **75** (Highest Risk: 1; Lowest Risk: 100)
- Credit Score : **536** (Highest Risk: 101; Lowest Risk: 670)

The Credit Score Class of this business is based on the following factors:

- No payment experiences reported
- Higher risk industry based on delinquency rates for this industry
- Limited business activity signals reported in the past 12 months

Credit Score Class Percentile Trend:

Notes:

- The Commercial Credit Score Risk Class indicates that this firm shares some of the same business and financial characteristics of other companies with this classification. It does not mean the firm will necessarily experience severe delinquency.
- The Incidence of Delinquent Payment is the percentage of companies with this classification that were reported 91 days past due or more by creditors. The calculation of this value is based on D&B's trade payment database.
- The Commercial Credit Score percentile reflects the relative ranking of a firm among all scorable companies in D&B's file.
- The Commercial Credit Score offers a more precise measure of the level of risk than the Risk Class and Percentile. It is especially helpful to customers using a scorecard approach to determining overall business performance.

Norms	National %
This Business	75
Region: SOUTH ATLANTIC	43
Industry: HEALTH CARE SERVICES	69
Employee range:	UN
Years in Business: 26+	85

This business has a Credit Score Percentile that shows:

- Lower risk than other companies in the same region.
- Lower risk than other companies in the same industry.
- Higher risk than other companies with a comparable number of years in business.

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14 (ALT III) and DFAR 252.227-7014(f), respectively.

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AM Best rating for Aetna Better Health® of West Virginia

BEST'S CREDIT REPORT

Coventry Health Care of West Virginia, Inc.

Charleston, West Virginia, United States 25301
Exec. Office: 9881 Mayland Drive, Richmond, Virginia, United States 23233

AMB #: 064186 **NAIC #:** 95408 **FEIN#:** 55-0712129

Phone: 804-747-3700 **Fax:** 804-346-4057 **Website:** www.cvty.com

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Coventry Health Care of West Virginia, Inc.

Credit Report

Report Release Date:
November 29, 2018

Rating Effective Date:
November 29, 2018

Disclosure Information: View A.M. Best's Rating Disclosure Form

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Ultimate Parent: 058700 - Aetna Inc.
A.M. Best Rating Unit: 069015 - Aetna Health & Life Group

Best's Credit Ratings:

Rating Effective Date: November 29, 2018

Best's Financial Strength Rating:	A	**Outlook:**	Stable	**Action:**	Affirmed
Best's Issuer Credit Rating:	a	**Outlook:**	Stable	**Action:**	Affirmed

Five Year Credit Rating History:

	Best's Financial Strength Ratings			Best's Issuer Credit Ratings		
Date	**Rating**	**Outlook**	**Action**	**Rating**	**Outlook**	**Action**
11/29/2018	A	Stable	Affirmed	a	Stable	Affirmed
08/22/2018	A	Stable	Affirmed	a	Stable	Affirmed
12/06/2017	A u	Negative	Under Review	a u	Negative	Under Review
06/22/2016	A	Stable	Affirmed	a	Stable	Affirmed
07/07/2015	A u	Negative	Under Review	a u	Negative	Under Review
06/12/2015	A	Stable	Affirmed	a	Stable	Affirmed
06/19/2014	A	Stable	Affirmed	a	Stable	Affirmed

Rating Rationale:

Coventry Health Care of West Virginia, Inc. (CHCWV), is a member of Aetna Health & Life Group and as such provides the Aetna/CVS Health organization with rate flexibility and geographic diversification to offer products regionally. Additionally, CHCWV benefits from th financial flexibility of its ultimate parent, Aetna Inc./CVS Health.

For more detail regarding the Rating Rationale and Best's Credit Report for the Rating Unit, view Aetna Health & Life Group (AMB# 069015).

Financial Data Notes:

Time Period: Annual - 2017 **Status:** A.M. Best Quality Cross Checked

Key Financial Indicators:

Key Financial Indicators (000)

	Year End - December 31				
	2017	2016	2015	2014	2013
Assets	148,747	170,962	120,522	96,793	78,298
Policyholders' Surplus	68,154	72,514	64,512	57,418	44,399
Net Premiums Written	552,638	548,838	342,792	297,688	235,059
Total Revenues	559,272	548,667	344,763	299,379	236,099
Net Income	12,624	22,589	18,554	30,964	17,323

Source: Bestlink - Best's Statement File - Health, US

Key Financial Indicators - A.M. Best Ratios (%)

	Year End - December 31				
	2017	2016	2015	2014	2013
Profitability					
Loss Ratio	90.5	86.1	83.4	76.6	79.0
Administrative Expense Ratio	7.3	7.6	7.9	8.5	10.2
Combined Ratio	97.8	93.7	91.3	85.1	89.2

Source: Bestlink - Best's Statement File - Health, US

(*) Within several financial tables of this report, this company is compared against the Total US Life & Health HMO Medical Companies.
(*) Data reflected within all tables of this report has been compiled from the company-filed statutory statement.

Credit Analysis:

Balance Sheet Strength

Capitalization:

Capital Generation Analysis

	Year End - December 31				
	2017	2016	2015	2014	2013
Pre-tax Net Operating Gain ($000)	15,870	34,367	31,727	46,130	26,332
Realized Capital Gains ($000)	32	361	-231	38	41
Income Taxes ($000)	3,278	12,139	12,942	15,205	9,050
Unrealized Capital Gains ($000)	15	162	-18	-26	-26
Net Contributed Capital ($000)	-15,000	-15,000	-15,000	-17,000	-10,400
Other Changes ($000)	-1,999	251	3,559	-919	516
Change in Capital & Surplus ($000)	-4,360	8,002	7,095	13,019	7,412
Change in Capital & Surplus (%)	-6.0	12.4	12.4	29.3	20.0

Source: Bestlink - Best's Statement File - Health, US

Liquidity Analysis

	Year End - December 31				
	2017	2016	2015	2014	2013
Premium Receivable Turnover (months)	0.2	1.0	0.6	0.2	0.2
Cash to Claims & Payables (%)	230.8	165.8	219.0	325.5	314.8
Claims to Net Premiums Earned (%)	9.5	11.7	12.8	8.7	9.6
Health Average Claims Pay Period (days)	39.2	50.7	56.7	42.3	47.5
Total Health IBNR Pay Period (days)	39.2	50.7	56.7	42.3	47.4

Liquidity Ratios (%)

	Company					Industry Composite				
	Year End - December 31					Year End - December 31				
	2017	2016	2015	2014	2013	2017	2016	2015	2014	2013
Current liquidity	153.7	118.8	173.7	216.4	214.2	82.9	85.8	82.7	78.5	89.0
Overall Liquidity	184.6	173.7	215.2	245.8	231.0	171.8	171.3	169.7	167.8	190.4

Source: Bestlink - Best's Statement File - Health, US
Industry Composite: Total US Life & Health HMO Medical Companies - Bestlink - Best's Statement File - Health, US

Capitalization: (Continued...)

Leverage Analysis

	Year End - December 31				
	2017	2016	2015	2014	2013
Equity Per Member Per Month ($)	42.39	47.28	55.55	55.49	48.37

	Company					Industry Composite				
	Year End - December 31					Year End - December 31				
	2017	2016	2015	2014	2013	2017	2016	2015	2014	2013
Net Premiums Written to Capital	8.1	7.6	5.3	5.2	5.3	5.3	5.5	5.5	5.3	4.6
Capital & Surplus to Total Liabilities	84.6	73.7	115.2	145.8	131.0	71.8	71.3	69.7	67.8	90.4

Source: Bestlink - Best's Statement File - Health, US
Industry Composite: Total US Life & Health HMO Medical Companies - Bestlink - Best's Statement File - Health, US

Asset Liability Management – Investments:

Bond Portfolio - 2017 Bonds Distribution by Maturity (%)

	Years					Years Average
	0-1	1-5	5-10	10-20	20+	Maturity
Government	0.6	5.4	...	...	...	2.8
Govt Agencies	3.0	7.9	21.3	5.9	2.2	8.2
Industry & Miscellaneous	9.1	34.8	8.7	1.2	...	3.6
Total	12.6	48.0	30.0	7.1	2.2	5.4

Source: Bestlink - Best's Statement File - Health, US

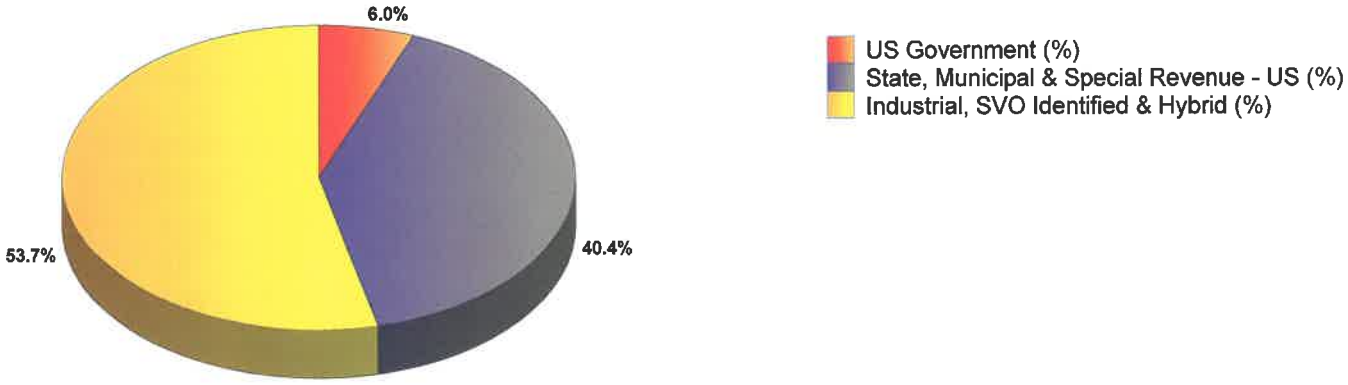
Bond Distribution by Issuer Type

	Year End - December 31				
	2017	2016	2015	2014	2013
Bonds ($000)	124,482	93,187	97,165	69,252	50,570
US Government (%)	6.0	9.6	11.6	2.3	1.2
Foreign Government (%)	...	1.1	1.0	1.4	2.0
State, Municipal & Special Revenue - US (%)	40.4	46.9	40.0	56.7	48.9
Industrial, SVO Identified & Hybrid (%)	53.7	42.5	47.4	39.6	47.9

Source: Bestlink - Best's Statement File - Health, US

Asset Liability Management – Investments: (Continued...)

2017 Bond Distribution By Issuer Type



Source: Bestlink - Best's Statement File - Health, US

Operating Performance

Underwriting Results:

Profitability Test (%)

	Year End - December 31					
	2017	2016	2015	2014	2013	5-YR Avg/Total
Net Operating Gains to Total Assets	7.9	15.3	17.3	35.3	23.5	17.7
Net Operating Gains to Total Revenues	2.3	4.1	5.4	10.3	7.3	5.1
Operating Return on Equity	17.9	32.4	30.8	60.7	42.5	34.9
Net Yield	2.78	2.17	2.18	1.82	1.60	2.19
Pre-tax Invest Total Return	2.82	2.90	1.78	1.84	1.67	2.31

Source: Bestlink - Best's Statement File - Health, US

Net Underwriting Gains ($000)

	Year End - December 31				
	2017	2016	2015	2014	2013
Comprehensive	39	120	198	7,915	8,916
Medicare	3,526	5,724	308	-825	-712
Medicaid	9,017	26,241	29,128	37,481	17,08[illegible]
Other health	-51	-13	116	123	...
Total	12,531	32,071	29,751	44,694	25,292

Underwriting Results: (Continued...)

Source: Bestlink - Best's Statement File - Health, US

Business Profile

The following text is derived from Best's Credit Report on Aetna Health & Life Group (AMB# 069015):

Aetna life and health entities, including Aetna Life Insurance Company (ALIC), Aetna Health and Life Insurance Company, Aetna Health Insurance Company, Aetna Health Insurance Company of New York, First Health Life & Health Insurance Company, and number of Aetna health and dental maintenance organizations in multiple states provide individual and group coverage throughout the United States. Aetna Life and Casualty (BM) Ltd. is a Bermuda domiciled company that provides health insurance benefits to expatriate employees. The business profile for these companies is favorable.

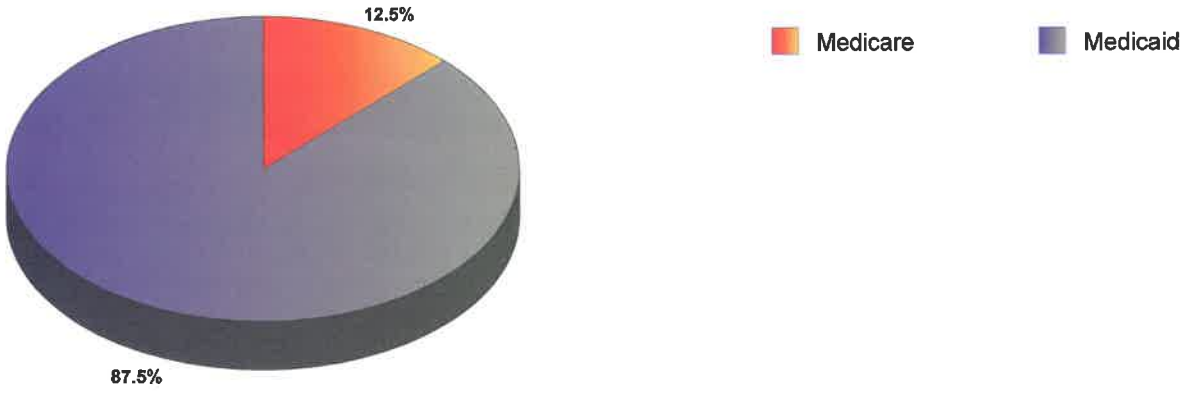
The Aetna organization is one of the nation's leading providers of employee health insurance benefits. Aetna has a nationwide customer base, broad provider networks and a comprehensive product portfolio. Aetna's medical membership was approximately 22.2 million members as of year end 2017, and is geographically dispersed across the United States and internationally serving the needs of an estimated 38 million people. The market share position varies by segment and is in the top five nationally for group commercial (both self-insured and full risk) and Medicare Advantage. Aetna markets its products to employer groups, ranging from large multi-site national accounts to mid-sized and small-employer groups, as well as individuals, college students, part-time and hourly workers, government sponsored plans, labor groups and expatriates. The company has one of the most expansive nationwide provider networks. Within the health segment, Aetna is active in commercial, Medicare, Medicaid and international health markets. The commercial segment's membership has fluctuated over the last three years, as Aetna entered and later exited multiple ACA exchange markets. More recently, Medicaid enrollment has been affected by the loss of several contracts, while Medicare product has experienced steady growth. Aetna has grown the geographic footprint of its Medicare Advantage products with 60% of Medicare beneficiaries having access to Aetna products in 2018 compared to 45% in 2015. Aetna targets further expansion of its government programs, and expects commercial segment membership to remain flat or decline slightly. In November 2017, Aetna sold its Group segment (employer paid life and disability products, primarily written at ALIC) to Hartford Life and Accident Insurance Company.

In early 2017, Aetna's intention to acquire Humana Inc. (Humana) and significantly increase its share in the Medicare Advantage market was blocked by the Department of Justice on antitrust grounds. Aetna initially announced its intention to acquire Humana in mid-2015. This Department of Justice decision indicated a limitation on Aetna's ability for large-scale horizontal growth through new acquisitions in the near to medium term. The organization shifted its strategy to becoming a leader in personalized data driven health care delivery by building partnerships within local communities and outreach to members empowered by strong digital platform. Aetna has focused on creating partnerships with providers to allow for efficient and cost-effective care delivery. Approximately half of Aetna's medical expenses are through value based models which Aetna plans to expand in the next several years.

Aetna envisions the company eventually evolving into a health care logistics organization where the relationship with members and understanding of their needs coupled with localized health care delivery capabilities will ensure better outcomes at a lower cost. That will be achieved in part through the impact on members' health through data driven behavioral and lifestyle changes. Aetna has begun building an information technology platform to support that strategy. The pending transaction with CVS Health is in line with Aetna's strategy to build a vertically integrated healthcare delivery model focused on localized healthcare delivery. CVS Health clinics and retail footprint may allow the combined organization to further develop customer interactions and lower the cost of healthcare services.

Prior to 2015, Aetna had a history of successful expansion through large and mid-size acquisitions both in the U.S. and globally. In 2013, Aetna completed its largest acquisition of Coventry Health Care, Inc. (Coventry). The acquisition allowed Aetna to gain Coventry's government program expertise, increased the scope of Aetna operations into new geographies, and to gain a stronger presence in Medicare Advantage and Medicaid programs. A number of the Coventry entities have been merged into other Aetna companies where its market segment and businesses overlapped and have successfully integrated to create operational efficiencies within the organization. Aetna has actively strengthened its capabilities through other smaller acquisitions to support its strategy for growth and profitability in the Health Care segment. These acquisitions have included: Medicity, Prodigy Health Group, PayFlex Holdings, InterGlobal, bSwift and companies that write primarily Medicare Supplement business. These transactions have effectively supported a greater long term strategy to strengthen Aetna's core service capabilities and expanded its presence both within the United States and internationally.

2017 Top Product Lines of Business (Net Premiums Written)



Source: Bestlink - Best's Statement File - Health, US

2017 By-Line Business

	Direct Premiums Written		Reinsurance Premiums Assumed		Reinsurance Premiums Ceded		Net Premiums Written	
Product Line	**($000)**	**(%)**	**($000)**	**(%)**	**($000)**	**(%)**	**($000)**	**(%)**
Comprehensive	-79	...	...	...	...	...	-79	...
Medicare	69,394	12.5	...	...	499	25.7	68,895	12.5
Medicaid	485,267	87.5	...	...	1,445	74.3	483,823	87.5
Total	554,582	100.0	...	...	1,944	100.0	552,638	100.0

Source: Bestlink - Best's Statement File - Health, US

Geographical Breakdown By Direct Premium Writings

	2017	2016	2015	2014	2013
West Virginia	554,582	549,524	342,796	297,701	237,737
Total	554,582	549,524	342,796	297,701	237,737

Source: Bestlink - Best's Statement File - Health, US

Financial Statements:

Balance Sheet:

Balance Sheet:

Admitted Assets	Year End - December 31	
	2017 ($000)	2016 ($000)
Bonds	124,482	93,187
Common Stocks	915	1,394
Mortgage Loans	3,473	...
Cash & short-term investments	-2,760	12,379
Receivables for securities	...	9,125
Net Deferred Tax Asset	...	...
Premiums & consideration due	17,135	49,866
Healthcare & other receivables	...	...
Receivable from affiliates	...	...
Accrued investment income	1,141	833
Other Assets	4,362	4,179
Total Assets	148,747	170,962

Liabilities & Surplus	Year End - December 31	
	2017 ($000)	2016 ($000)
Claims payable	53,138	64,495
Unpaid claims adjustment expenses	1,024	1,008
Accrued medical incentive pool	2,114	2,553
Advance premiums	...	...
Commissions, taxes & expenses	1,119	6,768
Health policy reserves	997	...
Health claim reserves	...	...
Payable to affiliates	21,310	19,112
Payable for securities	...	3,773
Payable for securities lending	...	...
Other liabilities	891	738
Total liabilities	80,593	98,448
Common stock	1,000	1,000
Paid in and contributed capital	84,841	84,841
Unassigned surplus	-28,870	-13,326
Other surplus	11,183	...
Total liabilities and Capital & Surplus	148,747	170,962

Source: Bestlink - Best's Statement File - Health, US

Summary of Operations:

Summary of Operations (000)

Income	2017 ($000)	Expenses	2017 ($000)
Net premium income	555,932	Increase in accident & health reserves	...
Fee-for-service	...	Hospital/medical services	344,458
Risk revenue	...	Other professional services	25,685
Net investment income	3,348	Outside referrals	2,796
Net gain/loss from agents balances	...	Emergency room and out of area	32,818
Other revenues	-8	Prescription drugs	89,278
		Incentive pool & withheld adjustments	8,472
		Other medical & hospital expenses	...
		Net reinsurance recoveries	659
		General administrative expenses	25,310
		Other expenses	15,243
Total revenue	559,272	Total expenses	543,401
		Pre-tax operating income	15,870
		Federal income tax	3,278
		Net operating income	12,592

Source: Bestlink - Best's Statement File - Health, US

Coventry Health Care of West Virginia, Inc.

Report Revision Date:
July 3, 2019

Company Attributes:

Industry:	Insurance
Business Type:	Health - Medical HMO
Entity Type:	Operating Company
Organization Type:	Stock
Business Status:	In Business - Actively Underwriting
Marketing Type:	Broker
Financial Size:	XV ($2 Billion or greater)

Company History:

Date Incorporated: 08/11/1994 **Date Commenced:** 01/02/1995 **Domicile:** United States: West Virginia

ompany Operations:

Licensed Territory: (Current since 04/08/2015).The company is licensed in West Virginia.

2018 Rank	Top 5 Lines of Business by NPW	
1	Medicaid	88.9%
2	Medicare	11.1%

Source: Bestlink - Best's Statement File - Health, US

2018 Rank	Top 5 Geographic Distribution by DPW	
1	United States: WV	100.0%

Company Management:

Last significant update on 01/22/2019

Officers

CFO: Debra J. Bacon
Chief Investment Officer: Kevin J. Casey
Controller: Frank F. Chronister III (Corporate)
President and CEO: Laurie A. Brubaker
Vice President and Treasurer: John P. Maroney
Vice President and Secretary: Robert M. Kessler

Company Management: (Continued...)

Directors

Debra J. Bacon
Laurie A. Brubaker
Mary L. E. Osborne

Regulatory:

Auditor: KPMG, LLP

An examination of the financial condition was made as of December 31, 2015, by the insurance department of West Virginia. The 2018 annual independent audit of the company was conducted by KPMG, LLP. The annual statement of actuarial opinion is provided by William R. Jones, FSA, MAAA, Valuation Actuary.

Additional Resources:

Related News
Rating Activity and Announcements
Company Overview
Archived Best's Credit Report
Corporate Changes & Retirements
BestAlert Service
Best's Credit Ratings Mobile Application

A Best's Financial Strength Rating opinion addresses the relative ability of an insurer to meet its ongoing insurance obligations. The ratings are not assigned to specific insurance policies or contracts and do not address any other risk, including, but not limited to, an insurer's claims-payment policies or procedures; the ability of the insurer to dispute or deny claims payment on grounds of misrepresentation or fraud; or any specific liability contractually borne by the policy or contract holder. A Financial Strength Rating is not a recommendation to purchase, hold or terminate any insurance policy, contract or any other financial obligation issued by an insurer, nor does it address the suitability of any particular policy or contract for a specific purpose or purchaser.

A Best's Issue/Issuer Credit Rating is an opinion regarding the relative future credit risk of an entity, a credit commitment or a debt or debt-like security.

Credit risk is the risk that an entity may not meet its contractual, financial obligations as they come due. These credit ratings do not address any other risk, including but not limited to liquidity risk, market value risk or price volatility of rated securities. The rating is not a recommendation to buy, sell or hold any securities, insurance policies, contracts or any other financial obligations, nor does it address the suitability of any particular financial obligation for a specific purpose or purchaser.

In arriving at a rating decision, A.M. Best relies on third-party audited financial data and/or other information provided to it. While this information is believed to be reliable, A.M. Best does not independently verify the accuracy or reliability of the information. Any and all ratings, opinions and information contained herein are provided "as is," without any express or implied warranty.

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Aetna Better Health® of West Virginia Capital Support Letter

aetna™

July 10, 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 December 31, 2020.

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
Vice President and Secretary
Aetna Health Holdings, LLC

Appendix E

Sample Subcontractor Metrics Tracking Report from
Current Subcontractors Q4 2018 .....App E-3

First Choice Subcontractor Agreement.....App E-13

SkyGen/Scion Dental Subcontractor Agreement.....App E-21

Vision Service Plan, Inc. Subcontractor Agreement.....App E-39

Regulatory Compliance Addendum .....App E-87

Attached are three 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 E, page 87. For any proposed new subcontractors such as KEPRO, we will provide the Department with the Subcontractor agreement within the timeframe required.

Sample Subcontractor Metrics Tracking Report from Current Subcontractors Q4 2018

EVI RE

Performance Measure	Oct 2018	Nov 2018	Dec 2018	Q4	2018 YTD Totals	Performance Standard Met?	Corrective Actions Planned if needed	Notes
CUSTOMERS SERVICES								
Total cases received	547	493	411	1451	4588	Yes		
Total calls answered	542	493	411	1446	4565	Yes		
Number of calls abandoned	5	0	0	5	23	Yes		
ASA in seconds	11.46	5.46	6.17	7.7	9.14	Yes		
Answer Rate (w/i 30 sec)	89.20%	99.60%	99.50%	95.03%	93.16%	Yes		
Average abandonment rate	0.90%	0.00%	0.00%	0.30%	0.49%	Yes		
CLAIMS PROCESSING TURNAROUND TIMES / ACCURACY								
Claim Age When Processed (1-30 days)	N/A	N/A	N/A	N/A	N/A			
Claim Age When Processed (31-45 days)	N/A	N/A	N/A	N/A	N/A			
Claim Age When Processed (46 - 60 days)	N/A	N/A	N/A	N/A	N/A			
Claim Age When Processed (61 + days)	N/A	N/A	N/A	N/A	N/A			
Interest Paid	N/A	N/A	N/A	N/A	N/A			
Claims adjudication financial accuracy*	N/A	N/A	N/A	N/A	N/A			
Claims adjudication overall accuracy*	N/A	N/A	N/A	N/A	N/A			
CLAIMS DATA / ELECTRONIC /PAPER								
Total # of Claims Received	N/A	N/A	N/A	N/A	N/A			
% Electronic Claims	N/A	N/A	N/A	N/A	N/A			
% Paper Claims	N/A	N/A	N/A	N/A	N/A			
NETWORK ADEQUACY								
Number of Providers Credentialed*	N/A	N/A	N/A	N/A	N/A			

EVICORE

Performance Measure	Oct 2018	Nov 2018	Dec 2018	Q4	2018 YTD Totals	Performance Standard Met?	Corrective Actions Planned if needed	Notes
Number of Providers Re-Credentialed*	N/A	N/A	N/A	N/A	N/A			
Geo Access								
COMPLAINT SUMMARY	N/A	N/A	N/A	N/A	N/A			
Turn around time for response to member complaints*								
Provider appeals*								
Provider Appointment Survey	N/A	N/A	N/A	N/A	N/A			
Appointment waiting time for Emergency Care*								
Number of offices contacted								
Number completed								
Number of compliant providers								
Total number of providers surveyed								
Appointment waiting time for Urgent Care*								
Number of offices contacted								
Number completed								
Number of compliant providers								
Total number of providers surveyed								
Appointment waiting time for routine Care*								
Number of offices contacted								
Number completed								
Number of compliant providers								
Total number of providers surveyed								
UM	2061	1857	1436	5354	17300	Yes		
IRR	N/A	N/A	N/A	N/A	N/A			
General Clinical Review Specialists	N/A	N/A	N/A	N/A	N/A			

Performance Measure	Oct 2018	Nov 2018	Dec 2018	Q4	2018 YTD Totals	Performance Standard Met?	Corrective Actions Planned if needed	Notes
General Dental Directors	N/A	N/A	N/A	N/A	N/A			
Ortho Clinical Review Specialists	N/A	N/A	N/A	N/A	N/A			
Ortho Dental Directors	N/A	N/A	N/A	N/A	N/A			
UM Prior Auth Tat	N/A	N/A	N/A	N/A	N/A			
UM Retro Auth TAT	N/A	N/A	N/A	N/A	N/A			
% Approved	81.08%	79.11%	83.64%	81.28%	89.39%	Yes		
% Admin Denied	0.18%	0.20%	0.16%	0.18%	0.51%	Yes		
% Clinical Denied	17.95%	20.69%	16.20%	18.28%	15.76%	Yes		
% Not Determined/Not Required	N/A	N/A	N/A	N/A	N/A			
Fraud and Abuse								
Audits completed *								
Recovery*								
QOC Meeting Dates								
Privacy Breach								

SKYGEN

Performance Measure	Target	Q3	Oct 2018	Nov 2018	Dec 2018	Q4	2018 YTD Totals	Performance Standard Met?	Corrective Actions Planned if needed	Notes	Oct 2018	Nov 2018	Dec 2018	Q4	2018 YTD Totals
CUSTOMERS SERVICES															
Total Calls Received		1202	376	291	309	976	4,633	Yes							
Calls Answered		1196	375	291	307	973	4,619	Yes							
% of Calls Answered in 30 Seconds	85%	98%	98%	99%	99%	99%	98%	Yes							
ASA in seconds	30 Seconds	4	4	4	4	12	26	Yes							
Calls Abandoned		1	0	0	0	0	3	Yes							
Average abandonment rate	<5%	0%	0%	0%	0%	0%	0%	Yes							
CLAIMS PROCESSING TURNAROUND TIMES / ACCURACY	***Reported Quarterly***														
Claims Processed (1-30 days)	N/A	19768	6970	7816	6539	21325	82,242	Yes							
Claims Processed (31-45 days)	N/A	0	0	0	0	0	0								
Claims Processed (46 - 90 days)	N/A	0	0	0	0	0	0								
Claims Processed (90 + days)	N/A	0	0	0	0	0	0								
Claims Not Adjudicated	N/A	1774	3065	1618	770	5453	10,808	Yes							
Claim Adjudication Payment Accuracy	95%	100%	100%	100%	100%	100%	100%	Yes							
Claims Adjudication Financial Accuracy	95%	100%	100%	100%	100%	100%	100%	Yes							
Claims Adjudication Overall Accuracy	95%	100%	100%	100%	100%	100%	100%	Yes							
CLAIMS DATA / ELECTRONIC /PAPER															
Total # of Claims Received	N/A	20755	8581	6988	6037	21606	84,828	Yes							
% Electronic Claims	N/A	91%	88%	88%	90%	89%	90%	Yes							
% Paper Claims	N/A	9%	12%	12%	10%	11%	11%	Yes							
NETWORK ADEQUACY															
Number of Providers Credentialed*	N/A	60	17	13	7	37	137	Yes							
Number of Providers Re-Credentialed*	N/A	10	0	0	0	0	40	Yes							
Geo Access															
COMPLAINT SUMMARY															
Member Complaints Received	N/A	1	0	0	0	0	11	Yes							
Provider Complaints Received	N/A	0	0	0	0	0	8	Yes							
Provider Appointment Survey															
Appointment waiting time for Emergency Care*	N/A	Within 48 Hours			Within 48 Hours	Within 48 Hours	Within 48 Hours						Within 48 Hours	Within 48 Hours	Within 48 Hours
Number of offices contacted	N/A	99			115	115		Yes							
Number completed	N/A	99			115	115		Yes							
Number of compliant providers	N/A	99			115	115		Yes							
Total number of providers surveyed	N/A	99			115	115		Yes							
Appointment waiting time for Urgent Care*	N/A	Within 72 Hours			Within 72 Hours	Within 72 Hours	Within 72 Hours						Within 72 Hours	Within 72 Hours	Within 72 Hours
Number of offices contacted	N/A	99			115	115		Yes							
Number completed	N/A	99			115	115		Yes							
Number of compliant providers	N/A	99			115	115		Yes							
Total number of providers surveyed	N/A	99			115	115		Yes							
Appointment waiting time for routine Care*	N/A	Within 90 Calendar Days			Within 90 Calendar Days	Within 90 Calendar Days	Within 90 Calendar Days						Within 90 Calendar Days	Within 90 Calendar Days	Within 90 Calendar Days
Number of offices contacted	N/A	99			115	115		Yes							
Number completed	N/A	99			115	115		Yes							

Performance Measure	Target	Q3	Oct 2018	Nov 2018	Dec 2018	Q4	2018 YTD Totals	Performance Standard Met?	Corrective Actions Planned if needed	Notes	Oct 2018	Nov 2018	Dec 2018	Q4	2018 YTD Totals
Number of compliant providers	N/A	99			115	115		Yes							
Total number of providers surveyed	N/A	99			115	115		Yes							
UM															
Number of Denials		315	124	111	90	325	1,237	Yes							
IRR	N/A	N/A	N/A	N/A	N/A	N/A	N/A								
UM Prior Auth TAT**	7 Days	1	1	1	2	4	6	Yes							
UM Retro Auth TAT**	30 Days	5	NA	NA	NA	NA	N/A								
Fraud and Abuse	Scion Dental is not delegated FWA														
Audits completed *		N/A	N/A	N/A	N/A	N/A	N/A								
Recovery*		N/A	N/A	N/A	N/A	N/A	N/A								
QOC Meeting Dates	Scion Dental does not hold QOC meetings. We do have a Quality Improvement Committee, were QOC was discussed during their December 9, 2016 meeting.														
Privacy Breach		0													

** Average TAT days

VSP

Performance Measure	Target	2017 YTD Totals	Q3	Oct 2018	Nov 2018	Dec 2018	Q4	2018 YTD Totals	Performance Standard Met?	Corrective Actions Planned if needed	Notes
CUSTOMERS SERVICES											
Total Calls Received	*All Business/Not Broken Out*	14,754,134	2,546,232	889,065	875,956	1,019,537	2,784,558	1,529,236	Yes		
% of Calls Answered in 30 Seconds	85%	86%	81.90%	97.5%	89.70%	83.00%	86.35%	84.09%	Yes		
ASA in seconds	30 Seconds	20	:35	:06	:15	:37	:19	:24	Yes		
Calls Abandoned	*All Business/Not Broken Out*	192,359	55,885	3,642	9,321	23,755	36,718	165,923	Yes		
Average abandonment rate	<5%	1%	2.19%	0.41%	1.06%	2.33%	1.27%	1.55%	Yes		
CLAIMS PROCESSING TURNAROUND TIMES / ACCURACY											
Claims Processed (1-30 days)	N/A	21,326	5,447	2,233	1,532	1,539	5,304	20,107	Yes		
Claims Processed (31-45 days)	N/A	16	3	6	9	7	22	28	Yes		
Claims Processed (46 - 90 days)	N/A	0	1	0	4	0	4	7	Yes		
Claims Processed (90 + days)	N/A	2	1	0	6	0	6	8	Yes		
Claims Not Adjudicated	N/A	NA	N/A	N/A	N/A	N/A	N/A	N/A			
Claim Adjudication Payment Accuracy	98%	99.95%		-	-	-	-	-	Yes		
Claims Adjudication Financial Accuracy	99%	***99.51%***		-	-	-	-	-	Yes		
Claims Adjudication Overall Accuracy	85%	***99.97%***		-	-	-	-	-	Yes		
CLAIMS DATA / ELECTRONIC /PAPER											
Total # of Claims Received	N/A	***21,344***	5,452.00	2,239	1,551	1,546	5,336	20,150	Yes		
% Electronic Claims	N/A	***13,689***	85.57%	***86.74%***	67.69%	86.68%	80.37%	83.65%	Yes		
% Paper Claims	N/A	***7,655***	14.43%	***13.26%***	32.30%	13.32%	19.63%	16.35%	Yes		
NETWORK ADEQUACY											
Number of Providers Credentialed*	N/A	21,344	1	0	1	3	4	9	Yes		
Number of Providers Re-Credentialed*	N/A	13,689	3	6	3	1	10	25	Yes		
Geo Access		***7,655***									
COMPLAINT SUMMARY											
Member Complaints Received	N/A	***6***	4	0	0	0	0	4	Yes		
Provider Complaints Received	N/A	***4***	0	0	0	0	0	0	Yes		
Provider Appointment Survey											
Appointment waiting time for Emergency Care*	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
Number of offices contacted	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
Number completed	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
Number of compliant providers	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
Total number of providers surveyed	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
Appointment waiting time for Urgent Care*	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
Number of offices contacted	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
Number completed	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A			

VSP

Performance Measure	Target	2017 YTD Totals	Q3	Oct 2018	Nov 2018	Dec 2018	Q4	2018 YTD Totals	Performance Standard Met?	Corrective Actions Planned if needed	Notes
Number of compliant providers	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
Total number of providers surveyed	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
Appointment waiting time for routine Care*	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
Number of offices contacted	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
Number completed	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
Number of compliant providers	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
Total number of providers surveyed	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
UM	Discuss during JOC Thurs 09/14										
IRR	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
UM Prior Auth Tat	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
UM Retro Auth TAT	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
Fraud and Abuse											
Audits completed *		0	0	0	0	0	0	0			
Recovery*		NA	N/A	N/A	N/A	N/A	N/A	N/A			
QOC Meeting Dates											
Privacy Breach											

NOTES:

The Customer Service results are for VSP as a whole.

VSP's service level is measured as 80% of calls answered in 30 seconds.

First Choice Subcontractor Agreement

STATEMENT OF WORK

Short Form

Supplier	First Choice Services
Project Name	West Virginia Tobacco Quitline
Governing Contract (or other applicable documents)	Master Business Agreement between First Choice Services and Aetna Life Insurance Company
Procurement Project Lead	John Carter
Aetna Project Manager/Contact	Todd White
Date	7/1/2018

1. Details of Services Provided:

1.1 Project Overview (Brief high level overview that explains what is to be accomplished and will state any assumptions) :

West Virginia Aetna Medicaid Members (For the purposes of this Schedule, the term "Medicaid Members" is defined as those persons enrolled in any Aetna Medicaid program who qualifies for the Services under this Schedule) will be enrolled into the West Virginia Tobacco Quitline. Upon enrollment, Medicaid Members will receive four proactive coaching calls from a tobacco cessation coach unlimited reactive coaching, and authorization of up to 90 days of nicotine replacement therapy.

First Choice is the Supplier for the West Virginia Tobacco Quitline ("QL") and provides cessation services for Aetna Medicaid Members trying to quit using nicotine products ("Smoking Cessation Program"). The Quitline provides enrollment into a tobacco cessation program including four proactive coaching calls from a certified tobacco treatment specialist, unlimited reactive coaching calls, and up to 90 days authorization of patches, gum, lozenges, Wellbutrin or Chantix (for Medicaid Members). Supplier requires that all tobacco coaches are certified tobacco cessation specialists, with a Bachelors degree in a health or social services field and that each coach has several years experience working in the tobacco cessation field. Upon calling the Quitline, the call agent will determine the caller's eligibility with Aetna and determining eligibility through the State of West Virginia's Medicaid portal, and, if eligible, then proceed to enroll them into the QL program for Aetna Medicaid. After enrollment, the Medicaid Member will receive their first initial coaching call, discussing with their coach their quit attempt and nicotine replacement therapy. If the caller is a Medicaid Member, they will then need to obtain an Rx from their physician for the type of product they would like to use. After obtaining the Rx, they will call the QL, and share the Rx info and their tobacco coach will obtain authorization for the Rx.

2. Deliverables

2.1 Supplier Deliverables:

Deliverable	Deliverable Description	Due Date	Payment Date	Milestone Dates

30% or more report quitting smoking after the 4th coaching call, no credit to Aetna.

25 -29.9% report quitting smoking at the 4th coaching call, 15% credit to Aetna.

20-24.9% report quitting smoking at the 4th coaching call, 20% credit to Aetna.

15-19.9% report quitting smoking at the 4th coaching call, 25% credit to Aetna.

14.9% or less report quitting smoking at the 4th coaching call, 30% credit to Aetna.

6. Contact Information

Aetna:	Contact Information	Roles & Responsibilities
Project Manager	Todd White	
Procurement	John Carter	
Medicaid Vendor Management	Debbie Hilker	
Supplier:		
Project Manager	Heather McDaniel	Manage staff related to the tobacco quitline, handle any issues that may arise, and provide billing and reporting.
Account Manager/Exec	Heather McDaniel	

AETNA LIFE INSURANCE COMPANY

Collin Bailey
Collin Bailey (Dec 21, 2018)

Authorized Signature

Collin Bailey

Print Name

Senior Director, Strategic Procurement

Title

Dec 21, 2018

FIRST CHOICE SERVICES

D Scott Jarrett
D Scott Jarrett (Dec 21, 2018)

Authorized Signature

D Scott Jarrett

Print Name

President & CEO

Title

Dec 21, 2018

EXHIBIT/ADDENDUM] ___

STATEMENT OF WORK

Short Form

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Project Name	West Virginia Tobacco Quitline
Governing Contract (or other applicable documents)	Master Business Agreement between First Choice Services and Aetna Life Insurance Company
Procurement Project Lead	John Carter
Aetna Project Manager/Contact	Todd White
Date	7/1/2018

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1.1 Project Overview (Brief high level overview that explains what is to be accomplished and will state any assumptions) :

West Virginia Aetna Medicaid Members (For the purposes of this Schedule, the term "Medicaid Members" is defined as those persons enrolled in any Aetna Medicaid program who qualifies for the Services under this Schedule) will be enrolled into the West Virginia Tobacco Quitline. Upon enrollment, Medicaid Members will receive four proactive coaching calls from a tobacco cessation coach unlimited reactive coaching, and authorization of up to 90 days of nicotine replacement therapy.

First Choice is the Supplier for the West Virginia Tobacco Quitline ("QL") and provides cessation services for Aetna Medicaid Members trying to quit using nicotine products ("Smoking Cessation Program"). The Quitline provides enrollment into a tobacco cessation program including four proactive coaching calls from a certified tobacco treatment specialist, unlimited reactive coaching calls, and up to 90 days authorization of patches, gum, lozenges, Wellbutrin or Chantix (for Medicaid Members). Supplier requires that all tobacco coaches are certified tobacco cessation specialists, with a Bachelors degree in a health or social services field and that each coach has several years experience working in the tobacco cessation field. Upon calling the Quitline, the call agent will determine the caller's eligibility with Aetna and determining eligibility through the State of West Virginia's Medicaid portal, and, if eligible, then proceed to enroll them into the QL program for Aetna Medicaid. After enrollment, the Medicaid Member will receive their first initial coaching call, discussing with their coach their quit attempt and nicotine replacement therapy. If the caller is a Medicaid Member, they will then need to obtain an Rx from their physician for the type of product they would like to use. After obtaining the Rx, they will call the QL, and share the Rx info and their tobacco coach will obtain authorization for the Rx.

2. Deliverables

2.1 Supplier Deliverables:

Deliverable	Deliverable Description	Due Date	Payment Date	Milestone Dates

Monthly Participation and Annual Reports	Monthly Participation reports will include the name, and birthdate of the member, date and time they enrolled, and if they completed coaching calls. Annual report includes quit rates and comparison of previous years data.			
Follow up Surveys	Follow up surveys include questions regarding quit status, NRT products used, and suggestions for improvements of the program.			

2.2 Responsibilities of the Parties:

Suppliers Duties and Responsibilities: In addition to the above, Supplier shall cooperate with Aetna's reasonable processes to evaluate Supplier's data security measures, protocols, and protections. Supplier shall maintain and perform health care industry standard administrative, physical, and technical safeguards for protection of the security, confidentiality and integrity of Aetna Confidential Information (as defined in the Agreement), and the information of Aetna's Members. Supplier shall have a documented, comprehensive information security program that codifies such safeguards. The requirements set forth in this section are in addition to, and not in lieu of, the Parties' obligations under the Business Associate Agreement.

3. Term

Start Date	7/1/2018
End Date	6/30/2019

The End Date may be extended by mutual agreement of the Parties in writing.

4. Acceptance of Deliverables

Acceptance shall be at the sole discretion of the Aetna Project Coordinator. If at any time during the Project, the Aetna Project Coordinator feels that the Project is not proceeding in the direction as discussed and outlined herein, Aetna reserves the right to halt or redirect the Project and/or cancel it; and/or halt or delay payment as he/she deems appropriate. Aetna shall provide Supplier with written notice of such action. Any services not meeting acceptance, will be corrected as detailed in a written communication to the Supplier according to the Agreement and will be at no additional cost to Aetna.

5. Fees and Payment Schedules

For each Member enrolled in the Smoking Cessation Program, the Supplier shall invoice Aetna for the following:

1. Enrollment (per Member):
2. First Pro-Active Coaching Session (per Member):
3. Second through Fourth Pro-Active Coaching Session (per Member):
4. Reactive Coaching Sessions (per Member):

The Services under this Statement of Work for the Term set forth in this Schedule shall not exceed without mutual agreement by the Parties in writing.

Service Level Agreement Metrics:

30% or more report quitting smoking after the 4th coaching call, no credit to Aetna.

25 -29.9% report quitting smoking at the 4th coaching call, 15% credit to Aetna.

20-24.9% report quitting smoking at the 4th coaching call, 20% credit to Aetna.

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6. Contact Information

Aetna:	**Contact Information**	**Roles & Responsibilities**
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Procurement	John Carter	
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Supplier:		
Project Manager	Heather McDaniel	Manage staff related to the tobacco quitline, handle any issues that may arise, and provide billing and reporting.
Account Manager/Exec	Heather McDaniel	

AETNA LIFE INSURANCE COMPANY

Collin Bailey
Collin Bailey (Dec 21, 2018)

Authorized Signature

Collin Bailey

Print Name

Senior Director, Strategic Procurement

Title

Dec 21, 2018

FIRST CHOICE SERVICES

D Scott Jarrett
D Scott Jarrett (Dec 21, 2018)

Authorized Signature

D Scott Jarrett

Print Name

President & CEO

Title

Dec 21, 2018

EXHIBIT/ADDENDUM] ___

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	

Adjustments to PMPM Service Fees. Following the Initial Term, and on each annual anniversary date thereafter (each an "Anniversary Date"), the compensation paid to Provider for performance of the Administrative Services pursuant to this Agreement, including PMPM Service Fees, shall be reviewed by both Parties. If mutually agreed upon, such fees shall be adjusted for the upcoming contract year.

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 (10^{th}) 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: Gary Brooks

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: Gary Brooks

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 Plan	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						
8329 & 8384	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 (60^{th}) 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

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 (6^{th}) 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

Sample Member and Provider Authorization Letters

Sample Member Notification of Lack of Medical Necessity Letter

Aetna Better Health® of West Virginia
500 Virginia Street East, Suite 400
Charleston, WV 25301

aetna®

Notice Date: July 23, 2019

RE: [redacted]
ID#: [redacted]
Date of Birth: [redacted]
Authorization: [redacted]
Requesting Doctor: [redacted]
Date of Request: [redacted]

Dear [redacted]:

This letter is to let you know that we will not pay for a substance put into your knees with a needle (Euflexxa injection), because it is not medically needed.

Euflexxa injections may be needed if you've tried at least three months of medication by mouth, to bring down the swelling in your knees and/or medication that you rub on your knees. Your records don't say these things. You should discuss treatment options with your provider. Decisions about the care you will have are between you and your provider. We made this decision using Aetna Clinical Policy Bulletin 0179 (Viscosupplementation).

You, your doctor, or provider can get a free copy of the Member Handbook, or a copy of all documents, records and information, including the criteria and/or guidelines used to make our decision. To request this information, call our Member Services number **1-888-348-2922** or send a written request to fax number **1-866-366-7008** or write to us at:

Aetna Better Health of West Virginia
500 Virginia Street East, Suite 400
Charleston, WV 25301

If your doctor would like to discuss this case, has more information, or if anything changes with your health, your doctor can call us to talk to one of our doctors. Your doctor can call us at **1-866-389-1667**.

If you do not agree with our answer, you can ask us to look at your request again. This is called an appeal. If you want to appeal, a different reviewer will look at your request. Then we will tell you if we will or will not pay for the services you requested.

You, your doctor, or provider can ask for a fast appeal if you need something fast (when serious injury or

death may happen). You need to call Member Services and tell them that you want a fast appeal. They will tell you what you need to do. Please see the attached appeal document.

You may appeal this determination by submitting a written request within 60 calendar days from the date on this notice. If the requested service has already been provided, your doctor or provider may appeal this determination by submitting a written request within 90 calendar day from the date on this notice:

Aetna Better Health of West Virginia
Attn: Appeals
500 Virginia Street East, Suite 400
Charleston, WV 25301

If you have any questions, please call Member Services at **1-888-348-2922**. If you are hearing or speech impaired, call TTY**: 711**. They will connect you to TTY services.

Sincerely,

[redacted]

[redacted]
Medical Director
Aetna Better Health of West Virginia

EH

Enclosure(s):
Notice of Action Statement
Nondiscrimination Notice

cc:
[redacted]

AETNA BETTER HEALTH OF WEST VIRGINIA

Notice of action statement

Grievances

As a Medicaid member, you may file a grievance regarding any aspect of service delivery provided or paid for by Aetna Better Health of West Virginia at any time. If you do not agree with a decision made by Aetna Better Health of West Virginia, are not happy with any services received, are unhappy about any other part of Aetna Better Health of West Virginia or your provider, you (without getting in trouble) can get in touch with Aetna Better Health of West Virginia by calling at 888-348-2922 (TTY/TDD 711), or writing it down and sending it to:

Aetna Better Health of West Virginia
Attention: Complaint and Appeal Department
500 Virginia Street, East
Suite 400
Charleston, WV 25301

Aetna Better Health of West Virginia will provide translation services as needed at no cost to you.

Informal grievances/Complaints

Informal Grievances are when you call Aetna Better Health of West Virginia to tell us you are not happy with any matter related to Aetna Better Health of West Virginia, such as our decision to not pay a claim or okay health care for you, or you are unhappy with any part of your benefits, services, Aetna Better Health of West Virginia, or its network of providers. If you call the Member Service Department at 888-348-2922, they will take all of the information you give them and investigate the problem. They will try to get you an answer in thirty (30) calendar days from the date the Informal Grievace was filed. If they are not able to answer your question in thirty (30) calendar days, they will call you or write you back and let you know. You can file an Informal Grievance/Complaint at any time.

To file a Complaint, you can call us at **888-348-2922** (TTY/TDD 711) and we will ask for the information listed below and write down the Complaint for you. We will let you know when we have received your Complaint and you can get copies of documents, records and information about the Complaint. We will give these documents to you for free. Your complaint will be reviewed and resolved within 30 calendar days of receipt.

You can also send us a letter that has:

- Your name
- Your mailing address
- The reason why you are filing the Complaint and what you want **Aetna Better Health of West Virginia** to do

If your Complaint involves a Quality of Care or Quality of Service issue, we will research your Complaint; notify the appropriate **Aetna Better Health of West Virginia** department or committee of your Complaint, and the corrective action(s) that was taken, if any, to resolve the Complaint. You will only be contacted if we need additional information to resolve your Complaint.

Formal grievances

If you are not happy with our answer to your Informal Grievance, you or someone with your okay (including a health care provider) can file a Formal Grievance. You may also skip the Informal Grievance process and file a Formal Grievance right away. If your Formal Grievance is because we have denied any part of your request fo. a health care service, it is called an "Appeal."

Appeals

To file an Appeal you will need to send us a letter that has:

- Your name
- Your provider's name
- The date of service
- Your mailing address
- The reason why we should change our decision
- A copy of any information that you think supports your Appeal, such as written comments, additional documents, records or information related to your Appeal

You must file an appeal within sixty (60) calendar days from the date on the notice of action from Aetna Better Health.

A Committee will look at your Appeal. None of the people on the Appeal Committee will have been involved in our initial decision to not authorize or pay for the health services you are appealing. If your Appeal involves a medical issue, the Committee will also talk to a health care professional who has the appropriate training and experience in the field of medicine necessary for making the decision on the medical issue. If your Appeal is an administrative appeal (one not based on a medical issue), the Appeal Committee will consist of Health Plan senior management. You can come to the Appeal Committee meeting and talk to the Appeal Committee. You have the right to be represented during the appeal process.

Aetna Better Health of West Virginia must process and provide notice to you regarding your appeal within thirty (30) calendar days.

If Aetna Better Health of West Virginia needs more information for the Appeal, or if you want to provide more information, you or Aetna Better Health of West Virginia can ask for fourteen (14) more calendar days to finish the Appeal. If Aetna Better Health of West Virginia decides to extend the review time to finish the appeal, you will be notified in writing within two (2) calendar days that you have the right to file a grievance if you disagree with the extension.

Written Complaints and Appeals should be mailed to:
Aetna Better Health of West Virginia
Attention: Complaint and Appeal Department
500 Virginia Street, East
Suite 400
Charleston, WV 25301

If you are not able to file a written Appeal or Complaint, you can call **Aetna Better Health of West Virginia** at 888-348-2922 and we will ask for the information listed above, and write down the Appeal/Complaint for yo. We will let you know when we have received your Appeal or Complaint and you can get copies of documents, records, and information about the Appeal or Complaint. We will give these documents to you for free.

Fast appeals

If your Appeal is about our decision to not approve or pay for some or all of your health care services, and you need an Appeal decision fast because you have not gotten the health care services and you might be badly hurt if you had to wait for a normal Appeal decision, like the one described above, you can ask for a fast Appeal. You can file a Fast Appeal within 60 calendar days from the date on the notice of action from **Aetna Better Health of West Virginia.**

If we allow a fast Appeal, we will schedule a meeting with the Committee no later than forty-eight (48) hours after we get your Appeal. We will call you twenty-four (24) hours after we get your Appeal to let you know the date, time, and place of the meeting. We will make a decision on your Appeal no later than seventy-two (72) hours after we get your Appeal. You will get a written notice explaining the next steps in the process. **Aetna Better Health of West Virginia** will provide the results of your fast appeal to the State so that they can determine a timeframe for resolution.

To file a Fast Appeal you will need to provide us with:

- Your name
- Your provider's name
- The date of service
- Your mailing address
- The reason why we should change our decision
- A copy of any information that you think supports your Appeal, such as written comments, additional documents, records or information related to your Appeal

You can file a Fast Appeal by either calling us, or mailing or faxing the information to:
Aetna Better Health of West Virginia
Attention: Complaint and Appeal Department
500 Virginia Street, East
Suite 400
Charleston, WV 25301

Phone Number 888-348-2922 (TTY/TDD 711)
FAX - 888-388-1752

If we decide your Appeal is not a fast Appeal, we will handle your Appeal like the normal Appeals described in the section above.

State Fair Hearing process

If you are not happy with **Aetna Better Health of West Virginia**'s Appeal decision, and your Appeal is about our decision to deny, reduce, change or terminate payment for your health care services, you can request a State Fair Hearing if it is within 120 calendar days from the notice of resolution from **Aetna Better Health of West Virginia**. You can only request a State Fair Hearing if it relates to a denial of a service, a reduction in service, termination of a previously authorized service, or failure to provide service timely. You will get a notice mailed to you within ten (10) days before any action is taken.

If a State Fair Hearing is requested, the State will hear your case and give you a decision in writing within ninety (90) days of the date you asked for a State Fair Hearing. If are still not happy with the decision, youcan

take your case to Circuit Court. If you want to proceed in taking your case to Circuit Court, you must file within thirty (30) days of your notice of the State Fair Hearing decision. You can file an appeal to the Bureau for Medical Services (BMS).
Send your request for an appeal to:
Bureau for Medical Services
Office of Medicaid Managed Care
350 Capitol Street, Room 251
Charleston, WV 25301-3708

The BMS decision will be sent to you in writing.

If you are not happy with the Bureau for Medical Services decision, you can appeal to the West Virginia Insurance Commissioner by sending your appeal to:
The Office of the Insurance Commissioner
P.O. Box 50540
Charleston, WV 25305-0540

Aetna Better Health of West Virginia will continue your benefits during the time of an appeal process or State Fair Hearing when:

- You or your provider file an appeal on a timely basis;
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized provider;
- The original period covered by the original authorization has not expired; and
- You request an extension of benefits.

To request an extension of benefits, call member service at **888-348-2922**.

Aetna Better Health of West Virginia will pay for the services in question when the final result of the appeal to overturn the original decision. **Aetna Better Health of West Virginia** will pay for some or all of the services as determined by the final appeal decision. If the final result of your appeal is to uphold the original decision to deny, reduce, change or end payment for your services, **Aetna Better Health of West Virginia** may take back the money that was paid for the services while the appeal was in process, and you will be responsible for paying for the services.

If you are not satisfied with the decision of the Office of the Insurance Commissioner, you may appeal to Circuit Court. Your appeal must be filed within thirty (30) days after the Insurance Commissioner's order has been mailed.

Appeals after 120 Days

If you did not request a State Fair Hearing within the 120 days, you may still be able to appeal **Aetna Better Healthf of West Virginia**'s Appeal decision that you are unhappy with. You can also use this process if the decision is related to a Complaint rather than an Appeal. You must have gone through **Aetna Better Health of West Virginia**'s Grievance process and it must be within one (1) year of the date of the original decision or issue that you did not agree with or were not happy with.

Keeping Your Grievance and Appeals

Aetna Better Health of West Virginia will keep copies of your grievance and appeals documents, records and information about the grievance and appeal for your review for ten (10) years.

Nondiscrimination Notice

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  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
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  - Qualified interpreters
  - Information written in other languages

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card or **1-800-385-4104**.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with our Civil Rights Coordinator at:

Address:	Attn: Civil Rights Coordinator 4500 E. Cotton Center Blvd Phoenix, AZ 85040
Telephone:	1-888-234-7358, TTY 711
Email:	MedicaidCRCoordinator@aetna.com

You can file a grievance in person or by mail or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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Parent(s) or Guardian(s) of [redacted]
[redacted]
[redacted]

Sample Provider Notification of Lack of Medical Necessity Letter

Aetna Better Health® of West Virginia
500 Virginia Street East, Suite 400
Charleston, WV 25301

Notice Date: July 23, 2019

RE: [redacted]
ID#: [redacted]
Date of Birth: [redacted]
Authorization: [redacted]
Requesting Doctor: [redacted]
Date of Request: [redacted]

Dear [redacted]:

This letter is to let you know that we will not pay for a substance put into your knees with a needle (Euflexxa injection), because it is not medically needed.

Euflexxa injections may be needed if you've tried at least three months of medication by mouth, to bring down the swelling in your knees and/or medication that you rub on your knees. Your records don't say these things. You should discuss treatment options with your provider. Decisions about the care you will have are between you and your provider. We made this decision using Aetna Clinical Policy Bulletin 0179 (Viscosupplementation).

You, your doctor, or provider can get a free copy of the Member Handbook, or a copy of all documents, records and information, including the criteria and/or guidelines used to make our decision. To request this information, call our Member Services number **1-888-348-2922** or send a written request to fax number **1-866-366-7008** or write to us at:

Aetna Better Health of West Virginia
500 Virginia Street East, Suite 400
Charleston, WV 25301

If your doctor would like to discuss this case, has more information, or if anything changes with your health, your doctor can call us to talk to one of our doctors. Your doctor can call us at **1-866-389-1667**.

If you do not agree with our answer, you can ask us to look at your request again. This is called an appeal. If you want to appeal, a different reviewer will look at your request. Then we will tell you if we will or will not pay for the services you requested.

You, your doctor, or provider can ask for a fast appeal if you need something fast (when serious injury or

death may happen). You need to call Member Services and tell them that you want a fast appeal. They will tell you what you need to do. Please see the attached appeal document.

You may appeal this determination by submitting a written request within 60 calendar days from the date on this notice. If the requested service has already been provided, your doctor or provider may appeal this determination by submitting a written request within 90 calendar day from the date on this notice:

Aetna Better Health of West Virginia
Attn: Appeals
500 Virginia Street East, Suite 400
Charleston, WV 25301

If you have any questions, please call Member Services at **1-888-348-2922.** If you are hearing or speech impaired, call TTY**: 711**. They will connect you to TTY services.

Sincerely,

[redacted]

[redacted]
Medical Director
Aetna Better Health of West Virginia

EH

Enclosure(s):
Notice of Action Statement
Nondiscrimination Notice

cc:
[redacted]

AETNA BETTER HEALTH OF WEST VIRGINIA

Notice of action statement

Grievances

As a Medicaid member, you may file a grievance regarding any aspect of service delivery provided or paid for by Aetna Better Health of West Virginia at any time. If you do not agree with a decision made by Aetna Better Health of West Virginia, are not happy with any services received, are unhappy about any other part of Aetna Better Health of West Virginia or your provider, you (without getting in trouble) can get in touch with Aetna Better Health of West Virginia by calling at 888-348-2922 (TTY/TDD 711), or writing it down and sending it to:

Aetna Better Health of West Virginia
Attention: Complaint and Appeal Department
500 Virginia Street, East
Suite 400
Charleston, WV 25301

Aetna Better Health of West Virginia will provide translation services as needed at no cost to you.

Informal grievances/Complaints

Informal Grievances are when you call Aetna Better Health of West Virginia to tell us you are not happy with any matter related to Aetna Better Health of West Virginia, such as our decision to not pay a claim or okay health care for you, or you are unhappy with any part of your benefits, services, Aetna Better Health of West Virginia, or its network of providers. If you call the Member Service Department at 888-348-2922, they will take all of the information you give them and investigate the problem. They will try to get you an answer in thirty (30) calendar days from the date the Informal Grievace was filed. If they are not able to answer your question in thirty (30) calendar days, they will call you or write you back and let you know. You can file an Informal Grievance/Complaint at any time.

To file a Complaint, you can call us at **888-348-2922** (TTY/TDD 711) and we will ask for the information listed below and write down the Complaint for you. We will let you know when we have received your Complaint and you can get copies of documents, records and information about the Complaint. We will give these documents to you for free. Your complaint will be reviewed and resolved within 30 calendar days of receipt.

You can also send us a letter that has:

- Your name
- Your mailing address
- The reason why you are filing the Complaint and what you want **Aetna Better Health of West Virginia** to do

If your Complaint involves a Quality of Care or Quality of Service issue, we will research your Complaint; notify the appropriate **Aetna Better Health of West Virginia** department or committee of your Complaint, and the corrective action(s) that was taken, if any, to resolve the Complaint. You will only be contacted if we need additional information to resolve your Complaint.

Formal grievances

If you are not happy with our answer to your Informal Grievance, you or someone with your okay (including a health care provider) can file a Formal Grievance. You may also skip the Informal Grievance process and file a Formal Grievance right away. If your Formal Grievance is because we have denied any part of your request fo. a health care service, it is called an "Appeal."

Appeals

To file an Appeal you will need to send us a letter that has:

- Your name
- Your provider's name
- The date of service
- Your mailing address
- The reason why we should change our decision
- A copy of any information that you think supports your Appeal, such as written comments, additional documents, records or information related to your Appeal

You must file an appeal within sixty (60) calendar days from the date on the notice of action from Aetna Better Health.

A Committee will look at your Appeal. None of the people on the Appeal Committee will have been involved in our initial decision to not authorize or pay for the health services you are appealing. If your Appeal involves a medical issue, the Committee will also talk to a health care professional who has the appropriate training and experience in the field of medicine necessary for making the decision on the medical issue. If your Appeal is an administrative appeal (one not based on a medical issue), the Appeal Committee will consist of Health Plan senior management. You can come to the Appeal Committee meeting and talk to the Appeal Committee. You have the right to be represented during the appeal process.

Aetna Better Health of West Virginia must process and provide notice to you regarding your appeal within thirty (30) calendar days.

If Aetna Better Health of West Virginia needs more information for the Appeal, or if you want to provide more information, you or Aetna Better Health of West Virginia can ask for fourteen (14) more calendar days to finish the Appeal. If Aetna Better Health of West Virginia decides to extend the review time to finish the appeal, you will be notified in writing within two (2) calendar days that you have the right to file a grievance if you disagree with the extension.

Written Complaints and Appeals should be mailed to:
Aetna Better Health of West Virginia
Attention: Complaint and Appeal Department
500 Virginia Street, East
Suite 400
Charleston, WV 25301

If you are not able to file a written Appeal or Complaint, you can call **Aetna Better Health of West Virginia** at 888-348-2922 and we will ask for the information listed above, and write down the Appeal/Complaint for yo. We will let you know when we have received your Appeal or Complaint and you can get copies of documents, records, and information about the Appeal or Complaint. We will give these documents to you for free.

Fast appeals

If your Appeal is about our decision to not approve or pay for some or all of your health care services, and you need an Appeal decision fast because you have not gotten the health care services and you might be badly hurt if you had to wait for a normal Appeal decision, like the one described above, you can ask for a fast Appeal. You can file a Fast Appeal within 60 calendar days from the date on the notice of action from **Aetna Better Health of West Virginia.**

If we allow a fast Appeal, we will schedule a meeting with the Committee no later than forty-eight (48) hours after we get your Appeal. We will call you twenty-four (24) hours after we get your Appeal to let you know the date, time, and place of the meeting. We will make a decision on your Appeal no later than seventy-two (72) hours after we get your Appeal. You will get a written notice explaining the next steps in the process. **Aetna Better Health of West Virginia** will provide the results of your fast appeal to the State so that they can determine a timeframe for resolution.

To file a Fast Appeal you will need to provide us with:

- Your name
- Your provider's name
- The date of service
- Your mailing address
- The reason why we should change our decision
- A copy of any information that you think supports your Appeal, such as written comments, additional documents, records or information related to your Appeal

You can file a Fast Appeal by either calling us, or mailing or faxing the information to:
Aetna Better Health of West Virginia
Attention: Complaint and Appeal Department
500 Virginia Street, East
Suite 400
Charleston, WV 25301

Phone Number 888-348-2922 (TTY/TDD 711)
FAX - 888-388-1752

If we decide your Appeal is not a fast Appeal, we will handle your Appeal like the normal Appeals described in the section above.

State Fair Hearing process

If you are not happy with **Aetna Better Health of West Virginia**'s Appeal decision, and your Appeal is about our decision to deny, reduce, change or terminate payment for your health care services, you can request a State Fair Hearing if it is within 120 calendar days from the notice of resolution from **Aetna Better Health of West Virginia**. You can only request a State Fair Hearing if it relates to a denial of a service, a reduction in service, termination of a previously authorized service, or failure to provide service timely. You will get a notice mailed to you within ten (10) days before any action is taken.

If a State Fair Hearing is requested, the State will hear your case and give you a decision in writing within ninety (90) days of the date you asked for a State Fair Hearing. If are still not happy with the decision, youcan

take your case to Circuit Court. If you want to proceed in taking your case to Circuit Court, you must file within thirty (30) days of your notice of the State Fair Hearing decision. You can file an appeal to the Bureau for Medical Services (BMS).
Send your request for an appeal to:
Bureau for Medical Services
Office of Medicaid Managed Care
350 Capitol Street, Room 251
Charleston, WV 25301-3708

The BMS decision will be sent to you in writing.

If you are not happy with the Bureau for Medical Services decision, you can appeal to the West Virginia Insurance Commissioner by sending your appeal to:
The Office of the Insurance Commissioner
P.O. Box 50540
Charleston, WV 25305-0540

Aetna Better Health of West Virginia will continue your benefits during the time of an appeal process or State Fair Hearing when:

- You or your provider file an appeal on a timely basis;
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized provider;
- The original period covered by the original authorization has not expired; and
- You request an extension of benefits.

To request an extension of benefits, call member service at **888-348-2922**.

Aetna Better Health of West Virginia will pay for the services in question when the final result of the appeal to overturn the original decision. **Aetna Better Health of West Virginia** will pay for some or all of the services as determined by the final appeal decision. If the final result of your appeal is to uphold the original decision to deny, reduce, change or end payment for your services, **Aetna Better Health of West Virginia** may take back the money that was paid for the services while the appeal was in process, and you will be responsible for paying for the services.

If you are not satisfied with the decision of the Office of the Insurance Commissioner, you may appeal to Circuit Court. Your appeal must be filed within thirty (30) days after the Insurance Commissioner's order has been mailed.

Appeals after 120 Days

If you did not request a State Fair Hearing within the 120 days, you may still be able to appeal **Aetna Better Healthf of West Virginia**'s Appeal decision that you are unhappy with. You can also use this process if the decision is related to a Complaint rather than an Appeal. You must have gone through **Aetna Better Health of West Virginia**'s Grievance process and it must be within one (1) year of the date of the original decision or issue that you did not agree with or were not happy with.

Keeping Your Grievance and Appeals

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You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD).

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Aetna Better Health® of West Virginia
500 Virginia Street East, Suite 400
Charleston, WV 25301

aetna®

FAX

Date: July 23, 2019

To: [redacted]
RE:
Phone: [redacted]
Fax: [redacted]

From: **Aetna Better Health of West Virginia**
Prior Authorizations
Phone: 1-888-348-2922
Fax: 1-866-366-7008

REMARKS: ☐ Urgent ☒ For Your Review ☐ Reply ASAP ☐ Please Comment

CONFIDENTIALITY NOTICE: This message is intended only for the user of the individual or entity to which it is addressed and may contain confidential and proprietary information. If you are not the intended recipient of the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is prohibited. If you received this communication in error, please notify the sender at the phone number above.

NOTICE TO RECIPIENT(S) OF INFORMATION:
Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2), which prohibit any further disclosure of this information by you without express written consent of the person to whom it pertains of as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Sample Member Notification of Non-Covered Services Letter

Aetna Better Health® of West Virginia
500 Virginia Street East, Suite 400
Charleston, WV 25301

Notice Date: July 11, 2019

RE: [redacted]
ID#: [redacted]
Date of Birth: [redacted]
Authorization: [redacted]
Requesting Doctor: [redacted]
Date of Request: [redacted]

Dear Parent(s) or Guardian(s) of [redacted]:

This letter is to let you know that we will pay for code 81243, which is a test used to see what conditions may have been passed to your child, from your family (genetic testing). However, we are not able to approve code 81229, which is another type of genetic testing.

We do not cover this requested code. See your Member Handbook:

Page 30: Health services prohibited by law or regulation.

You, your doctor, or provider can get a free copy of the Member Handbook, or a copy of all documents, records and information, including the criteria and/or guidelines used to make our decision. To request this information, call our Member Services number **1-888-348-2922** or send a written request to fax number **1-866-366-7008** or write to us at:

Aetna Better Health of West Virginia
500 Virginia Street East, Suite 400
Charleston, WV 25301

If you do not agree with our answer, you can ask us to look at your request again. This is called an appeal. If you want to appeal, a different reviewer will look at your request. Then we will tell you if we will or will not pay for the services you requested.

You, your doctor, or provider can ask for a fast appeal if you need something fast (when serious injury or death may happen). You need to call Member Services and tell them that you want a fast appeal. They will tell you what you need to do. Please see the attached appeal document.

You may appeal this determination by submitting a written request within 60 calendar days from the date on this notice:

Aetna Better Health of West Virginia
Attn: Appeals
500 Virginia Street East, Suite 400
Charleston, WV 25301

If you have any questions, please call Member Services at **1-888-348-2922**. If you are hearing or speech impaired, call TTY: 711. They will connect you to TTY services.

Sincerely,

[redacted]
[redacted]
Medical Director
Aetna Better Health of West Virginia

mds

Enclosure(s):
Notice of Action Statement
Nondiscrimination Notice

cc:
[redacted]

AETNA BETTER HEALTH OF WEST VIRGINIA

Notice of action statement

Grievances

As a Medicaid member, you may file a grievance regarding any aspect of service delivery provided or paid for by Aetna Better Health of West Virginia at any time. If you do not agree with a decision made by Aetna Better Health of West Virginia, are not happy with any services received, are unhappy about any other part of Aetna Better Health of West Virginia or your provider, you (without getting in trouble) can get in touch with Aetna Better Health of West Virginia by calling at 888-348-2922 (TTY/TDD 711), or writing it down and sending it to:

Aetna Better Health of West Virginia
Attention: Complaint and Appeal Department
500 Virginia Street, East
Suite 400
Charleston, WV 25301

Aetna Better Health of West Virginia will provide translation services as needed at no cost to you.

Informal grievances/Complaints

Informal Grievances are when you call Aetna Better Health of West Virginia to tell us you are not happy with any matter related to Aetna Better Health of West Virginia, such as our decision to not pay a claim or okay health care for you, or you are unhappy with any part of your benefits, services, Aetna Better Health of West Virginia, or its network of providers. If you call the Member Service Department at 888-348-2922, they will take all of the information you give them and investigate the problem. They will try to get you an answer in thirty (30) calendar days from the date the Informal Grievace was filed. If they are not able to answer your question in thirty (30) calendar days, they will call you or write you back and let you know. You can file an Informal Grievance/Complaint at any time.

To file a Complaint, you can call us at **888-348-2922** (TTY/TDD 711) and we will ask for the information listed below and write down the Complaint for you. We will let you know when we have received your Complaint and you can get copies of documents, records and information about the Complaint. We will give these documents to you for free. Your complaint will be reviewed and resolved within 30 calendar days of receipt.

You can also send us a letter that has:

- Your name
- Your mailing address
- The reason why you are filing the Complaint and what you want **Aetna Better Health of West Virginia** to do

If your Complaint involves a Quality of Care or Quality of Service issue, we will research your Complaint; notify the appropriate **Aetna Better Health of West Virginia** department or committee of your Complaint, and the corrective action(s) that was taken, if any, to resolve the Complaint. You will only be contacted if we need additional information to resolve your Complaint.

Formal grievances

If you are not happy with our answer to your Informal Grievance, you or someone with your okay (including a health care provider) can file a Formal Grievance. You may also skip the Informal Grievance process and file a Formal Grievance right away. If your Formal Grievance is because we have denied any part of your request fo. a health care service, it is called an "Appeal."

Appeals

To file an Appeal you will need to send us a letter that has:

- Your name
- Your provider's name
- The date of service
- Your mailing address
- The reason why we should change our decision
- A copy of any information that you think supports your Appeal, such as written comments, additional documents, records or information related to your Appeal

You must file an appeal within sixty (60) calendar days from the date on the notice of action from Aetna Better Health.

A Committee will look at your Appeal. None of the people on the Appeal Committee will have been involved in our initial decision to not authorize or pay for the health services you are appealing. If your Appeal involves a medical issue, the Committee will also talk to a health care professional who has the appropriate training and experience in the field of medicine necessary for making the decision on the medical issue. If your Appeal is an administrative appeal (one not based on a medical issue), the Appeal Committee will consist of Health Plan senior management. You can come to the Appeal Committee meeting and talk to the Appeal Committee. You have the right to be represented during the appeal process.

Aetna Better Health of West Virginia must process and provide notice to you regarding your appeal within thirty (30) calendar days.

If Aetna Better Health of West Virginia needs more information for the Appeal, or if you want to provide more information, you or Aetna Better Health of West Virginia can ask for fourteen (14) more calendar days to finish the Appeal. If Aetna Better Health of West Virginia decides to extend the review time to finish the appeal, you will be notified in writing within two (2) calendar days that you have the right to file a grievance if you disagree with the extension.

Written Complaints and Appeals should be mailed to:
Aetna Better Health of West Virginia
Attention: Complaint and Appeal Department
500 Virginia Street, East
Suite 400
Charleston, WV 25301

If you are not able to file a written Appeal or Complaint, you can call **Aetna Better Health of West Virginia** at 888-348-2922 and we will ask for the information listed above, and write down the Appeal/Complaint for yo. We will let you know when we have received your Appeal or Complaint and you can get copies of documents, records, and information about the Appeal or Complaint. We will give these documents to you for free.

Fast appeals

If your Appeal is about our decision to not approve or pay for some or all of your health care services, and you need an Appeal decision fast because you have not gotten the health care services and you might be badly hurt if you had to wait for a normal Appeal decision, like the one described above, you can ask for a fast Appeal. You can file a Fast Appeal within 60 calendar days from the date on the notice of action from **Aetna Better Health of West Virginia.**

If we allow a fast Appeal, we will schedule a meeting with the Committee no later than forty-eight (48) hours after we get your Appeal. We will call you twenty-four (24) hours after we get your Appeal to let you know the date, time, and place of the meeting. We will make a decision on your Appeal no later than seventy-two (72) hours after we get your Appeal. You will get a written notice explaining the next steps in the process. **Aetna Better Health of West Virginia** will provide the results of your fast appeal to the State so that they can determine a timeframe for resolution.

To file a Fast Appeal you will need to provide us with:

- Your name
- Your provider's name
- The date of service
- Your mailing address
- The reason why we should change our decision
- A copy of any information that you think supports your Appeal, such as written comments, additional documents, records or information related to your Appeal

You can file a Fast Appeal by either calling us, or mailing or faxing the information to:
Aetna Better Health of West Virginia
Attention: Complaint and Appeal Department
500 Virginia Street, East
Suite 400
Charleston, WV 25301

Phone Number 888-348-2922 (TTY/TDD 711)
FAX - 888-388-1752

If we decide your Appeal is not a fast Appeal, we will handle your Appeal like the normal Appeals described in the section above.

State Fair Hearing process

If you are not happy with **Aetna Better Health of West Virginia**'s Appeal decision, and your Appeal is about our decision to deny, reduce, change or terminate payment for your health care services, you can request a State Fair Hearing if it is within 120 calendar days from the notice of resolution from **Aetna Better Health of West Virginia.** You can only request a State Fair Hearing if it relates to a denial of a service, a reduction in service, termination of a previously authorized service, or failure to provide service timely. You will get a notice mailed to you within ten (10) days before any action is taken.

If a State Fair Hearing is requested, the State will hear your case and give you a decision in writing within ninety (90) days of the date you asked for a State Fair Hearing. If are still not happy with the decision, youcan

take your case to Circuit Court. If you want to proceed in taking your case to Circuit Court, you must file within thirty (30) days of your notice of the State Fair Hearing decision. You can file an appeal to the Bureau for Medical Services (BMS).
Send your request for an appeal to:
Bureau for Medical Services
Office of Medicaid Managed Care
350 Capitol Street, Room 251
Charleston, WV 25301-3708

The BMS decision will be sent to you in writing.

If you are not happy with the Bureau for Medical Services decision, you can appeal to the West Virginia Insurance Commissioner by sending your appeal to:
The Office of the Insurance Commissioner
P.O. Box 50540
Charleston, WV 25305-0540

Aetna Better Health of West Virginia will continue your benefits during the time of an appeal process or State Fair Hearing when:

- You or your provider file an appeal on a timely basis;
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized provider;
- The original period covered by the original authorization has not expired; and
- You request an extension of benefits.

To request an extension of benefits, call member service at **888-348-2922**.

Aetna Better Health of West Virginia will pay for the services in question when the final result of the appeal to overturn the original decision. **Aetna Better Health of West Virginia** will pay for some or all of the services as determined by the final appeal decision. If the final result of your appeal is to uphold the original decision to deny, reduce, change or end payment for your services, **Aetna Better Health of West Virginia** may take back the money that was paid for the services while the appeal was in process, and you will be responsible for paying for the services.

If you are not satisfied with the decision of the Office of the Insurance Commissioner, you may appeal to Circuit Court. Your appeal must be filed within thirty (30) days after the Insurance Commissioner's order has been mailed.

Appeals after 120 Days

If you did not request a State Fair Hearing within the 120 days, you may still be able to appeal **Aetna Better Healthf of West Virginia**'s Appeal decision that you are unhappy with. You can also use this process if the decision is related to a Complaint rather than an Appeal. You must have gone through **Aetna Better Health of West Virginia**'s Grievance process and it must be within one (1) year of the date of the original decision or issue that you did not agree with or were not happy with.

Keeping Your Grievance and Appeals

Aetna Better Health of West Virginia will keep copies of your grievance and appeals documents, records and information about the grievance and appeal for your review for ten (10) years.

Nondiscrimination Notice

Aetna complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Aetna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card or **1-800-385-4104**.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with our Civil Rights Coordinator at:

Address:	Attn: Civil Rights Coordinator 4500 E. Cotton Center Blvd Phoenix, AZ 85040
Telephone:	1-888-234-7358, TTY 711
Email:	MedicaidCRCoordinator@aetna.com

You can file a grievance in person or by mail or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, and its affiliates.

Multi-language Interpreter Services

ENGLISH: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card or **1-800-385-4104** (TTY: **711**).

SPANISH: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que aparece en el reverso de su tarjeta de identificación o al **1-800-385-4104** (TTY: **711**).

CHINESE: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電您的 ID 卡背面的電話號碼或 **1-800-385-4104** (TTY: **711**)。

FRENCH: ATTENTION : si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le numéro indiqué au verso de votre carte d'identité ou le **1-800-385-4104** (ATS : **711**).

GERMAN: ACHTUNG: Wenn Sie deutschen sprechen, können Sie unseren kostenlosen Sprachservice nutzen. Rufen Sie die Nummer auf der Rückseite Ihrer ID-Karte oder **1-800-385-4104** (TTY: **711**) an.

ARABIC: ملحوظة: إذا كنت تتحدث باللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل على الرقم الموجود خلف بطاقتك الشخصية أو عل **1-800-385-4104**(للصم والبكم: **711**)

VIETNAMESE: CHÚ Ý: nếu bạn nói tiếng việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Hãy gọi số có ở mặt sau thẻ id của bạn hoặc **1-800-385-4104** (TTY: **711**).

KOREAN: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드 뒷면에 있는 번호로나 **1-800-385-4104** (TTY: **711**) 번으로 연락해 주십시오.

JAPANESE: 注意事項:日本語をお話になる方は、無料で言語サポートのサービスをご利用いただけます。IDカード裏面の電話番号、または**1-800-385-4104** (TTY: **711**)までご連絡ください。

TAGALOG: PAUNAWA: Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tumawag sa numero na nasa likod ng iyong ID card o sa **1-800-385-4104** (TTY: **711**).

ITALIAN: ATTENZIONE: Nel caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuita. Chiamare il numero sul retro della tessera oppure il numero **1-800-385-4104** (utenti TTY: **711**).

THAI: ข้อควรระวัง: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทรติดต่อหมายเลขที่อยู่ด้านหลังบัตร ID ของคุณ หรือหมายเลข **1-800-385-4104** (TTY: **711**)

NEPALI: ध्यान दिनुहोस्: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि नि:शुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध छन्। तपाईंको आइडी कार्डको पछाडि रहेको नम्बर वा **1-800-385-4104** (TTY: **711**) मा फोन गर्नुहोस्।

PERSIAN: اگر به زبان فارسی صحبت می کنید، به صورت رایگان می توانید به خدمات کمک زبانی دسترسی داشته باشید. با شماره درج شده در پشت کارت شناسایی یا با شماره **1-800-385-4104** (TTY: **711**) تماس بگیرید.

RUSSIAN: ВНИМАНИЕ: если вы говорите на русском языке, вам могут предоставить бесплатные услуги перевода. Позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки, или по номеру **1-800-385-4104** (TTY: **711**).

URDU: توجہ دیں: اگر آپ اردو زبان بولتے ہیں، تو زبان سے متعلق مدد کی خدمات آپ کے لئے مفت دستیاب ہیں - اپنے شناختی کارڈ کے پیچھے موجود نمبر پر یا **1-800-385-4104** (TTY: **711**) پر رابطہ کریں-

Aetna Better Health® of West Virginia
500 Virginia Street East, Suite 400
Charleston, WV 25301

aetna®

FAX

Date: July 11, 2019

To: [redacted]
RE:
Phone: [redacted]
Fax: [redacted]

From: **Aetna Better Health of West Virginia**
Prior Authorizations
Phone: 1-888-348-2922
Fax: 1-866-366-7008

REMARKS: ☐ Urgent ☒ For Your Review ☐ Reply ASAP ☐ Please Comment

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NOTICE TO RECIPIENT(S) OF INFORMATION:
Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2), which prohibit any further disclosure of this information by you without express written consent of the person to whom it pertains of as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Sample Provider Notification of Non-Covered Services Letter

Aetna Better Health® of West Virginia
500 Virginia Street East, Suite 400
Charleston, WV 25301

Notice Date: July 11, 2019

RE: [redacted]
ID#: [redacted]
Date of Birth: [redacted]
Authorization: [redacted]
Requesting Doctor: [redacted]
Date of Request: [redacted]

Dear Parent(s) or Guardian(s) of [redacted]:

This letter is to let you know that we will pay for code 81243, which is a test used to see what conditions may have been passed to your child, from your family (genetic testing). However, we are not able to approve code 81229, which is another type of genetic testing.

We do not cover this requested code. See your Member Handbook:

Page 30: Health services prohibited by law or regulation.

You, your doctor, or provider can get a free copy of the Member Handbook, or a copy of all documents, records and information, including the criteria and/or guidelines used to make our decision. To request this information, call our Member Services number **1-888-348-2922** or send a written request to fax number **1-866-366-7008** or write to us at:

Aetna Better Health of West Virginia
500 Virginia Street East, Suite 400
Charleston, WV 25301

If you do not agree with our answer, you can ask us to look at your request again. This is called an appeal. If you want to appeal, a different reviewer will look at your request. Then we will tell you if we will or will not pay for the services you requested.

You, your doctor, or provider can ask for a fast appeal if you need something fast (when serious injury or death may happen). You need to call Member Services and tell them that you want a fast appeal. They will tell you what you need to do. Please see the attached appeal document.

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500 Virginia Street East, Suite 400
Charleston, WV 25301

If you have any questions, please call Member Services at **1-888-348-2922**. If you are hearing or speech impaired, call TTY: 711. They will connect you to TTY services.

Sincerely,

[redacted]

[redacted]
Medical Director
Aetna Better Health of West Virginia

mds

Enclosure(s):
Notice of Action Statement
Nondiscrimination Notice

cc:
[redacted]

AETNA BETTER HEALTH OF WEST VIRGINIA

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If your Appeal is about our decision to not approve or pay for some or all of your health care services, and you need an Appeal decision fast because you have not gotten the health care services and you might be badly hurt if you had to wait for a normal Appeal decision, like the one described above, you can ask for a fast Appeal. You can file a Fast Appeal within 60 calendar days from the date on the notice of action from **Aetna Better Health of West Virginia.**

If we allow a fast Appeal, we will schedule a meeting with the Committee no later than forty-eight (48) hours after we get your Appeal. We will call you twenty-four (24) hours after we get your Appeal to let you know the date, time, and place of the meeting. We will make a decision on your Appeal no later than seventy-two (72) hours after we get your Appeal. You will get a written notice explaining the next steps in the process. **Aetna Better Health of West Virginia** will provide the results of your fast appeal to the State so that they can determine a timeframe for resolution.

To file a Fast Appeal you will need to provide us with:

- Your name
- Your provider's name
- The date of service
- Your mailing address
- The reason why we should change our decision
- A copy of any information that you think supports your Appeal, such as written comments, additional documents, records or information related to your Appeal

You can file a Fast Appeal by either calling us, or mailing or faxing the information to:
Aetna Better Health of West Virginia
Attention: Complaint and Appeal Department
500 Virginia Street, East
Suite 400
Charleston, WV 25301

Phone Number 888-348-2922 (TTY/TDD 711)
FAX - 888-388-1752

If we decide your Appeal is not a fast Appeal, we will handle your Appeal like the normal Appeals described in the section above.

State Fair Hearing process

If you are not happy with **Aetna Better Health of West Virginia**'s Appeal decision, and your Appeal is about our decision to deny, reduce, change or terminate payment for your health care services, you can request a State Fair Hearing if it is within 120 calendar days from the notice of resolution from **Aetna Better Health of West Virginia**. You can only request a State Fair Hearing if it relates to a denial of a service, a reduction in service, termination of a previously authorized service, or failure to provide service timely. You will get a notice mailed to you within ten (10) days before any action is taken.

If a State Fair Hearing is requested, the State will hear your case and give you a decision in writing within ninety (90) days of the date you asked for a State Fair Hearing. If are still not happy with the decision, youcan

take your case to Circuit Court. If you want to proceed in taking your case to Circuit Court, you must file within thirty (30) days of your notice of the State Fair Hearing decision. You can file an appeal to the Bureau for Medical Services (BMS).
Send your request for an appeal to:
Bureau for Medical Services
Office of Medicaid Managed Care
350 Capitol Street, Room 251
Charleston, WV 25301-3708

The BMS decision will be sent to you in writing.

If you are not happy with the Bureau for Medical Services decision, you can appeal to the West Virginia Insurance Commissioner by sending your appeal to:
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P.O. Box 50540
Charleston, WV 25305-0540

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- The services were ordered by an authorized provider;
- The original period covered by the original authorization has not expired; and
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If you are not satisfied with the decision of the Office of the Insurance Commissioner, you may appeal to Circuit Court. Your appeal must be filed within thirty (30) days after the Insurance Commissioner's order has been mailed.

Appeals after 120 Days

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Aetna Better Health of West Virginia will keep copies of your grievance and appeals documents, records and information about the grievance and appeal for your review for ten (10) years.

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  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
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  - Information written in other languages

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card or **1-800-385-4104**.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with our Civil Rights Coordinator at:

Address:	Attn: Civil Rights Coordinator 4500 E. Cotton Center Blvd Phoenix, AZ 85040
Telephone:	1-888-234-7358, TTY 711
Email:	MedicaidCRCoordinator@aetna.com

You can file a grievance in person or by mail or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD).

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ENGLISH: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card or **1-800-385-4104** (TTY: **711**).

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FRENCH: ATTENTION : si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le numéro indiqué au verso de votre carte d'identité ou le **1-800-385-4104** (ATS : **711**).

GERMAN: ACHTUNG: Wenn Sie deutschen sprechen, können Sie unseren kostenlosen Sprachservice nutzen. Rufen Sie die Nummer auf der Rückseite Ihrer ID-Karte oder **1-800-385-4104** (TTY: **711**) an.

ARABIC: ملحوظة: إذا كنت تتحدث باللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل على الرقم الموجود خلف بطاقتك الشخصية أو عل **1-800-385-4104**(للصم والبكم: **711**)

VIETNAMESE: CHÚ Ý: nếu bạn nói tiếng việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Hãy gọi số có ở mặt sau thẻ id của bạn hoặc **1-800-385-4104** (TTY: **711**).

KOREAN: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드 뒷면에 있는 번호로나 **1-800-385-4104** (TTY: **711**) 번으로 연락해 주십시오.

JAPANESE: 注意事項:日本語をお話になる方は、無料で言語サポートのサービスをご利用いただけます。IDカード裏面の電話番号、または**1-800-385-4104** (TTY: **711**)までご連絡ください。

TAGALOG: PAUNAWA: Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tumawag sa numero na nasa likod ng iyong ID card o sa **1-800-385-4104** (TTY: **711**).

ITALIAN: ATTENZIONE: Nel caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuita. Chiamare il numero sul retro della tessera oppure il numero **1-800-385-4104** (utenti TTY: **711**).

THAI: ข้อควรระวัง: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทรติดต่อหมายเลขที่อยู่ด้านหลังบัตร ID ของคุณ หรือหมายเลข **1-800-385-4104** (TTY: **711**)

NEPALI: ध्यान दिनुहोस्: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि नि:शुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध छन्। तपाईंको आइडी कार्डको पछाडि रहेको नम्बर वा **1-800-385-4104** (TTY: **711**) मा फोन गर्नुहोस्।

PERSIAN: اگر به زبان فارسی صحبت می کنید، به صورت رایگان می توانید به خدمات کمک زبانی دسترسی داشته باشید. با شماره درج شده در پشت کارت شناسایی یا با شماره **1-800-385-4104** (TTY: **711**) تماس بگیرید.

RUSSIAN: ВНИМАНИЕ: если вы говорите на русском языке, вам могут предоставить бесплатные услуги перевода. Позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки, или по номеру **1-800-385-4104** (TTY: **711**).

URDU: توجہ دیں: اگر آپ اردو زبان بولتے ہیں، تو زبان سے متعلق مدد کی خدمات آپ کے لئے مفت دستیاب ہیں - اپنے شناختی کارڈ کے پیچھے موجود نمبر پر یا **1-800-385-4104** (TTY: **711**) پر رابطہ کریں-

Sample Member Notification of Non-Participating Provider / Out-of-Network Services Letter

Aetna Better Health® of West Virginia
500 Virginia Street East, Suite 400
Charleston, WV 25301

Notice Date: July 19, 2019

RE: [redacted]
ID#: [redacted]
Date of Birth: [redacted]
Authorization: [redacted]
Requesting Doctor: [redacted]
Date of Request: [redacted]

Dear [redacted]:

This letter is to let you know we will not pay for service with Cleveland Clinic Foundation. This is not a participating provider. Please look at your Provider Directory or call Member Services at **1-888-348-2922** for help in finding a doctor or provider. If you need additional assistance finding a network doctor or facility, you can request to speak to a case manager by calling **1-888-348-2922**.

See your Member Handbook:
Out of Network Services
You can go to a provider outside the Aetna Better Health network only if: (1) the care is needed; and (2) there are no Aetna Better Health providers who can give you the care needed.

You, your doctor, or provider can get a free copy of the Member Handbook, or a copy of all documents, records and information, including the criteria and/or guidelines used to make our decision. To request this information, call our Member Services number **1-888-348-2922** or send a written request to fax number **1-866-366-7008** or write to us at:

Aetna Better Health of West Virginia
500 Virginia Street East, Suite 400
Charleston, WV 25301

If you do not agree with our answer, you can ask us to look at your request again. This is called an appeal. If you want to appeal, a different reviewer will look at your request. Then we will tell you if we will or will not pay for the services you requested.

You may appeal this determination by submitting a written request within 60 calendar days from the date on this notice:

Aetna Better Health of West Virginia
Attn: Appeals
500 Virginia Street East, Suite 400
Charleston, WV 25301

You, your doctor, or provider can ask for a fast appeal if you need something fast (when serious injury or death may happen). You need to call Member Services and tell them you want a fast appeal. They will tell you what you need to do. We will have a doctor who is the same kind of doctor as your doctor look at your medical records.

If we allow the fast appeal, we will give you an answer to your fast appeal in 72 hours from the first time we hear from you. You can also ask for a fast appeal by writing a letter. Please see the attached appeal document.

If you have any questions, please call Member Services at **1-888-348-2922**. If you are hearing or speech impaired, call TTY**: 711**. They will connect you to TTY services.

Sincerely,

[redacted]
[redacted]
Medical Director
Aetna Better Health of West Virginia

mds

Enclosure(s):
Notice of Action Statement
Nondiscrimination Notice

cc:
[redacted]

AETNA BETTER HEALTH OF WEST VIRGINIA

Notice of action statement

Grievances

As a Medicaid member, you may file a grievance regarding any aspect of service delivery provided or paid for by Aetna Better Health of West Virginia at any time. If you do not agree with a decision made by Aetna Better Health of West Virginia, are not happy with any services received, are unhappy about any other part of Aetna Better Health of West Virginia or your provider, you (without getting in trouble) can get in touch with Aetna Better Health of West Virginia by calling at 888-348-2922 (TTY/TDD 711), or writing it down and sending it to:

Aetna Better Health of West Virginia
Attention: Complaint and Appeal Department
500 Virginia Street, East
Suite 400
Charleston, WV 25301

Aetna Better Health of West Virginia will provide translation services as needed at no cost to you.

Informal grievances/Complaints

Informal Grievances are when you call Aetna Better Health of West Virginia to tell us you are not happy with any matter related to Aetna Better Health of West Virginia, such as our decision to not pay a claim or okay health care for you, or you are unhappy with any part of your benefits, services, Aetna Better Health of West Virginia, or its network of providers. If you call the Member Service Department at 888-348-2922, they will take all of the information you give them and investigate the problem. They will try to get you an answer in thirty (30) calendar days from the date the Informal Grievace was filed. If they are not able to answer your question in thirty (30) calendar days, they will call you or write you back and let you know. You can file an Informal Grievance/Complaint at any time.

To file a Complaint, you can call us at **888-348-2922** (TTY/TDD 711) and we will ask for the information listed below and write down the Complaint for you. We will let you know when we have received your Complaint and you can get copies of documents, records and information about the Complaint. We will give these documents to you for free. Your complaint will be reviewed and resolved within 30 calendar days of receipt.

You can also send us a letter that has:

- Your name
- Your mailing address
- The reason why you are filing the Complaint and what you want **Aetna Better Health of West Virginia** to do

If your Complaint involves a Quality of Care or Quality of Service issue, we will research your Complaint; notify the appropriate **Aetna Better Health of West Virginia** department or committee of your Complaint, and the corrective action(s) that was taken, if any, to resolve the Complaint. You will only be contacted if we need additional information to resolve your Complaint.

Formal grievances

If you are not happy with our answer to your Informal Grievance, you or someone with your okay (including a health care provider) can file a Formal Grievance. You may also skip the Informal Grievance process and file a Formal Grievance right away. If your Formal Grievance is because we have denied any part of your request fo. a health care service, it is called an "Appeal."

Appeals

To file an Appeal you will need to send us a letter that has:

- Your name
- Your provider's name
- The date of service
- Your mailing address
- The reason why we should change our decision
- A copy of any information that you think supports your Appeal, such as written comments, additional documents, records or information related to your Appeal

You must file an appeal within sixty (60) calendar days from the date on the notice of action from Aetna Better Health.

A Committee will look at your Appeal. None of the people on the Appeal Committee will have been involved in our initial decision to not authorize or pay for the health services you are appealing. If your Appeal involves a medical issue, the Committee will also talk to a health care professional who has the appropriate training and experience in the field of medicine necessary for making the decision on the medical issue. If your Appeal is an administrative appeal (one not based on a medical issue), the Appeal Committee will consist of Health Plan senior management. You can come to the Appeal Committee meeting and talk to the Appeal Committee. You have the right to be represented during the appeal process.

Aetna Better Health of West Virginia must process and provide notice to you regarding your appeal within thirty (30) calendar days.

If Aetna Better Health of West Virginia needs more information for the Appeal, or if you want to provide more information, you or Aetna Better Health of West Virginia can ask for fourteen (14) more calendar days to finish the Appeal. If Aetna Better Health of West Virginia decides to extend the review time to finish the appeal, you will be notified in writing within two (2) calendar days that you have the right to file a grievance if you disagree with the extension.

Written Complaints and Appeals should be mailed to:
Aetna Better Health of West Virginia
Attention: Complaint and Appeal Department
500 Virginia Street, East
Suite 400
Charleston, WV 25301

If you are not able to file a written Appeal or Complaint, you can call **Aetna Better Health of West Virginia** at 888-348-2922 and we will ask for the information listed above, and write down the Appeal/Complaint for yo. We will let you know when we have received your Appeal or Complaint and you can get copies of documents, records, and information about the Appeal or Complaint. We will give these documents to you for free.

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Email:	MedicaidCRCoordinator@aetna.com

You can file a grievance in person or by mail or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD).

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TAGALOG: PAUNAWA: Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tumawag sa numero na nasa likod ng iyong ID card o sa **1-800-385-4104** (TTY: **711**).

ITALIAN: ATTENZIONE: Nel caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuita. Chiamare il numero sul retro della tessera oppure il numero **1-800-385-4104** (utenti TTY: **711**).

THAI: ข้อควรระวัง: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทรติดต่อหมายเลขที่อยู่ด้านหลังบัตร ID ของคุณ หรือหมายเลข **1-800-385-4104** (TTY: **711**)

NEPALI: ध्यान दिनुहोस्: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि नि:शुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध छन्। तपाईंको आइडी कार्डको पछाडि रहेको नम्बर वा **1-800-385-4104** (TTY: **711**) मा फोन गर्नुहोस्।

PERSIAN: اگر به زبان فارسی صحبت می کنید، به صورت رایگان می توانید به خدمات کمک زبانی دسترسی داشته باشید. با شماره درج شده در پشت کارت شناسایی یا با شماره **1-800-385-4104** (TTY: **711**) تماس بگیرید.

RUSSIAN: ВНИМАНИЕ: если вы говорите на русском языке, вам могут предоставить бесплатные услуги перевода. Позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки, или по номеру **1-800-385-4104** (TTY: **711**).

URDU: توجہ دیں: اگر آپ اردو زبان بولتے ہیں، تو زبان سے متعلق مدد کی خدمات آپ کے لئے مفت دستیاب ہیں - اپنے شناختی کارڈ کے پیچھے موجود نمبر پر یا **1-800-385-4104** (TTY: **711**) پر رابطہ کریں۔

Aetna Better Health® of West Virginia
500 Virginia Street East, Suite 400
Charleston, WV 25301

aetna®

FAX

Date: July 19, 2019

To: [redacted]

RE:

Phone: [redacted]
Fax: [redacted]

From: **Aetna Better Health of West Virginia**
Prior Authorizations
Phone: 1-888-348-2922
Fax: 1-866-366-7008

REMARKS: ☐ Urgent ☒ For Your Review ☐ Reply ASAP ☐ Please Comment

[redacted]

CONFIDENTIALITY NOTICE: This message is intended only for the user of the individual or entity to which it is addressed and may contain confidential and proprietary information. If you are not the intended recipient of the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is prohibited. If you received this communication in error, please notify the sender at the phone number above.

NOTICE TO RECIPIENT(S) OF INFORMATION:
Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2), which prohibit any further disclosure of this information by you without express written consent of the person to whom it pertains of as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Sample Provider Notification of Non-Participating Provider / Out-of-Network Services Letter

Aetna Better Health® of West Virginia
500 Virginia Street East, Suite 400
Charleston, WV 25301

Notice Date: July 19, 2019

RE: [redacted]
ID#: [redacted]
Date of Birth: [redacted]
Authorization: [redacted]
Requesting Doctor: [redacted]
Date of Request: [redacted]

Dear [redacted]:

This letter is to let you know we will not pay for service with Cleveland Clinic Foundation. This is not a participating provider. Please look at your Provider Directory or call Member Services at **1-888-348-2922** for help in finding a doctor or provider. If you need additional assistance finding a network doctor or facility, you can request to speak to a case manager by calling **1-888-348-2922**.

See your Member Handbook:
Out of Network Services
You can go to a provider outside the Aetna Better Health network only if: (1) the care is needed; and (2) there are no Aetna Better Health providers who can give you the care needed.

You, your doctor, or provider can get a free copy of the Member Handbook, or a copy of all documents, records and information, including the criteria and/or guidelines used to make our decision. To request this information, call our Member Services number **1-888-348-2922** or send a written request to fax number **1-866-366-7008** or write to us at:

Aetna Better Health of West Virginia
500 Virginia Street East, Suite 400
Charleston, WV 25301

If you do not agree with our answer, you can ask us to look at your request again. This is called an appeal. If you want to appeal, a different reviewer will look at your request. Then we will tell you if we will or will not pay for the services you requested.

You may appeal this determination by submitting a written request within 60 calendar days from the date on this notice:

Aetna Better Health of West Virginia
Attn: Appeals
500 Virginia Street East, Suite 400
Charleston, WV 25301

You, your doctor, or provider can ask for a fast appeal if you need something fast (when serious injury or death may happen). You need to call Member Services and tell them you want a fast appeal. They will tell you what you need to do. We will have a doctor who is the same kind of doctor as your doctor look at your medical records.

If we allow the fast appeal, we will give you an answer to your fast appeal in 72 hours from the first time we hear from you. You can also ask for a fast appeal by writing a letter. Please see the attached appeal document.

If you have any questions, please call Member Services at **1-888-348-2922**. If you are hearing or speech impaired, call TTY: **711**. They will connect you to TTY services.

Sincerely,

[redacted]
[redacted]
Medical Director
Aetna Better Health of West Virginia

[redacted]

Enclosure(s):
Notice of Action Statement
Nondiscrimination Notice

cc:
[redacted]

AETNA BETTER HEALTH OF WEST VIRGINIA

Notice of action statement

Grievances

As a Medicaid member, you may file a grievance regarding any aspect of service delivery provided or paid for by Aetna Better Health of West Virginia at any time. If you do not agree with a decision made by Aetna Better Health of West Virginia, are not happy with any services received, are unhappy about any other part of Aetna Better Health of West Virginia or your provider, you (without getting in trouble) can get in touch with Aetna Better Health of West Virginia by calling at 888-348-2922 (TTY/TDD 711), or writing it down and sending it to:

Aetna Better Health of West Virginia
Attention: Complaint and Appeal Department
500 Virginia Street, East
Suite 400
Charleston, WV 25301

Aetna Better Health of West Virginia will provide translation services as needed at no cost to you.

Informal grievances/Complaints

Informal Grievances are when you call Aetna Better Health of West Virginia to tell us you are not happy with any matter related to Aetna Better Health of West Virginia, such as our decision to not pay a claim or okay health care for you, or you are unhappy with any part of your benefits, services, Aetna Better Health of West Virginia, or its network of providers. If you call the Member Service Department at 888-348-2922, they will take all of the information you give them and investigate the problem. They will try to get you an answer in thirty (30) calendar days from the date the Informal Grievace was filed. If they are not able to answer your question in thirty (30) calendar days, they will call you or write you back and let you know. You can file an Informal Grievance/Complaint at any time.

To file a Complaint, you can call us at **888-348-2922** (TTY/TDD 711) and we will ask for the information listed below and write down the Complaint for you. We will let you know when we have received your Complaint and you can get copies of documents, records and information about the Complaint. We will give these documents to you for free. Your complaint will be reviewed and resolved within 30 calendar days of receipt.

You can also send us a letter that has:

- Your name
- Your mailing address
- The reason why you are filing the Complaint and what you want **Aetna Better Health of West Virginia** to do

If your Complaint involves a Quality of Care or Quality of Service issue, we will research your Complaint; notify the appropriate **Aetna Better Health of West Virginia** department or committee of your Complaint, and the corrective action(s) that was taken, if any, to resolve the Complaint. You will only be contacted if we need additional information to resolve your Complaint.

Formal grievances

If you are not happy with our answer to your Informal Grievance, you or someone with your okay (including a health care provider) can file a Formal Grievance. You may also skip the Informal Grievance process and file a Formal Grievance right away. If your Formal Grievance is because we have denied any part of your request fo. a health care service, it is called an "Appeal."

Appeals

To file an Appeal you will need to send us a letter that has:

- Your name
- Your provider's name
- The date of service
- Your mailing address
- The reason why we should change our decision
- A copy of any information that you think supports your Appeal, such as written comments, additional documents, records or information related to your Appeal

You must file an appeal within sixty (60) calendar days from the date on the notice of action from Aetna Better Health.

A Committee will look at your Appeal. None of the people on the Appeal Committee will have been involved in our initial decision to not authorize or pay for the health services you are appealing. If your Appeal involves a medical issue, the Committee will also talk to a health care professional who has the appropriate training and experience in the field of medicine necessary for making the decision on the medical issue. If your Appeal is an administrative appeal (one not based on a medical issue), the Appeal Committee will consist of Health Plan senior management. You can come to the Appeal Committee meeting and talk to the Appeal Committee. You have the right to be represented during the appeal process.

Aetna Better Health of West Virginia must process and provide notice to you regarding your appeal within thirty (30) calendar days.

If Aetna Better Health of West Virginia needs more information for the Appeal, or if you want to provide more information, you or Aetna Better Health of West Virginia can ask for fourteen (14) more calendar days to finish the Appeal. If Aetna Better Health of West Virginia decides to extend the review time to finish the appeal, you will be notified in writing within two (2) calendar days that you have the right to file a grievance if you disagree with the extension.

Written Complaints and Appeals should be mailed to:
Aetna Better Health of West Virginia
Attention: Complaint and Appeal Department
500 Virginia Street, East
Suite 400
Charleston, WV 25301

If you are not able to file a written Appeal or Complaint, you can call **Aetna Better Health of West Virginia** at 888-348-2922 and we will ask for the information listed above, and write down the Appeal/Complaint for yo. We will let you know when we have received your Appeal or Complaint and you can get copies of documents, records, and information about the Appeal or Complaint. We will give these documents to you for free.

Fast appeals

If your Appeal is about our decision to not approve or pay for some or all of your health care services, and you need an Appeal decision fast because you have not gotten the health care services and you might be badly hurt if you had to wait for a normal Appeal decision, like the one described above, you can ask for a fast Appeal. You can file a Fast Appeal within 60 calendar days from the date on the notice of action from **Aetna Better Health of West Virginia.**

If we allow a fast Appeal, we will schedule a meeting with the Committee no later than forty-eight (48) hours after we get your Appeal. We will call you twenty-four (24) hours after we get your Appeal to let you know the date, time, and place of the meeting. We will make a decision on your Appeal no later than seventy-two (72) hours after we get your Appeal. You will get a written notice explaining the next steps in the process. **Aetna Better Health of West Virginia** will provide the results of your fast appeal to the State so that they can determine a timeframe for resolution.

To file a Fast Appeal you will need to provide us with:

- Your name
- Your provider's name
- The date of service
- Your mailing address
- The reason why we should change our decision
- A copy of any information that you think supports your Appeal, such as written comments, additional documents, records or information related to your Appeal

You can file a Fast Appeal by either calling us, or mailing or faxing the information to:
Aetna Better Health of West Virginia
Attention: Complaint and Appeal Department
500 Virginia Street, East
Suite 400
Charleston, WV 25301

Phone Number 888-348-2922 (TTY/TDD 711)
FAX - 888-388-1752

If we decide your Appeal is not a fast Appeal, we will handle your Appeal like the normal Appeals described in the section above.

State Fair Hearing process

If you are not happy with **Aetna Better Health of West Virginia**'s Appeal decision, and your Appeal is about our decision to deny, reduce, change or terminate payment for your health care services, you can request a State Fair Hearing if it is within 120 calendar days from the notice of resolution from **Aetna Better Health of West Virginia**. You can only request a State Fair Hearing if it relates to a denial of a service, a reduction in service, termination of a previously authorized service, or failure to provide service timely. You will get a notice mailed to you within ten (10) days before any action is taken.

If a State Fair Hearing is requested, the State will hear your case and give you a decision in writing within ninety (90) days of the date you asked for a State Fair Hearing. If are still not happy with the decision, youcan

take your case to Circuit Court. If you want to proceed in taking your case to Circuit Court, you must file within thirty (30) days of your notice of the State Fair Hearing decision. You can file an appeal to the Bureau for Medical Services (BMS).
Send your request for an appeal to:
Bureau for Medical Services
Office of Medicaid Managed Care
350 Capitol Street, Room 251
Charleston, WV 25301-3708

The BMS decision will be sent to you in writing.

If you are not happy with the Bureau for Medical Services decision, you can appeal to the West Virginia Insurance Commissioner by sending your appeal to:
The Office of the Insurance Commissioner
P.O. Box 50540
Charleston, WV 25305-0540

Aetna Better Health of West Virginia will continue your benefits during the time of an appeal process or State Fair Hearing when:

- You or your provider file an appeal on a timely basis;
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized provider;
- The original period covered by the original authorization has not expired; and
- You request an extension of benefits.

To request an extension of benefits, call member service at **888-348-2922**.

Aetna Better Health of West Virginia will pay for the services in question when the final result of the appeal to overturn the original decision. **Aetna Better Health of West Virginia** will pay for some or all of the services as determined by the final appeal decision. If the final result of your appeal is to uphold the original decision to deny, reduce, change or end payment for your services, **Aetna Better Health of West Virginia** may take back the money that was paid for the services while the appeal was in process, and you will be responsible for paying for the services.

If you are not satisfied with the decision of the Office of the Insurance Commissioner, you may appeal to Circuit Court. Your appeal must be filed within thirty (30) days after the Insurance Commissioner's order has been mailed.

Appeals after 120 Days

If you did not request a State Fair Hearing within the 120 days, you may still be able to appeal **Aetna Better Healthf of West Virginia**'s Appeal decision that you are unhappy with. You can also use this process if the decision is related to a Complaint rather than an Appeal. You must have gone through **Aetna Better Health of West Virginia**'s Grievance process and it must be within one (1) year of the date of the original decision or issue that you did not agree with or were not happy with.

Keeping Your Grievance and Appeals

Aetna Better Health of West Virginia will keep copies of your grievance and appeals documents, records and information about the grievance and appeal for your review for ten (10) years.

Nondiscrimination Notice

Aetna complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Aetna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card or **1-800-385-4104**.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with our Civil Rights Coordinator at:

Address:	Attn: Civil Rights Coordinator 4500 E. Cotton Center Blvd Phoenix, AZ 85040
Telephone:	1-888-234-7358, TTY 711
Email:	MedicaidCRCoordinator@aetna.com

You can file a grievance in person or by mail or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, and its affiliates.

Multi-language Interpreter Services

ENGLISH: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card or **1-800-385-4104** (TTY: **711**).

SPANISH: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que aparece en el reverso de su tarjeta de identificación o al **1-800-385-4104** (TTY: **711**).

CHINESE: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電您的 ID 卡背面的電話號碼或 **1-800-385-4104** (TTY: **711**)。

FRENCH: ATTENTION : si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le numéro indiqué au verso de votre carte d'identité ou le **1-800-385-4104** (ATS : **711**).

GERMAN: ACHTUNG: Wenn Sie deutschen sprechen, können Sie unseren kostenlosen Sprachservice nutzen. Rufen Sie die Nummer auf der Rückseite Ihrer ID-Karte oder **1-800-385-4104** (TTY: **711**) an.

ARABIC: ملحوظة: إذا كنت تتحدث باللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل على الرقم الموجود خلف بطاقتك الشخصية أو على **1-800-385-4104**(للصم والبكم: **711**)

VIETNAMESE: CHÚ Ý: nếu bạn nói tiếng việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Hãy gọi số có ở mặt sau thẻ id của bạn hoặc **1-800-385-4104** (TTY: **711**).

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THAI: ข้อควรระวัง: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทรติดต่อหมายเลขที่อยู่ด้านหลังบัตร ID ของคุณ หรือหมายเลข **1-800-385-4104** (TTY: **711**)

NEPALI: ध्यान दिनुहोस्: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि नि:शुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध छन्। तपाईंको आइडी कार्डको पछाडि रहेको नम्बर वा **1-800-385-4104** (TTY: **711**) मा फोन गर्नुहोस्।

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RUSSIAN: ВНИМАНИЕ: если вы говорите на русском языке, вам могут предоставить бесплатные услуги перевода. Позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки, или по номеру **1-800-385-4104** (TTY: **711**).

URDU: توجہ دیں: اگر آپ اردو زبان بولتے ہیں، تو زبان سے متعلق مدد کی خدمات آپ کے لئے مفت دستیاب ہیں - اپنے شناختی کارڈ کے پیچھے موجود نمبر پر یا **1-800-385-4104** (TTY: **711**) پر رابطہ کریں-

Appendix G

HRA Screening ..... App G-3

HCE Screening ..... App G-9

Behavioral Health Screen ..... App G-13

Sample Care Plan ..... App G-19

HRA Screening

Screening: HRA/HRQ

ABHWVA
Care Management
Case Manager (CM), Care Management Associate (CMA)

aetna

Score 0-100 with 100 representing maximum risk for high cost/utilization

Q#	Question/Selections
1	**How well do you speak English? (Single Pick):** ☐Not at all ☐Not well ☐Well ☐Very well
2	**Do you have a doctor/primary care provider (PCP) or clinic you go to when you are sick? What is their name? _____ (Single Pick):** ☐Yes, only one ☐More than one ☐No I do not have one
3	**Does your doctor or clinic give you pills or medicine you have to take every day? (Single Pick):** ☐Yes **(If yes, go to Q4)** ☐No **(If no, got to Q5)**
4	**Show if Q3 = Yes** **Have you stopped taking any pills or medicine and NOT told your doctor? (Single Pick):** ☐Yes ☐No
5	**Show if Q3 = No** **Do you have a dental problem?** ☐Yes ☐No
6	**Do you need help finding a dentist?** ☐Yes ☐No
7	**Would you say that in general your health is ... (Single Pick):** ☐Excellent ☐Very Good ☐Good ☐Fair

	☐Poor
8	**In the last month, how many days did you feel so bad that you could not work, take care of yourself, or have fun? (Single Pick):** ☐___ Number of days ☐None
9	**In the last month, how many days were you sad, stressed, down, or had problems with bad feelings? (Single Pick):** ☐___ Number of days ☐None
10	**Have you gone to a doctor or clinic for mood or stress problems or for drug or alcohol problems? (Single Pick):** ☐Yes (if yes, go to QT #10) ☐No (if no, got to QT #9)
11	**Do you think you need to? (Single Pick):** ☐Yes ☐No
12	**How many times in the last month did you have more than 4-5 drinks (alcohol) at once? (Single Pick):** ☐___Number of times ☐None
13	**A doctor or clinic told me I have this: (check all that apply to you) (Multi Pick):** ☐Currently Pregnant ☐Breathing problems like asthma, difficulty breathing, COPD ☐Blood Pressure problems like hypertension ☐Bone or joint problems like arthritis, amputation, chronic low back pain ☐Bowel or stomach problems like ulcers, chronic diarrhea ☐Cancer ☐Diabetes ☐Hearing problems like deafness, hearing aids ☐Heart problems like chest pain, heart attacks, Heart Failure ☐Infection problems like Hepatitis, HIV/AIDS or TB ☐Kidney problems like dialysis ☐Mental Health problems like depression, anxiety, alcohol or drug use

	☐Nerve or brain problems like: Stroke, Multiple Sclerosis, Spinal Cord Injury ☐Vision problems like blindness ☐Transplant (specify type) ☐Other (Please list)
14	**Do you feel you have any control over your health problems or illnesses? (Single Pick):** • On a scale of 1-10: 1 2 3 4 5 6 7 8 9 10 Degree of control: 1 = Absolutely no control 10 = LARGE amount of control
15	**How many different addresses have you had in the last 12 months? (Single Pick):** ☐Only 1 address in last year ☐2-3 addresses ☐More than 3 ☐I am homeless or sleep in a shelter right now
16	**In the last 6 months, were you sick enough to go to the emergency room or stay the night in the hospital more than two times? (Single Pick):** ☐Yes ☐No
17	**Do you use tobacco products?** ☐ Yes – doesn't want to quit or reduce ☐ Yes – would like to quit or reduce ☐ No Additional Instructions 1. *Mail smoking cessation information if member says "yes" to either* 2. *If yes and wants to quit – Provide referrals to smoking cessation programs.* ★ **Material Request – Contact** ★ **Member Community Resources/Referral**

HCE Screening

Quick Guide to the HCE Contact Assessment Social Determinants of Health

DEMOGRAPHICS

Question	Options
Race (1)	White Hispanic, Latino, or Spanish Origin Black or African American Asian American Indian or Alaska Native Middle Eastern or North African Native Hawaiian or Other Pacific Islander Some other race ethnicity or origin <specify>
Are you of Hispanic or Latino origin? (2)	Yes <prompts to address #3> No
Ethnicity (3)	Mexican or Mexican American Puerto Rican Cuban Other Hispanic or Latino Origin <specify>
Gender (4)	Female Male Transgender female to male Transgender male to female Other Decline to answer
Sexual Orientation (5)	Heterosexual Gay (homosexual or lesbian) Bisexual Other
Place of Residence (6)	Enter City Enter State Enter County
Place of Residence-zip code (7)	Enter zip code
Where is your place of birth? (8)	Enter City Enter State Enter Country
Were you born on a Reservation? (9)	Yes <please specify name> No

ECONOMIC STABILITY

Question	Options
Sources of Income (10)	Employed, Full-time Employed, Part-time Retired Disability/SSI (Supplemental Security Income) Social Security Food Stamps TANF Unemployed Other <specify>
Type of Employment (11)	Education and Health Services Wholesale and Retail Trade Manufacturing Construction Professional and Technical Services Self Employed Other <specify>
Food Security-The food that we bought just didn't last and we didn't have money to get more. (12)	Often True Sometimes True Never True
Food Security-We couldn't afford to eat balanced meals. (13)	Often True Sometimes True Never True
Food Security-In the last 12 months, we re you ever hungry, but didn't eat, because there wasn't enough food?(14)	Yes No
Housing Status (15)	Own Rent Shelter Homeless Other <specify>
Have you had stable housing for the last 12 months? (16)	Yes No

EDUCATION

Question	Options
Prefers to be spoken to in English (17)	Yes No, if no what language <specify> Spanish Chinese French and French Creole Tagalog Vietnamese Korean German Arabic Russian Italian Portugues e Hindi Polish Japanese Other <specify, prompts to address #18>
Language other than English (18)	Other <specify>
English as a Second Language(19)	Yes No
Interpretation Services Needed-PART A (20)	No Yes, <if yes, select which service from list>
Interpretation Services Needed-PART B (21)	ASL (American Sign Language) Braille Language Interpreter TTY/TDD Other, please specify
Highest level of education achieved (22)	Less than high school High school graduate Some college Technical/Vocational school Associates' degree Bachelor's degree Professional/Graduate degree
Do you have custody of children/dependents that are under the age of 5? (23)	Yes <prompts to address #24> No
Does the child/these children attend preschool? (24)	Yes No <specify who provides care>

SOCIAL AND COMMUNITY CONTEXT

Question	Options
Have you ever been incarcerated? (25)	Yes <in the last 12 months?> Yes No No
Have you ever been institutionalized? (26)	Yes <in the last 12 months?> Yes No No
Has dependable family, friends and/or social supports? (27)	Yes <specify> No
Participates in social, cultural, recreational, and/or community groups and activities (28)	Yes <specify> No
Has religious or spiritual associations? (29)	Yes <specify> No
Has perceptions of discrimination? (30)	Yes <specify> No

HEALTH AND HEALTH CARE

Question	Options
Primary source of health care services (31)	Emergency Room Health Home/Medical Home PCP Public Health Clinics (FQHC, RHC, CMHCs, Indian Health Services (IHS) and Migrant Clinics) Specialist Urgent Care Clinics Other <specify>
Has reliable transportation? (32)	Yes <specify sources of transportation> No
How long does it usually take you to get to your provider? (33)	<15 Minutes 15-30 Minutes 31-60 Minutes 61-90 Minutes 91-120 Minutes >120 Minutes
Distance to PCP (34)	<10 miles 10-20 miles > 20 miles
Are there times when it is difficult for you to follow doctor's orders? (35)	Yes No
How often do you take medications as recommended? (36)	Always Most of the time Sometimes Never
Do you take vitamins or supplements? (37)	Yes <specify, prompts to address #38> No
How often do you take vitamins or supplements as recommended? (38)	Always Most of the time Sometimes Never
How often do health providers explain things in a way you can understand? (39)	Always Most of the time Sometimes Never
Do you have a dental problem? (40)	Yes <please specify> No
Do you need help finding a dentist? (41)	Yes No

NEIGBORHOOD AND BUILT ENVIRONMENT

Question	Options
Have you been exposed to violence? (42)	Yes <describe> No
Do you feel you are in danger? (43)	Yes <describe> No
Have you been exposed to environmental risk factors or hazards? Part A (44)	Yes <specify from pick list in below question #45> No
Have you been exposed to environmental risk factors or hazards? PART B (45)	Asbestos Chemicals Contaminated Water Lead Pesticides Smoking Used Needle Exposure Other <specify>

The Quick Guide to the HCE Contact Assessment is a tool that highlights all the social determinants of health (SDoH) data that can be collected in the member's record in the electronic care management system. Use this tool to help you navigate the six (6) tabs within the HCE Contact Assessment.

Behavioral Health Screen

Screener: K6
ABHWVA
Care Management
Case Manager

aetna

http://www.hcp.med.harvard.edu/ncs/ftpdir/k6/IWER_K6.pdf
http://www.hcp.med.harvard.edu/ncs/ftpdir/k6/Self%20admin_K6.pdf

Q#	Question/Selections
	Was this tool completed by telephone or face to face? ☐Face to face ☐Telephone
The following questions ask about how you have been feeling during the past 30 days. For each question, please circle the number that best describes how often you had this feeling.	
1	**During the past 30 days, about how often did you feel…** **…nervous?** ☐All of the time ☐Most of the time ☐Some of the time ☐A little of the time ☐None of the time ☐Don't know ☐Refused **<Narrative>**
1a	**During the past 30 days, about how often did you feel…** **…hopeless?** ☐All of the time ☐Most of the time ☐Some of the time ☐A little of the time ☐None of the time ☐Don't know ☐Refused **<Narrative>**
1b	**During the past 30 days, about how often did you feel…** **…Restless or fidgety?** ☐All of the time ☐Most of the time ☐Some of the time ☐A little of the time ☐None of the time ☐Don't know ☐Refused **<Narrative>**
1c	**During the past 30 days, about how often did you feel…** **…so depressed that nothing could cheer you up?** ☐All of the time

	☐Most of the time ☐Some of the time ☐A little of the time ☐None of the time ☐Don't know ☐Refused **<Narrative>**
1d	**During the past 30 days, about how often did you feel...** **...that everything was an effort?** ☐All of the time ☐Most of the time ☐Some of the time ☐A little of the time ☐None of the time ☐Don't know ☐Refused **<Narrative>**
1e	**During the past 30 days, about how often did you feel...** **...worthless?** ☐All of the time ☐Most of the time ☐Some of the time ☐A little of the time ☐None of the time ☐Don't know ☐Refused **<Narrative>**
2	**The last six questions asked about feelings that might have occurred during the past 30 days. Taking them altogether, did these feelings occur more often in the past 30 days than is usual for you, about the same as usual, or less often than usual? (If you never have any of these feelings, choose about the same as usual).** **More often than usual** ☐More often than usual ☐Some ☐A little ☐A little ☐Some ☐A lot
The next few questions are about how these feelings may have affected you in the past 30 days.	
3	**During the past 30 days, how many days out of 30 were you totally unable to work or carry out your normal activities because of these feelings?** Number of Days **<Narrative>**

4	**Not counting the days you reported in response to Q3, how many days in the past 30 were you able to do only half or less of what you would normally have been able to do, because of these feelings?** Number of Days **<Narrative>**
5	**During the past 30 days, how many times did you see a doctor or other health professional about these feelings?** Number of times **<Narrative>**
6	**During the past 30 days, how often have physical health problems been the main cause of these feelings?** ☐All of the time ☐Most of the time ☐Some of the time ☐A little of the time ☐None of the time ☐Don't know ☐Refused

If the member scores 13 or higher; it is recommended that the member be referred to a mental health resource for further support. If the score is less than 13, the member may not need a referral; however, if the member feels that a referral to a resources should be made, proceed with the referral. If a mental health crisis is suspected, follow the organizations standard workflow processes.
Score:
<Narrative>

BACK TO TOP

Created/Revised	Revised by:	Date:	Changes: Yes/No
Created			
Reviewed	Virginia McCarthy	4/9/15	Yes
Reviewed	Virginia McCarthy	2/22/16	
Reviewed	Eric Davis/Tammy Smith	3/29/16	
Reviewed	Tamara Spencer/ Dr. Richard Buzard	11/21/18	No

Sample Care Plan

Aetna Better Health® of West Virginia
500 Virginia Street East, Suite 400
Charleston, WV 25301

aetna®

Parent(s)/Guardian(s) [redacted]

May 21, 2019

Care Plan for: [redacted]
Member ID #: [redacted]

Dear [redacted]

Thank you for talking with me today. This plan is a summary of our discussion. Please use this list to keep track of what you do.

Together we set the following goals:

- [redacted] will learn ways to manage his/her condition one step at a time. By 06/20/2019
- [redacted] will have good follow up treatment and services. By 06/20/2019

To accomplish these goals, we agreed to these actions:

What we will do?	Who will do?	By when?	Completed?
Talk with provider/caregiver and others to coordinate care/services	[redacted]	06/20/2019	In progress
Assist with transition of care from one provider to another		06/20/2019	Not yet started
Set up appointment with/FOR - dental check-up		06/20/2019	Not yet started
Assist [redacted] with developing coping skills, relaxation, and ways that member can deal with:mood disorder, BH conditions Mental Health Condition - Complete PRTF stay at Highland admit date 5/16/19		06/20/2019	In progress
Call, contact or refer community resources- Send information on local resources Food bank / food delivery - food pantry and SNAP info, 211		06/20/2019	In progress

We will review this care plan on or before 06/20/2019 and will update it as needed. I look forward to our continued work towards a healthier you! Please call me at (888) 348-2922 if you have questions.

Sincerely,

[redacted]
clinical CM
Care Management Team

Aetna Better Health® of West Virginia
500 Virginia Street East, Suite 400
Charleston, WV 25301

Take this care plan to your doctor. If you have questions to ask your doctor, write them in the space below.

Questions to ask my doctor:

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  - o Qualified sign language interpreters
  - o Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - o Qualified interpreters
  - o Information written in other languages

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card or **1-800-385-4104**.

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Address: Attn: Civil Rights Coordinator
4500 East Cotton Center Boulevard
Phoenix, AZ 85040
Telephone: **1-888-234-7358 (TTY 711)**
Email: MedicaidCRCoordinator@aetna.com

You can file a grievance in person or by mail or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.

hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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ENGLISH: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card or **1-800-385-4104** (TTY: **711**).

SPANISH: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que aparece en el reverso de su tarjeta de identificación o al **1-800-385-4104** (TTY: **711**).

CHINESE: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電您的 ID 卡背面的電話號碼或 **1-800-385-4104** (TTY: **711**)。

FRENCH: ATTENTION: si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le numéro indiqué au verso de votre carte d'identité ou le **1-800-385-4104** (ATS: 711).

GERMAN: ACHTUNG: Wenn Sie deutschen sprechen, können Sie unseren kostenlosen Sprachservice nutzen. Rufen Sie die Nummer auf der Rückseite Ihrer ID-Karte oder **1-800-385-4104** (TTY: **711**) an.

ARABIC: ملحوظة: إذا كنت تتحدث باللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل على الرقم الموجود خلف بطاقتك الشخصية أو على **1-800-385-4104**(للصم والبكم: **711**)

VIETNAMESE: CHÚ Ý: nếu bạn nói tiếng việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Hãy gọi số có ở mặt sau thẻ id của bạn hoặc **1-800-385-4104** (TTY: **711**).

KOREAN: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드 뒷면에 있는 번호로나 **1-800-385-4104** (TTY: **711**) 번으로 연락해 주십시오.

JAPANESE: 注意事項:日本語をお話になる方は、無料で言語サポート のサービスをご利用いただけます。IDカード 裏面の電話番号、または**1-800-385-4104** (TTY: **711**)までご連絡くださ い。

TAGALOG: PAUNAWA: Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tumawag sa numero na nasa likod ng iyong ID card o sa **1-800-385-4104** (TTY: **711**).

ITALIAN: ATTENZIONE: Nel caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuita. Chiamare il numero sul retro della tessera oppure il numero **1-800-385-4104** (utenti TTY: **711**).

THAI: ข้อควรระวัง: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทรติดต่อหมายเลขที่อยู่ด้านหลังบัตร ID ของคุณ หรือหมายเลข **1-800-385-4104** (TTY: **711**)

NEPALI: ध्यान दिनुहोस्: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि निःशुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध छन्। तपाईंको आइडी कार्डको पछाडि रहेको नम्बर वा **1-800-385-4104** (TTY: **711**) मा फोन गर्नुहोस्।

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