

## Transmittal Letter



During the second annual Spring Festival Health Fair at Northpark, an attendee receives a blood pressure check and education regarding access to care and healthy living.

*All photos herein are presented with the express and written consent of the individuals in them.*

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**Jennifer Barrett**

Agency for Health Care Administration  
Mailroom  
Building 2, 1st Floor, Suite 1500  
2727 Mahan Drive  
Tallahassee, FL 32308-5403

**Date**

October 16, 2017

**Laurie Brubaker**

Chief Executive Officer  
Aetna Medicaid  
4500 E. Cotton Center Blvd.  
Phoenix, AZ 85040  
Phone: 602-659-1160

**AETNA BETTER HEALTH® OF FLORIDA**

RE: AHCA ITN 001-17/18

To Whom It May Concern:

Coventry Health Care of Florida, Inc. dba Aetna Better Health® of Florida (Aetna) is pleased to present its response to the State of Florida, Agency for Health Care Administration for Solicitation Number AHCA ITN 001-17/18-Region in Region 1 for the Statewide Medicaid Managed Care Program.

We authorize release of the redacted version of our response to the Invitation to Negotiate in the event the Agency receives a public record request.

The following is our general information:

Coventry Health Care of Florida, Inc.  
dba Aetna Better Health of Florida  
1340 Concord Terrace, Sunrise, Florida, 33323

The following is our tax identification number:

65-0986441

We consider it a privilege to serve Florida's most vulnerable citizens. We have partnered successfully with the State to transform positively the health and well-being of its Medicaid enrollees. As we look to the future, we are excited about the innovative ways in which we can continue to collaborate with AHCA to improve member-centric, integrated care delivery, to meet the diverse needs of all the Floridians we will serve, and to meet State goals.

Sincerely,

Laurie Brubaker  
Chief Executive Officer  
Aetna Medicaid  
4500 E. Cotton Center Blvd.  
Phoenix, AZ 85040  
(602) 659-1160  
BrubakerL2@Aetna.com

Heidi E. Garwood, ESQ  
Chief Executive Officer for Florida Aetna Medicaid  
Coventry Health Care of Florida, Inc.  
dba Aetna Better Health of Florida  
1340 Concord Terrace  
Sunrise, FL 33323  
(954) 858-3495  
GarwoodH@aetna.com



## Exhibit A-2-a: Qualification of Plan Eligibility



Aetna Better Health® of Florida's Community Development Manager, Carl Lee, presents an exercise-themed gift basket to an excited recipient at an annual fitness fair providing neighborhoods with resources to lead healthier lives. The gift basket includes a core ball, jump rope, thigh toner, pedometer, resistance bands, dumbbells, and workout bands.

*All photos herein are presented with the express and written consent of the individuals in them.*

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**EXHIBIT A-2-a**  
**QUALIFICATION OF PLAN ELIGIBILITY**

**RESPONDENT NAME: COVENTRY HEALTH CARE OF FLORIDA, INC. D/B/A**  
**AETNA BETTER HEALTH OF FLORIDA**

**1. IDENTIFICATION OF PLAN TYPES**

I hereby certify that my company is submitting a response to AHCA ITN 001-17/18 to operate as one of the following plan types in Region 1:

☒ Comprehensive Plan

**OR**

☐ Long-Term Care Plus Plan

**OR**

☐ Managed Medical Assistance Plan

**OR**

☐ Specialty Plan

**2. QUALIFICATION OF PLAN ELIGIBILITY**

I hereby certify my company currently operates as one (1) of the following:

☒ HMO Health Maintenance Organization and possess a current Florida Certificate of Authority and Health Care Provider Certificate in at least one (1) Florida county.

**OR**

☐ PSN that possesses a Florida Third Party Administrator License or a subcontract/letter of agreement with a Florida-licensed Third Party Administrator. A copy of the Third Party Administrator license, or subcontract/letter of agreement, must be submitted with the solicitation response.

In addition, the respondent shall complete **Exhibit A-2-b**, Provider Service Network Certification of Ownership and Controlling Interest.

**OR**

**EXHIBIT A-2-a**  
**QUALIFICATION OF PLAN ELIGIBILITY**

☐ Exclusive Provider Organization that meets the licensure requirements of Section 627.6472, Florida Statutes.

**OR**

☐ Accountable Care Organization authorized under federal law.

**Signature below indicates the respondent's full acknowledgement of, understanding of, and agreement with the certification identified above as written and without caveat.**

**Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida**  
**Respondent Name**

  
**Authorized Official Signature**

10/16/17  
**Date**

**Laurie Brubaker**  
**Authorized Official Printed Name**

**Chief Executive Officer, Aetna Medicaid**  
**Authorized Official Title**

**Failure to submit, Exhibit A-2-a, Qualification of Plan Eligibility, signed by an authorized official may result in the rejection of response.**

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## Exhibit A-2-b: Provider Service Network Certification of Ownership and Controlling Interest (if applicable)



An attendee of the Seventh Avenue Wellness Fair and Hurricane Relief Event receives information regarding Aetna Better Health® of Florida's services while enjoying music, food, and fun activities with her family.

*All photos herein are presented with the express and written consent of the individuals in them.*

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COVENTRY HEALTH CARE OF FLORIDA, INC. DBA  
AETNA BETTER HEALTH® OF FLORIDA

**Exhibit A-2-b, Provider Service Network Certification of Ownership  
and Controlling Interest is not applicable.**



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## Exhibit A-2-c: Additional Required Certifications and Statements



Aetna Better Health® of Florida's Chief Medical Officer, Dr. Jorge Cabrera, presents \$25,000 from the Aetna Foundation to Urban Strategies Regional Director Kristie Stutler and Community Coordinator Rachel Walker. Representative Roy Hardemon (D-Miami) also attended to offer his support and kind words regarding the effective work of the HEAL program. This funding will help provide resources in distressed neighborhoods and public housing communities.

Urban Strategies is a national not-for-profit corporation that works with developers to rebuild neighborhoods with a range of amenities and comprehensive service supports.

*All photos herein are presented with the express and written consent of the individuals in them.*

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**EXHIBIT A-2-c**  
**ADDITIONAL REQUIRED CERTIFICATIONS AND STATEMENTS**  
**(10-2-17)**

**RESPONDENT NAME:** Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida

**1. ACCEPTANCE OF SOLICITATION REQUIREMENTS**

I hereby certify that I understand and agree that my organization has read all requirements and Agency specifications provided in this solicitation, accepts said requirements, and that this response is made in accordance with the provisions of such requirements and specifications. By my written signature below, I guarantee and certify that all items included in this response shall meet or exceed any and all such requirements and Agency specifications. I further agree, if awarded a Contract resulting from this solicitation, to deliver services that meet or exceed the requirements and specifications provided in this solicitation.

**AND**

**2. ACCEPTANCE OF CONTRACT TERMS AND CONDITIONS**

I hereby certify that should my organization be awarded a Contract resulting from this solicitation, it will comply with all terms and conditions as specified in this solicitation and in the Agency Standard Contract (**Exhibit A-8, including Attachments II - V**).

**AND**

**3. STATEMENT OF NO-INVOLVEMENT**

I hereby certify that neither my organization nor any person with an interest in the organization had any prior involvement in performing a feasibility study of the implementation of the subject Contract, in drafting of this solicitation or in developing the subject program.

**AND**

**4. PROHIBITION OF GRATUITIES**

I hereby certify that no elected official or employee of the State of Florida has or shall benefit financially or materially from such my organization's response or subsequent Contract in violation of the provisions of Chapter 112, Florida Statutes. I understand that any Contract issued as a result of this solicitation may be terminated if it is determined that gratuities of any kind were either offered or received by any of the aforementioned parties.

**EXHIBIT A-2-c**  
**ADDITIONAL REQUIRED CERTIFICATIONS AND STATEMENTS**  
**(10-2-17)**

**AND**

**5. NON-COLLUSION CERTIFICATION**

I hereby certify that all persons, companies, or parties interested in the response as principals are named therein, that the response is made without collusion with any other person, persons, organization, or parties submitting a response; that it is in all respects made in good faith; and as the signer of the response, I have full authority to legally bind the prospective respondent to the provisions of this solicitation.

**AND**

**6. PERFORMANCE OF SERVICES**

I hereby certify my organization shall ensure all services, provided directly or indirectly under the Contract resulting from this solicitation, will be performed within the borders of the United States and its territories and protectorates.

**AND**

**7. ORGANIZATIONAL CONFLICT OF INTEREST CERTIFICATION**

The standards on organizational conflicts of interest in Title 48, Code of Federal Regulations, Subpart 9.5 – Organizational and Consultant Conflicts of Interest and Section 287.057(17), Florida Statutes, apply to this solicitation. A respondent with an actual or potential organizational conflict of interest shall disclose the conflict. If the respondent believes the conflict of interest can be mitigated, neutralized or avoided, the respondent shall submit a Conflict of Interest Mitigation Plan with its response, that shall, at a minimum:

- a)** Identify any relationship, financial interest or other activity which may create an actual or potential organizational conflict of interest.
- b)** Describe the actions the respondent intends to take to mitigate, neutralize, or avoid the identified organizational conflicts of interest.
- c)** Identify the official within the respondent's organization responsible for making conflict of interest determinations.

The Conflict of Interest Mitigation Plan will be evaluated as acceptable or not acceptable. The Agency reserves the right to request additional information from the respondent or other sources, as deemed necessary, to determine whether or not the plan adequately neutralizes, mitigates, or avoids the identified conflicts.

**EXHIBIT A-2-c**  
**ADDITIONAL REQUIRED CERTIFICATIONS AND STATEMENTS**  
**(10-2-17)**

Pursuant to the aforementioned requirements, I hereby certify that, to the best of my knowledge, my organization (including its subcontractors, subsidiaries and partners):

Please check the applicable paragraph below. Do not check more than one of the paragraphs below.

- ☒ Has no existing relationship, financial interest or other activity which creates any actual or potential organizational conflicts of interest relating to the award of a Contract resulting from this solicitation.
- ☐ Has included information in its response to this solicitation detailing the existence of actual or potential organizational conflicts of interest and has provided a "Conflict of Interest Mitigation Plan", as outlined above.

**AND**

**8. RESPONDENT ATTESTATION FOR EXHIBIT A-4**

I hereby certify that no modification and/or alteration has been made to the template, narrative and/or instructions contained in **Exhibit A-4**, Submission Requirements and Evaluation Criteria, including **Exhibits A-4-a, A-4-b, A-4-c and A-4-d**, including all exhibits/attachments, as applicable.

I understand the Agency may not consider supplemental response narrative for evaluation which is not contained within the Response Sections contained in **Exhibit A-4**, Submission Requirements and Evaluation Criteria.

**AND**

**9. RESPONDENT ATTESTATION FOR ATTACHMENT C, COST PROPOSAL INSTRUCTIONS AND RATE METHODOLOGY NARRATIVE**

I hereby certify that no modification and/or alteration has been made to the template, narrative and/or instructions contained in **Attachment C, Cost Proposal Instructions and Rate Methodology Narrative**, including all applicable exhibits.

**EXHIBIT A-2-c**  
**ADDITIONAL REQUIRED CERTIFICATIONS AND STATEMENTS**  
**(10-2-17)**

**AND**

**10. RESPONDENT ATTESTATION REGARDING SCRUTINIZED COMPANIES LIST**

I hereby certify that my company is not listed on either the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List, created pursuant to Section 215.473, Florida Statutes. Pursuant to Section 287.135(5), Florida Statutes, the respondent agrees the Agency may immediately terminate the resulting Contract for cause if the respondent is found to have submitted a false certification or if the respondent is placed on the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List during the term of the resulting Contract.

**AND**

**11. NAMES OF OPERATION**

I hereby certify the following is a list of all names under which my organization has operated during the past five (5) years (since July 14, 2012).

Coventry Health Care of Florida, Inc.

In addition, Coventry Health Care of Florida, Inc. has used the following dba's since July 14, 2012

- Aetna Better Health of Florida

- Buena Vista

**AND**

**12. BUSINESS RELATIONSHIP**

The respondent shall disclose any business relationship (as defined in Section 409.966(3)(e), Florida Statutes) with any other eligible Managed Care Plan that is a potential respondent to this solicitation. Such disclosure shall include identifying information for each Managed Care Plan, the nature of the business relationship, the current service area of each Managed Care Plan (by line of business), and the signature of the authorized representative for each Managed Care Plan.

**EXHIBIT A-2-c**  
**ADDITIONAL REQUIRED CERTIFICATIONS AND STATEMENTS**  
**(10-2-17)**

The respondent must disclose any business relationship(s) in the space provided below:

**Not applicable.**

**AND**

**13. COMPLETE MEDICAID PROVIDER ENROLLMENT PACKAGE SUBMISSION**

I hereby certify my organization, if awarded a Contract, shall provide the Agency with an accurate and complete Medicaid Provider Enrollment Application, including all ownership and principal fingerprint cards and processing fees, within thirty (30) days after the Contract award is complete.

**AND**

**14. REQUIRED PLAN READINESS DOCUMENTATION**

I hereby certify my organization, if awarded a Contract, shall submit to the Agency all required Plan Readiness documentation within established timeframes as required in **Attachment A**, Instructions and Special Conditions, **Section E.**, Contract Implementation.

**AND**

**15. CERTIFICATION REGARDING TERMINATED CONTRACTS**

I hereby certify that my organization (including its subsidiaries and affiliates) has not unilaterally or willfully terminated any previous contract prior to the end of the contract with a State or the Federal government and has not had a contract terminated by a State or the Federal government for cause, prior to the end of the contract, within the past five (5) years (since July 14, 2012), other than those listed on **Page 6** of this Exhibit.

**AND**

**16. LIST OF TERMINATED CONTRACTS**

List the terminated contracts in chronological order and provide a brief description (half-page or less) of the reason(s) for the termination. Additional pages may be

**EXHIBIT A-2-c**  
**ADDITIONAL REQUIRED CERTIFICATIONS AND STATEMENTS**  
**(10-2-17)**

submitted; however, no more than five (5) additional pages should be submitted in total.

The Agency is not responsible for confirming the accuracy of the information provided.

The Agency reserves the right within its sole discretion, to determine the respondent to be an non-responsible vendor based on any or all of the listed contracts and therefore may reject the respondent's reply.

**Respondent Name:Coventry Health Care of Florida, Inc. dba Aetna Better Health of Florida**

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**Client's Name:Nevada Department of Health and Human Services Division of Health Care Financing and Policy**

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**Term of Terminated Contract: July 2017 through August 2017**

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**Description of Services: Medical, behavioral health, and vision**

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**Brief Summary of Reason(s) for Contract Termination: After unsuccessful attempts to collaborate with the State to increase membership (which at less than 2000 members was far less than needed to ensure delivery of quality care and competitive programs), our affiliate, Aetna Better Health of Nevada Inc., gave notice of its intent to terminate the contract. The State opted to waive the full, 180-day notice period to minimize member disruption from continuing enrollment and then having to transition members to other health plans later.**

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**Respondent Name:Coventry Health Care of Florida, Inc. dba Aetna Better Health of Florida**

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**Client's Name:US Dept. of Health and Human Services Centers for Medicare and Medicaid Services; NY Dept. of Health**

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**Term of Terminated Contract: Sept. 2014 - present; anticipated termination date Dec. 2017**

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**Description of Services: Manage provision of covered services for physical and behavioral health to Medicare and Medicaid dual-eligible members; provide related operational services, including medical management, quality management, care management, member services, marketing, provider services, and network development.**

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**EXHIBIT A-2-c**  
**ADDITIONAL REQUIRED CERTIFICATIONS AND STATEMENTS**  
**(10-2-17)**

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**Brief Summary of Reason(s) for Contract Termination:** In June 2017, our affiliate, Aetna Better Health Inc. d/b/a Aetna Better Health of New York gave notice of its intent to terminate its Fully Integrated Duals Advantage (FIDA) contract because enrollment has never exceeded 70 members. The program has faced enrollment challenges since its inception, and other MCOs have already exited the program. In accordance with the notice requirements of the contract, the health plan will continue to serve FIDA members until December 31, 2017.

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**EXHIBIT A-2-c**  
**ADDITIONAL REQUIRED CERTIFICATIONS AND STATEMENTS**  
**(10-2-17)**

Signature below indicates the respondent's full acknowledgement of; understanding of; and agreement with all of the certifications and statements identified above in Items 1 through 16 as written and without caveat.

Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida

Respondent Name

Laurie Brubaker

Authorized Official Signature

10/16/17

Date

Laurie Brubaker

Authorized Official Printed Name

Chief Executive Officer, Aetna Medicaid

Authorized Official Title

Failure to submit, Exhibit A-2-c, Additional Required Certifications and Statements, signed by an authorized official may result in the rejection of response.

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## Exhibit A-3-a: Milliman Organizational Conflict of Interest Mitigation Plan



During a healthy eating and active living event sponsored by Aetna Better Health® of Florida, Ted E. Bear M.D. greets a young attendee with a warm high-five before participating in fun activities such as a bounce house and face painting.

*All photos herein are presented with the express and written consent of the individuals in them.*

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**EXHIBIT A-3-a**  
**MILLIMAN ORGANIZATIONAL**  
**CONFLICT OF INTEREST MITIGATION PLAN**

**RESPONDENT NAME:** Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida

The Agency for Health Care Administration (“Agency” or “AHCA”) “must avoid, neutralize, or mitigate significant potential organizational conflicts of interest (OCI) before a Contract is awarded. If the Agency elects to mitigate the significant potential organizational conflict or conflicts of interest, an adequate mitigation plan, including organizational, physical, and electronic barriers, shall be developed. [Section 287.057(17)(a)(1), Florida Statutes]

The Agency has determined that in order to evaluate proposals and negotiate a Contract that is in the best interests of the State, it is necessary to use the services of Milliman, Inc. (“Milliman”) to act as an actuary and advisor throughout all stages of the “Statewide Medicaid Managed Care Program” competitive solicitation. The Agency reasonably anticipates one or more prospective respondents may also use Milliman. The Agency has determined that all reasonably anticipated OCIs relating to Milliman may be mitigated by the following mitigation plan, which has been agreed to by Milliman:

**I. Milliman**

- a.** All Milliman personnel who will perform services under the “Statewide Medicaid Managed Care Program” competitive solicitation shall be part of a separate internal Milliman working group (the “Milliman AHCA Group”) with its own internal electronic and hard folders.
- b.** All documents or communications received or generated by the Milliman AHCA Group that relate in any way to this solicitation shall be placed only in this Group’s separate files.
- c.** Each member of the Milliman AHCA Group shall submit **Exhibit A-3-b**, Milliman Employee Organizational Conflict of Interest Affidavit indicating they will provide actuarial services to the Agency.
- d.** No Milliman personnel, other than the Milliman AHCA Group personnel shall have access to the Milliman AHCA’s Groups files.
- e.** The above-listed personnel shall not discuss any information relating to the SMMC ITN Services with any other Milliman personnel.

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**EXHIBIT A-3-a**  
**MILLIMAN ORGANIZATIONAL**  
**CONFLICT OF INTEREST MITIGATION PLAN**

**II. Respondents**

- a. Any actual or prospective respondent who is using Milliman for this procurement must disclose this fact in its initial reply to the solicitation. Specifically, a respondent wishing to use Milliman must:
  - i. Identify itself and its intent to use Milliman;
  - ii. Identify the specific Milliman personnel that will be assisting the respondent in the procurement;
  - iii. Submit **Exhibit A-3-b, Milliman Employee Organizational Conflict of Interest Affidavit** forms, completed by each identified Milliman personnel.
- b. All replies submitted in response to this solicitation must include the completed declaration in **Section IV.** of this Exhibit, signed by the authorized official who signed the reply on behalf of the respondent.
- c. Any actual or prospective respondent who learns there is a reasonable basis to believe there has or may have been a violation of the Milliman OCI Mitigation Plan shall, within seventy-two (72) hours, notify the Agency of the facts and circumstances of the possible violation.

**III. Protests**

- a. **Actual or prospective respondents are advised they have a burden to diligently investigate and challenge potential OCIs relating to Milliman.**
- b. All challenges to the Milliman OCI Mitigation Plan must be timely filed as a challenge to the specifications of this solicitation. Similarly, challenges to amendments to the Milliman OCI Mitigation Plan must be timely filed as specifications challenges.
- c. All challenges to Milliman-related information provided by actual or prospective respondents and posted by the Agency must be timely filed as specifications challenges.
- d. **All protests filed after a Notice of Intent to Award has been posted which allege a Milliman-related OCI shall be limited to alleged violations of the Milliman OCI Mitigation Plan.**

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**EXHIBIT A-3-a**  
**MILLIMAN ORGANIZATIONAL**  
**CONFLICT OF INTEREST MITIGATION PLAN**

**IV. Declaration**

Declaration of Laurie Brubaker  
**Authorized Official Printed Name**

Pursuant to Section 92.525, Florida Statutes, Laurie Brubaker  
**Authorized Official Printed Name**

declares that:

1. I am over the age of 21 and am competent to testify as to the matters stated in this declaration.
2. I declare that I have read the Milliman Organizational Conflict of Interest Mitigation Plan, and that Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida

**Respondent Name**

will directly and indirectly fully comply with the Milliman Organizational Conflict of Interest Mitigation Plan through all stages of the procurement.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 16<sup>th</sup> day of October 2017.



**Authorized Official Signature**

Laurie Brubaker  
**Authorized Official Printed Name**

**Failure to submit, Exhibit A-3-a, Milliman Organizational Conflict of Interest Mitigation Plan, certified by an authorized official may result in the rejection of response.**

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## Exhibit A-3-b: Milliman Employee Organizational Conflict of Interest Affidavit (if applicable)



Aetna Better Health® of Florida Chief Executive Officer Heidi Garwood and Chief Operations Officer Claudia Lamazares were honored guests at the Embrace Girls Foundation's tea party. The sharp young participants interviewed both executives to expand the young ladies' knowledge of health care and of the executives' roles within the community.

The Embrace Girls Foundation, Inc. is a mentoring program through which girls ages 4 to 12 learn to become healthy, confident, ambitious, and academically excellent individuals.

*All photos herein are presented with the express and written consent of the individuals in them.*

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COVENTRY HEALTH CARE OF FLORIDA, INC. DBA  
AETNA BETTER HEALTH® OF FLORIDA

**Exhibit A-3-b, Milliman Employee Organizational Conflict of Interest  
Affidavit is not applicable.**



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## Original Proposal Guarantee



During the Seventh Avenue Wellness Fair and Hurricane Relief Event, residents of the City Liberty community engaged with community members and shared a warm meal.

*All photos herein are presented with the express and written consent of the individuals in them.*

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**BID BOND**

**Travelers Casualty and Surety Company of America**  
**Hartford, CT 06183**

KNOWN ALL BY THESE PRESENTS, That we, Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida, as Principal, and Travelers Casualty and Surety Company of America, as Surety, are held and firmly bound unto State of Florida Agency for Health Care Administration, as Obligee, in the sum of One Million Dollars and No Cents Dollars ( \$1,000,000.00 ) for the payment of which we bind ourselves, and our successors and assigns, jointly and severally, as provided herein.

WHEREAS, Principal has submitted or is about to submit a bid to the Obligee on a contract for Statewide Managed Care Program Region 1; Advertisement Number: AHCA ITN 001-17/18- Region 1 ("Project").

NOW, THEREFORE, the condition of this bond is that if Obligee accepts Principal's bid, and Principal enters into a contract with Obligee in conformance with the terms of the bid and provides such bond or bonds as may be specified in the bidding or contract documents, then this obligation shall be void; otherwise Principal and Surety will pay to Obligee the difference between the amount of Principal's bid and the amount for which Obligee shall in good faith contract with another person or entity to perform the work covered by Principal's bid, but in no event shall Surety's and Principal's liability exceed the penal sum of this bond.

Signed this 29th day of September, 2017.

Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida  
(Principal)

By: Debra J. Baum

Travelers Casualty and Surety Company of America

By: Justine M. Bailey  
Justine M. Bailey, Attorney-in-Fact





## POWER OF ATTORNEY

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

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

Attorney-In Fact No.

232429

Certificate No. 007301914

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

Jeffrey M. Johnson, Cameron W. Blackey, Daniel T. Boormeester, Matthew Kieras, Mary N. Smith, Helen B. Honan, Sarah Marks, Thomas J. McElligott, Karen L. Nigrelli, Kristin Philipp, Christopher J. Ward, Patricia A. Wood, Katherine K. Zalios-Wood, Jamie L. Damiano, Tiffany York, Justine M. Bailey, Daniel Peck, Amanda Bartolomei, Danielle Schiller, Alissa Wood, Jennifer Conner, Nathan Capitanio, Marypat Henry, Onera Flowers, Kelly D. Dyson, and Thomas Young

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

IN WITNESS WHEREOF, the Companies have caused this instrument to be signed and their corporate seals to be hereto affixed, this 20th day of July, 2017.

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

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



State of Connecticut  
City of Hartford ss.

By:

Robert L. Raney, Senior Vice President

On this the 20th day of July, 2017, before me personally appeared Robert L. Raney, who acknowledged himself to be the Senior Vice President of Farmington Casualty Company, Fidelity and Guaranty Insurance Company, Fidelity and Guaranty Insurance Underwriters, Inc., St. Paul Fire and Marine Insurance Company, St. Paul Guardian Insurance Company, St. Paul Mercury Insurance Company, Travelers Casualty and Surety Company, Travelers Casualty and Surety Company of America, and United States Fidelity and Guaranty Company, and that he, as such, being authorized so to do, executed the foregoing instrument for the purposes therein contained by signing on behalf of the corporations by himself as a duly authorized officer.

In Witness Whereof, I hereunto set my hand and official seal.  
My Commission expires the 30th day of June, 2021.



Marie C. Tetreault  
Marie C. Tetreault, Notary Public

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

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

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

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

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

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

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed the seals of said Companies this 29<sup>th</sup> day of September, 20 17.

  
Kevin E. Hughes, Assistant Secretary



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



## Financial Information



In the aftermath of Hurricane Irma, a mother and her child enjoy a happy moment during the Seventh Avenue Wellness Fair and Hurricane Relief Event, at which residents and their children enjoyed music, a warm meal, a bounce house, and games. Many residents donated blood and received free health screenings.

*All photos herein are presented with the express and written consent of the individuals in them.*

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## Financial Statements

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AETNA BETTER HEALTH® OF FLORIDA

**Financial Information is being provided electronically  
per Addendum 2, dated October 2, 2017,  
Q&A #52 and #56**



COVENTRY HEALTH CARE OF FLORIDA, INC. DBA  
AETNA BETTER HEALTH® OF FLORIDA

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## Pro Forma Financial Statements

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COVENTRY HEALTH CARE OF FLORIDA, INC. DBA  
AETNA BETTER HEALTH® OF FLORIDA

## **Pro Forma Financial Statements**

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## Surplus

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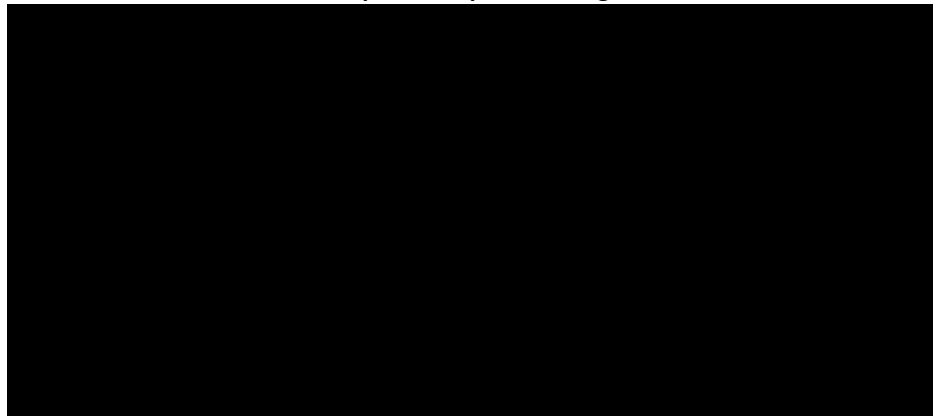
## Surplus

Aetna Better Health of Florida will maintain minimum surplus and capital through income from operations and will comply with all State and Federal financial requirements. Florida Health Plan Administrators, LLC, the direct parent company of Aetna Better Health of Florida, will unconditionally guarantee performance by Aetna Better Health of Florida in each and every obligation, warranty, covenant, term, and condition of the contract executed by the parties. There is no maximum limit to the financial support that will be provided by Florida Health Plan Administrators, LLC.

## REQUIRED SURPLUS

As shown in **Table 8.3**, Aetna meets the specified surplus funding requirements by maintaining insolvency protection accounts in accordance with Florida Statutes, Section 641.225, in excess of two percent of annualized premiums, and well in excess of 10 percent of total liabilities. Please refer to **Exhibit 8.3** for bank account statements evidencing account balances as of June 30, 2017.

**Table 8.3: Required Surplus Funding Calculation**

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## Insolvency Protection

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## Insolvency Protection Account

Aetna Better Health of Florida will maintain minimum surplus and capital through income from operations and will comply with all State and Federal financial requirements. Florida Health Plan Administrators, LLC, the direct parent company of Aetna Better Health of Florida, will unconditionally guarantee performance by Aetna Better Health of Florida in each and every obligation, warranty, covenant, term, and condition of the contract executed by the parties. There is no maximum limit to the financial support that will be provided by Florida Health Plan Administrators, LLC.

### INSOLVENCY PROTECTION ACCOUNT

As shown in **Table 8.4**, Aetna meets the specified insolvency protection account funding requirements by maintaining deposit accounts in accordance with Florida statutory requirements, in excess of two percent of the annualized contract amount. Please refer to **Exhibit 8.4** for bank account statements evidencing account balances as of June 30, 2017.



If Aetna is awarded a contract in excess of the total capitation payments amount specified in **Table 8.4**, we will fund on a monthly basis the additional five percent of the capitation premium through income from operations until we reach the required two percent of the total annualized contract. If needed, our corporate Investment/Treasury team will complete a wire transfer to fund any shortfall in the insolvency protection accounts. This team routinely assesses the financial position of each subsidiary. An estimated net worth calculation is completed one month prior to the close of quarterly financials. Any capital contributions needed are submitted to capital planning for transfer of funds to the subsidiary 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 capital planning for immediate transfer of funds prior to the release of the financial statement. In instances where a subsidiary has needed capital, the subsidiary's parent has made and will continue to make capital contributions (without restriction) to the subsidiary.



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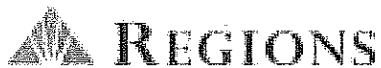
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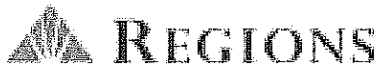
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## Exhibit A-4-a: General Submission Requirements and Evaluation Criteria and Applicable Attachments/Exhibits



The grandmother of a Head Start student smiles happily as she enters a meeting to discuss her grandchild's education.

Head Start promotes school readiness for children under age five from low-income families through education and health, social, and other services.

*All photos herein are presented with the express and written consent of the individuals in them.*

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**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**RESPONDENT NAME:** Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida

**A. RESPONDENT BACKGROUND / EXPERIENCE**

**SRC# 1 – Managed Care Experience (Statewide):**

The respondent, including respondent's parent, affiliate(s) and subsidiary(ies), shall provide a list of all current and/or recent (within five (5) years of the issue date of this solicitation (since July 14, 2012) contracts for managed care services (e.g. medical care, integrated medical and behavioral health services, transportation services and/or long-term services and support).

The respondent shall provide the following information for each identified contract:

- a. The Medicaid population served (such as TANF, ABD, dual eligible);
- b. The name and address of the client;
- c. The name of the contract;
- d. The specific start and end dates of the contract;
- e. A brief narrative describing the role of the respondent and scope of the work performed, including covered populations and covered services;
- f. The use of administrative and/or delegated subcontractor(s) and their scope of work;
- g. The annual contract amount (payment to the respondent) and annual claims payment amount;
- h. The scheduled and actual completion dates for contract implementation;
- i. The barriers encountered that hindered implementation (if applicable) and the resolutions;
- j. Accomplishments and achievements;
- k. Number of enrollees, by health plan type (e.g., commercial, Medicare, Medicaid); and
- l. Whether the contract was capitated, FFS or other payment method.

In addition, the respondent shall describe its experience in delivering managed care services (e.g. medical care, integrated medical and behavioral health services, transportation services and/or long-term services and support), to Medicaid populations similar to the target population (such as TANF, ABD, dual eligible) identified in this solicitation.

For this SRC, the respondent may include experience provided by subcontractors for which the respondent was contractually responsible, if the respondent plans to use those same subcontractors for the SMMC program.

**Response:**

Effectively navigating the increasing complexities of the Medicaid landscape requires deep experience and understanding of all the populations, their needs, their circles of support, and their barriers to care. The Aetna organization has over 160 years of experience operating in all 50 states and is among the nation's leading diversified health care benefits companies, serving an estimated 46.7 million individuals with information and resources necessary to help them make better-informed decisions about their health care. Aetna Inc. was recently named to

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Fortune's 2017 list of Most Admired Companies, ranking second in the health insurance category. (For purposes of this proposal, the respondent is Coventry Health Care of Florida, Inc. dba Aetna Better Health® of Florida [Aetna Better Health of Florida]. For simplicity, throughout our proposal, we will use "Aetna" to refer to Aetna Better Health of Florida, its parent organizations and/or its affiliate organizations. Where clarity dictates, however, we will refer to the health plan or its parent and affiliate organizations using their specific entity names.)

Aetna offers a broad range of traditional and consumer-directed health insurance products and related services, including Medicaid health care management services; government-sponsored plans; medical, pharmacy, dental, behavioral health, group life, and disability plans; medical management capabilities; workers' compensation administrative services; and health information technology products and services. Aetna's customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers, labor groups, and expatriates.

Aetna's Medicaid organization currently serves 3 million Medicaid enrollees—including Temporary Assistance for Needy Families (TANF); Children's Health Insurance Program (CHIP); aged, blind and disabled (ABD); dually eligible; and Long-term Services and Supports (LTSS)—through its management of Medicaid managed care plans in 14 states: Florida, Arizona, Illinois, Kentucky, Louisiana, Maryland, Michigan, New York, New Jersey, Ohio, Pennsylvania, Texas, Virginia, and West Virginia. We were recently awarded new contracts to serve Virginia Medicaid's statewide LTSS program and California's Medi-Cal geographic managed care expansion in San Diego and Sacramento counties.

In Florida, as the number one NCQA rated plan in the State (number 15 nationally), Aetna Better Health is privileged to serve more than 100,000 Medicaid enrollees under the SMMC contract. We hold a comprehensive Managed Medical Assistance (MMA) and Long-Term Care (LTC) contract in Region 11 and LTC contracts in Regions 6, 7, and 9. We also serve CHIP enrollees through the Florida Healthy Kids program in Regions 1, 2, 3, 5, 6, 7, 8, 9, and 11. In addition to our Medicaid line of business, Aetna provides health care coverage to over 1.2 million members in commercially insured programs, State employee programs and Medicare Advantage enrollees in Florida. Aetna is also a large employer in the State of Florida employing over 5,000 employees in multiple offices across the state with total claims paid across all product lines in excess of \$3.8 billion.

Aetna, as a steward of public programs in Florida, delivers an innovative integrated care approach, quality-driven provider networks, streamlined processes, expanded benefits, the State's top NCQA scores, and high rates of enrollee satisfaction which establishes the framework necessary to achieve the State's overall objective - for Medicaid enrollees to receive all medically necessary services in a timely manner and in the most appropriate setting, thereby achieving the best possible quality outcomes while containing costs.

### **CURRENT AND/OR RECENT CONTRACTS FOR MANAGED CARE SERVICES**

In accordance with the Agency's responses to Questions 406 and 412, Amendment 2, Aetna has provided information pertaining to our Medicaid managed care contracts managed by Aetna's parents, affiliates, and/or subsidiaries in table format in Attachment SRC 1: Managed Care Experience Tables.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **EXPERIENCE DELIVERING MANAGED CARE SERVICES TO MEDICAID POPULATIONS SIMILAR TO THE TARGET POPULATION**

**CRITERION 5:** The extent to which the respondent's Medicaid populations served are similar to the populations served by the SMMC program

For 30 years, our Aetna Medicaid organization has honed its approach to serving high-acuity, medically frail, and low-income populations with diverse benefits. Our experience in implementing, managing, and caring for ABD, dual-eligible enrollees, and other populations similar to those served by the Statewide Medicaid Managed Care (SMMC) program results in improved access to culturally competent care, higher quality care in appropriate settings, and a simplified enrollee experience. Our Medicaid enrollees include special-needs children, pregnant women and families, individuals with disabilities, seniors who are eligible for Medicare and Medicaid, those who receive community-based services, and individuals living in long-term care facilities.

Aetna Better Health of Florida proudly serves the TANF, ABD, long term care (LTC), and dually eligible populations under the SMMC contract. We hold a comprehensive Managed Medical Assistance (MMA) and LTC contract in Region 11 and LTC contracts in Regions 6, 7, and 9. We also serve CHIP enrollees through the Florida Healthy Kids program in Regions 1, 2, 3, 5, 6, 7, 8, 9, and 11. In partnership with providers, community organizations and resources, and other key stakeholders, we offer an extensive suite of programs and services that work in concert to meet the individual needs of our enrollees. Our integrated, person-centered approach drives our decision-making, informs our policies and culture, and fosters our ongoing efforts with physicians, hospitals, and health networks to align economic incentives.

We draw upon a comprehensive network of Medicaid health plans and a variety of benefit administration systems across the Aetna organization to complement and enhance our services to Florida's Medicaid enrollees. For example, in Arizona, Aetna manages Southwest Catholic Health Network Corporation dba Mercy Care Plan, the longest-running and most highly integrated program. Mercy Care Plan serves approximately 945,000 enrollees in the TANF and CHIP programs; ABD enrollees; enrollees in LTSS; individuals with intellectual or developmental disabilities; integration of medical and behavioral health services for individuals with serious mental illness and dual-eligible populations in addition to behavioral health.

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

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

The following is an overview of Aetna's current experience serving Medicaid populations similar to the target population, through its management of health plans nationally:

- Arizona:
  - TANF, CHIP, ABD/Supplemental Security Income (SSI), LTSS, Affordable Care Act (ACA), individuals with serious mental illness, behavioral health, and foster children
  - 1,342,364 total Medicaid enrollees
  - 2002 – present
- Florida:
  - TANF, Florida Healthy Kids, ABD/SSI, LTSS, and behavioral health
  - 103,834 total Medicaid enrollees
  - 1993 – present
- Illinois:
  - TANF, ABD/SSI, LTSS, duals, ACA, and behavioral health
  - 235,760 total Medicaid enrollees
  - 2011 – present
- Kentucky:
  - TANF, CHIP, ABD/SSI, ACA, behavioral health, and foster children
  - 254,220 total Medicaid enrollees
  - 2011 – present
- Louisiana:
  - TANF, CHIP, ABD/SSI, ACA, behavioral health, and foster children
  - 113,701 total Medicaid enrollees
  - 2015 – present
- Michigan:
  - TANF, CHIP, ABD/SSI, LTSS, Duals, ACA, behavioral health, and foster children
  - 53,527 total Medicaid enrollees
  - 2004 – present
- New Jersey:
  - TANF, CHIP, ABD/SSI, LTSS, and ACA
  - 36,170 total Medicaid enrollees
  - 2014 – present
- New York:
  - LTSS and duals
  - 4,291 total Medicaid enrollees
  - 2012 – present
- Ohio:
  - LTSS and duals
  - 23,480 total Medicaid enrollees
  - 2014 – present
- Pennsylvania:
  - TANF, CHIP, ABD/SSI, and ACA
  - 221,645 total Medicaid enrollees
  - 2010 – present
- Texas:
  - TANF, CHIP, LTSS, and behavioral health
  - 286,271 total Medicaid enrollees
  - 2006 – present

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Virginia
  - TANF, CHIP, ABD/SSI, LTSS, behavioral health, and foster children
  - 49,009 total Medicaid enrollees
  - 1996 – present
- West Virginia:
  - TANF, ABD/SSI, ACA, and behavioral health
  - 128,395 total Medicaid enrollees
  - 1996 – present

### **TANF Population Experience**

TANF/CHIP eligible enrollees are served in programs in 11 states, with TANF in California scheduled for go-live in January 2018. In our years of serving the TANF population in Florida, Aetna has gained a valuable understanding of the needs, challenges, and barriers to optimal care facing this special population. A few examples of our comprehensive and extensive care management capabilities for the benefit of the TANF Medicaid population follow. These examples include 1) increasing immunizations, well visits, and required EPSDT screenings; 2) early detection, screening, and early intervention services; and 3) increasing prenatal care, including identifying and serving high-risk pregnant women.

### **Increasing Immunizations, Well Visits, and Required EPSDT Screenings**

We are committed to making sure all Medicaid-eligible enrollees under the age of 21 receive EPSDT services and their parents, guardians, and providers use resources effectively. To that end, our EPSDT program promotes collaboration amongst enrollees, providers, state agencies, community organizations, and other stakeholders. EPSDT funding is key to ensuring children and adolescents receive appropriate preventive, dental, mental health, and developmental and specialty services.

Care coordinators are training on EPSDT coverage and identifying gaps in care to ensure coordination of services. Enrollees are contacted with preventive screening reminders through mailings, interactive voice response calls, and text messaging. For example, we mail postcard reminders with age-appropriate health care recommendations. EPSDT tracking and outreach activities include identifying and contacting the parents/guardians of children months prior to the child turning two to ensure the child is receiving appropriate services. During inbound calls, we remind enrollees with gaps in care of the services they need. New enrollees are contacted within 30 days of enrollment to offer assistance in accessing well-child visit services following the periodicity schedule. Enrollee welcome packets include information on EPSDT screenings and services.

### **Early Detection, Screening, and Early Intervention Services**

Early intervention (EI) services are supports to help children with developmental delays connect with family and community activities. Care coordinators link enrollees to early intervention supports and resources to help family members and caregivers enhance their children's learning and development through everyday learning opportunities. Aetna contracts with EI-certified providers to deliver services in the child's natural environment to the fullest extent possible. Natural environments include the child's home or a community-based setting in which children without disabilities also participate. Ensuring these children receive all necessary

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

EPSDT services helps prevent and/or decrease complications and utilization from occurring later in life. Early detection, screening, and interventions are important in detecting developmental, physical, and behavioral issues. Aetna care coordinators link enrollees to needed services, including early detection and intervention services, programs (e.g., early hearing detection), and resources.

### **Increasing Prenatal Care, including Identifying and Serving High-Risk Pregnant Women**

Aetna's overall approach to serving pregnant women includes engagement strategies, services and programs, and care planning. Our emphasis is on early identification and early engagement to get pregnant women into care management before they deliver. We use a variety of mechanisms for early identification of expectant mothers, including prior authorization, pharmacy data, and direct referrals from providers, community health workers, and peer support specialists. Establishing trusting relationships and providing a motivational framework for our enrollees are two important care management priorities for ensuring healthy mothers and babies. We also provide high-risk obstetrical care management, educational materials, address social determinants of health, arrange prenatal appointments, and address social and safety issues of our enrollees.

The Text4baby program is a key component of our prenatal health strategy. As the largest mobile health initiative in the nation, Text4baby helps pregnant women and new mothers keep themselves and their babies healthy through a series of text messages. The service is for pregnant women and mothers with infants under one year of age. Expectant and new moms receive free text messages containing expert health tips and safety information timed to correspond to their due date or the baby's birth date. After delivery, there are additional text messages related to postpartum depression, immunizations, and well-baby checks.

When pregnant women have comorbidities (e.g., asthma, diabetes, cancer, tobacco use, depression), we coordinate care to ensure they receive the care they need, which may include home health visits, diabetes education, and nutritional services, to address and manage their conditions during and after their pregnancy. By working with the enrollee and her obstetrician or primary care provider (PCP) to address her comorbid conditions, the enrollee's chance of complications are reduced, and the likelihood of a full-term, healthy delivery improved.

### **ABD/SSI Population Experience**

Aetna presently serves ABD/SSI Medicaid populations in 10 states, and has served Floridians receiving ABD/SSI benefits for 15 years. We understand that ABD/SSI enrollees have increased vulnerabilities because of clinical and social challenges that can present material barriers to care. Our special programs for ABD/SSI populations are designed to improve the experience of care for these enrollees.

Transition-of-care services: When an enrollee's condition and care needs change, particularly due to a chronic or acute illness, we work to provide care coordination and continuity during and after the transition from one health care setting to another. For enrollees residing in nursing homes, our registered clinicians identify enrollees who might be ready to transition to home- and community-based settings, as well as evaluate those who are at risk for being designated with custodial needs during an admission for nursing facility rehabilitation.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

For enrollees experiencing an acute hospital or nursing facility admission, our licensed clinicians assist with transition of care by working collaboratively with care managers and the medical director to identify and facilitate discharge needs. Aetna's discharge planning process begins upon notification our enrollee has been admitted inpatient. Care managers and utilization management staff members work with hospital or other facility discharge planners to facilitate the enrollee's transition to the least restrictive level of care possible after discharge. Activities include identifying enrollees' needs, determining the appropriate post-discharge placement setting, and establishing the post-discharge services necessary after an acute hospital, nursing home, or rehabilitation facility admission.

Intensive-level care management services for ABD/SSI enrollees are provided for 30 days after hospital discharge. Enrollees have direct and daily access to a care manager who assists them in every aspect of care transitions. Additionally, Aetna's integrated care management model helps to ensure enrollees have the supports and services necessary to facilitate discharge success, such as coordination of all home health and durable medical equipment needs, transportation, medication adherence, and assistance with appointments for diagnostic testing and follow-up care. In coordinating transitions to the community, our long-term care staff serves as advocates, using motivational interviewing techniques to help identify the goals that are most important to the enrollee.

Wellness and prevention programs and chronic diseases: Aetna is committed to a collaborative approach to chronic condition management, especially for those enrollees with multiple comorbidities such as asthma, hypertension, cardiovascular disease, and/or depression. We work with enrollees to provide personalized support and to promote healthy lifestyle options. As part of our patient-centered approach to support prevention and wellness interventions related to obesity and diabetes, we contact enrollees with targeted initiatives. These efforts focus on annual dilated eye exam, low-density lipoprotein, and HbA1c testing; daily blood glucose self-monitoring; body mass index screening; Type-2 diabetes screening at prenatal visits; coaching for self-management of condition; nutrition; exercise; weight management; annual flu shot; annual pneumonia shot; and addressing gaps in care.

### **LTSS**

Our years of experience working with Medicaid and Medicare enrollees, combined with our highly knowledgeable clinical and administrative staff, give Florida enrollees the benefit of proven managed care practices. Currently, Aetna operates LTSS programs in nine states: Arizona, Florida, Illinois, Michigan, New Jersey, New York, Ohio, Texas, and Virginia.

In 2007, our parent company, Aetna Inc., acquired Schaller Anderson, Inc. (Schaller Anderson), a privately held Medicaid managed care company. Schaller Anderson was founded in 1986 by Don Schaller and Joe Anderson, who had been the director and deputy director (respectively) of the Arizona Medicaid program since the time of its creation in 1981 as the first fully capitated statewide managed care program in the nation. Aetna's history managing the LTSS population dates back to the late 1980s through Schaller Anderson's management of a managed care organization participating in the Arizona Long Term Services (ALTCs) program. Throughout that decade and those that followed, Schaller Anderson remained at the forefront of innovation in Medicaid managed care as states across the nation built on Arizona's success. For example, our Illinois plan successfully transitioned 17.4% of its nursing facility population back into the

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

community from 2013 to 2015 using the Aetna Medicaid organization's integrated care and transitioning principles.

In Florida, we were among the first in the State to serve dually eligible Floridians in a nursing home diversion program with interventions designed to support them in home- and community-based settings. Our dedicated care managers meet with enrollees face-to-face in order to establish trusting relationships and open communication, helping to connect them with their integrated care teams and community resources for support. We are committed to working with the State to support LTC transitioning efforts by transitioning enrollees from institutional settings into home and community environments, diverting admissions to facilities, and increasing the use of home and community-based services to accommodate enrollees who want to live independently in the community of their choosing.

Our Florida enrollees determine whether they reside in a facility or in the community. While some enrollees do require facility care, the majority can live independently with minimal assistance through the services provided by our LTC program. Enrollees are equipped with the skills to live in the environment they choose and to live life on their terms. Care managers review available housing options with every LTC enrollee to support community living, integration, and transitioning efforts. For enrollees interested in moving from institutional care to community-based living, care managers work with community-based resources to promote safe, appropriate, and cost-effective integration back into the community.

### **Experience Providing Integrated Medical and Behavioral Health Services**

**CRITERION 1:** The extent of the respondent's experience with providing integrated medical and behavioral health services

Aetna is a market leader in providing innovative, outcome-driven, cost-effective integrated physical and behavioral health care to Medicaid recipients across the United States. Through our strategic alignment Florida and other states we serve, we prove the success of our integrated care model. We bring our expertise nationally to Florida to promote, incentivize, and remove barriers to integrating medical and behavioral health services throughout the systems of care that serve enrollees in each region of the State.

In providing care coordination and benefit administration in Florida, we engage stakeholders including enrollees and their families, federally qualified health centers, PCPs, community mental health centers, hospital systems, behavioral health specialists, State agencies, community partners, and advocacy groups to lay a foundation that facilitates a new way of thinking about health care: one in which enrollees are at the center of a team of integrated service providers and stakeholders. This new framework is steeped in the fact that Aetna is more than just an insurance company—we are a holistic health partner.

Each enrollee's unique health care needs are intricately woven together by his or her personal life story. We have learned that the best way to serve each individual's needs within a diverse population is to integrate medical and behavioral health services within an integrated system of care.

Aetna's biopsychosocial approach to providing care commits us to the integration of physical, behavioral, and oral health and keeps us mindful that enrollees often face social determinants of

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

health, illness, and disabilities that contribute directly to the complexity of their lives. Successfully promoting growth of integrated medical and behavioral health services across Florida begins with the example we set. By integrating medical and behavioral health services throughout our own internal system of care (Care Management, Provider Network, Utilization Management, Enrollee Services), we coordinate enrollees' physical, behavioral, and social needs in an individualized, person-centered, holistic manner.

Aetna Better Health of Florida has successfully subcontracted with Beacon Health Options (Beacon) for the past 12 years, delegating management of behavioral health benefits and the specialty behavioral health network. Beacon strongly supports the Aetna integrated care management model and has a strong record of accomplishment promoting integrated medical and behavioral health services models in many locations across the State. Combining our mutual strengths and resources, Aetna and Beacon have formed an integrated partner model that is fully capable of meeting and exceeding the State's goals for this procurement.

This model extends well beyond simply co-locating clinical staff. Aetna and Beacon have an aligned clinical vision that enables our clinical staff to work side-by-side to integrate utilization management and care management seamlessly for all enrollees. The experience of our enrollees and our providers will be that we speak with a single voice, doing what is best for our enrollees.

Beacon brings to our collaboration the strongest network of Medicaid behavioral health providers in Florida, many of whom are already progressing toward full integration of medical and behavioral health services. Tighter integration of medical and behavioral health resources within the plan will enable us to accelerate the growth of integrated behavioral health and primary care models throughout all regions of the State.

Aetna's experience establishing integrated medical and behavioral health services in Florida furnishes us with an in-depth understanding of how to develop network adequacy best for populations in urban and rural settings. We value contracted relationships with community mental health centers that are scalable to maintain access to behavioral health services for all Florida enrollees. Our strong history of innovation, most notably with pioneering our integrated care management model, as well as our population health initiative designed to support providers, delivers quality, efficient care.

One unique example of our experience with the integration of medical and behavioral health services is the work we have done in Arizona through the Aetna Medicaid organization's management of Mercy Maricopa Integrated Care (MMIC), an Arizona health plan. Since 2014, MMIC has coordinated medical and behavioral health services as well as housing, employment, and court services to Medicaid enrollees in the Phoenix, Arizona metropolitan area. MMIC was the first regional behavioral authority in Arizona and the second health plan in the nation to integrate medical, behavioral health, and substance abuse services for Medicaid-eligible individuals with a serious mental illness. The integrated model serves approximately 20,000 individuals in Maricopa County.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **SUBCONTRACTORS' EXPERIENCE IN COORDINATING OR PROVIDING SERVICES TO MEDICAID RECIPIENTS**

**CRITERION 2:** The extent of the respondent's subcontractors' experience in coordinating or providing services to Medicaid recipients

Aetna has a proven record of improving outcomes for our Florida enrollees by providing appropriate, coordinated care and services in a financially responsible manner. Whenever possible, we utilize the services of entities that fall under the Aetna organizational umbrella for services in support of the contract. Doing so enables us to use entities that have established processes adherent with internal controls that meet Aetna standards to promote quality and compliance in our commitment to achieving AHCA's goals. To leverage operational efficiencies, the following Aetna affiliates, through a series of intercompany agreements reviewed and approved by AHCA, manage and support many of the functions to be performed under the contract, including but not limited to, the services described as follows:

- Aetna Medicaid Administrators LLC: Management services for physical and behavioral health, including care and disease management, quality management, utilization management, enrollment processing, claims payment, program integrity monitoring, internal audit, executive oversight, information systems, finance, actuarial, procurement, insurance, risk management, and compliance oversight and monitoring, among other functions
- Aetna Health Management, LLC: After-hours call center, provider credentialing, pharmacy benefit management (PBM) administrative services (when not performed by Caremark PCS Health LLC [CVS Health]), and Aetna's nurse-informed health line, among other functions
- Aetna Life Insurance Company: Information technology data center infrastructure, human resources services and support, and procurement support/contracting

To improve overall access to services and complement our clinical model, we also use non-Aetna owned subcontractors who contribute additional capacity, specific experience, or expertise to our mission of achieving the Agency's goals. Aetna selects qualified subcontractors with experience in and knowledge of the Florida Statewide Medicaid Managed Care program:

- Access2Care (formerly known as TMS Management Group, Inc.): Access2Care provides non-emergency transportation management to Medicaid and Medicare enrollees through government and managed care organization contracts, with customized programs for each unique region and diverse population. Annually, Access2Care manages 8.6 million trip requests for over 5.5 million covered lives across urban, suburban, rural, and remote rural regions in 29 states and the District of Columbia. Its parent company, Envision Healthcare Holdings, Inc., was founded in 2005 to provide a broad range of coordinated, clinically based solutions across the continuum of care, from medical transportation and hospital encounters to comprehensive care alternatives in various settings. Its Florida office is located in Clearwater.
- Beacon Health Options (Beacon): Our behavioral health manager, Beacon, combines two of the country's most prominent behavioral health companies—Beacon Health Strategies and ValueOptions. Together they serve more than 50 million people across all 50 states. Beacon has programs serving Medicaid recipients and other public sector populations in 26 states and the District of Columbia. It has contracted directly with State

## **EXHIBIT A-4-a**

### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

and county agencies since 1995 to manage Medicaid behavioral health carve-out programs, including Florida's MediPass program. It is accredited by both the Utilization Review Accreditation Commission (URAC) and the National Committee for Quality Assurance (NCQA), and it offers superior clinical mental health and substance use disorder management, a strong employee assistance program, work/life support, specialty programs for autism and depression, and insightful analytics to improve the delivery of care.

- CVS Health: As Aetna's PBM since 2011, CVS Health provides prior authorization services, utilization review, and pharmacy network management. Pharmaceutical Card System, a predecessor of Caremark, was founded in 1969 in Scottsdale, Arizona, effectively launching the pharmacy benefit management industry. Today, CVS Health serves more than 2,000 clients and more than 88 million members across all 50 states, Puerto Rico, and the Virgin Islands. CVS has supported managed Medicaid clients since 1988 and presently serves approximately 1.7 million Medicaid enrollees in Florida. CVS Health currently has 862 retail pharmacies, 1 specialty mail pharmacy, and 3 Coram CVS/Specialty infusion pharmacies in Florida. CVS Health has received URAC accreditation in PBM, drug therapy management, specialty pharmacy, and mail service pharmacy.
- Firstsource Solutions/Firstsource Transaction Service, LLC: Firstsource Solutions performs overflow claims processing for us, and has offices located in Tampa, Florida. Firstsource is a global provider of business process outsourcing services with more than 26,000 employees in total. Firstsource entered the health care space with its 2005 acquisition of an existing health care company originally started in 1993. Since then, it has increased its portfolio of clients in both the payer and provider space through acquisitions and organic growth. Today, Firstsource services 22 health care payers (including 5 of the top 10 insurers in the United States) and more than 1,000 hospitals and service providers.
- iCare Health Solutions: Our ophthalmology, optometry, and vision services vendor is iCare Health Solutions, which was founded in 1982 and has served Medicaid populations since 2013. With offices in Miami and Tampa, iCare provides vision services to over 3 million individuals annually. Their program uses a powerful technology-driven infrastructure combined with simple and effective benefit management services to support integrated eye care delivery.
- Managed Care of North America, Inc.: Our dental benefits administrator is Managed Care of North America, Inc. (MCNA), which provides exceptional service to state agencies and managed care organizations for Medicaid, CHIP, and Medicare enrollees. Founded in Florida in 1992, MCNA is headquartered in Fort Lauderdale and serves approximately 4 million children and adults nationwide. It was the first dental plan in the country to be awarded full URAC Dental Plan Accreditation. MCNA underwrites Medicaid and CHIP dental programs in Florida, Arkansas, Idaho, Iowa, Louisiana, Nebraska, and Texas. The corporate leadership team has over 200 years of combined experience in patient care, financial administration, and corporate compliance.
- MedSolutions, Inc. dba eviCore healthcare (eviCore): We collaborate with eviCore healthcare for radiology and musculoskeletal pain management services. EviCore has been serving Medicaid enrollees since 2006. A national leader in integrated, innovative care management solutions for managed care organizations, eviCore began providing services in the managed care setting in the early 1990s as MedSolutions, Inc. and CareCore National. These two companies merged and became eviCore healthcare in

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

2015. With 25 years of combined experience, eviCore currently covers over 100 million lives. Its Florida offices are located in Melbourne.
- Public Partnerships, LLC: Our consumer directive services vendor and fiscal employer/gent is Public Partnerships, LLC, which formed in the late 1990s to serve the Robert Wood Johnson Foundation's National Self Determination Grant initiative. Currently, Public Partnerships, LLC, provides fiscal management services and related supports for participant direction in 24 states across 51 Medicaid waiver and state-funded programs serving over 65,100 participants and over 76,000 support workers each year. Sharing Aetna's commitment to keeping enrollees at the center of all we do, Public Partnerships, LLC, empowers enrollees to make decisions over some of the most important activities of their lives—what kind of care they need to stay at home, who should provide that care, and how it should be managed.

### **OVERCOMING BARRIERS TO IMPLEMENTATION**

**CRITERION 3:** The extent to which the barriers to implementation experienced by the respondent have clear resolutions outlined

Aetna's years of experience serving Florida's Medicaid enrollees and 30 years in the national Medicaid market uniquely situates us for smooth, seamless implementation of a statewide, comprehensive LTC and MMA program. We view the Agency as a partner in ensuring successful implementation and minimizing disruption to enrollees. Aetna's Implementation team already includes Florida health plan staff; highly experienced, integrated, cross-functional leaders; and subject matter experts (SMEs) from Aetna's national Medicaid team as well as employees from physical health, behavioral health, and long-term care functional areas. Aetna's extensive clinical, operational, and technology implementation experts support our local health plan expertise. Our Implementation director has more than 40 years of clinical experience implementing Medicaid and Medicare-Medicaid programs, including LTC programs, and the dedicated experts on the team follow a proven implementation process grounded in numerous successful implementations and program expansions.

Aetna engages with the Agency, our providers, and our community partners continuously in order to form collaborative relationships that foster readiness. We engage our stakeholders in comprehensive planning as well as thorough and clear communication. In our years of experience implementing managed care programs in Florida, we understand that introducing new programs to new populations in new regions takes time and requires an intense focus on enrollee care. From the beginning, we expect and prepare for increased call volume by providing additional staff members who are ready to answer enrollee questions and avoid gaps in care. Providers are engaged through outreach initiatives to manage, support, and maintain continuity of care. Provider communication efforts reduce confusion about contract details and assure practitioners that we will honor prior authorizations. Enrollees can see their preferred practitioners even when they are out of network, while we work to contract with the provider or enter into a single-case agreement to reduce disruption for enrollees.

We will leverage our existing Florida footprint and successful implementation of our current Medicaid contract to complement Aetna's seasoned, well-established approach to help ensure a successful expansion upon award. In our experience, we know that implementing expanded programs in new regions can present challenges and requires a methodical and proven approach to addressing potential barriers and setbacks. Therefore, we develop a

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

comprehensive work plan to address all activities, work streams, and variables as part of our approach to a successful implementation. We recognize that a strong working relationship with the Agency is critical, and if awarded, we would collaborate with AHCA in developing the implementation work plan and addressing all areas of sensitivity and concern, such as enrollee transitions, outreach, and communication. The potential barriers to implementation in Florida and our proposed solutions follow:

Potential Barrier 1: Complex implementation with various interdependent activities that need to be organized, managed/facilitated, and tracked (e.g., staffing, facilities planning and IT/systems configuration to include new regions).

Solutions:

- Comprehensive project management model to guide implementation
- Formal project management governance process that includes oversight and multiple-tier review process for all project work streams
- Dedicated project management team with experience successfully facilitating large-scale new business implementations, migrations, and insourcing projects
- Daily command center meetings to review the project plan, dashboards, and progress reports with leadership and management teams

Potential Barrier 2: Hiring a large volume of staff to accommodate growth

Solutions:

- Begin recruiting, screening, interviewing and hiring with significant lead time (i.e., at least three months prior to regional go-live)
- Conduct regional job fairs with rapid screening sessions to triage candidates
- Develop pre-recruiting partnerships with local associations, recruiting agencies, and job-training organizations; for example, when we implemented the LTSS program in Virginia, we were able to quickly hire more than 300 new staff due to a detailed hiring project plan that included posting positions on the Aetna website; on LinkedIn; at local colleges, universities, and community based organizations; local health care associations; and other websites, and we conducted 10 major job fairs across Virginia in 7 different regions over 4 months attended by over 400 candidates with 107 job fair candidates offered positions. Additionally, we received over 10,000 resumes; screened over 1,000 candidates; conducted more than 800 individual interviews as well as second, third and fourth interviews depending on the position; completed background checks; and hired 331 new employees in 4 short months.

Potential Barrier 3: Effectively training a large volume of staff

Solutions:

- Development of a detailed and thorough training project plan as well as on-going training Multimodal training that includes in-person and virtual training, shadowing, and post-training testing

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Intensive initial training that includes Florida Medicaid program-specific information and requirements
- Ongoing talent development that includes Florida-specific trainings, career planning, and mentoring

### **Strengthening Communication between the Implementation Team and the Agency**

We believe regular status reports and communication are imperative to successful implementation. Within our extensive and rigorous implementation governance, we conduct in-depth status meetings to monitor implementation. The implementation team works interdepartmentally and collaboratively to identify risks, determine and execute mitigation strategies, and resolve issues as quickly as possible. Any issues that need immediate intervention are communicated and addressed within hours. The implementation team completes a status report that they review weekly with the health plan and the Aetna Medicaid organization's leadership, who provide guidance and final decisions. We will provide monthly implementation dashboard reports to inform the Agency on progress toward milestones and efforts to address any challenges that arise.

### **Fulfilling System-Build and Report Requirements**

Dedicated experts managing exchanges and regulatory reporting will work with the Agency's designees to understand requirements fully and coordinate testing of file exchanges and regulatory reports. Aetna has done this successfully in Florida and in all other states we serve. With our experience in Florida, we know and understand the State's requirements and are experienced at fulfilling them. We perform exhaustive system testing of our applications, operational and management reports, files, and file exchanges with providers, clearinghouses, and vendors. We use a dedicated team and detailed plan to govern all testing. The plan specifies the test data set, expected results, and test protocols and rules. At each stage, testers must document any defects, coordinate repair of those defects with the appropriate team members, and document their approval of the system test results at 100% before they move to the next stage in the testing process.

Our testing encompasses functional testing, such as health-risk assessment functionality; performance testing; user acceptance testing; end-to-end testing; and other system-specific tests, including Section 508 testing of our external websites. All of the following major systems and process areas are tested, including, but not limited to, care management, enrollee management, call centers, and provider interfaces.

### **Forging Relationships with Operational Counterparts at the State**

Establishing operations and operational readiness are the most critical parts of our implementation. We gather, confirm, and incorporate the Florida regulatory and technical requirements into our clinical services, administrative operations, transaction platforms, and program management. We use the most current companion/reporting manual to guide us in all aspects of the Agency's reporting criteria. Our business systems and processes support staff in a way that serves the individual needs of each enrollee and provider. We will conduct a focused, intensive, multiday review of any new Florida contract with key leaders and SMEs from the health plan and national team. By doing so, our implementation team achieves clarity, alignment, and shared ownership of the program requirements and related deliverables. Each

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

work group reviews their operational and technical work plan document and contributes deliverables such as updated policies and procedures, enrollee and provider materials, system applications, and training material.

### **NOTABLE ACCOMPLISHMENTS AND ACHIEVEMENTS**

**CRITERION 4:** The extent to which the respondent has listed accomplishments and achievements that are relevant to this solicitation

While our programs and services continue to evolve and expand, our mission remains the same—building a healthier community by improving the lives and well-being of every enrollee we are privileged to serve. Our years of experience working with states and Medicaid enrollees, coupled with our knowledgeable clinical and administrative staff and innovative technology solutions, afford our enrollees the benefit of evidence-based managed care that has been tested in practice.

In Florida, Aetna is privileged to serve more than 100,000 Medicaid enrollees. We provide and manage high-quality integrated health care services for the TANF, ABD, LTC, and Florida Healthy Kids populations. Aetna is committed to continuous quality improvement to fulfill the aim of improved health outcomes for all enrollees. Our results are reflected in consistently achieving high NCQA status ratings. In 2017, Aetna received the top NCQA ranking among all Florida Medicaid plans for the second year in a row, and we are among the top 15 Medicaid plans in the country.

NCQA accreditation demonstrates a commitment to quality, outstanding clinical performance, and consumer experience. In Florida, Aetna has achieved an NCQA accreditation level of Commendable, awarded to organizations with well-established programs for service and clinical quality that meet rigorous requirements for consumer protection and quality improvement. We are tightly focused on achieving the .25-point improvement required to achieve the NCQA accreditation level of Excellent.

Select highlights demonstrating the value and impact of our work in Florida and our alignment to the Agency's goals follow.

#### **Overall Inpatient Utilization Management**

Our Utilization Management department focuses on decreasing over- and underutilization. Our successes to date include the following:

- Inpatient per member, per month decreased spend by 15.97% despite an average increase in risk scores of 5.4%
- Cost per admission decreased by 7.08% across all lines of business
- Bed days per thousand decreased by 13.83%
- Admission per thousand decreased by 21.52%
- Observation conversions of 1- to 2-day day inpatient stays have steadily increased, resulting in an average savings of \$1,500 (or 40%) per observation stay

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **Neonatal Intensive Care Unit**

By managing, monitoring, evaluating, and approving the utilization of care our enrollees receive, we have achieved the following results:

- Inpatient per-member-per month spend decreased by 40.80%
- Bed days per thousand decreased by 48.03%
- Admission per thousand decreased by 31.65%
- Average length of stay decreased by 23.97%
- Cost per admission decreased by 13.39%

### **Prior Authorization**

Through our quality management process, we evaluate and update our prior-authorization guidelines. As a result, prior-authorization requirements for more than 800 codes will be removed, with a scheduled rollout in the fourth quarter of 2017.

### **Spinal Fusion Initiative**

The spinal fusion initiative provides expert review of spinal cases by our orthopedic surgeon consultant. Aetna's spine surgery precertification process will maximize consistency of medical necessity determinations for both inpatient and outpatient spinal procedures to reduce costly and unnecessary spinal surgery. Recent studies have shown a more than 20% reduction in unnecessary surgery from redirection to care that is more conservative and effective for the enrollee.

### **Safety and Monitoring Program**

The Safety and Monitoring Solution uses benchmarks and algorithms to target enrollees who may be abusing controlled substances. It reduces fraud, waste, and abuse through regular claims monitoring to identify enrollees with high-cost drug use patterns that may suggest potential abuse or misuse. A clinical pharmacist conducts an analysis of the generated profiles, which are stratified by risk score. If a potential case of fraud or misuse is identified, CVS Health sends a letter to the appropriate prescriber(s) alerting them to the issue and conducts follow-up activities on targeted participants for up to six months. CVS Health collaborates with Aetna to provide enrollee case details quarterly to engage care management and the Special Investigation Unit for additional monitoring, investigation, and intervention.

### **Dental**

Aetna's person-centered approach includes dental care, which affects overall health. We expanded our adult dental benefit in June 2016 to add restorative services for adults and periodontal services for pregnant women so enrollees can retain their natural teeth, avoid the stigma of tooth loss, and reduce costly and often ineffective emergency department visits by treating caries before teeth become symptomatic and lead to additional oral and overall health issues.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **Pharmacy Advisor® Support Program**

Our Pharmacy Advisor® support program helps enrollees with chronic conditions to adhere to their medications. Targeted conditions that are prevalent and costly include depression, diabetes, high cholesterol, hypertension, and respiratory diseases. Through this program, the PBM will proactively communicate with prescribing providers when enrollees stop using prescribed therapies, enabling providers to contact the enrollees, encourage them to keep taking their medications, and explain why it is important. Improved adherence with medication regimens can help slow disease progression and reduce medical costs.

### **Retrospective Safety Review**

The retrospective drug utilization review program includes pharmacist review, within 72 hours, of retail and mail claims to identify potential safety issues such as serious drug interactions that were not addressed or identified at point of sale. As potential issues are identified, prescribing providers are faxed patient profiles and recommendations. The prescribing provider is contacted by phone in serious cases.

### **Evaluation Criteria:**

1. The extent of the respondent's experience with providing integrated medical and behavioral health services.
2. The extent of the respondent's subcontractors' experience in coordinating or providing services to Medicaid recipients.
3. The extent to which the barriers to implementation experienced by the respondent have clear resolutions outlined.
4. The extent to which the respondent has listed accomplishments and achievements that are relevant to this solicitation.
5. The extent to which the respondent's Medicaid populations served are similar to the populations served by the SMMC program.

**Score:** This section is worth a maximum of 25 raw points with each of the above components being worth a maximum of 5 points each.

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## A. RESPONDENT BACKGROUND / EXPERIENCE

### SRC# 1 – MANAGED CARE EXPERIENCE (STATEWIDE)

#### Attachment SRC# 1: Managed Care Experience Tables

#### HEALTH PLANS OWNED BY AETNA INC.

The health plans that follow are/were owned by Aetna Inc. and managed by Aetna affiliates that currently provide (and will continue to provide) administrative services for Aetna Better Health of Florida. The health plans within this table have or had direct contractual relationships with the State agencies in their respective states. The scope of services and populations shown for each health plan is an aggregate of the services provided and populations served for the entire period set forth under the relevant contract term. Depending on contract requirements, some services and/or populations may or may not be/have been covered at a given point during the time period.

The table that follows lists Florida contracts first, and then lists the remaining contracts in alphabetical order by state.

#### Note regarding item f.:

As described in more detail in the narrative response to SRC# 1, in general, Aetna affiliates perform the following types of services for the health plans we manage, including, but not limited to: management services for physical and behavioral health, including care and disease management, quality management, utilization management, enrollment processing, claims payment, program integrity monitoring, internal audit, executive oversight, information systems, finance, actuarial, procurement, insurance, risk management, compliance oversight and monitoring, after-hours call center, provider credentialing, pharmacy benefit management (PBM) administrative services (when not performed by Caremark PCS Health), Aetna's nurse-informed health line, information technology data center infrastructure, human resources services and support, and procurement support and contracting services. In the item addressing the use of administrative and/or delegated subcontractor(s) and their scope of work, item f., we list services performed by unaffiliated subcontractors.

#### Note regarding item g.:

Some of our plans report pass-through revenue and claims, which are monies received by the managed care organization (MCO) from the state/agency to be distributed directly to providers or third-party vendors by the MCO. The types of pass-through revenue and claims vary by state/agency, but are based on pre-determined agreements between the state/agency and MCO. The total of monies received (pass-through revenue) is equal to the total of monies distributed (pass-through claims) so that these "pass-through" amounts net to zero. If a plan reports pass-through revenue and claims, this is noted in item g.

#### Note regarding item i.:

In regard to the barriers to implementation, we interpret item i. to be asking about barriers that prevented timely implementation of the contract. If the contract was implemented on the scheduled completion date, we indicated that there were no barriers to implementation. We discuss general barriers to implementation in the narrative portion of the response to SRC# 1.

<b>State</b>	Florida		<input checked="" type="checkbox"/> Owned by Aetna Inc. <input type="checkbox"/> Non-owned by Aetna Inc.	
<b>Health plan name</b>	Coventry Health Care of Florida, Inc. dba Aetna Better Health of Florida			
<b>a. Medicaid population served</b>	CHIP			
<b>b. Name and address of client</b>	Florida Healthy Kids Corporation 661 East Jefferson Street, 2nd Floor Tallahassee, FL 32302			
<b>c. Name of contract</b>	Florida Healthy Kids	<b>d. Contract start and end dates</b>	1993 to present	
<b>Current contract duration</b>	10/1/2015 - 9/30/2017 (with 2 one year renewal options through 9/30/2019)			
<b>e. Scope of work performed, covered populations and covered services</b>	Coventry Health Care of Florida, Inc. dba Aetna Better Health of Florida provides managed care services for the Florida Healthy Kids CHIP population for children ages 0 to 18. Covered services include medical, behavioral health, pharmacy, vision, dental, and non-emergency transportation (NEMT).			
<b>f. Subcontractors</b>	Pharmacy benefits management, behavioral health, vision, translation/interpretation, after-hours call center, nurse line, loss prevention, data entry, and printing/mailing services.			
<b>g. Annual contract amount and annual claims payment amount</b>				
	<b>2016</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>
<b>Contract amount</b>	\$57,359,394	\$31,855,180	\$28,537,373	\$31,849,980
<b>Claims payment</b>	\$48,254,508	\$31,386,291	\$27,462,112	\$23,863,545
<b>6/2017 YTD</b>	<b>Contract amount</b>	\$17,234,904	<b>Claims payment</b>	\$10,559,990
<b>h. Contract implementation dates, scheduled and actual</b>	Implementation scheduled and executed: 1993			
<b>i. Implementation barriers and resolutions</b>	None			
<b>j. Relevant accomplishments and achievements</b>	<ul style="list-style-type: none"> <li>• NCQA accreditation – Commendable</li> <li>• Number one ranking for quality among all contractors in State; top 15 plans in U.S.</li> <li>• State-specific rankings – 4.0 rating</li> <li>• 2017 Overall Rating of Health Plan: Adult 79.05 percent (2017 CSS National Medicaid Average was 72.44 percent) and Child 91.25 percent (2017 CSS National Medicaid Average was 84.39 percent)</li> <li>• Aetna Better Health of Florida met 100 percent of hybrid measures for 2016 at the 50th percentile rate, and 64 percent met the 75th percentile rate (of prior year quality compass).</li> </ul>			



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	<ul style="list-style-type: none"><li>• Implementation of Emergency Notification System that advises PCPs in real time when one of their patients is admitted to a hospital or presents at the ED</li><li>• Development of targeted community engagement to improve the communities we serve; examples include Zika education, medical symposiums, CPR certification, health education sponsorships, and nutritional education for high risk children/ communities</li></ul>
<b>k. Number of enrollees, by health plan type</b>	Medicaid enrollees: 41,020 (June 2017)
<b>l. Type of contract</b>	Capitated

<b>State</b>	Florida	<input checked="" type="checkbox"/> Owned by Aetna Inc. <input type="checkbox"/> Non-owned by Aetna Inc.				
<b>Health plan name</b>	Coventry Health Care of Florida, Inc. dba Aetna Better Health of Florida					
<b>a. Medicaid population served</b>	TANF, ABD, LTC, Duals					
<b>b. Name and address of client</b>	Florida Department of Children and Families – Southern Region 401 NW 2nd Avenue N1007 Miami, Florida 33128					
<b>c. Name of contract</b>	Statewide Medicaid Managed Care – Managed Medical Assistance – Medicaid only	<b>d. Contract start and end dates</b>		01/2014 – present		
<b>Current contract duration</b>	1/1/2014 - 12/31/2018 (with renewal options of no more than 3 years; State is not exercising this option, so contract termination is set for 12/31/2018)					
<b>e. Scope of work performed, covered populations and covered services</b>	Coventry Health Care of Florida, Inc. dba Aetna Better Health of Florida provides managed care services for TANF, ABD, LTC, and Duals, including pregnant women, infants, children, low-income families and adults, individuals receiving SSI, and LTSS individuals. Covered services include medical, behavioral health, HCBS/LTC, pharmacy, vision, dental, and NEMT.					
<b>f. Subcontractors</b>	Pharmacy benefits management, behavioral health, vision, translation/interpretation, after-hours call center, nurse line, loss prevention, data entry, and printing/mailing services					
<b>g. Annual contract amount and annual claims payment amount</b>						
Note: The following amounts reflect pass-through revenue and claims.						
	<b>YTD June 2017</b>	<b>2016</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>
<b>Contract amount</b>	\$209,732,933	\$424,777,369	\$360,294,135	\$301,017,706	n/a	n/a
<b>Claims payment</b>	\$190,873,209	\$371,921,472	\$333,468,440	\$298,670,408	n/a	n/a
<b>h. Contract implementation dates, scheduled and actual</b>	Implementation scheduled and executed on: 01/2014					
<b>i. Implementation barriers and resolutions</b>	None					
<b>j. Relevant accomplishments and achievements</b>	<ul style="list-style-type: none"> <li>• NCQA accreditation – Commendable; number one ranking for quality among all contractors in State; top 15 plans in U.S.</li> <li>• State-specific rankings - 4.0 rating</li> <li>• 2017 Overall Rating of Health Plan: Adult 79.05% (2017 CSS National Medicaid Average was 72.44%) and Child 91.25% (2017</li> </ul>					



	CSS National Medicaid Average was 84.39%)
<b>j. Relevant accomplishments and achievements</b>	<ul style="list-style-type: none"><li>• Aetna Better Health of Florida met 100% of hybrid measures for 2016 at the 50th percentile rate, and 64% met the 75th percentile rate (of prior year quality compass).</li><li>• Implementation of Emergency Notification System that advises PCPs in real time when one of their patients is admitted to a hospital or presents at the ED</li><li>• Development of targeted community engagement to improve the communities we serve; examples include Zika education, medical symposiums, CPR certification, health education sponsorships, and nutritional education for high risk children/communities</li><li>• Aetna Better Health of Florida has experienced a decrease in emergency department (ED) visits and costs per member per month for a savings of \$906,932.48 in 2016.</li></ul> <p><u>Medical Management High ER Utilizers Program</u> Medical Management High ER Utilizers Program resulted in a year-over-year decline in emergency department visits per 1000 members as follows: 2013 – 741.91; 2014 – 673.04; 2015 – 641.64; 2016 – 615.76</p> <p><u>NICU Program</u> NICU concurrent review is overseen by our chief medical officer and through this project, we have achieved the following results:</p> <ul style="list-style-type: none"><li>• Inpatient PMPM spend decreased by 40.80%</li><li>• Bed days per thousand decreased by 48.03%</li><li>• Admission per thousand decreased by 31.65%</li><li>• Average length of stay decreased by 23.97%</li><li>• Cost per Admission decreased by 13.39%</li></ul> <p><u>Inpatient utilization management results</u></p> <ul style="list-style-type: none"><li>• Inpatient per-member-per-month decreased spend by 15.97% despite an average increase in risk scores of 5.4%</li><li>• Cost per admission decreased by 7.08 %</li><li>• Bed days per thousand decreased by 13.83%</li><li>• Admission per thousand decreased by 21.52%</li><li>• Observation conversions of 1 – 2 day inpatient stays have steadily increased, resulting in an average savings of \$1,500 (or 40%) per observation stay</li></ul>
<b>k. Number of enrollees, by health plan type</b>	Medicaid enrollees: 62,814 (June 2017)
<b>l. Type of contract</b>	Capitated

<b>State</b>	Florida		<input checked="" type="checkbox"/> Owned by Aetna Inc. <input type="checkbox"/> Non-owned by Aetna Inc.		
<b>Health plan name</b>	Coventry Health Care of Florida, Inc. dba Aetna Better Health of Florida				
<b>a. Medicaid population served</b>	TANF, ABD				
<b>b. Name and address of client</b>	Agency for Health Care Administration 2727 Mahan Drive Tallahassee, FL 32308				
<b>c. Name of contract</b>	Medicaid HMO contract	<b>d. Contract start and end dates</b>	09/2002 – 08/2014*		
*Note: This contract terminated when the State implemented the SMMC MMA contract. Aetna Better Health of Florida now supports TANF and ABD enrollees through the SMMC MMA Contract, number FP022.					
<b>e. Scope of work performed, covered populations and covered services</b>	Coventry Health Care of Florida, Inc., provided managed care services for TANF, ABD, LTC, and Duals, including pregnant women, infants, children, low-income families and adults, individuals receiving SSI, and LTC individuals. Covered services included medical, behavioral health, HCBS/LTC, pharmacy, vision, dental, and NEMT.				
<b>f. Subcontractors</b>	Transportation, pharmacy, vision, dental, and behavioral health				
<b>g. Annual contract amount and annual claims payment amount</b>					
	<b>2016</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>
<b>Contract amount*</b>	n/a	n/a	n/a	\$123,860,038	\$73,158,661
<b>Claims payment*</b>	n/a	n/a	n/a	\$113,070,923	\$64,742,762
*Note: Historical claims payment amounts broken out separately for the TANF/ABD and LTC populations or contracts are not available for the contract years 2012 and 2013. Therefore, the amounts provided in the Contract Amount and Claims Payment fields show the annual aggregate contract and claims payment amounts for TANF, ABD, and LTC populations/contracts.					
<b>h. Contract implementation dates, scheduled and actual</b>	Implementation scheduled and executed on: 09/2002				
<b>i. Implementation barriers and resolutions</b>	None				
<b>j. Relevant accomplishments and achievements</b>	<u>Child Health Check-ups (EPSDT)</u> Achieved screening levels in excess of the 80% threshold with intense focus on improving our participation ratios. Our robust outreach initiatives include educational materials, reminder letters, partnering with providers and hospitals to disseminate information at health fairs, personalized telephone calls, assistance with scheduling appointments, and age-appropriate incentive gifts. These efforts promote Child Health Check-ups and dental screenings for Medicaid children and				



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	adolescents up to age 21.
<b>k. Number of enrollees, by health plan type</b>	Medicaid enrollees: 31,648 (2013)
<b>l. Type of contract</b>	Capitated

<b>State</b>	Florida		<input checked="" type="checkbox"/> Owned by Aetna Inc. <input type="checkbox"/> Non-owned by Aetna Inc.		
<b>Health plan name</b>	Coventry Health Care of Florida, Inc.				
<b>a. Medicaid population served</b>	LTSS				
<b>b. Name and address of client</b>	Florida Department of Elder Affairs 4040 Esplanade Way, Ste. 360E, Tallahassee, Florida 32399				
<b>c. Name of contract</b>	Nursing Home Diversion Program	<b>d. Contract start and end dates*</b>	09/1999 – 12/2013		
<p>*Note: There were two LTC contracts during this time period. The first was the Nursing Home Diversion Program governed by the Department of Elder Affairs, which ran from September 1999 through July 2013, and was phased out when the Statewide Medicaid Managed Care program began. The second contract was with AHCA and ran from August 2013 through December 2013, when it became inactive due to the implementation of the new Statewide Medicaid Managed Care (SMMC) contract. It included the MMA program and the LTC program combined in one contract, and began on January 1, 2014. Aetna Better Health of Florida now supports LTC enrollees through the LTC program.</p>					
<b>e. Scope of work performed, covered populations and covered services</b>	Coventry Health Care of Florida, Inc., provided managed care services for the LTC population, including frail elders aged 65 years or older who were found by the Comprehensive Assessment and Review for Long-Term Care Services (CARES) to be at risk of nursing home placement. Covered services included medical, behavioral health, HCBS/LTC, pharmacy, vision, dental, and NEMT.				
<b>f. Subcontractors</b>	Transportation, pharmacy, vision, dental, and behavioral health				
<b>g. Annual contract amount and annual claims payment amount</b>					
	<b>2016</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>
<b>Contract amount*</b>	n/a	n/a	n/a	\$123,860,038	\$73,158,661
<b>Claims payment*</b>	n/a	n/a	n/a	\$113,070,923	\$64,742,762
<p>*Note: Historical claims payment amounts broken out separately for the TANF, ABD, and LTC populations or contracts are not available for the contract years 2012 and 2013. Therefore, the amounts provided in the Contract Amount and Claims Payment fields show the annual aggregate contract and claims payment amounts for TANF, ABD, and LTC populations/contracts.</p>					
<b>h. Contract implementation dates, scheduled and actual</b>	Implementation scheduled and executed on: 09/1999				
<b>i. Implementation barriers and resolutions</b>	None				



<b>j. Relevant accomplishments and achievements</b>	<p><u>Improving Enrollee Retention Rates</u> Coventry determined in 2008 that while baseline retention rates for our LTC Community Diversion Program were high (96.02%), we discovered a specific trend among those who voluntarily disenrolled: the enrollee was often admitted to a nursing facility without our knowledge or involvement. We subsequently educated caregivers, assisted living facility (ALF) providers, and facility staff on the importance of timely health plan notification prior to enrollee admissions. This ultimately led to better opportunities for nursing home diversion, enhanced enrollee retention, and a satisfaction rate of 98.25% in 2009, re-measurement year one.</p> <p><u>Osteoporosis Management Program</u> We implemented interventions to increase bone mineral density (BMD) screening and onset of prescription drug therapy for osteoporosis for female Medicare enrollees (age 67 and older) within six months after skeletal fracture. Over the first two years of implementation, the incidence of appropriate testing and treatment rose from 9% to 46% in our Medicare Advantage population, and the incidence of testing/treatment rose from 5% to 50% in our Medicare SNP population.</p>
<b>k. Number of enrollees, by health plan type</b>	Medicaid enrollees: 3,426 (2013)
<b>l. Type of contract</b>	Capitated

<b>State</b>	Florida		<input checked="" type="checkbox"/> Owned by Aetna Inc. <input type="checkbox"/> Non-owned by Aetna Inc.		
<b>Health plan name</b>	Coventry Health Plan of Florida, Inc.				
<b>a. Medicaid population served</b>	TANF, ABD				
<b>b. Name and address of client</b>	Florida Agency for Health Care Administration 2727 Mahan Drive, MS #50 Tallahassee, Florida 32308				
<b>c. Name of contract</b>	Medicaid HMO Contract	<b>d. Contract start and end dates</b>	09/2002 – 08/2014		
<b>e. Scope of work performed, covered populations and covered services</b>	Coventry Health Plan of Florida, Inc., provided managed care services for the TANF and ABD populations, including pregnant women, infants, children, children/youth with special health care needs, low income adults, LTC individuals, and individuals receiving SSI. Covered services included medical, behavioral health, pharmacy, and vision.				
<b>f. Subcontractors</b>	Pharmacy, vision, dental, behavioral health, and transportation				
<b>g. Annual contract amount and annual claims payment amount</b>					
	<b>2016</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>
<b>Contract amount</b>	n/a	n/a	\$0	\$65,413,132	\$59,331,987
	n/a	n/a	\$0	\$59,551,914	\$51,773,076
<b>h. Contract implementation dates, scheduled and actual</b>	Implementation scheduled and executed on: 09/2002				
<b>i. Implementation barriers and resolutions</b>	None				
<b>j. Relevant accomplishments and achievements</b>	Not available				
<b>k. Number of enrollees, by health plan type</b>	Medicaid enrollees: 23,567 (2013)				
<b>l. Type of contract</b>	Capitated				



<b>State</b>	Delaware		<input checked="" type="checkbox"/> Owned by Aetna Inc. <input type="checkbox"/> Non-owned by Aetna Inc.		
<b>Health plan name</b>	Delaware Physicians Care, Incorporated				
<b>a. Medicaid population served</b>	TANF, CHIP, ABD, ACA, LTSS, DUALS				
<b>b. Name and address of client</b>	Delaware Department of Health and Social Services, Division of Medicaid & Medical Assistance 1901 N. Du Pont Highway, Main Bldg. New Castle, DE 19720				
<b>c. Name of contract</b>	Managed Care Contract	<b>d. Contract start and end dates</b>	07/2004 to 12/2014		
<b>e. Scope of work performed, covered populations and covered services</b>	Delaware Physicians Care, Incorporated (DCPI), provided managed care services for populations including pregnant women, infants, children, children/youth with special health care needs, low income adults, ACA individuals, LTSS individuals and individuals receiving SSI. Covered services included medical, behavioral health, vision, and dental.				
<b>f. Subcontractors</b>	Pharmacy and vision				
<b>g. Annual contract amount and annual claims payment amount</b>					
	<b>2016</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>
<b>Contract amount</b>	n/a	n/a	\$848,847,892	\$753,627,338	\$654,140,128
<b>Claims payment</b>	n/a	n/a	\$783,799,689	\$684,082,740	\$586,536,066
<b>h. Contract implementation dates, scheduled and actual</b>	Implementation scheduled and executed on: Medicaid - 07/2004; MLTSS - 04/2012				
<b>i. Implementation barriers and resolutions</b>	None				
<b>j. Relevant accomplishments and achievements</b>	<ul style="list-style-type: none"> <li>• DPCI was privileged to serve Delawareans for 10 years, during which time we focused on improving quality of life for the underserved and most vulnerable members of the State.</li> <li>• Between April 2012 and December 2013, our DPCI LTSS plan increased the percentage of members receiving home and community-based services from 42.9% to 51.4%</li> <li>• We served approximately 137,000 enrolled members (including DSHP Plus), which represented a 71% market share.</li> <li>• DPCI achieved high quality standards and was ranked #27 in the country by the National Committee for Quality Assurance.</li> <li>• We are among the founding entities of the Delaware Health Information Network.</li> <li>• Through the Money Follows the Person program, we contributed to meeting 64% of the State's goal of moving members from</li> </ul>				

	institutional to community settings.
<b>j. Relevant accomplishments and achievements</b>	<ul style="list-style-type: none"> <li>• DPCI was among the first managed care organizations to introduce progressive value-based payment models with long-standing programs, including pay for quality and patient-centered medical homes that ultimately aligned and supported Delaware's State Innovation Model grant.</li> <li>• Awarded Medicaid Health Plan Association (MHPA) best practice recognition for three programs – Project Engage, Success Connections and Control your Heart for the Future heart failure telemonitoring program.</li> <li>• Meyers Group 2012 provider satisfaction survey indicated a provider loyalty of 93.8%</li> <li>• Consistent with Affordable Care Act (ACA) Program Integrity standards, DPCI increased its fraud and abuse platform to include a Member Verification of Services program. Over 7,500 letters were sent to members. Fraud programs recouped \$360,000 in 2012.</li> <li>• Conducted "Treat Your Body Right" performances by YoJo in the Red Clay School District, targeting elementary schools whose demographics indicated a high concentration of Medicaid eligible members</li> <li>• Implemented a readmission monitoring program for members who were recently discharged from an inpatient physical health facility. DPCI increased homecare visits which resulted in decreased readmission rates in Q4 2012. A similar program for behavioral health was launched in early 2013.</li> <li>• Established a Patient-Centered Medical Home (PCMH) initiative with Westside Family Health Care (FQHC)</li> <li>• Achieved the 90th percentile NCQA benchmark for "Rating of the Health Plan" on both the Child and Adult 2012 CAHPS surveys</li> <li>• In 2013, we demonstrated our experience in timely payment of claims in Delaware through a greater than 99% prompt payment rate.</li> </ul>
<b>k. Number of enrollees, by health plan type</b>	Medicaid enrollees: 130,584 (2014)
<b>l. Type of contract</b>	Capitated



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<b>State</b>	Illinois	<input checked="" type="checkbox"/> Owned by Aetna Inc. <input type="checkbox"/> Non-owned by Aetna Inc.				
<b>Health plan name</b>	Aetna Better Health, Inc. dba Aetna Better Health of Illinois					
<b>a. Medicaid population served</b>	TANF, ACA					
<b>b. Name and address of client</b>	Illinois Department of Healthcare and Family Services (Chicago Office) 401 South Clinton Street Chicago, Illinois 60607  Illinois Department of Healthcare and Family Services (Springfield Office) 100 South Grand Avenue East Springfield, Illinois 62762					
<b>c. Name of contract</b>	Family Health Plan (FHP) – ACA Contract	<b>d. Contract start and end dates</b>	08/2014 – present			
<b>Current contract duration</b>	8/1/2014 – 6/30/2019 (with renewal options up to 5 years through 6/30/2024).					
<b>e. Scope of work performed, covered populations and covered services</b>	Aetna Better Health, Inc. dba Aetna Better Health of Illinois provides managed care services for the TANF and ACA populations, including pregnant women, infants, children, children/youth with special health care needs, low income adults, individuals on SSI. Covered services include medical, behavioral health, HCBS/LTSS, pharmacy, vision, dental, and NEMT.					
<b>f. Subcontractors</b>	Dental, vision, pharmacy, and transportation					
<b>g. Annual contract amount and annual claims payment amount</b>						
Note: The following amounts reflect pass-through revenue and claims.						
	<b>YTD June 2017</b>	<b>2016</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>
<b>Contract amount</b>	\$373,751,095	\$618,420,088	\$409,035,683	\$13,095,995	n/a	n/a
<b>Claims payment</b>	\$356,939,209	\$628,041,487	\$380,382,113	\$11,677,713	n/a	n/a
<b>h. Contract implementation dates, scheduled and actual</b>	Implementation scheduled and executed on: 08/2014					
<b>i. Implementation barriers and resolutions</b>	None					
<b>j. Relevant accomplishments and achievements</b>	NCQA accreditation – Interim <u>Other notable achievements</u> Two PIPs that we have implemented to address HEDIS care gaps: 1. We identified an opportunity for improvement when HEDIS results showed our ICP rates for diabetic retinal exams (DRE) to be below the HEDIS 25th percentile. We elicited enrollee feedback and learned that some enrollees were not receiving eye exams because					

	<p>they were homebound and had difficulty getting to their providers. To address this gap, Aetna approached Canary Telehealth to develop a creative solution to assist enrollees in nursing facilities and their homes. Through this partnership, we were able to provide onsite eye exams for over 400 enrollees. Along with other interventions, our 2016 DRE rates improved to 63.19%, placing Aetna in the HEDIS 75th percentile. We improved access and the quality of care for our enrollees while reducing short and long-term costs through our partnership with Canary Telehealth and early identification and intervention for vision problems in enrollees living with diabetes.</p> <p>2. We launched aggressive inpatient census management to improve postpartum care and well-child newborn follow-up; Aetna is on track to achieve the 50th percentile for prenatal care and the 75th percentile for postpartum care (HEDIS 2017).</p>
<b>k. Number of enrollees, by health plan type</b>	Medicaid enrollees: 192,957 (June 2017)
<b>l. Type of contract</b>	Capitated



<b>State</b>	Illinois	<input checked="" type="checkbox"/> Owned by Aetna Inc. <input type="checkbox"/> Non-owned by Aetna Inc.			
<b>Health plan name</b>	Aetna Better Health, Inc. dba Aetna Better Health of Illinois				
<b>a. Medicaid population served</b>	ABD, LTSS				
<b>b. Name and address of client</b>	Illinois Department of Healthcare and Family Services (Chicago Office) 401 South Clinton Street Chicago, Illinois 60607  Illinois Department of Healthcare and Family Services (Springfield Office) 100 South Grand Avenue East Springfield, Illinois 62762				
<b>c. Name of contract</b>	Integrated Care Plan Contract	<b>d. Contract start and end dates</b>	04/2011 – present		
<b>e. Scope of work performed, covered populations and covered services</b>	Aetna Better Health, Inc. dba Aetna Better Health of Illinois provides managed care services for the ABD and LTSS populations, including pregnant women, infants, children, children/youth with special health care needs, low income adults, and individuals on SSI. Covered services include medical, behavioral health, HCBS/LTSS, pharmacy, vision, dental, and NEMT.				
<b>f. Subcontractors</b>	Pharmacy, dental, vision, and transportation				
<b>g. Annual contract amount and annual claims payment amount</b> Note: The following amounts reflect pass-through revenue and claims.					
	<b>2016</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>
<b>Contract amount</b>	\$663,515,571	\$760,809,290	\$550,768,263	\$305,211,544	\$230,516,689
<b>Claims payment</b>	\$662,288,678	\$714,437,986	\$494,686,234	\$268,700,369	\$190,519,230
<b>YTD June 2017</b>	<b>Contract amount</b>	\$345,106,291	<b>Claims payment</b>	\$296,910,859	
<b>h. Contract implementation dates, scheduled and actual</b>	Implementation scheduled and executed on: 04/2011				
<b>i. Implementation barriers and resolutions</b>	None				

<b>j. Relevant accomplishments and achievements</b>	<ul style="list-style-type: none"> <li>• NCQA accreditation – Interim</li> <li>• Successes achieved for LTSS enrollees between 2013 and 2015: <ul style="list-style-type: none"> <li>– Inpatient PMPM decreased by 44.8%</li> <li>– Bed days per thousand decreased by 35.5%</li> <li>– Cost per bed day decreased by 14.0%</li> <li>– Transition of 17.4% of enrollees from nursing facility care to HCBS</li> </ul> </li> </ul> <p><i>Continued on next page</i></p>
<b>j. Relevant accomplishments and achievements</b>	<p><u>Other notable achievements</u></p> <p>Two PIPs that we have implemented to address HEDIS care gaps:</p> <ol style="list-style-type: none"> <li>1. We identified an opportunity for improvement when HEDIS results showed our ICP rates for diabetic retinal exams (DRE) to be below the HEDIS 25th percentile. We elicited enrollee feedback and learned that some enrollees were not receiving eye exams because they were homebound and had difficulty getting to their providers. To address this gap, Aetna approached Canary Telehealth to develop a creative solution to assist enrollees in nursing facilities and their homes. Through this partnership, we were able to provide onsite eye exams for over 400 enrollees. Along with other interventions, our 2016 DRE rates improved to 63.19%, placing Aetna in the HEDIS 75th percentile. We improved access and the quality of care for our enrollees while reducing short and long-term costs through our partnership with Canary Telehealth and early identification and intervention for vision problems in enrollees living with diabetes.</li> <li>2. We launched aggressive inpatient census management to improve postpartum care and well-child newborn follow-up; Aetna is on track to achieve the 50th percentile for prenatal care and the 75th percentile for postpartum care (HEDIS 2017).</li> </ol>
<b>k. Number of enrollees, by health plan type</b>	<p>Medicaid enrollees: 28,496 (June 2017)</p>
<b>l. Type of contract</b>	<p>Capitated</p>



<b>State</b>	Illinois	<input checked="" type="checkbox"/> Owned by Aetna Inc. <input type="checkbox"/> Non-owned by Aetna Inc.				
<b>Health plan name</b>	Aetna Better Health, Inc. dba Aetna Better Health of Illinois					
<b>a. Medicaid population served</b>	MLTSS (MCD Duals only)					
<b>b. Name and address of client</b>	Illinois Department of Healthcare and Family Services (Chicago Office) 401 South Clinton Street Chicago, Illinois 60607  Illinois Department of Healthcare and Family Services (Springfield Office) 100 South Grand Avenue East Springfield, Illinois 62762					
<b>c. Name of contract</b>	Managed Long Term Supports and Services Program*	<b>d. Contract start and end dates</b>	07/2016 – present			
*Note: This is a standalone MLTSS contract that started in 2016 as a companion contract to the Duals contract, which follows, that was issued as part of the separate MMAI RFP from 2013.						
<b>Current contract duration</b>	7/1/2016 - 12/31/2017 (with renewal options up to 6 years through 12/31/2025)					
<b>e. Scope of work performed, covered populations and covered services</b>	Aetna Better Health, Inc. dba Aetna Better Health of Illinois provides managed care services for the managed LTSS Duals population including individuals aged 65 years and older, and adults with disabilities requiring long-term care. Covered services include medical, behavioral health, HCBS/LTSS, pharmacy, vision, dental, and NEMT.					
<b>f. Subcontractors</b>	Dental, vision, and transportation					
<b>g. Annual contract amount and annual claims payment amount</b>						
	<b>YTD June 2017</b>	<b>2016</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>
<b>Contract amount</b>	\$94,247,534	\$52,360,751	n/a	n/a	n/a	n/a
<b>Claims payment</b>	\$92,936,647	\$52,250,165	n/a	n/a	n/a	n/a
<b>h. Contract implementation dates, scheduled and actual</b>	Implementation scheduled and executed on: 07/2016					
<b>i. Implementation barriers and resolutions</b>	None					

<p><b>j. Relevant accomplishments and achievements</b></p>	<ul style="list-style-type: none"> <li>• NCQA accreditation – Interim</li> <li>• Successes achieved for LTSS enrollees between 2013 and 2015: <ul style="list-style-type: none"> <li>– Inpatient PMPM decreased by 44.8%</li> <li>– Bed days per thousand decreased by 35.5%</li> <li>– Cost per bed day decreased by 14.0%</li> <li>– Transition of 17.4% of enrollees from nursing facility care to HCBS</li> </ul> </li> <li>• We identified an opportunity for improvement when HEDIS results showed our ICP rates for diabetic retinal exams (DRE) to be below the HEDIS 25th percentile and developed a PIP to address it. We elicited enrollee feedback and learned that some enrollees were not receiving eye exams because they were homebound and had difficulty getting to their providers. To address this gap, Aetna approached Canary Telehealth to develop a creative solution to assist enrollees in nursing facilities and their homes. Through this partnership, we were able to provide onsite eye exams for over 400 enrollees. Along with other interventions, our 2016 DRE rates improved to 63.19%, placing Aetna in the HEDIS 75th percentile. We improved access and the quality of care for our enrollees while reducing short and long-term costs through our partnership with Canary Telehealth and early identification and intervention for vision problems in enrollees living with diabetes.</li> </ul>
<p><b>k. Number of enrollees, by health plan type</b></p>	<p>Medicaid enrollees: 7,425 (June 2017)</p>
<p><b>l. Type of contract</b></p>	<p>Capitated</p>



<b>State</b>	Illinois	<input checked="" type="checkbox"/> Owned by Aetna Inc. <input type="checkbox"/> Non-owned by Aetna Inc.				
<b>Health plan name</b>	Aetna Better Health, Inc. dba Aetna Better Health of Illinois					
<b>a. Medicaid population served</b>	Duals					
<b>b. Name and address of client</b>	Illinois Department of Healthcare and Family Services (Chicago Office) 401 South Clinton Street Chicago, Illinois 60607  Illinois Department of Healthcare and Family Services (Springfield Office) 100 South Grand Avenue East Springfield, Illinois 62762					
<b>c. Name of contract</b>	Medicare-Medicaid Alignment Initiative	<b>d. Contract start and end dates</b>	11/2013 – present			
<b>Current contract duration</b>	3/1/2014 – 12/31/2015 (with 2 one-year renewal options through 12/31/2017)					
<b>e. Scope of work performed, covered populations and covered services</b>	Aetna Better Health, Inc. dba Aetna Better Health of Illinois provides managed care services for individuals dually eligible for Medicare and Medicaid. Covered services include medical, behavioral health, HCBS/LTSS, pharmacy, vision, dental, and NEMT.					
<b>f. Subcontractors</b>	Dental, vision, and transportation					
<b>g. Annual contract amount and annual claims payment amount</b>						
	<b>YTD June 2017</b>	<b>2016</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>
<b>Contract amount</b>	\$84,432,874*	\$159,103,266	\$173,416,637	\$74,671,149	n/a	n/a
<b>Claims payment</b>	\$68,968,798	\$124,870,863	\$178,518,845	\$69,025,570	n/a	n/a
*Note: The decrease from 2016 to 2017 is reflective of the removal of MCD Duals, which are now served by the MLTSS (MCD Duals Only) contract begun in 2016, mentioned previously.						
<b>h. Contract implementation dates, scheduled and actual</b>	Implementation scheduled and executed on: 11/2013					
<b>i. Implementation barriers and resolutions</b>	None					

<b>j. Relevant accomplishments and achievements</b>	<p>NCQA accreditation – Interim <u>Other notable achievements</u></p> <p>Two PIPs that we have implemented to address HEDIS care gaps:</p> <ol style="list-style-type: none"> <li>1. We identified an opportunity for improvement when HEDIS results showed our ICP rates for diabetic retinal exams (DRE) to be below the HEDIS 25th percentile. We elicited enrollee feedback and learned that some enrollees were not receiving eye exams because they were homebound and had difficulty getting to their providers. To address this gap, Aetna approached Canary Telehealth to develop a creative solution to assist enrollees in nursing facilities and their homes. Through this partnership, we were able to provide onsite eye exams for over 400 enrollees. Along with other interventions, our 2016 DRE rates improved to 63.19%, placing Aetna in the HEDIS 75th percentile. We improved access and the quality of care for our enrollees while reducing short and long-term costs through our partnership with Canary Telehealth and early identification and intervention for vision problems in enrollees living with diabetes.</li> <li>2. We launched aggressive inpatient census management to improve postpartum care and well-child newborn follow-up; Aetna is on track to achieve the 50th percentile for prenatal care and the 75th percentile for postpartum care (HEDIS 2017).</li> </ol>
<b>k. Number of enrollees, by health plan type</b>	<p>Medicaid enrollees: 6,882 (June 2017)</p>
<b>l. Type of contract</b>	<p>Capitated</p>



<b>State</b>	Iowa	<input checked="" type="checkbox"/> Owned by Aetna Inc. <input type="checkbox"/> Non-owned by Aetna Inc.			
<b>Health plan name</b>	Aetna Health of Iowa, Inc. dba Coventry Health Care of Iowa, Inc.				
<b>a. Medicaid population served</b>	ACA				
<b>b. Name and address of client</b>	Iowa Department of Human Services Iowa Medicaid Enterprise 100 Army Post Road Des Moines, Iowa 50315				
<b>c. Name of contract</b>	Medicaid Expansion	<b>d. Contract start and end dates</b>		01/2014 – 12/2015	
<b>e. Scope of work performed, covered populations and covered services</b>	Aetna Health of Iowa, Inc. dba Coventry Health Care of Iowa, Inc., provided managed care services for Medicaid expansion individuals aged 21 to 65 years. Covered services included medical, behavioral health, pharmacy, and vision.				
<b>f. Subcontractors</b>	Behavioral health, pharmacy, vision, radiology and pain management prior authorization, and claims editing				
<b>g. Annual contract amount and annual claims payment amount</b>					
	<b>2016</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>
<b>Contract amount</b>	n/a	\$31,200,000	\$33,300,000	n/a	n/a
<b>Claims payment</b>	n/a	\$27,599,061	\$29,279,291	n/a	n/a
<b>h. Contract implementation dates, scheduled and actual</b>	Implementation scheduled and executed on: 01/2014				
<b>i. Implementation barriers and resolutions</b>	None				
<b>j. Relevant accomplishments and achievements</b>	EPSDT Incentive Program – This program was implemented in 2005. Members or parents were sent a reminder card to take to their provider for signature during the EPSDT visit. Once the signed card was returned to the plan, members received a \$5 gift card to Toys R Us, Subway, or Blockbuster through the mail.				
<b>k. Number of enrollees, by health plan type</b>	Medicaid enrollees: 7,045 (2015)				
<b>l. Type of contract</b>	Capitated				

<b>State</b>	Kansas		<input checked="" type="checkbox"/> Owned by Aetna Inc. <input type="checkbox"/> Non-owned by Aetna Inc.		
<b>Health plan name</b>	Coventry Health Care of Kansas, Inc.				
<b>a. Medicaid population served</b>	TANF, CHIP				
<b>b. Name and address of client</b>	Kansas Department of Administration 900 SW Jackson St. Topeka, Kansas 66612				
<b>c. Name of contract</b>	KanCare	<b>d. Contract start and end dates</b>		2007 – 12/2012	
<b>e. Scope of work performed, covered populations and covered services</b>	Coventry Health Care of Kansas, Inc., provided managed care services for the TANF and CHIP populations, including pregnant women, infants, children, children/youth with special health care needs, low income adults, and individuals receiving SSI. Covered services included medical, behavioral health, pharmacy, dental, and NEMT.				
<b>f. Subcontractors</b>	Transportation, pharmacy, dental, and behavioral health				
<b>g. Annual contract amount and annual claims payment amount</b>					
	<b>2016</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>
<b>Contract amount</b>	n/a	n/a	n/a	n/a	\$314,891,098
<b>Claims payment</b>	n/a	n/a	n/a	n/a	\$294,004,147
<b>h. Contract implementation dates, scheduled and actual</b>	Implementation scheduled and executed: 2007				
<b>i. Implementation barriers and resolutions</b>	None				
<b>j. Relevant accomplishments and achievements</b>	<p><u>Emergency Room Visits and Hospitalizations for Asthma per 1000 Members</u>          Historically, we found a seasonal variation in both ER utilization and inpatient utilization. The fall and spring are periods of high utilization for both ER visits and hospitalizations. It is the goal of this program to reduce the overall spike in utilization through education directed to both providers and members and a strong education emphasis prior to the spring and fall of each year. Comparing the December YTD utilization for 2011 versus the same period for 2010, we have seen a 3.54% decrease in ER utilization and a .64% decrease in IP hospitalizations for asthmatics.</p> <p><u>Medical Clinical Notifications</u>          For Calendar Year 2011, Coventry's Member Services made 31,322 Medicaid clinical notifications with 59% of contacted members either promising to schedule or being assisted to schedule appointments. 36% of contacted members had already scheduled or had already</p>				



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	been to appointments. <u>EQRO Rating for the UM Plan</u> FHP's 2009/2010 Annual External Quality Review Report submitted March 11, 2011, by Kansas Foundation for Medical Care, Inc. noted that the FHP Utilization Management Plan reviewed during the onsite audit conducted by Kansas Health Policy Authority (KHPA) in October 2009 was "excellent."
<b>k. Number of enrollees, by health plan type</b>	Medicaid enrollees: 151,215 (2012)
<b>l. Type of contract</b>	Capitated

<b>State</b>	Kentucky		<input checked="" type="checkbox"/> Owned by Aetna Inc. <input type="checkbox"/> Non-owned by Aetna Inc.		
<b>Health plan name</b>	Aetna Better Health of Kentucky Insurance Company dba Aetna Better Health of Kentucky				
<b>a. Medicaid population served</b>	TANF, CHIP, ABD, ACA, dual-eligible (administer Medicaid portion only), foster care				
<b>b. Name and address of client</b>	Kentucky Cabinet for Health and Family Services Office of the Secretary 275 E. Main St. Frankfort, KY 40621				
<b>c. Name of contract</b>	Kentucky Medicaid and KCHIP	<b>d. Contract start and end dates</b>	07/2011 – present		
<b>Current contract duration</b>	07/01/2017 – 12/31/2017. The initial term of our current contract was 07/01/2015 – 06/30/2016 with 4 one year renewal options; however, the state subsequently revised the length of the renewal terms for all plans to 6 months				
<b>e. Scope of work performed, covered populations and covered services</b>	Aetna Better Health of Kentucky provides managed care services for the TANF, CHIP, ABD, ACA, dual-eligible populations, including pregnant women, infants, children, children/youth with special health care needs, low income adults, children in foster care, individuals receiving SSI, ACA individuals, and dually eligible enrollees. Covered services include medical, behavioral health, pharmacy, vision, and dental.				
<b>f. Subcontractors</b>	Pharmacy benefits management, dental, nurse line, and vision				
<b>g. Annual contract amount and annual claims payment amount</b>					
	<b>2016</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>
<b>Contract amount</b>	\$1,169,433,495	\$1,375,008,983	\$1,551,748,645	\$1,061,060,088	\$955,843,901
<b>Claims payment</b>	\$920,622,659	\$916,483,018	\$1,222,041,236	\$892,279,558	\$968,509,468
<b>YTD June 2017</b>	<b>Contract amount</b>	\$536,572,828		<b>Claims payment</b>	\$486,173,960
<b>h. Contract implementation dates, scheduled and actual</b>	The state delayed implementation for all plans from an anticipated date of 07/2011 to an actual date of 11/2011; we implemented on the revised scheduled date.				
<b>i. Implementation barriers and resolutions</b>	None				

<p><b>j. Relevant accomplishments and achievements</b></p>	<ul style="list-style-type: none"> <li>• Full NCQA Accreditation</li> <li>• State-specific rankings - 3.5 rating for 2017-2018</li> <li>• Opioid Program Aetna is at the forefront of developing programs to address the opioid epidemic, not only at the state-level, but across the nation. To that end, we have established a set of five-year goals which include: <ul style="list-style-type: none"> <li>- Increase usage of multi-modal treatment for members with chronic pain, by 50%</li> <li>- Increase usage of Medication Assisted Treatment (MAT) by 50%</li> <li>- Decrease inappropriate opioid prescribing by 50%</li> </ul> The plan has identified Kentucky-specific initiatives to reach these goals. Those initiatives include: <ul style="list-style-type: none"> <li>- Recently donating over 1,000 doses of Narcan to communities in Northern and Eastern Kentucky</li> <li>- Establishing partnerships with local organizations to increase access to needle exchange programs</li> <li>- Exploring grant opportunities with two local programs that allow women to obtain treatment for addiction and keep their young children in their care</li> <li>- Outreach to 900 OB and midwife practitioners to educate them about our Neonatal Abstinence Syndrome (NAS) case management program</li> </ul> </li> <li>• Hepatitis C Program Members diagnosed with Hepatitis C in KY have risen and the CDC reports that KY has twice the national average. Aetna partners with our providers to help members who are diagnosed with hepatitis C to achieve the best health outcomes possible. Aetna responded by implementing a hepatitis C case management program to compliment the recommended medication regimen. Our provider partnerships help us to identify and refer members who may be qualified to receive Hepatitis C anti-viral medication treatment. Members referred to case management prior to submitting the prior authorization for Hepatitis C treatment have better outcomes. The program offers intensive case management; it is a multidisciplinary collaboration with the member and providers to navigate the health care benefit. There are daily medical director meetings to discuss referrals and any areas of concern. The care managers work with the members to address not only the medication therapy, but other physical, behavioral and social barriers that may impact adherence to treatment.</li> </ul>
<p><b>k. Number of enrollees, by health plan type</b></p>	<p>Medicaid enrollees: 254,220 (June 2017)</p>
<p><b>l. Type of contract</b></p>	<p>Capitated</p>

<b>State</b>	Louisiana		<input checked="" type="checkbox"/> Owned by Aetna Inc. <input type="checkbox"/> Non-owned by Aetna Inc.			
<b>Health plan name</b>	Aetna Better Health, Inc. dba Aetna Better Health of Louisiana					
<b>a. Medicaid population served</b>	TANF, CHIP, ABD, ACA					
<b>b. Name and address of client</b>	Louisiana Department of Health and Hospitals 628 N. Fourth St. Baton Rouge, LA 70801					
<b>c. Name of contract</b>	Healthy Louisiana – Medicaid and CHIP	<b>d. Contract start and end dates</b>	02/2015 – present			
<b>Current contract duration</b>	2/1/2015 - 1/31/2018 (with option of 1 two-year renewal through 12/31/2019)					
<b>e. Scope of work performed, covered populations and covered services</b>	Aetna Better Health, Inc. dba Aetna Better Health of Louisiana provides managed care services for the TANF, CHIP, ABD, and ACA populations, including pregnant women, infants, children, children/youth with special health care needs, low income adults, individuals receiving SSI, ACA individuals and children in foster care. Covered services include medical, behavioral health, pharmacy, vision, dental, and NEMT.					
<b>f. Subcontractors</b>	Pharmacy, dental, transportation, vision					
<b>g. Annual contract amount and annual claims payment amount</b>						
Note: The following amounts reflect pass-through revenue and claims.						
	<b>YTD June 2017</b>	<b>2016</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>
<b>Contract amount</b>	\$294,444,372	\$418,323,592	\$180,946,342	n/a	n/a	n/a
<b>Claims payment</b>	\$231,104,850	\$370,235,779	\$170,221,344	n/a	n/a	n/a
<b>h. Contract implementation dates, scheduled and actual</b>	Implementation scheduled and executed on: 02/2015					
<b>i. Implementation barriers and resolutions</b>	None					
<b>j. Relevant accomplishments and achievements</b>	<ul style="list-style-type: none"> <li>• NCQA accreditation – Interim; scored 100% on interim survey</li> <li>• Notable HEDIS/CAHPS measures, including year-over-year improvements               <ul style="list-style-type: none"> <li>• 21% decrease in In-patient admissions (2016 compared to 2015 – Year Over Year)</li> <li>• 14.5 % decrease in NICU admissions</li> <li>• 18.9 % decrease in readmissions</li> <li>• From 2016 to 2017, achieved 57% increase in HEDIS measures year over year, specifically antidepressant compliance, diabetes control medications and medication adherence for asthma medications</li> </ul> </li> </ul>					



	<ul style="list-style-type: none"><li>• 67% of our members are now served by physicians in a value-based payment model which will align incentives for quality improvement in the future</li><li>• Over 50 of our care management staff have completed specialized training presented by the Louisiana Adverse Childhood Experiences (ACE) Educator Program to frame our trauma informed care model</li><li>• Conduct biweekly rounds with Access Health – Largest FQHC provider in LA , our VBS partner to promote coordination of care throughout the care continuum</li><li>• We have a full time, dedicated Health Equity Director focused on health disparities and our programs to address social determinants of health. Staff from across the health plan along with representatives of numerous community partner agencies to participate in an Aetna Medicaid Poverty Simulation event in New Orleans - an interactive event in which participants role play scenarios forcing them to prioritize needs such as housing, food, education, work, and health care and gain insights into the challenges our members face.</li><li>• NICU admission rate was reduced by 67.8% for 2016 to 2017</li><li>• 90.6% generic fill rate</li></ul>
<b>k. Number of enrollees, by health plan type</b>	Medicaid enrollees: 113,701 (June 2017)
<b>l. Type of contract</b>	Capitated

<b>State</b>	Maryland	<input checked="" type="checkbox"/> Owned by Aetna Inc. <input type="checkbox"/> Non-owned by Aetna Inc.	
<b>Health plan name</b>	Aetna Health Inc. (PA) dba Aetna Better Health of Maryland		
<b>a. Medicaid population served</b>	TANF, CHIP		
<b>b. Name and address of client</b>	Maryland Department of Health and Mental Hygiene HealthChoice and Acute Care Administration 201 W. Preston St, 2nd Floor Baltimore, Maryland 21201		
<b>c. Name of contract</b>	Medicaid HealthChoice Program	<b>d. Contract start and end dates</b>	10/2017 – Present
<b>e. Scope of work performed, covered populations and covered services</b>	Aetna Health Inc. (PA) dba Aetna Better Health of Maryland provides managed care services for the TANF and CHIP populations, including pregnant women, infants, children, children/youth with special health care needs, low income adults, and individuals receiving SSI. Covered services include medical, behavioral health, pharmacy, and vision; as well as adult dental and NEMT beginning in January 2018.		
<b>f. Subcontractors</b>	Vision, NEMT (begins 2018) and adult dental (begins 2018)		
<b>g. Annual contract amount and annual claims payment amount</b>	As of the date of printing, we have no information regarding the annual contract and claims payment amounts because the program went live October 23, 2017.		
<b>h. Contract implementation dates, scheduled and actual</b>	Implementation scheduled and executed on: 10/23/2017 in Baltimore City and 12 counties (remaining counties to be implemented upon achieving network adequacy)		
<b>i. Implementation barriers and resolutions</b>	None		
<b>j. Relevant accomplishments and achievements</b>	This contract is too new to have reportable achievements.		
<b>k. Number of enrollees, by health plan type</b>	As of the date of printing, we have no information regarding the number of enrollees because the program went live October 23, 2017.		
<b>l. Type of contract</b>	Capitated		



<b>State</b>	Maryland		<input checked="" type="checkbox"/> Owned by Aetna Inc. <input type="checkbox"/> Non-owned by Aetna Inc.		
<b>Health plan name</b>	Coventry Health Care of Delaware, Inc.				
<b>a. Medicaid population served</b>	TANF, ABD				
<b>b. Name and address of client</b>	Maryland Department of Health and Mental Hygiene HealthChoice and Acute Care Administration 201 W. Preston St, 2nd Floor Baltimore, Maryland 21201				
<b>c. Name of contract</b>	Diamond State Health Plan – Medicaid only	<b>d. Contract start and end dates</b>	09/2003 – 10/2013		
<b>e. Scope of work performed, covered populations and covered services</b>	Coventry Health Care of Delaware, Inc. provided managed care services for the TANF and ABD populations, including pregnant women, children, low-income families and adults, and individuals receiving SSI. Covered services included medical, behavioral health, pharmacy, vision, dental and NEMT.				
<b>f. Subcontractors</b>	Pharmacy benefits management, adult dental, substance abuse, high-tech radiology, vision, and nurse line				
<b>g. Annual contract amount and annual claims payment amount</b>					
	<b>2016</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>
<b>Contract amount</b>	n/a	n/a	n/a	\$44,528,016	\$54,373,833
<b>Claims payment</b>	n/a	n/a	n/a	\$34,640,716	\$47,151,625
<b>h. Contract implementation dates, scheduled and actual</b>	Implementation scheduled and executed on: 09/2003				
<b>i. Implementation barriers and resolutions</b>	None				
<b>j. Relevant accomplishments and achievements</b>	<ul style="list-style-type: none"> <li>• URAC accredited</li> <li>• 96% EQRO audit in 2010</li> <li>• Partnered and collaborated with FQHCs on preventive health and school based health centers (SBHC)</li> <li>• Partnered and collaborated with DHMH on teen pregnancy initiatives</li> <li>• Look at Me, I Am Three! Dental Program – Implemented in 2005, this dental outreach initiative was developed to promote the receipt of dental care for three (3) year old members. Participants received a \$25 gift certificate to a local toy store upon confirmation of their appointment. After the initial six (6) months of the program, ninety (90) members had enrolled.</li> </ul>				
<b>k. Number of enrollees, by health plan type</b>	Medicaid enrollees: 12,854 (2012)				

<b>I. Type of contract</b>	Capitated				
<b>State</b>	Michigan	<input checked="" type="checkbox"/> Owned by Aetna Inc. <input type="checkbox"/> Non-owned by Aetna Inc.			
<b>Health plan name</b>	Aetna Better Health of Michigan Inc.				
<b>a. Medicaid population served</b>	TANF, CHIP, ABD, ACA				
<b>b. Name and address of client</b>	Michigan Department of Community Health 400 S. Pine Lansing, Michigan 48909				
<b>c. Name of contract</b>	Healthy Michigan/MiChild – Medicaid and CHIP	<b>d. Contract start and end dates</b>	10/2004 – present		
<b>Current contract duration</b>	1/1/2016 - 12/31/2020 (with 3 one-year renewal options through 12/31/2023)				
<b>e. Scope of work performed, covered populations and covered services</b>	Aetna Better Health of Michigan Inc. provides managed care services for the TANF, CHIP, ABD, and ACA populations, including pregnant women, infants, children, children/youth with special health care needs, low income adults, individuals receiving SSI, ACA individuals, and children in foster care. Covered services include medical, behavioral health, pharmacy, vision, and NEMT.				
<b>f. Subcontractors</b>	Dental, vision, and transportation				
<b>g. Annual contract amount and annual claims payment amount</b>					
Note: The following amounts reflect pass-through revenue and claims.					
	<b>2016*</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>
<b>Contract amount</b>	\$220,190,388	\$163,031,791	\$185,435,853	\$163,296,311	\$173,078,041
<b>Claims payment</b>	\$182,386,782	\$120,625,298	\$149,454,863	\$142,521,755	\$148,203,613
*Note: In 2016, the CHIP population began to be covered under this contract.					
<b>YTD June 2017</b>	<b>Contract amount</b>	\$102,487,713	<b>Claims payment</b>	\$95,699,992	
<b>h. Contract implementation dates, scheduled and actual</b>	Implementation scheduled and executed on: 10/2004				
<b>i. Implementation barriers and resolutions</b>	None				



<b>j. Relevant accomplishments and achievements</b>	<ul style="list-style-type: none"><li>• Implementation of a Community Health Worker (CHW) program with an overwhelmingly positive impact. Members engaged by our CHWs include those resistant to case management, hard to reach members, and members identified with social determinants creating barriers to care. For example, members identifying transportation as a barrier were enrolled with our community health workers for health navigation and engagement. Through engagement in the program:<ul style="list-style-type: none"><li>- 83% experienced a decrease in ED utilization</li><li>- 68% experienced a decrease in IP utilization</li></ul></li><li>• Improved Prior Authorization provider (PA) communication: Aetna conducted a provider education campaign with the goal of improving ease of access to PA tools on the ABH website. This reduced the number of calls to the prior authorization department and contributed to improved staff productivity and decreased turn-around time on prior authorization requests. The monthly call volume in the prior authorization department was reduced by 500 provider calls per month.</li></ul> <p><u>HEDIS/CAHPS 2017 Improvement</u></p> <ul style="list-style-type: none"><li>• 29% of HEDIS measures are at or above the 75th percentile (an increase of 6 percentage points)</li><li>• 51% of HEDIS measures are at or above the 50th percentile (an increase of 5 percentage points)</li><li>• Increases were experienced in 78% of HEDIS measures</li><li>• 38% increase in overall CAHPS accreditation score</li></ul>
<b>k. Number of enrollees, by health plan type</b>	Medicaid enrollees: 45,931 (June 2017)
<b>l. Type of contract</b>	Capitated

<b>State</b>	Michigan		<input checked="" type="checkbox"/> Owned by Aetna Inc. <input type="checkbox"/> Non-owned by Aetna Inc.			
<b>Health plan name</b>	Aetna Better Health of Michigan Inc.					
<b>a. Medicaid population served</b>	Duals					
<b>b. Name and address of client</b>	Michigan Department of Community Health 400 S. Pine Lansing, Michigan 48909  Centers for Medicare and Medicaid Services 7500 Security Boulevard, S3-13-23 Baltimore, Maryland 21244					
<b>c. Name of contract</b>	Demonstration to Integrate Care for Persons Eligible for Medicare and Medicaid		<b>d. Contract start and end dates</b>	10/2014 – present		
<b>Current contract duration</b>	7/1/2014 - 12/31/2017 (with 2 one-year renewal options through 12/31/2019)					
<b>e. Scope of work performed, covered populations and covered services</b>	Aetna Better Health of Michigan Inc. provides managed care services for individuals dually eligible for Medicare and Medicaid. Covered services include medical, behavioral health, HCBS/LTSS, pharmacy, vision, and NEMT.					
<b>f. Subcontractors</b>	Pharmacy, dental, vision, transportation					
<b>g. Annual contract amount and annual claims payment amount</b>						
	<b>YTD June 2017</b>	<b>2016</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>
<b>Contract amount</b>	\$73,853,401	\$116,014,596	\$63,156,157	\$0	n/a	n/a
<b>Claims payment</b>	\$61,415,485	\$680,623,477	\$59,892,441	\$0	n/a	n/a
<b>h. Contract implementation dates, scheduled and actual</b>	Implementation scheduled and executed on: 10/2004					
<b>i. Implementation barriers and resolutions</b>	None					



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<b>j. Relevant accomplishments and achievements</b>	<ul style="list-style-type: none"><li>• Emergency room utilization reduction initiative: Aetna has decreased ED utilization by 8% from 2016 to 2017. One of the initiatives to decrease ED utilization included targeting certain conditions such as respiratory illnesses. The Influenza campaign is an educational outreach to members who are at risk for influenza and other respiratory illnesses. Care coordinators follow up with our members post ED visit, to assure that members are following up with PCP, and receiving any preventative treatment necessary; including flu vaccines if appropriate.</li><li>• Improved Prior Authorization provider (PA) communication: Aetna Better Health of Michigan carried out a provider education campaign with the goal of improving ease of access to PA tools on the ABH website. This reduced the number of calls to the prior authorization department and contributed to improved staff productivity and decreased turn-around time on prior authorization requests. The monthly call volume in the prior authorization department was reduced by 500 provider calls per month.</li></ul>
<b>k. Number of enrollees, by health plan type</b>	Medicaid enrollees: 7,596 (June 2017)
<b>l. Type of contract</b>	Capitated

State	Michigan		Michigan		
Health plan name	Aetna Better Health of Michigan Inc.				
a. Medicaid population served	CHIP				
b. Name and address of client	Michigan Department of Community Health 400 S. Pine Lansing, Michigan 48909  Centers for Medicare and Medicaid Services 7500 Security Boulevard, S3-13-23 Baltimore, Maryland 21244				
c. Name of contract	Healthy Michigan/MiChild – Medicaid and CHIP	d. Contract start and end dates	10/2010 – 12/2015		
Contract duration	This population moved to Healthy Michigan/MiChild Medicaid & CHIP contract in 2016				
e. Scope of work performed, covered populations and covered services	Aetna Better Health of Michigan, Inc., provided managed care services for the CHIP population, including children aged 0 to 18 years. Covered services included medical, pharmacy, vision, and NEMT.				
f. Subcontractors	Pharmacy benefits management, behavioral health, dental, transportation, vision, lab, and nurse line				
g. Annual contract amount and annual claims payment amount Note: The following amounts reflect pass-through revenue and claims.					
	2016	2015	2014	2013	2012
Contract amount	\$0	\$3,083,551	\$2,551,609	\$847,076	\$553,580
Claims payment	\$0	\$1,481,249	\$1,216,538	\$395,915	\$310,363
h. Contract implementation dates, scheduled and actual	Implementation scheduled and executed on: 10/2010				
i. Implementation barriers and resolutions	None				
j. Relevant accomplishments and achievements	<ul style="list-style-type: none"><li>• Full NCQA accreditation</li><li>• State-specific rankings - 3.0 rating</li></ul>				
k. Number of enrollees, by health plan type	Medicaid enrollees: 1,776 (2015)				
l. Type of contract	Capitated				



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<b>State</b>	Missouri		<input checked="" type="checkbox"/> Owned by Aetna Inc. <input type="checkbox"/> Non-owned by Aetna Inc.		
<b>Health plan name</b>	Aetna Better Health of Missouri, L.L.C. (fka HealthCare USA of Missouri, a Coventry health care plan)				
<b>a. Medicaid population served</b>	TANF, CHIP				
<b>b. Name and address of client</b>	Missouri Department of Social Services, Missouri HealthNet Division P.O. Box 6500 Jefferson City, MO 65102-6500				
<b>c. Name of contract</b>	MO HealthNet – Medicaid and CHIP		<b>d. Contract start and end dates</b>	1995 - 4/2017	
<b>e. Scope of work performed, covered populations and covered services</b>	Aetna Better Health of Missouri, L.L.C., provided managed care services for the TANF and CHIP populations, including pregnant women, infants, children, children/youth with special health care needs, and low income adults. Covered services included medical, behavioral health, vision, dental, and NEMT.				
<b>f. Subcontractors</b>	Behavioral health, dental, transportation, vision, and nurse line				
<b>g. Annual contract amount and annual claims payment amount</b>					
	<b>2016</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>
<b>Contract amount</b>	\$762,107,265	\$697,661,081	\$648,045,055	\$678,554,646	\$668,310,056
<b>Claims payment</b>	\$680,623,477	\$613,669,475	\$544,258,688	\$577,980,109	\$573,869,992
<b>YTD June 2017</b>	<b>Contract amount</b>	\$257,343,918		<b>Claims payment</b>	\$241,642,984
<b>h. Contract implementation dates, scheduled and actual</b>	Implementation scheduled and executed 1995				
<b>i. Implementation barriers and resolutions</b>	None				
<b>j. Relevant accomplishments and achievements</b>	<ul style="list-style-type: none"> <li>Through focused initiatives, we achieved statistically significant year-over-year improvements in multiple HEDIS measures; in 2015, we conducted 360 HEDIS events.</li> <li>With an NCQA accreditation level of “Commendable,” Aetna held the highest level of NCQA accreditation of any Medicaid health plan in the State. We were the top-rated Medicaid health plan in Missouri with an overall rating of 3.5, which includes a Consumer Satisfaction Rating of 4.0.</li> </ul>				
<b>k. Number of enrollees, by health plan type</b>	Medicaid enrollees: 278,765 (2016)				
<b>l. Type of contract</b>	Capitated				

Health plan name	Missouri Care, Inc.				
a. Medicaid population served	TANF, CHIP				
b. Name and address of client	Missouri Department of Social Services, Missouri HealthNet Division P.O. Box 6500 Jefferson City, MO 65102-6500				
c. Name of contract	TANF, CHIP	d. Contract start and end dates		1997 - 3/2013	
e. Scope of work performed, covered populations and covered services	Missouri Care, Inc., provided managed care services for the TANF and CHIP populations, including pregnant women, infants, children, children/youth with special health care needs, and low income adults. Covered services included medical, vision, dental, and NEMT.				
f. Subcontractors	Transportation, vision, dental				
g. Annual contract amount and annual claims payment amount					
	2016	2015	2014	2013	2012
Contract amount	n/a	n/a	n/a	\$75,049,913	\$229,357,465
Claims payment	n/a	n/a	n/a	\$74,290,402	\$205,632,420
h. Contract implementation dates, scheduled and actual	Implementation scheduled and executed 1997				
i. Implementation barriers and resolutions	None				
j. Relevant accomplishments and achievements	Not available				
k. Number of enrollees, by health plan type	Medicaid enrollees: 108,422 (2012)				
l. Type of contract	Capitated				



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<b>State</b>	Nebraska		<input checked="" type="checkbox"/> Owned by Aetna Inc. <input type="checkbox"/> Non-owned by Aetna Inc.		
<b>Health plan name</b>	Coventry Health Care of Nebraska, Inc. dba Aetna Better Health of Nebraska				
<b>a. Medicaid population served</b>	TANF, CHIP, ABD				
<b>b. Name and address of client</b>	Nebraska Department of Health and Human Services 301 Centennial Mall South Lincoln, Nebraska 68509				
<b>c. Name of contract</b>	Medicaid and CHIP		<b>d. Contract start and end dates</b>	4/2010 – 12/2016	
<b>e. Scope of work performed, covered populations and covered services</b>	Coventry Health Care of Nebraska, Inc. dba Aetna Better Health of Nebraska provided managed care services for the TANF, CHIP, and ABD populations, including pregnant women, infants, children, children/youth with special health care needs, low income families and adults, and individuals receiving SSI. Covered services included medical, vision, and NEMT.				
<b>f. Subcontractors</b>	Vision				
<b>g. Annual contract amount and annual claims payment amount</b> Note: The following amounts reflect pass-through revenue and claims.					
	<b>2016</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>
<b>Contract amount</b>	\$307,066,978	\$290,893,295	\$283,547,511	\$252,009,629	\$172,276,495
<b>Claims payment</b>	\$266,137,623	\$259,996,660	\$242,165,323	\$216,124,373	\$151,120,634
<b>h. Contract implementation dates, scheduled and actual</b>	Implementation scheduled and executed on: 04/2010				
<b>i. Implementation barriers and resolutions</b>	None				
<b>j. Relevant accomplishments and achievements</b>	<p>The results of our 2015 CAHPS® report on appointment wait times compared to the Center for the Study of Services overall child Medicaid average for all other health plans surveyed. The survey is based on responses from a random sample of 340 parents of Heritage Health child members age 17 years and younger. We had a CAHPS Steering Committee to research and develop ideas to identify wait-time barriers and opportunities to improve appointment wait times, if problems arise.</p> <p>Q. 4: In the last 6 months when your child needed care right away, how often did your child get care as soon as he or she needed? Percentage responding always/usually: 93.8%; CSS Medicaid National Average: 91.2%</p> <p>Q. 6: In the last 6 months, when you made an appointment for a checkup or routine care for your child, how often did your child get an</p>				

	appointment as soon as he or she needed? Percentage responding always/usually: 93.6%; CSS Medicaid National Average: 89.2%
<b>k. Number of enrollees, by health plan type</b>	Medicaid enrollees: 104,805 (2016)
<b>l. Type of contract</b>	Capitated



<b>State</b>	Nevada	<input checked="" type="checkbox"/> Owned by Aetna Inc. <input type="checkbox"/> Non-owned by Aetna Inc.			
<b>Health plan name</b>	Aetna Better Health of Nevada Inc. dba Aetna Better Health of Nevada				
<b>a. Medicaid population served</b>	TANF, CHIP, ACA				
<b>b. Name and address of client</b>	Department of Health and Human Services Division of Health Care Financing and Policy 1100 E. William Street Carson City, NV 89701				
<b>c. Name of contract</b>	Medicaid and CHIP	<b>d. Contract start and end dates</b>	07/01/2017 – 08/31/17		
<b>Current contract duration</b>	Because membership levels were far less than the critical number necessary to ensure a viable Medicaid plan capable of delivering quality care and competitive programs, and following numerous unsuccessful attempts to collaborate with the State to generate solutions to increase membership, Aetna gave notice to terminate the contract in accordance with the contract terms. To minimize enrollee disruption 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. We will continue to perform reporting activities for several months.				
<b>e. Scope of work performed, covered populations and covered services</b>	Aetna Better Health of Nevada Inc. dba Aetna Better Health of Nevada provided managed care services for the TANF, CHIP, and ACA populations, including pregnant women, infants, children, children/youth with special health care needs, and low income adults. The scope of covered services included medical, behavioral health, vision, dental, and NEMT.				
<b>f. Subcontractors</b>	Vision				
<b>g. Annual contract amount and annual claims payment amount</b>					
Note: The following amounts reflect pass-through revenue and claims.					
	<b>YTD 8/2017</b>	<b>2016</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>
<b>Contract amount</b>	\$1,677,433	n/a	n/a	n/a	n/a
<b>Claims payment</b>	\$1,652,409	n/a	n/a	n/a	n/a
<b>h. Contract implementation dates, scheduled and actual</b>	Implementation scheduled and executed on: 07/2017 Health plan passed readiness review on first review with no deficiencies				
<b>i. Implementation barriers and resolutions</b>	None				

<b>j. Relevant accomplishments and achievements</b>	Plan implementation was too recent to provide measurable accomplishment or achievements
<b>k. Number of enrollees, by health plan type</b>	Medicaid enrollees: 2,567
<b>l. Type of contract</b>	Capitated



<b>State</b>	New Jersey	<input checked="" type="checkbox"/> Owned by Aetna Inc. <input type="checkbox"/> Non-owned by Aetna Inc.				
<b>Health plan name</b>	Aetna Better Health, Inc. dba Aetna Better Health of New Jersey					
<b>a. Medicaid population served</b>	TANF, CHIP-plus, ABD, ACA expansion, LTSS, DDD, Duals					
<b>b. Name and address of client</b>	New Jersey Department of Human Services 7 Quakerbridge Plaza, 2nd Flr, Room 203 Mercerville, New Jersey 08619					
<b>c. Name of contract</b>	NJ FamilyCare – Medicaid and CHIP	<b>d. Contract start and end dates</b>	12/2014 – present			
<b>Current contract duration</b>	7/01/2017 - 6/30/2018 (with open ended one-year renewal options)					
<b>e. Scope of work performed, covered populations and covered services</b>	Aetna Better Health, Inc. dba Aetna Better Health of New Jersey provides managed care services for Medicaid and CHIP populations, including pregnant women, infants, children, children/youth with special health care needs, low income adults, children in foster care, individuals receiving SSI, ACA individuals, and LTSS individuals. Covered services include medical, behavioral health, pharmacy, vision, and dental.					
<b>f. Subcontractors</b>	Pharmacy, vision, and dental					
<b>g. Annual contract amount and annual claims payment amount</b>						
Note: The following amounts reflect pass-through revenue and claims.						
	<b>YTD June 2017</b>	<b>2016</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>
<b>Contract amount</b>	\$106,915,112	\$136,353,864	\$68,489,786	n/a	n/a	n/a
<b>Claims payment</b>	\$81,802,389	\$94,103,759	\$64,452,996	n/a	n/a	n/a
<b>h. Contract implementation dates, scheduled and actual</b>	Implementation scheduled and executed on: 12/2014					
<b>i. Implementation barriers and resolutions</b>	None					
<b>j. Relevant accomplishments and achievements</b>	<ul style="list-style-type: none"> <li>• NCQA Interim Accreditation; full review 2018</li> <li>• One of only 3 plans approved to expand statewide 6/28/2017</li> <li>• Primary Care Initiative: The plan has selectively focused on developing contracts and close partnerships with all 23 Federally Qualified Health Centers in the state, as distinct from the other four Medicaid MCOs; this involves assignment of a primary Account Manager in Provider Relations who serves as the direct contact, frequent meetings to address mutual issues and dedicated discussions of Quality Indicators</li> <li>• Community Care Management - Face-to-Face Program: Care</li> </ul>					

	managers in both the Integrated Care Management department for Core Medicaid and in the Integrated Long Term Care Management department for LTSS visit members face to face in the community to address care issues and social determinants of health; visits may occur at a provider office, place of care or in member homes
<b>k. Number of enrollees, by health plan type</b>	Medicaid enrollees: 36,170 (June 2017)
<b>l. Type of contract</b>	Capitated



<b>State</b>	New York	<input checked="" type="checkbox"/> Owned by Aetna Inc. <input type="checkbox"/> Non-owned by Aetna Inc.			
<b>Health plan name</b>	Aetna Better Health dba Aetna Better Health of New York				
<b>a. Medicaid population served</b>	LTSS				
<b>b. Name and address of client</b>	New York Department of Health Corning Tower, Room 1415, Empire State Plaza Albany, New York 12237				
<b>c. Name of contract</b>	Managed Long Term Care Partial Capitation Contract	<b>d. Contract start and end dates</b>		07/2012 – Present	
<b>Current contract duration</b>	9/1/2012 to 12/31/2014, with an extension through an amendment for the period 1/1/15 through 12/31/16 Note: Since 1/1/17 Aetna Better Health of New York and all other New York Managed Long Term Care Plans have been operating without a contract and will do so until the New York Department of Health issues a new contract that would be retroactively effective to that date. This is a common practice for the New York Department of Health. For example, the 1/1/15 amendment mentioned previously was issued in approximately August 2016, and was retroactive to 1/1/15.				
<b>e. Scope of work performed, covered populations and covered services</b>	Aetna Better Health dba Aetna Better Health of New York arranges for covered benefits for LTSS members. Covered services include medical management, member services, provider relations, network contracting, and quality management.				
<b>f. Subcontractors</b>	Dental, vision and transportation (NEMT)				
<b>g. Annual contract amount and annual claims payment amount</b>					
Note: The following amounts reflect pass-through revenue and claims.					
	<b>2016</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>
<b>Contract amount</b>	\$205,687,220	\$161,989,706	\$131,017,704	\$50,689,997	\$117,737
<b>Claims payment</b>	\$179,263,185	\$136,503,390	\$119,271,823	\$40,208,529	\$86,630
<b>YTD June 2017</b>	<b>Contract amount</b>	\$119,210,893	<b>Claims payment</b>	\$101,499,241	
<b>h. Contract implementation dates, scheduled and actual</b>	Implementation scheduled and executed on: 07/2012				
<b>i. Implementation barriers and resolutions</b>	None				

<b>j. Relevant accomplishments and achievements</b>	Our care management processes and quality initiatives have resulted in improved member outcomes. Our members have experienced the following positive outcomes: <ul style="list-style-type: none"><li>• Our Fall Rate at 10.4% performing better than plans Statewide average of 14.3%</li><li>• 20% improvement in glycemic control for members with diabetes taking diabetic medications</li></ul>
<b>k. Number of enrollees, by health plan type</b>	Medicaid enrollees: 4,237 (June 2017)
<b>l. Type of contract</b>	Capitated



<b>State</b>	New York	<input checked="" type="checkbox"/> Owned by Aetna Inc. <input type="checkbox"/> Non-owned by Aetna Inc.				
<b>Health plan name</b>	Aetna Better Health dba Aetna Better Health of New York					
<b>a. Medicaid population served</b>	Duals					
<b>b. Name and address of client</b>	New York Department of Health Corning Tower, Room 1415, Empire State Plaza Albany, New York 12237  Centers for Medicare and Medicaid Services 7500 Security Boulevard, S3-13-23 Baltimore, Maryland 21244					
<b>c. Name of contract</b>	Fully Integrated Duals Advantage program	<b>d. Contract start and end dates</b>	09/2014 – Present			
<b>Current contract duration</b>	9/6/2014 to 12/31/2017 (with 2 one-year renewal options, through 12/31/2019)					
<b>e. Scope of work performed, covered populations and covered services</b>	Aetna Better Health dba Aetna Better Health of New York provides Medicare and Medicaid physical and behavioral health care services to dual-eligible members. Covered services include medical management, quality management, care management, member services, marketing, provider services, and network development.					
<b>f. Subcontractors</b>	Dental, vision and transportation (NEMT)					
<b>g. Annual contract amount and annual claims payment amount</b>						
Note: The following amounts reflect pass-through revenue and claims.						
	<b>YTD June 2017</b>	<b>2016</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>
<b>Contract amount</b>	\$1,918,790	\$3,910,290	\$4,071,859	n/a	n/a	n/a
<b>Claims payment</b>	\$1,753,397	\$3,555,967	\$3,723,560	n/a	n/a	n/a
<b>h. Contract implementation dates, scheduled and actual</b>	Implementation scheduled and executed on: 09/2014					
<b>i. Implementation barriers and resolutions</b>	None					
<b>j. Relevant accomplishments and achievements</b>	Our care management processes and quality initiatives have resulted in improved member outcomes. Our members have experienced the following positive outcomes: <ul style="list-style-type: none"> <li>• Our Fall Rate at 10.4% performing better than plans Statewide average of 14.3%</li> <li>• 20% improvement in glycemic control for members with diabetes taking diabetic medications</li> </ul>					

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<b>k. Number of enrollees, by health plan type</b>	Medicaid enrollees: 54 (June 2017)
<b>l. Type of contract</b>	Capitated



<b>State</b>	Ohio	<input checked="" type="checkbox"/> Owned by Aetna Inc. <input type="checkbox"/> Non-owned by Aetna Inc.				
<b>Health plan name</b>	Aetna Better Health dba Aetna Better Health of Ohio					
<b>a. Medicaid population served</b>	Duals					
<b>b. Name and address of client</b>	Ohio Department of Medicaid Centers for Medicare and Medicaid Services 50 West Town Street Columbus, Ohio 43215  Centers for Medicare & Medicaid Services 7500 Security Boulevard, S3-13-23 Baltimore, Maryland 21244					
<b>c. Name of contract</b>	MyCare Ohio Plan	<b>d. Contract start and end dates</b>	06/01/2014 – present			
<b>Current contract duration</b>	6/1/2014 - 12/31/2015 (with 4 one-year renewal options, through 12/31/2019)					
<b>e. Scope of work performed, covered populations and covered services</b>	Aetna Better Health dba Aetna Better Health of Ohio provides managed care services for dual-eligible members. Covered services include medical, care management (waiver-only), pharmacy, dental, vision, and NEMT.					
<b>f. Subcontractors</b>	Transportation, dental, vision, pharmacy, and Care Management (Waiver service members only)					
<b>g. Annual contract amount and annual claims payment amount</b>						
	<b>YTD June 2017</b>	<b>2016</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>
<b>Contract amount</b>	\$469,706,413	\$848,436,831	\$774,568,274	\$335,487,662	n/a	n/a
<b>Claims payment</b>	\$361,479,932	\$687,980,023	\$693,725,187	\$308,294,455	n/a	n/a
<b>h. Contract implementation dates, scheduled and actual</b>	Implementation scheduled and executed on: 06/01/2014					
<b>i. Implementation barriers and resolutions</b>	None					
<b>j. Relevant accomplishments and achievements</b>	<ul style="list-style-type: none"> <li>Established partnership with AAAs               <ul style="list-style-type: none"> <li>In the first 18 months of program, rebalanced ratio to improve home and community based services compared to nursing facilities by 9%</li> <li>Rate of new individuals with long-term services and supports home and community based versus institutional is 80%</li> </ul> </li> </ul> <p><i>Continued on following page</i></p>					

<p><b>j. Relevant accomplishments and achievements</b></p>	<ul style="list-style-type: none"> <li>• Our integrated model of care processes and innovative behavioral health programs, specifically utilization of regionally based Behavioral Health Clinical Liaisons, have resulted in improved member outcomes. Specifically, our members have experienced the following positive outcomes: <ul style="list-style-type: none"> <li>– Lowest rate among all program health plans of behavioral health-related ED visits per 1000 members. Ranked Best in Class for CMS Core 9.1 Emergency Room Behavioral Health Services Utilization in 2016 and 2017</li> <li>– Achieved at or above NCQA 75th percentile for Follow-Up after Hospitalization for Mental Illness (FUH) 30-Day Follow-Up and 7-Day Follow-up in HEDIS 2016.</li> <li>– Achieved at or above NCQA 90th percentile for Antidepressant Medication Management (AMM) HEDIS measure for 2016</li> </ul> </li> <li>• Achieved at or above NCQA 75th percentile for Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) for HEDIS 2016.</li> <li>• Our care management processes, creation of supplemental data sources, and improved data collection processes with our provider groups have resulted in improved member outcomes and increased our compliance on providing care to our older population. Specifically, members age 66 and older have experienced the following positive outcomes from CY 2015 to CY 2016: <ul style="list-style-type: none"> <li>– An 183% increase in completion of an annual Functional Status Assessment</li> <li>– An 100% increase in the completion of an annual Medication Review</li> <li>– An 118% increase in the completion of an annual Pain Assessment</li> </ul> </li> </ul>
<p><b>k. Number of enrollees, by health plan type</b></p>	<p>Medicaid enrollees: 23,480 (June 2017)</p>
<p><b>l. Type of contract</b></p>	<p>Capitated</p>



<b>State</b>	Pennsylvania	<input checked="" type="checkbox"/> Owned by Aetna Inc. <input type="checkbox"/> Non-owned by Aetna Inc.			
<b>Health plan name</b>	Aetna Better Health, Inc. dba Aetna Better Health of Pennsylvania				
<b>a. Medicaid population served</b>	TANF, ABD, Medicaid Expansion population, Duals under age 21				
<b>b. Name and address of client</b>	Pennsylvania Department of Human Services Commonwealth Tower, 6 <sup>th</sup> Floor 303 Walnut Street Harrisburg, Pennsylvania 17101				
<b>c. Name of contract</b>	HealthChoices – Medicaid Only				
<b>d. Contract start and end dates and current contract duration*</b>	HealthChoices Lehigh/Capital Physical Grant Agreement No. 4000014648 04/2010 – present Current Contract amended through 12/31/18  HealthChoices South East Grant Agreement No. 4000014647 04/2010 – present Current Contract amended through 12/31/18  HealthChoices South West Grant Agreement No. 4000016408 04/2012 – present Current Contract amended through 12/31/18  HealthChoices New West Grant Agreement No. 4100060532 10/2012 – present Current Contract amended through 12/31/18  HealthChoices New East Grant Agreement No. 4100061963 03/2013 – present Current Contract amended through 12/31/18				
<b>e. Scope of work performed, covered populations and covered services</b>	Aetna Better Health, Inc. dba Aetna Better Health of Pennsylvania provides managed care services to the TANF, ABD, ACA expansion, and duals under age 21, including pregnant women, infants, children, children/youth with special health care needs, low income adults, individuals receiving SSI, and ACA individuals. Covered services include medical, pharmacy, vision, dental, and NEMT.				
<b>f. Subcontractors</b>	Pharmacy, vision, and dental benefits management				
<b>g. Annual contract amount and annual claims payment amount</b> Note: The following amounts reflect pass-through revenue and claims.					
	<b>2016</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>
<b>Contract amount</b>	\$902,842,259	\$775,277,846	\$550,768,263	\$670,017,060	\$293,410,358
<b>Claims payment</b>	\$632,241,163	\$594,049,135	\$494,686,234	\$614,558,280	\$276,109,506

YTD June 2017	Contract amount	\$492,420,189	Claims payment	\$363,939,162																											
h. Contract implementation dates, scheduled and actual	LC/SE Zones – 04/2010 SW Zone – 04/2012 NW Zone – 10/2012 NE Zone – 03/2013																														
i. Implementation barriers and resolutions	None																														
j. Relevant accomplishments and achievements	<ul style="list-style-type: none"><li>• Full NCQA accreditation</li><li>• State-specific rankings - 3.5 rating</li></ul> <p>Our state directed health plan performance program has demonstrated improved results. The most recent results for calendar year 2016 demonstrate a 55% improvement of 1 percentage point or more, with the HEDIS Controlling High Blood Pressure realizing a 5.5 percentage point and the Frequency of Prenatal Care measures demonstrating a 9.5 percentage point improvement. There was a 20% improvement in the number of P4P measures exceeding the NCQA 75th percentile.</p> <p>Our Quality Navigator Program provides live educational webinar s and on-site visits that utilize the whole –person approach in educating our providers on the care rendered to members to improve member outcomes that are demonstrated on our HEDIS and state performance measure rates.</p> <p>The following is a sample of measure results.</p> <table><tr><th>Submeasure</th><th>H2016 Final Rate</th><th>H2017 FINAL</th></tr><tr><td>Controlling High Blood Pressure</td><td>60.63%</td><td>66.07%</td></tr><tr><td>More than 81 percent of expected visits</td><td>61.92%</td><td>71.46%</td></tr><tr><td>Timeliness of prenatal care</td><td>81.07%</td><td>84.91%</td></tr><tr><td>Postpartum care</td><td>59.35%</td><td>62.74%</td></tr><tr><td>Six or more well child visits</td><td>64.58%</td><td>65.97%</td></tr><tr><td>Well child 3-6 yrs</td><td>69.44%</td><td>72.22%</td></tr><tr><td>Readmissions</td><td>7.87%</td><td>7.72%</td></tr><tr><td>Medical mgmt for asthma</td><td>40.51%</td><td>42.70%</td></tr></table> <p><u>Member Satisfaction</u></p> <p>The annual CAHPS results demonstrate improvement in the percentage of members who are satisfied with the services they obtain through our plan. The following is a sample of measures that improved</p>				Submeasure	H2016 Final Rate	H2017 FINAL	Controlling High Blood Pressure	60.63%	66.07%	More than 81 percent of expected visits	61.92%	71.46%	Timeliness of prenatal care	81.07%	84.91%	Postpartum care	59.35%	62.74%	Six or more well child visits	64.58%	65.97%	Well child 3-6 yrs	69.44%	72.22%	Readmissions	7.87%	7.72%	Medical mgmt for asthma	40.51%	42.70%
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	<p>from 2016 to 2017.</p> <ul style="list-style-type: none"><li>• Getting needed care: Improved from 25th to 75th percentile</li><li>• Ease of getting care with specialists: Improved from 50th to 75th percentile</li><li>• Getting care quickly: Improved from 25th to 75th percentile</li><li>• Getting urgent care: Improved from 50th to 75th percentile</li></ul> <p><u>Overall HEDIS rates</u></p> <p>Our 2017 HEDIS results demonstrate improvement in the percentage of measures that have exceeded the NCQA 50th percentile. The following chart demonstrates the change from calendar year 2015 compared to calendar year 2017:</p> <table><tr><th>Indicator</th><th>CY 2015</th><th>CY 2016</th></tr><tr><td>&gt;NCQA 50<sup>th</sup> percentile</td><td>23%</td><td>28%</td></tr><tr><td>&gt;NCQA 90<sup>th</sup> percentile</td><td>12%</td><td>24%</td></tr></table>	Indicator	CY 2015	CY 2016	>NCQA 50 <sup>th</sup> percentile	23%	28%	>NCQA 90 <sup>th</sup> percentile	12%	24%
Indicator	CY 2015	CY 2016								
>NCQA 50 <sup>th</sup> percentile	23%	28%								
>NCQA 90 <sup>th</sup> percentile	12%	24%								
<b>k. Number of enrollees, by health plan type</b>	Medicaid enrollees: 206,209 (June 2017)									
<b>l. Type of contract</b>	Capitated									

<b>State</b>	Pennsylvania		<input checked="" type="checkbox"/> Owned by Aetna Inc. <input type="checkbox"/> Non-owned by Aetna Inc.		
<b>Health plan name</b>	Aetna Better Health, Inc. dba Aetna Better Health Kids				
<b>a. Medicaid population served</b>	CHIP (children up to age 19)				
<b>b. Name and address of client</b>	Department of Human Services Children's Health Insurance Program (CHIP) 1142 Strawberry Square Harrisburg PA 17120				
<b>c. Name of contract</b>	Children's Health Insurance Program of Pennsylvania	<b>d. Contract start and end dates</b>	1993 – present		
<b>Current contract duration</b>	12/1/2013 - 11/30/2015 (with 3 one-year renewal options, through 11/30/2018)				
<b>e. Scope of work performed, covered populations and covered services</b>	Aetna Better Health, Inc. dba Aetna Better Health Kids provides managed care services to the CHIP population for children ages 0 through 18. Covered services include medical, pharmacy, vision, dental, behavioral health, and NEMT.				
<b>Subcontractors</b>	Pharmacy, vision, and dental benefits management				
<b>g. Annual contract amount and annual claims payment amount</b>					
	<b>2016</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>
<b>Contract amount</b>	\$17,534,322	\$17,047,237	\$24,557,733	\$47,775,236	\$68,464,464
<b>Claims payment</b>	\$15,054,239	\$12,245,536	\$16,267,204	\$36,319,858	\$58,048,602
<b>YTD June 2017</b>	<b>Contract amount</b>	\$13,745,362	<b>Claims payment</b>	\$10,659,390	
<b>h. Contract implementation dates, scheduled and actual</b>	Implementation scheduled and executed: 1993				
<b>i. Implementation barriers and resolutions</b>	None				
<b>j. Relevant accomplishments and achievements</b>	<ul style="list-style-type: none"> <li>• Full NCQA accreditation</li> <li>• State-specific ranking - 3.5</li> </ul>				
<b>k. Number of enrollees, by health plan type</b>	Medicaid enrollees: 15,436 (June 2017)				
<b>l. Type of contract</b>	Capitated				



<b>State</b>	Texas		<input checked="" type="checkbox"/> Owned by Aetna Inc. <input type="checkbox"/> Non-owned by Aetna Inc.	
<b>Health plan name</b>	Aetna Better Health of Texas, Inc.			
<b>a. Medicaid population served</b>	TANF, CHIP, LTSS			
<b>b. Name and address of client</b>	Texas Health and Human Services Commission Brown-Heatly Building 4900 N. Lamar Blvd. Austin, TX 78751-2316			
<b>c. Name of contract</b>	STAR – Medicaid and CHIP	<b>d. Contract start and end dates</b>	09/2006 – present	
<b>Current contract duration</b>	9/1/2011 - 8/31/2015 (with renewal options up to 4 years through 8/31/2019)			
<b>e. Scope of work performed, covered populations and covered services</b>	Aetna Better Health of Texas, Inc. provides managed care services to the TANF, CHIP, and LTSS populations, including pregnant women, infants, children, children/youth with special health care needs, and low-income adults. Covered services include medical, behavioral health, pharmacy, vision, dental, and NEMT.			
<b>f. Subcontractors</b>	Pharmacy benefits management and vision			
<b>g. Annual contract amount and annual claims payment amount</b>				
	<b>2016</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>
<b>Contract amount</b>	\$228,873,784	\$214,881,759	\$222,193,884	\$203,210,241
<b>Claims payment</b>	\$188,101,520	\$173,254,473	\$187,858,833	\$166,290,341
<b>YTD June 2017</b>	<b>Contract amount</b>	\$102,834,217	<b>Claims payment</b>	\$85,785,953
<b>h. Contract implementation dates, scheduled and actual</b>	Implementation scheduled and executed: 09/2006			
<b>i. Implementation barriers and resolutions</b>	None			
<b>j. Relevant accomplishments and achievements</b>	<ul style="list-style-type: none"> <li>47 out of 55 (85%) of HEDIS Measures for TX increased from 2016 to 2017</li> <li>EQRO Administrative Evaluation Scores of 95.4% a 22.6% improvement from 2015 to 2016</li> <li>Highest EQRO Quality Assessment and Performance Improvement Scores in the State for 2016 measurement year (99.4%)</li> </ul>			
<b>k. Number of enrollees, by health plan type</b>	Medicaid enrollees: 84,618 (June 2017)			
<b>l. Type of contract</b>	Capitated			

<b>State</b>	Texas		<input checked="" type="checkbox"/> Owned by Aetna Inc. <input type="checkbox"/> Non-owned by Aetna Inc.			
<b>Health plan name</b>	Aetna Better Health of Texas, Inc.					
<b>a. Medicaid population served</b>	CHIP					
<b>b. Name and address of client</b>	Texas Health and Human Services Commission Brown-Heatly Building 4900 N. Lamar Blvd. Austin, TX 78751-2316					
<b>c. Name of contract</b>	STAR Kids – Medicaid only		<b>d. Contract start and end dates</b>		11/2016 - Present	
<b>e. Scope of work performed, covered populations and covered services</b>	Aetna Better Health of Texas, Inc. provides managed care services to the CHIP population, including children and teenagers receiving SSI. Covered services include medical, behavioral health, pharmacy, vision, dental, and NEMT.					
<b>f. Subcontractors</b>	Pharmacy benefits management and vision					
<b>g. Annual contract amount and annual claims payment amount</b>						
	<b>YTD June 2017</b>	<b>2016</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>
<b>Contract amount</b>	\$46,726,951	\$16,319,989	n/a	n/a	n/a	n/a
<b>Claims payment</b>	\$38,050,845	\$14,937,905	n/a	n/a	n/a	n/a
<b>h. Contract implementation dates, scheduled and actual</b>	Implementation scheduled and executed: 11/2016					
<b>i. Implementation barriers and resolutions</b>	None					
<b>j. Relevant accomplishments and achievements</b>	Not available					
<b>k. Number of enrollees, by health plan type</b>	Medicaid enrollees: 5,081 (June 2017)					
<b>l. Type of contract</b>	Capitated					



**COVENTRY HEALTH CARE OF FLORIDA, INC. DBA  
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<b>State</b>	Virginia	<input checked="" type="checkbox"/> Owned by Aetna Inc. <input type="checkbox"/> Non-owned by Aetna Inc.			
<b>Health plan name</b>	Coventry Health Care of Virginia, Inc. dba Aetna Better Health of Virginia				
<b>a. Medicaid population served</b>	TANF, ABD, CHIP				
<b>b. Name and address of client</b>	Virginia Department of Social Services 600 East Broad Street, 11th Floor Richmond, Virginia 23219				
<b>c. Name of contract</b>	Medallion 3.0* – Medicaid Only	<b>d. Contract start and end dates</b>		07/1996 – present	
*Note: The Medallion 3.0 program contains CHIP/FAMIS in one contract and TANF/ABD in another. We are reporting these two contracts together because they represent the Medallion 3.0 program and they are combined in Commonwealth reporting. The ABD population will transition to the Commonwealth Coordinated Care Plus (CCC+) program in January 2018.					
<b>Current contract duration</b>	7/1/2017 - 12/31/2018. This contract will be replaced by Medallion 4.0 by the end of 2018. In August 2018, Medallion 3.0 will end and be replaced by Medallion 4.0 in the Tidewater region. Replacements will continue in a rolling manner by region until all regions have transferred.				
<b>e. Scope of work performed, covered populations and covered services</b>	Coventry Health Care of Virginia, Inc. dba Aetna Better Health of Virginia provides managed care services to the TANF, ABD, and CHIP populations, including Low Income Families with Children (LIFC) and ABD populations, as well as two recent expansion groups that include Foster Care/Adoption Assistance (FC/AA) and the Health and Acute Care Program (HAP) population. Covered services include medical, behavioral health, pharmacy, vision, and NEMT.				
<b>f. Subcontractors</b>	Pharmacy benefits management, behavioral health, vision, and transportation				
<b>g. Annual contract amount and annual claims payment amount</b>					
	<b>2016</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>
<b>Contract amount</b>	\$179,179,415	\$170,691,911	\$155,202,435	\$148,018,626	\$125,142,295
<b>Claims payment</b>	\$147,943,818	\$143,728,553	\$137,392,813	\$128,552,643	\$105,168,085
<b>YTD June 2017</b>	<b>Contract amount</b>	\$93,994,663		<b>Claims payment</b>	\$77,415,524
<b>h. Contract implementation dates, scheduled and actual</b>	Implementation scheduled and executed: 07/1996				
<b>i. Implementation barriers and resolutions</b>	None				

<p><b>j. Relevant accomplishments and achievements</b></p>	<ul style="list-style-type: none"> <li>• Full NCQA accreditation</li> <li>• State-specific ranking - 3.5</li> </ul> <p><b>Readmissions</b> Based on data from Jan, Feb and March, 2017:</p> <ul style="list-style-type: none"> <li>• Our readmission rate was 13.3% in January 2017, and went down to 11.1% in March 2017. This 20% relative decrease in readmission was due to our targeted efforts to ensure that individuals needing care management services receive them (including active care management, ensuring members get the appropriate follow up care they need, keeping them out of the hospital, increasing quality of care post-discharge); and our commitment to continuous quality improvement</li> </ul> <p>Based on data from 3/2016 to 3/2017:</p> <ul style="list-style-type: none"> <li>• Our readmission rate was 12.5% in March 2016 and 11.1% in March 2017, a 13% relative decrease.</li> </ul>
<p><b>k. Number of enrollees, by health plan type</b></p>	<p>Medicaid enrollees: 42,435 (June 2017)</p>
<p><b>l. Type of contract</b></p>	<p>Capitated</p>



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<b>State</b>	Virginia	<input checked="" type="checkbox"/> Owned by Aetna Inc. <input type="checkbox"/> Non-owned by Aetna Inc.	
<b>Health plan name</b>	Coventry Health Care of Virginia, Inc. dba Aetna Better Health of Virginia		
<b>a. Medicaid population served</b>	LTSS		
<b>b. Name and address of client</b>	Virginia Department of Social Services 600 East Broad Street, 11th Floor Richmond, Virginia 23219		
<b>c. Name of contract</b>	Commonwealth Coordinated Care Plus (CCC+)	<b>d. Contract start and end dates</b>	08/2017 – present
<b>Current contract duration</b>	8/2017 - 12/2022		
<b>e. Scope of work performed, covered populations and covered services</b>	Coventry Health Care of Virginia, Inc. dba Aetna Better Health of Virginia provides managed care services to the LTSS population, including members age 65 or older, children and adults with disabilities, nursing facility residents, and members receiving services through a home- and community based waiver. Covered non-developmental disability (DD) waiver services include medical, behavioral, substance use disorder, pharmacy, and transportation to non-waiver services.		
<b>f. Subcontractors</b>	Dental, vision, and transportation		
<b>g. Annual contract amount and annual claims payment amount</b>			
*Note: This program just began, and actual contract and claims payment amounts are not yet available.			
<b>h. Contract implementation dates, scheduled and actual</b>	Implementation scheduled and executed: 08/2017		
<b>i. Implementation barriers and resolutions</b>	None		
<b>j. Relevant accomplishments and achievements</b>	This contract is too new to have reportable achievements.		
<b>k. Number of enrollees, by health plan type</b>	Medicaid enrollees: 6,574 (September 2017)		
<b>l. Type of contract</b>	Capitated		

<b>State</b>	West Virginia		<input checked="" type="checkbox"/> Owned by Aetna Inc. <input type="checkbox"/> Non-owned by Aetna Inc.		
<b>Health plan name</b>	Coventry Health Care of West Virginia, Inc. dba Aetna Better Health of West Virginia				
<b>a. Medicaid population served</b>	TANF, ACA, ABD, SSI				
<b>b. Name and address of client</b>	West Virginia Department of Health and Human Resources Office of the Secretary One Davis Square, Suite 100 East Charleston, West Virginia 25301				
<b>c. Name of contract</b>	Mountain Health Trust	<b>d. Contract start and end dates</b>	07/1996 – present		
<b>Current contract duration</b>	7/1/2016 - 6/30/2017 (with 3 one-year renewal options through 06/30/2020)				
<b>e. Scope of work performed, covered populations and covered services</b>	Coventry Health Care of West Virginia, Inc. dba Aetna Better Health of West Virginia provides managed care services to TANF, ABD, SSI, and ACA expansion populations. Covered services include medical, children's dental, and behavioral health services.				
<b>f. Subcontractors</b>	Vision, children's dental, and tobacco cessation				
<b>g. Annual contract amount and annual claims payment amount</b> Note: The following amounts reflect pass-through revenue and claims.					
	<b>2016</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>
<b>Contract amount</b>	\$485,273,177	\$287,887,934	\$234,426,507	\$179,634,931	\$135,271,251
<b>Claims payment</b>	\$432,315,374	\$247,904,540	\$182,619,306	\$143,686,282	\$109,994,018
<b>YTD June 2017</b>	<b>Contract amount</b>	\$287,145,488		<b>Claims payment</b>	\$266,087,281
<b>h. Contract implementation dates, scheduled and actual</b>	Implementation scheduled and executed: 07/1996				
<b>i. Implementation barriers and resolutions</b>	None				



<b>j. Relevant accomplishments and achievements</b>	<ul style="list-style-type: none"><li>• Full NCQA accreditation – Commendable</li><li>• State-specific ranking - 3.5</li><li>• West Virginia cost trend (very efficient) 2% increase per year for 5 years in a row.</li><li>• Only West Virginia plan with “Commendable” NCQA rating.</li><li>• Our established network incorporates 95% of facilities and 85% of providers across the State.</li><li>• Through a PCMH agreement, we collaborated with a large provider group to engage with members and improve quality measures. We are proud of the fact that the group recently concluded its first full year as a PCMH with a 12.26% HEDIS improvement in its HEDIS adolescent well-child score.</li><li>• Received a perfect 100% overall score on the annual State external quality review (EQRO) for the third straight year in 2017; the only MCO in WV to receive a 100% overall score</li></ul>
<b>k. Number of enrollees, by health plan type</b>	Medicaid enrollees: 128,395 (June 2017)
<b>l. Type of contract</b>	Capitated

### HEALTH PLANS THAT ARE NOT OWNED BY AETNA INC. BUT MANAGED BY AETNA

The health plans listed as follow are not owned by Aetna Inc. but are or were managed by Aetna affiliates that are currently providing (and will continue to provide) administrative services for Aetna Better Health of Florida. The health plans within this table, rather than Aetna, have or had direct contractual relationships with the State agencies in their respective states. The scope of services and populations shown for each health plan is an aggregate of the services provided and populations served for the entire time period set forth under the relevant contract term. Depending on contract requirements, some services and/or populations may or may not be covered at a given point during this time period.

#### Note regarding item f.:

As described in more detail in the narrative response to SRC# 1, in general, Aetna affiliates perform the following types of services for the health plans we manage, including, but not limited to: management services for physical and behavioral health, including care and disease management, quality management, utilization management, enrollment processing, claims payment, program integrity monitoring, internal audit, executive oversight, shared services, information systems, finance, actuarial, procurement, insurance, risk management, compliance oversight and monitoring, after-hours call center, provider credentialing, pharmacy benefit management (PBM) administrative services (when not performed by Caremark PCS Health), Aetna's nurse-informed health line, information technology data center infrastructure, human resources services and support, and procurement support and contracting services. In the item addressing the use of administrative and/or delegated subcontractor(s) and their scope of work, item f., we list services performed by unaffiliated subcontractors.

#### Note regarding item g.:

The following tables do not include claims payments because they describe administrative service contracts in which Aetna acts only in an administrative capacity and receives an administrative service fee for provided services. This administrative service fee is the only revenue recognized by Aetna, and it is therefore this amount that is reported under the "Contract amount" field. In these administrative service contracts, Aetna may support claims processing administration, but acts only as an intermediary for processing these payments. Aetna does not receive capitation payments from the governmental agency, recognize any revenue pertaining to those payments, or assume any risk for medical payments under these contracts.

#### Note regarding item i.:

In regard to the item referring to barriers to implementation, we interpret item i. to be asking about barriers that prevented timely implementation of the contract. If the contract was implemented on the scheduled completion date, we indicated that there were no barriers to implementation. We discuss general barriers to implementation in the narrative portion of the response to SRC# 1.

<b>State</b>	Arizona	<input type="checkbox"/> Owned by Aetna Inc. <input checked="" type="checkbox"/> Non-owned by Aetna Inc.			
<b>Health plan name</b>	Southwest Catholic Health Network Corporation dba Mercy Care Plan				
<b>a. Medicaid population served</b>	TANF, CHIP, ACA				
<b>b. Name and address of client</b>	Arizona Health Care Cost Containment System (AHCCCS) 701 E. Jefferson Phoenix, Arizona 85034				
<b>c. Name of contract</b>	AHCCS Acute Care	<b>d. Contract start and end dates</b>		05/2002 – present	
<b>Current contract duration</b>	10/1/2013 - 9/30/2016 (with 2 one-year renewal options through 09/30/2018)				
<b>e. Scope of work performed, covered populations and covered services</b>	Southwest Catholic Health Network Corporation dba Mercy Care Plan provides managed care services to the TANF, CHIP, and ACA expansion populations, including pregnant women, infants, children, children/youth with special health care needs, low income families and adults, and children in foster care. Covered services include medical, behavioral health, pharmacy, vision, dental, and NEMT.				
<b>f. Subcontractors</b>	Pharmacy benefit management, dental, crisis intervention services, credentialing, adult day care audits, ALH audits, radiology review and pain management, HEDIS and CAHPS survey administration, prevention and wellness outreach services, member survey administration, claims processing, call center performance, prior authorization, and SSI conversion program assistance				
	<b>2016</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>
<b>YTD June 2017</b>					
<b>h. Contract implementation dates, scheduled and actual</b>	Implementation scheduled and executed: 10/1/2013				
<b>i. Implementation barriers and resolutions</b>	None				
<b>j. Relevant accomplishments and achievements</b>	<u>Reduce Readmissions Initiative</u> To reduce hospital readmission rates for a population of nearly 19,000 dual-eligible members, Mercy Care Plan (MCP) in Arizona implemented a program that prepares the member for discharge on the first day of hospital admission and features a follow-up call to the member on his or her first day home. Upon notification of an admission, Utilization Review clinicians collaborate with hospital discharge planning staff, members or their caregivers, care managers, primary care physicians, and other practitioners to facilitate discharge-planning efforts. This				

	<p>highly effective team approach results in improved continuity of care in the safest and most cost-effective setting and enables hospitals, the PCMH, and plan personnel to focus more closely on special social, economic, cultural, and language needs that will reinforce improved outcomes for the member.</p> <p>Achieved: MCP's discharge plan is part of an integrated care management approach that enabled MCP's Advantage segment to achieve a 9- to 10% readmission rate in 2016.</p> <p><u>Diabetes Self-Management Program</u></p> <p>Our care managers support members by emphasizing the importance of diabetic testing and education so the member is empowered to manage his or her condition better. We work with members to complete at a minimum annual testing of their HgA1c and annual retinal exams. We support members in scheduling tests and making transportation arrangements for their appointments, if needed. We document the results of each test in our care management system, update the member's care plan, and provide additional disease management support as determined by the member's condition. Members are encouraged to know the results of their hemoglobin A1c testing and to work closely with their primary care physicians to ensure their diabetes is optimally managed following national guidelines. Additionally, we provide diabetic retinal eye exams for members who are in skilled nursing facilities or who are homebound.</p> <p>Results: Mercy Care Plan's care management approach and in-residence diabetic retinal exam service enabled the plan to achieve a 79.4% rate of compliance with retinal exams for a 12-month period ending September 30, 2015, far exceeding the state's performance standard of 49%. A1c testing compliance is an impressive 94.2% and 80.5% of members had an A1c level less than 9%, a state benchmark.</p>
<b>k. Number of enrollees, by health plan type</b>	Medicaid enrollees: 354,851 (June 2017)
<b>I. Type of contract</b>	Mercy Care Plan is paid a capitated rate under its contract with the state Medicaid agency. Aetna Medicaid Administrators LLC (Aetna Medicaid Administrators) is paid a percentage of premium revenue for management services it provides to the plan.

<b>State</b>	Arizona	<input type="checkbox"/> Owned by Aetna Inc. <input checked="" type="checkbox"/> Non-owned by Aetna Inc.			
<b>Health plan name</b>	Southwest Catholic Health Network Corporation dba Mercy Care Plan				
<b>a. Medicaid population served</b>	LTSS				
<b>b. Name and address of client</b>	Arizona Health Care Cost Containment System (AHCCCS) 701 E. Jefferson Phoenix, Arizona 85034				
<b>c. Name of contract</b>	Arizona Long Term Care Services	<b>d. Contract start and end dates</b>	05/2002 – present		
<b>Current contract duration</b>	10/1/2011 - 9/30/2014 (with 3 one-year renewal options through 09/30/2017). NOTE: Contract recently retained through procurement award; new contract pending.				
<b>e. Scope of work performed, covered populations and covered services</b>	Southwest Catholic Health Network Corporation dba Mercy Care Plan provides managed care services to the LTSS population, including members who are age 65 or older, blind, have a developmental disability, or have a disability at any age and require ongoing nursing facility level care. Covered services include medical, behavioral health, case management, palliative care, vision, children's rehabilitative services, and podiatry.				
<b>f. Subcontractors</b>	Pharmacy benefit management, dental, crisis intervention services, credentialing, adult day care audits, ALH audits, radiology review and pain management, HEDIS and CAHPS survey administration, prevention and wellness outreach services, member survey administration, claims processing, call center performance, prior authorization, and SSI conversion program assistance				
	<b>2016</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>
<b>YTD June 2017</b>					
<b>h. Contract implementation dates, scheduled and actual</b>	Implementation scheduled and executed: 05/2002				
<b>i. Implementation barriers and resolutions</b>	None				
<b>j. Relevant accomplishments and achievements</b>	<u>ACTIVATE Model of Transitional Care Program</u> The ACTIVATE Program was developed in partnership with Foundation for Senior Living and Dignity Health to improve member health outcomes post discharge and decrease the risk of re-hospitalization. It includes an embedded nurse at the hospital who collaborates with hospital staff and has access to census and medical records. The nurse works with hospital staff to ensure that discharge planning starts on the day of admission, and the nurse works closely with the member/family,				

	<p>medical providers and the case manager for up to 30 days post-discharge. Primary Outcomes: Reduced readmission rates from 18 to 4 percent for members in the intervention.</p> <p><u>Behavioral Health (BH) Conditions Identification Initiative</u> Our BH Conditions Identification Initiative enables us to better coordinate members' medical and behavioral health care needs by identifying behavioral health conditions. Having this clinically important information enables medical management to direct appropriate behavioral health services and resources for those members who have co-morbid medical and behavioral health conditions. Since implementation, we have been successful in identifying more members with behavioral health conditions. Primary Outcomes: 32% increase in the percentage of members with behavioral health needs being identified for services, and a 58% increase in the percentage of members with drug alcohol dependence being identified for services. As a result, we were able to intervene more quickly to connect these members to services, improving engagement in care and outcomes.</p>
<b>k. Number of enrollees, by health plan type</b>	Medicaid enrollees: 11,269 (June 2017)
<b>I. Type of contract</b>	Mercy Care Plan is paid a capitated rate under its contract with the state Medicaid agency. Aetna Medicaid Administrators LLC (Aetna Medicaid Administrators), is paid a percentage of premium revenue for management services it provides to the plan.

<b>State</b>	Arizona		<input type="checkbox"/> Owned by Aetna Inc. <input checked="" type="checkbox"/> Non-owned by Aetna Inc.	
<b>Health plan name</b>	Southwest Catholic Health Network Corporation dba Mercy Care Plan			
<b>a. Medicaid population served</b>	DD/ABD			
<b>b. Name and address of client</b>	Arizona Department of Economic Security 701 E. Jefferson MD 8900 Phoenix, Arizona 85034			
<b>c. Name of contract</b>	Arizona Health Care Cost Containment System – Medicaid only	<b>d. Contract start and end dates</b>	05/2002 – present	
<b>Current contract duration</b>	10/1/2011 - 9/30/2014 (with 3 one-year renewal options through 09/30/2017)			
<b>e. Scope of work performed, covered populations and covered services</b>	Southwest Catholic Health Network Corporation dba Mercy Care Plan provides services to DD/ABD populations, including acute care services to individuals enrolled with the Department of Economic Security/Division of Developmental Disabilities who are ALTCS (Arizona Long Term Care System) eligible within the awarded geographic service areas. Covered services include those acute care services outlined within the managed care system to ensure members receive the most appropriate level of care.			
<b>f. Subcontractors</b>	Pharmacy benefit management, dental, crisis intervention services, credentialing, adult day care audits, ALH audits, radiology review and pain management, HEDIS and CAHPS survey administration, prevention and wellness outreach services, member survey administration, claims processing, call center performance, prior authorization, and SSI conversion program assistance			
	<b>2016</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>
<b>YTD June 2017</b>				
<b>h. Contract implementation dates, scheduled and actual</b>	Implementation scheduled and executed: 10/1/2011 and 10/1/2017			
<b>i. Implementation barriers and resolutions</b>	None			

<p><b>j. Relevant accomplishments and achievements</b></p>	<p><u>Reduce Readmissions Initiative</u> To reduce hospital readmission rates for a population of nearly 19,000 dual-eligible members, Mercy Care Plan (MCP) in Arizona implemented a program that prepares the member for discharge on the first day of hospital admission and features a follow-up call to the member on his or her first day home. Upon notification of an admission, Utilization Review clinicians collaborate with hospital discharge planning staff, members or their caregivers, care managers, primary care physicians, and other practitioners to facilitate discharge-planning efforts. This highly effective team approach results in improved continuity of care in the safest and most cost-effective setting and enables hospitals, the PCMH, and plan personnel to focus more closely on special social, economic, cultural, and language needs that will reinforce improved outcomes for the member. Achieved: MCP's discharge plan is part of an integrated care management approach that enabled MCP's Advantage segment to achieve a 9- to 10% readmission rate in 2016.</p> <p><u>Diabetes Self-Management Program</u> Our care managers support members by emphasizing the importance of diabetic testing and education so the member is empowered to manage his or her condition better. We work with members to complete at a minimum annual testing of their HgA1c and annual retinal exams. We support members in scheduling tests and making transportation arrangements for their appointments, if needed. We document the results of each test in our care management system, update the member's care plan, and provide additional disease management support as determined by the member's condition. Members are encouraged to know the results of their hemoglobin A1c testing and to work closely with their primary care physicians to ensure their diabetes is optimally managed following national guidelines. Additionally, we provide diabetic retinal eye exams for members who are in skilled nursing facilities or who are homebound. Results: Mercy Care Plan's care management approach and in-residence diabetic retinal exam service enabled the plan to achieve a 79.4% rate of compliance with retinal exams for a 12-month period ending September 30, 2015, far exceeding the state's performance standard of 49%. A1c testing compliance is an impressive 94.2% and 80.5% of members had an A1c level less than 9%, a state benchmark.</p>
<p><b>k. Number of enrollees, by health plan type</b></p>	<p>Medicaid enrollees: 29,112 (June 2017)</p>
<p><b>l. Type of contract</b></p>	<p>Mercy Care Plan is paid a capitated rate under its contract with the state Medicaid agency. Aetna Medicaid Administrators LLC (Aetna Medicaid Administrators) is paid a percentage of premium revenue for management services it provides to the plan.</p>

<b>State</b>	Arizona	<input type="checkbox"/> Owned by Aetna Inc. <input checked="" type="checkbox"/> Non-owned by Aetna Inc.				
<b>Health plan name</b>	Mercy Maricopa Integrated Care					
<b>a. Medicaid population served</b>	TANF, GMH/SA, ABD, SMI, ACA					
<b>b. Name and address of client</b>	Arizona Health Care Cost Containment System (AHCCCS) 801 E Jefferson St. Phoenix, AZ 85034					
<b>c. Name of contract</b>	AHCCCS Division of Health Care Management (DHCM) - Regional Behavioral Health Authority Maricopa (AHCCCS Contract number: YH17-0001 Amendment 6)		<b>d. Contract start and end dates</b>		04/2014 – present	
<b>Current contract duration</b>	4/1/2014 - 9/30/2018 (with 1 one-year plus 1 six-month renewal options through 03/31/2019)					
<b>e. Scope of work performed, covered populations and covered services</b>	Mercy Maricopa Integrated Care (Mercy Maricopa) provides managed care services to the TANF, GMH/SA, ABD, SMI, and ACA populations, including children and adolescents, children in foster and adoptive care, adults with a serious mental illness (SMI) determination, adults with general mental health issues (GMH), adults with substance abuse issues (SA), and individuals experiencing a behavioral health crisis. Covered services include behavioral and physical health care, peer- and family-run services, crisis intervention and substance use, and suicide prevention.					
<b>f. Subcontractors</b>	Pharmacy, transportation, behavioral health					
	<b>YTD June 2017</b>	<b>2016</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>
<b>h. Contract implementation dates, scheduled and actual</b>	Implementation scheduled and executed: 04/2014					
<b>i. Implementation barriers and resolutions</b>	None					

<b>j. Relevant accomplishments and achievements</b>	<ul style="list-style-type: none"> <li>• Improvements in psychiatric outcomes <ul style="list-style-type: none"> <li>– Psychiatric hospitalizations per 1,000 decreased 8% overall</li> <li>– Among ACT participants, psychiatric hospitalizations/1,000 decreased 28% and medical hospitalizations/1,000 decreased 36%</li> </ul> </li> <li>• Housing outcomes for SMI members <ul style="list-style-type: none"> <li>– Members attributed to participating Permanent Supported Housing Service providers, a 60% reduction in psychiatric hospital admissions was observed in the performance period compared to baseline</li> <li>– Reduction of 49% in the number of members who utilized mobile crisis services</li> <li>– Number of members who remained housed upon move in improved 65%</li> <li>– Number of members who secured housing within 30 days increased 47%</li> </ul> </li> <li>• Innovative Programs – Housing GMH/SA</li> <li>• Created innovative GMH/SA housing support program to delivery housing support services to high risk/high cost members in partnership with City of Phoenix and Valley United Sun which offered 255 housing subsidies to members participating in this program.</li> </ul>
<b>k. Number of enrollees, by health plan type</b>	Medicaid enrollees: 947,132 (June 2017)
<b>l. Type of contract</b>	Mercy Maricopa Integrated Care Plan is paid a capitated rate under its contract with the state. Aetna Medicaid Administrators is paid a percentage of premium revenue for management services it provides to the plan.

<b>State</b>	California		<input type="checkbox"/> Owned by Aetna Inc. <input checked="" type="checkbox"/> Non-owned by Aetna Inc.		
<b>Health plan name</b>	CHOC Health Alliance; a consortium between Children's Hospital of Orange County dba CHOC Children's Hospital and CHOC Physicians Network, Inc.				
<b>a. Medicaid population served</b>	TANF, ABD				
<b>b. Name and address of client</b>	CalOptima 505 City Parkway West Orange, California 92868				
<b>c. Name of contract</b>	Medi-Cal – Medicaid and CHIP	<b>d. Contract start and end dates</b>		06/1995 - 06/2014	
<b>e. Scope of work performed, covered populations and covered services</b>	CHOC Health Alliance provided managed care services for the TANF and ABD populations, including pregnant women, infants, children, children/youth with special health care needs, low income families and adults, and individuals receiving SSI. Covered services included medical, pharmacy, and NEMT.				
<b>f. Subcontractors</b>	None				
	<b>2016</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>
<b>h. Contract implementation dates, scheduled and actual</b>	Implementation scheduled and executed: 06/1995				
<b>i. Implementation barriers and resolutions</b>	None				
<b>j. Relevant accomplishments and achievements</b>	<p>Aetna was contracted to deliver managed care services for the Children's Health of Orange County (CHOC) Health Alliance from the beginning of the CalOptima program in 1995 through 2013. The CHOC Health Alliance is a Physician Hospital Organization (PHO) consisting of Children's Hospital of Orange County and the CHOC Physician Network. Aetna delivered all managed care services for all Medi-Cal beneficiaries in Orange County, including operations, financial and medical management, and ancillary support functions. During the 18-year contract, many successes were achieved in the areas of quality and improved care coordination. Enrollment reached approximately 125,000 members. In 2013, Aetna Medicaid and CHOC Health Alliance reached a mutual decision to terminate the agreement. All members were successfully transitioned to the new management company selected by CHOC, thus demonstrating Aetna Medicaid's commitment to these Medi-Cal beneficiaries.</p>				

<b>k. Number of enrollees, by health plan type</b>	Medicaid enrollees: 124,282
<b>l. Type of contract</b>	The state paid CHOC Health Alliance a capitated rate under CHOC's contract with the state. CHOC paid Aetna Medicaid Administrators a percentage of premium revenue for management services it provided to CHOC.

<b>State</b>	California	<input type="checkbox"/> Owned by Aetna Inc. <input checked="" type="checkbox"/> Non-owned by Aetna Inc.			
<b>Health plan name</b>	CHOC Health Alliance; a consortium between Children's Hospital of Orange County dba CHOC Children's Hospital and CHOC Physicians Network, Inc.				
<b>a. Medicaid population served</b>	CHIP				
<b>b. Name and address of client</b>	CalOptima 505 City Parkway West Orange, California 92868				
<b>c. Name of contract</b>	Medi-Cal – Medicaid and CHIP	<b>d. Contract start and end dates</b>		07/2008 – 6/2014	
<b>e. Scope of work performed, covered populations and covered services</b>	CHOC Health Alliance provided managed care services for the CHIP population, including children aged 0 to 18 years. Covered services included medical, pharmacy, and NEMT.				
<b>f. Subcontractors</b>	None				
	<b>2016</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>
<b>h. Contract implementation dates, scheduled and actual</b>	Implementation scheduled and executed: 07/2008				
<b>i. Implementation barriers and resolutions</b>	None				
<b>j. Relevant accomplishments and achievements</b>	<p>Aetna contracted to deliver managed care services for the Children's Health of Orange County (CHOC) Health Alliance from the beginning of the CalOptima program in 1995 through 2013. The CHOC Health Alliance is a Physician Hospital Organization (PHO) consisting of Children's Hospital of Orange County and the CHOC Physician Network. Aetna Medicaid delivered all managed care services for all Medi-Cal beneficiaries in Orange County, including operations, financial and medical management, and ancillary support functions. During the 18-year contract, many successes were achieved in the areas of quality and improved care coordination. Enrollment reached approximately 125,000 members. In 2013, Aetna Medicaid and CHOC Health Alliance reached a mutual decision to terminate the agreement. All members were successfully transitioned to the new management company selected by CHOC, thus demonstrating Aetna Medicaid's commitment to these Medi-Cal beneficiaries.</p>				
<b>k. Number of enrollees, by health plan type</b>	Medicaid enrollees: 124,282				

<b>I. Type of contract</b>	The state paid CHOC Health Alliance a capitated rate under CHOC's contract with the state. CHOC paid Aetna Medicaid Administrators a percentage of premium revenue for management services it provided to CHOC.
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<b>State</b>	Florida	<input type="checkbox"/> Owned by Aetna Inc. <input checked="" type="checkbox"/> Non-owned by Aetna Inc.			
<b>Health plan name</b>	Integral Health Plan, Inc.				
<b>a. Medicaid population served</b>	TANF, ABD				
<b>b. Name and address of client</b>	Florida Department of Children and Families – Northeast Region 5920 Arlington Expressway Jacksonville, Florida 32211  Florida Department of Children and Families – Central Region 400 W. Robinson St. Suite 1129 Orlando, Florida 32801  Florida Department of Children and Families – Suncoast Region 9393 North Florida Avenue Tampa, Florida 33612				
<b>c. Name of contract</b>	Managed Medical Assistance – Medicaid Only	<b>d. Contract start and end dates</b>	02/2010 – 06/2013		
<b>e. Scope of work performed, covered populations and covered services</b>	Integral Health Plan, Inc., provided managed care services for the TANF and ABD populations, including pregnant women, children, low-income families and adults, and individuals receiving SSI. Covered services included medical, behavioral health, pharmacy, vision, dental, and NEMT.				
<b>f. Subcontractors</b>	Pharmacy, dental, vision and transportation				
	<b>2016</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>
<b>h. Contract implementation dates, scheduled and actual</b>	Implementation scheduled and executed: 02/2010				
<b>i. Implementation barriers and resolutions</b>	None				

<b>j. Relevant accomplishments and achievements</b>	<p>Integral signed its first member in April 2010 and grew to more than 12,300 members in Collier, Manatee and Polk counties by March 2011. During this time, the plan:</p> <ul style="list-style-type: none"> <li>• Conducted dental screenings and handed out toothbrushes and toothpaste to more than 500 kids in a local Head</li> <li>• Start program in collaboration with Manatee County Rural Health Services</li> <li>• Established relationships with 75 social-services agencies</li> <li>• Participated in more than 27 community events</li> <li>• Sponsored Polk County Family Week</li> <li>• Held dental clinics for campers at Polk County Camp Rock in collaboration with the Central Florida Dental Department</li> <li>• Held three member orientation sessions</li> <li>• Joined local Chambers of Commerce</li> <li>• Increased member access to pediatric specialty providers</li> <li>• Filled care gaps for more than 30 specialty providers</li> <li>• Implemented TEXT4Baby for members who are pregnant or new mothers</li> <li>• Established newsletters for members and providers</li> </ul>
<b>k. Number of enrollees, by health plan type</b>	<p>Medicaid enrollees: 38,097</p>
<b>l. Type of contract</b>	<p>Integral Quality Care was paid a capitated rate. Aetna Medicaid as administrator was paid a percentage of Premium Revenue.</p>

<b>State</b>	Maryland		<input type="checkbox"/> Owned by Aetna Inc. <input checked="" type="checkbox"/> Non-owned by Aetna Inc.		
<b>Health plan name</b>	Maryland Care Inc., dba Maryland Physicians Care				
<b>a. Medicaid population served</b>	TANF, CHIP, ABD, ACA				
<b>b. Name and address of client</b>	Maryland Department of Health and Mental Hygiene 201 W. Preston St, Room 127 Baltimore, Maryland 21201				
<b>c. Name of contract</b>	Diamond State Health Plan – Medicaid and CHIP		<b>d. Contract start and end dates</b>	09/1996 – 7/2017	
<b>e. Scope of work performed, covered populations and covered services</b>	Maryland Care Inc., dba Maryland Physicians Care provided managed care services for the TANF, CHIP, ABD, and ACA populations, including pregnant women, infants, children, children/youth with special health care needs, low income adults, individuals receiving SSI, and ACA individuals. Covered services included medical, behavioral health, pharmacy, vision, dental and NEMT.				
<b>f. Subcontractors</b>	Pharmacy benefits management, dental, and vision				
	<b>2016</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>
YTD June 2017					
<b>h. Contract implementation dates, scheduled and actual</b>	Implementation scheduled and executed: 09/1996				
<b>i. Implementation barriers and resolutions</b>	None				
<b>j. Relevant accomplishments and achievements</b>	<ul style="list-style-type: none"> <li>• Achieved 100 percent regulatory compliance for 5 last years</li> <li>• Achieved score of 100 percent on annual EQRO audit 4 years in a row</li> <li>• Achieved Commendable NCQA ranking January 2016</li> </ul>				
<b>k. Number of enrollees, by health plan type</b>	Medicaid enrollees: 216,398 (June 2017)				
<b>l. Type of contract</b>	The state paid Maryland Physicians Care a capitated rate under its contract with the state. Maryland Physicians Care paid Aetna Medicaid Administrators a percentage of premium revenue for management services provided to Maryland Physicians Care.				

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<b>State</b>	Texas		<input type="checkbox"/> Owned by Aetna Inc. <input checked="" type="checkbox"/> Non-owned by Aetna Inc.		
<b>Health plan name</b>	CHRISTUS Health Plan				
<b>a. Medicaid population served</b>	TANF, CHIP				
<b>b. Name and address of client</b>	Texas Health and Human Services Commission Brown-Heatly Building 4900 N. Lamar Blvd. Austin, TX 78751-2316				
<b>c. Name of contract</b>	STAR – Medicaid and CHIP		<b>d. Contract start and end dates</b>	05/2011 – 02/2015	
<b>e. Scope of work performed, covered populations and covered services</b>	CHRISTUS Health Plan provided managed care services for the TANF and CHIP populations, including pregnant women, infants, children, children/youth with special health care needs, and low income adults. Covered services included medical, behavioral health, pharmacy, vision, and NEMT.				
<b>f. Subcontractors</b>	Pharmacy benefits management, vision and behavioral health				
	<b>2016</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>
<b>h. Contract implementation dates, scheduled and actual</b>	Implementation scheduled and executed: 05/2011				
<b>i. Implementation barriers and resolutions</b>	None				
<b>j. Relevant accomplishments and achievements</b>	In 2014, the Rating of the Health Care and Customer Services measure was at the 90th percentile				
<b>k. Number of enrollees, by health plan type</b>	Medicaid enrollees: 7,639 (2015)				
<b>l. Type of contract</b>	The state paid CHRISTUS a capitated rate under its contract with the state. CHRISTUS paid Aetna Medicaid Administrators a percentage of premium revenue for management services provided to CHRISTUS.				

<b>State</b>	Texas		<input type="checkbox"/> Owned by Aetna Inc. <input checked="" type="checkbox"/> Non-owned by Aetna Inc..		
<b>Health plan name</b>	Parkland Community Health Plan, Inc.				
<b>a. Medicaid population served</b>	TANF, CHIP				
<b>b. Name and address of client</b>	Texas Health and Human Services Commission Brown-Heatly Building 4900 N. Lamar Blvd. Austin, TX 78751-2316				
<b>c. Name of contract</b>	STAR - Medicaid and CHIP	<b>d. Contract start and end dates</b>	1998 – present		
<b>Current contract duration</b>	9/1/2011 - 8/31/2015 (with renewal options up to 4 years through 8/31/2019)				
<b>e. Scope of work performed, covered populations and covered services</b>	Parkland Community Health Plan, Inc., provides managed care services for the TANF and CHIP populations, including pregnant women, infants, children, children/youth with special health care needs, low income adults, and families. Covered services include medical, pharmacy, vision, and NEMT.				
<b>f. Subcontractors</b>	Pharmacy benefits management, vision and behavioral health.				
	<b>2016</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>
<b>YTD June 2017</b>					
<b>h. Contract implementation dates, scheduled and actual</b>	Implementation scheduled and executed: 1998				
<b>i. Implementation barriers and resolutions</b>	None				
<b>j. Relevant accomplishments and achievements</b>	<ul style="list-style-type: none"> <li>Member Satisfaction Goals for the Health plan rating is at 90th percentile</li> <li>47 out of 55 HEDIS Measures for TX increased.</li> <li>TX Percentage of HEDIS Measures Exceeding Prior Year's Rate was 85 percent</li> <li>Overall Provider Satisfaction with Parkland Community Health Plan (Aetna TPA) increase from 70.01% to 75.5%</li> </ul>				
<b>k. Number of enrollees, by health plan type</b>	Medicaid enrollees: 196,572 (June 2017)				
<b>l. Type of contract</b>	Parkland Community Health Plan is paid a capitated rate under its contract with the Texas Health and Human Services Commission. Aetna Medicaid Administrators is paid a percentage of premium revenue for management services it provides to the plan.				

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<b>State</b>	Virginia	<input type="checkbox"/> Owned by Aetna Inc. <input checked="" type="checkbox"/> Non-owned by Aetna Inc.			
<b>Health plan name</b>	Carilion Clinic Medicare Resources, LLC dba MajestaCare				
<b>a. Medicaid population served</b>	TANF, CHIP, ABD				
<b>b. Name and address of client</b>	Virginia Department of Medical Assistance Services Division 600 East Broad Street, 11th Floor Richmond, Virginia 23219				
<b>c. Name of contract</b>	Medicaid and CHIP	<b>d. Contract start and end dates</b>		06/2011 – 11/2014	
<b>e. Scope of work performed, covered populations and covered services</b>	Carilion Clinic Medicare Resources, LLC dba MajestaCare provided managed care services for the TANF, CHIP, and ABD populations, including pregnant women, infants, children, children/youth with special health care needs, low income adults and families, and children in foster care. Covered services included medical, behavioral health, pharmacy, vision, and NEMT.				
<b>f. Subcontractors</b>	None				
	<b>2016</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>
<b>h. Contract implementation dates, scheduled and actual</b>	Implementation scheduled and executed: 06/2011				
<b>i. Implementation barriers and resolutions</b>	None				
<b>j. Relevant accomplishments and achievements</b>	<ul style="list-style-type: none"> <li>Increased coordination between UM and CM - implemented post discharge impact program to reduce readmissions. Result was a reduction of 25%.</li> <li>Increased case management coordination to managing approx. 2% of population.</li> <li>Pharmacy edits for substance abuse issues with plan members-reduced cost from 1 month \$32K to \$11K - a 66% reduction in costs</li> <li>We were the first MCO to systematically address opiate dependence in Virginia through lock-ins and the Prescription Monitoring Program.</li> <li>We supported primary care physicians in the early identification and treatment of mental illness through reimbursement of tele psychiatry consultation codes.</li> <li>These programs reduced an MLR (Medical Loss Ratio) in 100 to high 88 - 12% reduction in the ratio or increased</li> </ul>				
<b>k. Number of enrollees, by health plan type</b>	Medicaid enrollees: 9,473 (2014)				



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<b>I. Type of contract</b>	The state paid MajestaCare a capitated rate under its contract with the state. MajestaCare paid Aetna Medicaid Administrators a percentage of premium revenue for management services provided to MajestaCare.
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**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**SRC# 2 – Florida Experience (Regional):**

The respondent shall provide documentation of the extent to which it has experience operating as a Florida Medicaid health plan in the region in which it plans to provide services or in any other region in the State of Florida. If applicable, the respondent shall provide the Agency Contract number and the regions of operation to show it has experience providing managed care services and/or LTC services in Florida. The respondent shall provide documentation of any Medicare Advantage Plan contracts for counties in the State of Florida.

**Response:**

Aetna has the experience necessary to effectively administer complex Medicaid managed care programs and achieve optimal health and cost-saving outcomes. With 30 years of experience serving 3 million enrollees across the nation, Aetna possesses the expertise and business acumen necessary to provide a quality-driven, integrated health care delivery model that directly aligns with the Agency's objectives. Furthermore, our Florida leadership team possesses more than 130 years of combined Florida Medicaid experience.

Our fundamental goal is to improve the health and well-being of our enrollees while providing budget predictability to AHCA. Aetna recently received the highest NCQA ranking among all Florida Medicaid plans for the second consecutive year, and we rank among the top 15 Medicaid plans in the country. Our experience implementing, managing, and caring for high-acuity Medicaid beneficiaries in Florida has resulted in improved access to care, higher quality care in the most appropriate settings, and a simplified, culturally competent enrollee experience for Florida Medicaid members.

**EXPERIENCE OPERATING AS A FLORIDA MEDICAID HEALTH PLAN**

The Aetna organization currently provides health care coverage to more than 100,000 Medicaid enrollees, more than 53,000 commercially insured enrollees, and approximately 114,700 Medicare Advantage enrollees in Florida. We are proud to serve the Temporary Assistance for Needy Families (TANF); aged, blind, and disabled (ABD); long-term services and supports (LTSS); and duals populations under the Statewide Medicaid Managed Care (SMMC) contract. Aetna holds a comprehensive Managed Medical Assistance (MMA) and Long-Term Care (LTC) contract in Region 11, and LTC contracts in Regions 6, 7, and 9. Additionally, we serve approximately 42,000 Florida Healthy Kids enrollees in Regions 1, 2, 3, 5, 6, 7, 8, 9, and 11.

Building and fostering relationships—the kind necessary to make a lasting difference—requires an enduring commitment. We apply this philosophy to serving the Florida Medicaid population and remain committed to supporting our enrollees' efforts to change their behaviors, follow their physicians' treatment recommendations, and adopt healthier lifestyles. By living our values of integrity, excellence, inspiration, and caring, we help to provide high-quality, person-centered health care to the State's most vulnerable citizens. Our enrollees are at the forefront of all we do, and we remain committed to improving their lives and well-being by offering the services and supports they need to maintain and enhance their health and overall quality of life.

In 2013, Aetna Inc. acquired Coventry Health Care, Inc., and its subsidiaries (including Coventry Health Care of Florida, Inc., which now does business as Aetna Better Health® of Florida). Aetna Better Health of Florida held a Medicaid HMO non-reform contract covering the TANF

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

and ABD populations from September 2002 through August 2014. These populations, along with the LTC population, are now covered by Florida's Statewide Medicaid Managed Care program, which was implemented in 2014.

In addition, from February 2010 through June 2013, Aetna Medicaid Administrators LLC (Aetna Medicaid Administrators), a third-party organization providing administrative services to its affiliate, Aetna Better Health of Florida, also provided administrative services to Integral Health Plan, Inc. dba Integral Quality Care (Integral) in support of Integral's Medicaid non-reform capitated provider service network contract serving the TANF and ABD populations. Aetna Medicaid Administrators ceased providing administrative services to Integral after Aetna Inc. acquired Coventry Health Care, Inc. to avoid any perceived conflict resulting from Aetna managing the newly acquired Coventry health plans in Florida, while also managing a competing plan (Integral) that was not owned by Aetna Inc.

An affiliate of Aetna Better Health of Florida, Coventry Health Plan of Florida, Inc. (Coventry Health Plan) also held a Medicaid HMO non-reform contract covering the TANF and ABD populations from September 2002 to August 2014. When the State of Florida procured its new Statewide Medicaid Managed Care program, Coventry Health Plan of Florida chose not to bid; instead, its affiliate Aetna Better Health of Florida bid and was awarded that business.

### **SMMC CONTRACTS**

CRITERION 1, Bullets 1 and 2: For the Managed Care Plan that is proposing to provide services under this solicitation, whether the respondent has: An existing SMMC Contract in that region or an existing SMMC Contract in another region in the State of Florida

Aetna holds existing SMMC contracts in the following regions:

- Region 6 (LTC): Agency contract number FP022
- Region 7 (LTC): Agency contract number FP022
- Region 9 (LTC): Agency contract number FP022
- Region 11 (Comprehensive MMA and LTC): Agency contract number FP022

### **MEDICARE ADVANTAGE PROGRAM CONTRACTS**

CRITERION 1, Bullet 3: For the Managed Care Plan that is proposing to provide services under this solicitation, whether the respondent has: A Medicare Advantage Plan contract in that region

Aetna holds Medicare Advantage program contracts in all 11 regions, as follows:

- Region 1: Contract number H5521
- Region 2: Contract number H5521
- Region 3: Contract numbers H1609, H5521, and H5522
- Region 4: Contract numbers H1609 and H5521
- Region 5: Contract numbers H1609, H5521, and H5522
- Region 6: Contract numbers H1609, H5521, and H5522
- Region 7: Contract numbers H1609, H5521, and H5522
- Region 8: Contract numbers H1609, H5521, and H5522
- Region 9: Contract numbers H1609, H3152, H5521, H5522, and H5793

**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

- Region 10: Contract numbers H1609, H3152, and H5521
- Region 11: Contract numbers H1609 and H5521

**Evaluation Criteria:**

For the Managed Care Plan that is proposing to provide services under this solicitation, whether the respondent has:

- An existing SMMC Contract in that region;
- An existing SMMC Contract in another region in the State of Florida; or
- A Medicare Advantage Plan contract in that region.

**Score:** This section is worth a maximum of 30 raw points as outlined below.

1. 20 points if the respondent already has an SMMC Contract in the region that it plans to provide services (MMA, LTC and/or Specialty).
2. 10 points if the respondent has an SMMC Contract in other regions in the State.
3. 5 additional points will be awarded if the respondent has a comprehensive (MMA & LTC) SMMC Contract in the region that it plans to provide Medicaid services.
4. 5 additional points will be awarded if the plan has a Medicare Advantage Plan in the region that it plans to provide services.
5. 0 points will be awarded if the plan does not have an SMMC Contract in Florida or a Medicare Advantage Plan contract in the region.

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**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**SRC# 3 – Statutorily Required Florida Presence (Statewide):**

The respondent shall provide information regarding whether each operational function, as defined in Section 409.966(3)(c)3, Florida Statutes, will be based in the State of Florida, and the extent to which operational functions will be conducted by staff in-house or through contracted arrangements, located in the State of Florida. This includes:

- a. Specifying the location of where the respondent's corporate headquarters will be located (as defined by Section 409.966(3)(c)3, Florida Statutes);
- b. Indicating whether the respondent is a subsidiary of, or a joint venture with, any other entity whose principal office will not be located in the State of Florida; and
- c. Identifying the number of full-time staff, by operational function (as defined in Section 409.966(3)(c)3, Florida Statutes), that will be located in the State of Florida and out of state.

**Note:** Pursuant to Section 409.966(3)(c)6., Florida Statutes, response to this submission requirement will be considered for negotiations.

**Response:**

Floridians serving Floridians—and the investment of time and resources necessary to build and foster lasting relationships—is the model upon which our plan management is founded. Through a series of mergers, acquisitions, and/or name changes, Coventry Health Care of Florida, Inc. dba Aetna Better Health® of Florida has been doing business in the State since 1999. Over the years, our local plan leaders and colleagues have advocated for, empathized with, listened to, and supported enrollees every step of the way towards reaching their health and wellness goals.

There is no substitute for being present—across all of Florida—helping to solve problems with enrollees, providers, and local communities alike. We live, work, and are actively involved in the communities we serve—collaborating with stakeholders, providers, State agencies, and community organizations. The Agency and its Medicaid enrollees are directly supported by a comprehensive, cross-functional team of experienced professionals based in Florida, coupled with other staff across the Aetna Medicaid organization. All of our key staff and health plan personnel are employees of an Aetna affiliate.

**LOCATION OF CORPORATE HEADQUARTERS**

**CRITERION 1:** Whether the respondent's corporate headquarters will be located in Florida (it is not a subsidiary of or a joint venture with any other entity whose principal office will be located outside of Florida)

Coventry Health Care of Florida, Inc. dba Aetna Better Health of Florida (Aetna Better Health of Florida) is a Florida corporation. Our primary business location is 1340 Concord Terrace, Sunrise, Florida, 33323.

## **EXHIBIT A-4-a**

### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

#### **Status as Subsidiary or Joint Venture**

The direct parent of Aetna Better Health of Florida is Florida Health Plan Administrators, LLC, a wholly owned subsidiary of Aetna Health Holdings, LLC. In turn, Aetna Health Holdings, LLC is wholly owned by Aetna Inc., the ultimate parent of Aetna Better Health of Florida. Florida Health Plan Administrators, LLC's principal office is in Sunrise, Florida. The corporate headquarters of Aetna Health Holdings, LLC, and Aetna Inc. is Hartford, Connecticut.

#### **Extent to Which Operational Functions will be performed in Florida**

CRITERION 2: The extent to which operational functions (claims processing, enrollee/member services, provider relations, utilization and prior authorization, case management, disease management and quality functions, and finance and administration) will be performed in the State of Florida

The following operational functions are performed in the State of Florida:

- Enrollee (member) services
- Provider services/relations
- Utilization management/prior authorization
- Care (case) management/disease management
- Quality improvement/quality management
- Finance administration
- Health plan administration

The following functions will be provided outside of the State of Florida:

- Claims processing
- Overflow call center calls, with backup call center agents located in Texas and Louisiana who are fully trained and prepared to assist Florida call center staff in an emergency and/or disaster recovery situation

In addition, Aetna performs other operational functions in Florida, including network contracting, reporting and analytics, marketing and outreach, claims research and resolution, and appeals and grievances. Please refer to Attachment SRC 3, Table SRC 3-1: Staffing Expectations Based Upon Membership Projections which illustrates that approximately 889 full-time employees will support Aetna Better Health of Florida, 746 of which will be located in Florida.

#### **Evaluation Criteria:**

1. Whether the respondent's corporate headquarters will be located in Florida (it is not a subsidiary of or a joint venture with any other entity whose principal office will be located outside of Florida).
2. The extent to which operational functions (claims processing, enrollee/member services, provider relations, utilization and prior authorization, case management, disease management and quality functions, and finance and administration) will be performed in the State of Florida.

**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**Score:** This section is worth a maximum of 15 raw points. Each of the above components is worth a maximum of 5 points each as described below. 5 additional points will be awarded if respondent meets Items 1(a) and 2(a) below.

**For Item 1:**

- (a) 5 points for corporate headquarters in Florida and no parent or joint venture organization outside Florida;
- (b) 0 points if no relevant corporate headquarters in Florida.

**For Item 2:**

- (a) 5 points if all functions will be performed in Florida;
- (b) 4 points for 6-7 functions to be performed in Florida;
- (c) 3 points for 4-5 functions to be performed in Florida;
- (d) 2 points for 2-3 functions to be performed in Florida;
- (e) 1 point for 1 function to be performed in Florida;
- (f) 0 points for no functions to be performed in Florida;
- (g) 0 points if only community outreach, medical director and State administrative functions will be performed in Florida.

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COVENTRY HEALTH CARE OF FLORIDA, INC. DBA  
AETNA BETTER HEALTH® OF FLORIDA

## **Attachment SRC# 3**



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**SRC# 3: Table SRC 3-1: Staffing Expectations Based upon Membership Projections**

Operational Function	FTE Count		In-House or Contracted
Corporate Headquarters	In-State:	6	In-house
	Out-of-State:	0	
Enrollee Services	In-State:	168	In-house
	Out-of-State:	11	
Claims Processing	In-State:	0	In-house
	Out-of-State:	83	
Provider Services	In-State:	75	In-house
	Out-of-State:	0	
Utilization Management and Prior Authorization	In-State:	126	In-house
	Out-of-State:	18	
Care Management/Disease Management	In-State:	309	In-house
	Out-of-State:	0	
Quality functions	In-State:	32	In-house
	Out-of-State:	8	
Finance	In-State:	6	In-house
	Out-of-State:	4	
Administration	In-State:	24	In-house
	Out-of-State:	20	
	<b>TOTAL</b>	889	



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## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **SRC# 4 – Contract Performance (Statewide):**

The respondent shall state whether, in the past five (5) years (since July 14, 2012), it has voluntarily terminated all or part of a managed care contract under which it provided health care services as the insurer; has had such a contract partially or fully terminated before the contract end date (with or without cause); has withdrawn from a contracted service area; or has requested a reduction of enrollment levels. If so, describe the contract; the month and year of the contract action; the reason(s) for the termination, withdrawal, or enrollment level reduction; the parties involved; and provide the name, address and telephone number of the client/other party. If the Contract was terminated based on the respondent's performance, describe any corrective action taken to prevent any future occurrence of the problem leading to the termination. Include information for the respondent as well as the respondent's affiliates and subsidiaries and its parent organization and that organizations' affiliates and subsidiaries.

#### **Response:**

#### **CONTRACT PERFORMANCE**

CRITERION 1: The extent to which the respondent or parent or subsidiary or affiliates have requested enrollment level reductions or voluntarily terminated all or part of a contract

CRITERION 2: The extent to which the respondent or parent or subsidiary or affiliates has had contract(s) terminated due to performance

CRITERION 3: The extent to which the respondent or parent or subsidiary or affiliates had terminations for performance issues related to patient care rather than administrative concerns (e.g., reporting timeliness)

CRITERION 4: The extent to which the respondent or parent or subsidiary or affiliates had terminations for performance issues related to provider network management, claims processing or solvency concerns.

Consistent with Statewide Medicaid Managed Care Program Questions and Answers (Questions and Answers), Question Number 410 (Q410), we are limiting our response to SRC# 4 to contracts for Medicaid managed care services. Specifically, Q410 confirmed our understanding that SRC# 4 is limited to Medicaid managed care contracts. In addition, Q410 states, "[o]nly contracts for managed care services as specified in SRC# 1 need be provided." The scope of SRC# 1 is addressed in Q406, which also confirmed our understanding that SRC# 1 is limited to the Medicaid line of business and that respondents are not required to provide information for other lines of business, such as commercial or Medicare. If the Agency seeks additional information, we will supplement our response upon request.

In the past five years since July 14, 2012, respondent, Aetna Better Health® of Florida, and/or its affiliates and subsidiaries and its parent organizations and those organizations' affiliates and subsidiaries in the Medicaid line of business have NOT had:

- Contract(s) terminated due to performance
- Terminations for performance issues related to patient care rather than administrative concerns (e.g., reporting timeliness)

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Terminations for performance issues related to provider network management, claims processing, or solvency concerns

In addition, in the past five years since July 14, 2012, respondent, Coventry Health Care of Florida dba Aetna Better Health of Florida, and/or its affiliates and subsidiaries and its parent organizations and that organizations' affiliates and subsidiaries in the Medicaid line of business, have NOT withdrawn from a contracted service area or requested a reduction of enrollment levels.

Our affiliate, Coventry Health Care of Delaware, Inc., served Temporary Assistance for Needy Families (TANF) and aged, blind, and disabled (ABD) populations in the State of Maryland from September 2003 through December 2013. This contract was terminated after Aetna Inc. acquired Coventry Health Care, Inc. to avoid any conflict of interest that would result from Aetna operating the newly acquired plan (Coventry Health Care of Delaware, Inc.), while also continuing to provide administrative services to Maryland Physicians Care, Inc., a third-party plan administered by Aetna Medicaid Administrators LLC (Aetna Medicaid Administrators). The contract was with the Maryland Department of Health and Mental Hygiene HealthChoice (now known as the Maryland Department of Health), 201 West Preston Street, Room 127, Baltimore, Maryland, 21201. Susan Tucker, Executive Director, is the department contact and can be reached at (410) 767-1430.

Our affiliate, Aetna Better Health of Nevada Inc., served Affordable Care Act, Children's Health Insurance Program, and TANF populations from July 2017 through August 2017. 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. This decision followed numerous unsuccessful attempts to collaborate with the State to generate solutions to increase membership. 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. The contract was with the Nevada Department of Health and Human Services Division of Health Care Financing and Policy, 1100 East William Street, Carson City, Nevada, 89701. Tammy Ritter is a Department contact and can be reached at (775) 684-3655.

Our affiliate Aetna Better Health Inc. dba Aetna Better Health of New York has been contracted to serve dually eligible enrollees in the Fully Integrated Duals Advantage (FIDA) program since September 2014. The FIDA program has faced enrollment challenges since its inception because it is not mandatory and most eligible people who were initially automatically enrolled in the program chose to opt out. Currently, there are approximately 5,000 FIDA enrollees in the State, among 14 MCO plans. Some MCOs have already exited the FIDA program, and the number of MCOs participating in FIDA is subject to further reduction if plans continue to withdraw. Because our enrollment has 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 we will continue to serve enrollees under the contract until December 31, 2017. The contract is between Aetna Better Health of New York; United States Department of Health and Human Services Centers for Medicare & Medicaid Services, 7500 Security Boulevard, S3-13-23,

**EXHIBIT A-4-a**  
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Baltimore, Maryland 21244, (212) 616-2400; and the New York Department of Health, Corning Tower, Room 1415, Empire State Plaza, Albany, New York 12237, (800) 541-2831.

In addition, the following represent terminations of plan management services agreements (PMSAs) between Aetna affiliates and the health plans referenced in each description. In each of these instances, the unaffiliated health plans, and not Aetna Inc. or one of its subsidiaries, had direct contractual relationships with the State agencies. The management services provided typically included, but may not have been limited to, care and disease management, quality management, utilization management, enrollment processing, claims payment administration, program integrity monitoring, internal audit, information systems, finance, actuarial, procurement, insurance, risk management, and compliance oversight and monitoring, among other functions:

- Aetna Medicaid Administrators held a PMSA with CHOC for management services in connection with CHOC Health Alliance, a consortium between Children's Hospital of Orange County dba CHOC Children's Hospital and CHOC Physicians Network (CHOC) from June 1995 to June 2014. After unsuccessful rate negotiations, Aetna Medicaid Administrators provided notice of its intent to terminate the PMSA in accordance with the contract terms. CHOC's contract with the State remained intact, and there was no disruption to enrollees. [REDACTED]
- Aetna Medicaid Administrators held a PMSA with Integral Health Plan, Inc. dba Integral Quality Care (Integral) from March 2010 to June 2013. That agreement was terminated by Aetna Medicaid Administrators after Aetna Inc. acquired Coventry Health Care, Inc., to avoid any conflict of interest resulting from Aetna Inc. owning newly acquired Florida health plans while managing a competing plan (Integral) that was not owned by Aetna Inc. Integral's contract with the State remained intact, and there was no disruption to enrollees. [REDACTED]
- Aetna Life Insurance Company (ALIC) held a PMSA with CHRISTUS Health Plan from May 2011 to February 2015. After unsuccessful rate negotiations, ALIC provided notice of its intent to terminate the PMSA in accordance with the contract terms. CHRISTUS' contract with the State remained intact, and there was no disruption to enrollees. [REDACTED]
- Aetna Medicaid Administrators held a PMSA with Maryland Care, Inc. dba Maryland Physicians Care (Maryland Physicians Care) from September 1996 through June 2017. Maryland Physicians Care issued a bid for this business, and Aetna Medicaid Administrators was not selected. Maryland Physicians Care gave notice of its intent to terminate the PMSA, which would have automatically renewed otherwise. Maryland Physicians Care's contract with the State remained intact, and there was no disruption to

**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

enrollees. 

**Evaluation Criteria:**

1. The extent to which the respondent or parent or subsidiary or affiliates have requested enrollment level reductions or voluntarily terminated all or part of a contract.
2. The extent to which the respondent or parent or subsidiary or affiliates has had contract(s) terminated due to performance.
3. The extent to which the respondent or parent or subsidiary or affiliates had terminations for performance issues related to patient care rather than administrative concerns (e.g., reporting timeliness).
4. The extent to which the respondent or parent or subsidiary or affiliates had terminations for performance issues related to provider network management, claims processing or solvency concerns.

**Score:** This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each as described below.

**For Item 1:**

- (a) 5 points for no voluntary termination of all or part of a contract, no requests for enrollment level reduction and no service area withdrawals;
- (b) 0 points for any voluntary terminations, requests for enrollment level reductions, or service area withdrawals.

**For Item 2:**

- (a) 5 points for no involuntary terminations;
- (b) 0 points for any involuntary termination based on performance.

**For Item 3:**

- (a) 5 points for no contract terminations related to patient care;
- (b) 0 points if termination related to patient care.

**For Item 4:**

- (a) 5 points for no contract terminations related to provider network management, claims processing or solvency concerns;
- (b) 0 points if termination related to performance issues related to provider network management, claims processing or solvency concerns.

**EXHIBIT A-4-a  
GENERAL SUBMISSION REQUIREMENTS  
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**AND EVALUATION CRITERIA (10-2-17)**

**B. Agency Goals**

**SRC# 5 – Disease Management (DM) Program (Statewide):**

The respondent shall describe its proposed approach to implementation of specific disease management programs and how they will be used to advance the Agency's goals as stated in **Attachment A**, Instructions and Special Conditions, **Section A.**, Overview, **Sub-Section 15.**, Program Objectives and Goals, of this solicitation. The respondent's description shall include:

- a. A description of each proposed disease management program;
- b. A description of the algorithm used to identify and stratify eligible enrollees by severity and risk level;
- c. A description of the evidence-based guidelines utilized in the approach;
- d. A description of how disease management programs are integrated with case management/care coordination programs; and
- e. A description of performance metrics used to evaluate the efficacy of the disease management program, including cost-savings, increase in treatment adherence, and measurement of the impact on potentially preventable events, including relevant experience to provide support for the use of the specific performance metrics.

**Response:**

Aetna is deeply committed to changing our enrollees' lives for the better and to improving their quality of care while reducing health care costs. Our disease management programs focus on achieving optimal outcomes for enrollees living with the conditions identified in the Invitation to Negotiate (ITN)—asthma, cancer, diabetes, hypertension, mental health, and substance use disorder (SUD)—along with core conditions that include chronic obstructive pulmonary disorder, congestive heart failure, coronary artery disease, and depression. These programs are highly effective in the management of chronic disease among our enrollees, resulting in improved health outcomes and savings.

Multidisciplinary teams emphasize self-management to empower enrollees to assume greater responsibility for their health and, as a result, are healthier over the long term. Our integrated care management approach emphasizes a holistic assessment of the enrollee's physical, behavioral, and social issues. In our view, a comprehensive, holistic approach more fully captures the enrollee's real-life issues associated with managing complex comorbid conditions that require multiple medications and coordination of social support and other services. Care managers take care of the enrollee as a whole, as well as incorporate their social support networks and families into their care.

The foundation of our care management approach is based upon the enrollee's self-described needs and goals. We use an integrated module, the Patient Activation Measure (PAM), to evaluate the enrollee's readiness for change and level of activation. This ensures the plan of care is developed at the appropriate level with the enrollee's goals.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Our improved utilization rates are a reflection of this integrated approach. For a 24-month measurement period ending May 2016, Aetna achieved the following outcomes:

- Inpatient per member per month costs decreased spend by 15.97% despite an average increase in risk scores of 5.4%
- Cost per admission decreased by 7.08% across all lines of Medicaid business
- Bed days per thousand decreased by 13.83%
- Admission per thousand decreased by 21.52%
- Observation conversions of 1- to 2-day inpatient stays increased, resulting in an average savings of \$1,500 (or 40%) per observation stay

Aetna is committed to improving utilization outcomes to support the Agency's goal of reducing potentially preventable events.

### **APPROACH TO IMPLEMENTATION OF DISEASE MANAGEMENT PROGRAMS**

**CRITERION 3:** The extent to which the respondent's algorithm and risk stratification approach is well defined and describes the data sources that will be utilized

Enrollees with a disease diagnosis are identified monthly in a variety of ways, including claims data, special needs reports, health risk assessments, internal referrals, and other methods of surveillance (e.g., provider referral). Enrollees are stratified for interventions based on our predictive modeling Consolidated Outreach and Risk Evaluation™ (CORE) tool, and they are offered disease management assistance through our integrated care management program. Our program is provided as an adjunct to our enrollees' health plan benefit structure. Identification, risk stratification, interventions, and communications are not intended, and will not be used, to replace the individualized health care provided by the enrollee's primary care provider (PCP) or other health providers.

We know from experience that that many of our enrollees have more than one chronic condition and often require more than simple disease or chronic condition education. They require the holistic, person-centered care inherent to Aetna's unique approach to care and disease management. Aetna uses all available resources at our disposal and employs a multidisciplinary approach. This approach combines the knowledge and expertise of the enrollee and his or her care management team, circle of support, providers, and involved community organizations.

Aetna promotes collaboration, communication, and data sharing among providers by including them on an interdisciplinary care team for enrollees in intensive care management, our highest level of care management. The interdisciplinary care team is supported by our innovative and proprietary population health tool, CareUnify<sup>SM</sup>, which empowers providers and our care managers with instant access to a complete profile of their patients and greater visibility into the entire biopsychosocial complexity of each individual. CareUnify can be applied to support the care for every disease and condition described in this response. The system is designed to push and pull data to/from various systems and has the ability to align providers from different organizations using care paths to drive care coordination. For example, CareUnify has several care transition paths that can be tailored to each provider's workflow, while allowing all participants of the care team, regardless of their system, to be aligned on a workflow tied to each enrollee's episode of care, providing clearer handoffs and ensuring all aspects of an enrollee's care are met. An enrollee's interdisciplinary team also includes pharmacists who

## **EXHIBIT A-4-a**

### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

review enrollees with complex medication needs and or have opioid prescriptions that merit review.

CareUnify is designed for all participants to co-create a single, person-centered plan of care and service plan owned and controlled by the enrollee—true person-centered care. In fact, CareUnify enables enrollees to create a personalized video that reflects their values, beliefs, and preferences. This video can be shared across providers at the enrollee's discretion, thereby allowing all care providers to better understand and appreciate who the enrollee is and what the enrollee defines as important to his or her care. Care providers can also communicate through CareUnify in real time, exchanging information with one another and with the enrollee, which prevents duplication of services.

#### **Algorithm and Risk Stratification Approach**

Our approach is to identify the most complex enrollees, requiring urgent outreach and integrated care management support. We focus on individuals with patterns of high utilization as the highest-risk enrollees. CORE is a predictor of the likelihood of emergency department and/or inpatient utilization in the next 12 months. Proprietary and evidence-based, CORE is a stratification tool that uses time-tested analytic methods honed for more than 10 years. Scores are generated from internally developed algorithms based on Medicaid population data and our clinical and informatics expertise. Inputs to the algorithms include demographics, along with medical, behavioral, and pharmacy claims data. The model is run for our entire population monthly, and the results are reviewed by the appropriate clinical teams for enrollee contact and intervention opportunities.

CORE's analysis is based on three risk metrics:

- Predictive model general risk score: We consider enrollees who are in the top 1% of the population based on highest general risk score as high risk.
- Emergency department (ED) risk score: Enrollees with 80% or greater risk score we identify as high risk of an ED visit during the next 12 months.
- Inpatient admission risk score: Enrollees with 70% or greater risk score we identify as high risk of a physical or behavioral inpatient admit during the next 12 months. This risk score excludes maternity admits.

ED and inpatient risk scores are produced using logistical regression models to predict the probability of an occurrence within the next 12 months. Indicators include prior-year ED, inpatient, and specialist utilization; comorbidities; and pharmacy complexity. Specific behavioral health risk indicators include behavioral health admissions and readmissions, presence of serious emotional disturbance, polyprescriber and polypharmacy activity for behavioral health medications, and concurrent use of multiple medications from one behavioral health therapy class.

Through CareUnify, we share risk stratification information with our provider partners—traditional and non-traditional—to establish care priorities and care coordination activities. The information is well received by providers who often report challenges in identifying their highest risk patients and prioritizing the care they need.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Our assessments and plans of care follow evidence-based clinical practice guidelines embedded in our business application software, including algorithms to guide care managers through assessment, engagement, and education on management of each condition. We meet enrollees where they are, using the PAM to help determine an enrollee's readiness for change and activation level. The clinical practice guidelines promote consistent application of evidence-based treatment methodologies for enrollees, facilitating improvement of health care, reducing unnecessary variations in care, and preventing over- and under-utilization.

Enrollees are assigned according to complexity and complete individual assessments that include comprehensive condition-specific assessments targeting enrollees with complex, comorbid physical and behavioral health conditions. Enrollees are supported by an interdisciplinary care team that includes a pharmacist and medical director to review medications and treatments to ensure we are directing our care to the most important or pressing issues.

Our assessments, including PAM, are focused on understanding the enrollee's ability and readiness to engage in self-management of a chronic condition as well as understanding the individual's barriers to effective self-management. We use a tailored approach to educate enrollees about their chronic conditions, which correlates to their stage of activation and readiness to learn. For example, if an enrollee is not interested in smoking cessation, we will explore the barriers and perceptions of the enrollee and tailor our plan of care according to the enrollee's ability and readiness to quit. We advance the plan of care as the enrollee moves through the readiness to change and begins to change his or her behavior. We coordinate appointments, referrals, durable medical equipment (DME), and community and peer supports that further benefit enrollees. Each assessment is designed to identify and manage comorbid conditions, including screening for depression, substance use, and other mental health disorders as part of every standard chronic condition assessment.

We have learned through experience that many of our enrollees have economic and social barriers (e.g., employment, housing, food security, health literacy, access to transportation, and education level) to self-management and that they need more than simple disease or chronic condition education. During each phase of our initial screening, comprehensive assessment, and care planning interview conducted by our care managers, we seek to identify social determinants of health that must be addressed first to help our enrollees engage in improving their personal health and well-being. For example, if an enrollee has difficulty paying utility bills, we will connect the enrollee to the Florida 2-1-1 help line for a referral to an emergency home energy assistance program.

We assess an enrollee's comprehensive needs using the health risk questionnaire (HRQ), which helps us identify needs for immediate engagement. The HRQ includes social questions including an enrollee's English proficiency, association with a PCP, patient-centered medical home or health center, and housing stability. The condition-specific assessments identify disease-specific signs and symptoms and guide the care manager in developing an evidence-based plan of care. Our gaps in care report identify any HEDIS screenings that are due and allow the care manager to coordinate the appropriate referrals. Predictive modeling helps the care manager understand the risk for future emergency room and hospital admissions, with the objective of addressing the root causes of previous inpatient or ED use so they can be corrected, with the aim of further avoidable utilization.

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### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

We assess enrollees' needs in these areas and link them to community supports. Our Enrollee Services representatives and Care Management staff use our extensive database of local community services (which is updated continually to meet specific enrollee needs) to access and coordinate non-covered services such as housing and employment for any enrollee to supplement covered benefits. We make referrals to and/or coordinate with community-based resources, and follow up with enrollees to help ensure their needs were met.

#### **INTEGRATION WITH CARE MANAGEMENT AND CARE COORDINATION**

**CRITERION 4:** The adequacy of the respondent's description of how its disease management programs will be integrated into case management/care coordination programs

Care managers serve as the single point of contact for each enrollee. Care managers collaborate with the enrollee, his or her supports, and his or her interdisciplinary care team to create a plan of care that includes mutually agreed-upon enrollee-centered goals and actions for the enrollee. Goal development includes the following steps:

- The care manager arranges for both covered and non-covered services to be coordinated for the enrollee.
- The care manager collaborates with enrollees, their families, community supports, community-based case managers, providers, and practitioners to enhance care outcomes.
- Enrollees are encouraged to follow age-appropriate screening, health maintenance guidelines, and evidence-based care for chronic physical and behavioral conditions.
- Assessment and encounter are reviewed to identify comorbidities and to reducing unhealthy behaviors (e.g., tobacco use or substance use) in an enrollee-centered manner.
- Identifying the issues that affect all enrollees, including their physical and behavioral health concerns; caregiver concerns and circle of support needs; community health support needs; transportation challenges; access to care issues; and knowledge gaps that prevent enrollees from achieving their personal health care goals.

#### **Integrated Workflows Create Action Steps for an Enrollee's Providers**

CareUnify features industry-leading and proprietary features—care paths and the quality gaps closure system—that take information and convert it into meaningful and actionable steps for the entire care team, regardless of their affiliation or the four walls within which they sit. These features can be applied to any condition we support.

Care paths are specialized workflows designed to create simple, predefined steps shared by a team of providers around a common clinical event tied to best practices. While a care path can be created for any number of clinical events that require team coordination, a very common care path successfully used in CareUnify is related to managing a transition of care after an enrollee is discharged from a hospital stay. Here is how a care path works:

- The CareUnify system will trigger and send an admission, discharge, and transfer event notification within the system to the practice care coordinator at the provider office who is assigned in the system.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Once the clinical event occurs, the practice care coordinator assigned to the enrollee can create a custom or predefined care path from the library, which sets out the action steps needed to ensure a successful care transition.
- Key steps might include scheduling the PCP or specialist follow-up, medication reconciliation, in-home assessment, ordering DME, and scheduling transportation.
- The practice care coordinator can assign different individuals ownership for specific steps; assignments can be made to individuals on the care team whether inside or outside of the practice coordinator's organization.
- CareUnify tracks each care path action step and enrollee assignment and automatically sends notifications to the entire team when action steps are completed (or missed) based on the completion dates set.

The power of the care path function is to ensure accountability for providing quality care and to prevent duplication of services. More importantly, setting a care path, tied to key clinical events, helps keep the care team aligned in their efforts and minimizes confusion for the enrollee about who is coordinating specific components of care. It also promotes enrollee safety by ensuring key care actions like medication reconciliation do not fall through the cracks.

### **Care Management Program Engagement with Multiple Levels of Support**

Within 30 days of enrollment, Aetna makes welcome calls to new enrollees that include a brief health screening with questions about specific physical conditions, history of mental health treatment, smoking, ED utilization, and scheduled appointments with a PCP. With the enrollee's consent, we make a warm transfer for positive responses to our care management associate. The care management associate reviews the responses and schedules an appointment with a care manager for either a face-to-face or a telephonic visit. Aetna reports daily on enrollees identified for receiving care management through survey triggers to make sure we have appropriately scheduled all enrollees. If an enrollee does not disclose conditions in the survey, we have several ways to identify him or her for care management support. These ways include data from pharmacy and health services, referrals from providers, and other resources supporting the enrollee.

We have three levels of care management support, including intensive, supportive, and population health (self-managed). Enrollees stratified for the supportive level of care management may have short-term clinical needs such as clinical screening, services requiring referrals, and/or education about self-management for a chronic disease. Depending upon an enrollee's needs, we may use assessments for coexisting medical and behavioral health conditions, specific disease assessment for symptoms, education and treatment adherence, tobacco use/assistance with cessation, and nutrition assessment. We can also complete behavioral health screenings using tools such as the Kessler Psychological Distress Scale, Edinburgh Postnatal Depression Scale, UNCOPE for substance use, CRAFFT for children under 21, and the Pediatric Symptom Checklist-17.

### **Postpartum Depression Program**

In collaboration with Aetna, Beacon uses an SUD track that is funneled through an integrated model of care within Beacon's Care Management department. The referral process in place facilitates referrals from Aetna, PCPs, providers, and/or practitioners. The SUD track encompasses multiple components to address the needs of the enrollees—from identification of

## **EXHIBIT A-4-a**

### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

an existing substance use clinical issue or diagnosis, through the treatment phase of the interventions, to the abstinence and recovery period. Primary outreach includes five primary goals:

- Successful outreach to enrollees to engage them in treatment: If the enrollee is not engaged in behavioral health treatment (medication management, therapy, psychosocial rehabilitation), he or she is educated on services available under the Medicaid benefit plan. Beacon will assist in the coordination of available substance use services covered under the enrollee's benefit coverage that meet medical necessity and promote abstinence and sobriety/recovery. The enrollee will also be referred for targeted care management for monitoring of compliance and ongoing linkage to treatment by a psychiatrist, substance use professional, alcohol and substance use programs, and community resources.
- Education on the Healthy Behaviors program: This includes information on available resources, incentives for compliance with treatment (if applicable), and benefits of participation.
- Identification of assigned care coordinator or care manager as an added resource for the enrollee: The assigned care manager will complete a screening tool (CAGE, COWS, and DAST). In addition to the targeted care manager in the community, the designated care manager will be responsible for monitoring the enrollee's level of participation and progress.
- Designated staff that contributes to the care plan developed in collaboration with treating practitioners; this staff will also communicate progress to providers with appropriate consent.
- Integration of medical/substance use/mental health care in coordination with Aetna

We conduct regular telephonic follow-up based on an enrollee's needs, willingness to participate, and availability for calls. Additionally, appropriate condition-specific education and assistance is provided through chronic-condition Krames patient education materials. Because it is sometimes difficult to connect with enrollees by telephone, we collaborate with the primary provider and caregiver (with the enrollee's consent) for the conditions.

Enrollees who stratify for intensive care management support are identified as biopsychosocially complex and high risk. Enrollees receive many of the same support components as supportive care management with increased intensity in interventions. Enrollees complete a comprehensive assessment with a care manager, and additional chronic condition or behavioral health appropriate assessments based on the specific conditions and comorbidities identified. We outreach the enrollee per the intensive care management standards at least once a month and more often as enrollee's condition warrants. We offer face-to-face visits on a quarterly basis or when needed for changes in condition or social circumstances. For example, we may need to see the enrollee after a change in family support to ensure they have the support and services they need. We may also see an enrollee if he or she reports an increase in symptoms, and/or call us with concerns that cannot be addressed over the phone. We follow standard integrated care management processes to identify enrollee-centered goals and an agreed-upon plan of care.

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**GENERAL SUBMISSION REQUIREMENTS**  
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Integrated System of Care Model

We believe our enrollees are best served by an integrated system of care, which aligns with objectives outlined in the Agency's "Behavioral Health Services Revenue Maximization Plan" published December 2016. Aetna's integrated system of care is a coordinated model of health care and related services that work in concert for each enrollee and his or her circle of support. By building upon enrollees' strengths and removing barriers to care, each individual is afforded the opportunity to pursue those goals that are most important to him or her. An integrated system of care includes physical, behavioral, and oral health services, as well as services that address the social determinants of health and well-being. While each enrollee population with special needs benefits from this system of care, the mix of services may differ to reflect his or her specific needs best. A system of care for enrollees with special needs coordinates the mix of resources capable of serving them within a region.

Aetna understands that effective coordination and integration of services between primary care and specialty providers delivers the best results for the enrollee. We have proven processes that enable us to deliver integrated care services to our enrollees at the right time and in the right setting to optimize health outcomes. We focus on access to care for the enrollee, offering a broad provider network, and the ability for enrollees to see specialty providers without a referral from a PCP. To improve enrollee outcomes, we encourage coordination between the PCP and the specialty provider, and we incorporate the specialist into the interdisciplinary care team for an integrated care management approach. Our approach requires collaboration among each enrollee and his or her practitioners, providers, case managers, family members, and circle of support. The CareUnify population health management technology solution will enable providers to digitally share and aggregate actionable data across systems and organizations with the purpose of promoting effective and efficient care coordination.

\*\*\*\*\*[REDACTED]\*\*\*\*\*

[REDACTED]

[REDACTED]

[REDACTED]

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**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

[REDACTED]

[REDACTED]

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By achieving the objective of influencing the care delivery system to a system of care, an enrollee's health care outcomes and functioning are improved at home, at school, at work, in the community, and throughout life.

**PROPOSED DM PROGRAM: CANCER**

**CRITERION 1.a:** The extent to which the respondent proposes an innovative and evidence-based approach to disease management for the following conditions: (a) Cancer

According to the Florida Department of Health, cancer is the leading cause of death in Florida, surpassing heart disease in 2011. Approximately one-third of the most common cancers are due to lifestyles—tobacco, poor diet, obesity, and lack of physical activity—according to the National Cancer Institute. Region 3 has the highest age-adjusted cancer mortality according to State data. Our program is designed to help our enrollees understand and cope with a cancer diagnosis and the challenges of living with cancer. Care managers support enrollees with their coordination of care among specialty providers, pharmacists, and services, including non-emergent transportation or DME. We also take an active role in the authorization and fulfillment of an enrollee's medication as well as monitoring the enrollee's medication adherence. The side effects of medication on an enrollee, particularly related to chemotherapy, can result in ED visits and hospital admissions.

Aetna's care managers help ensure the goals of an enrollee's plan of care are aligned with his or her treatment plan from an oncologist or other specialty provider. CareUnify streamlines communication, collaboration, and data exchanges with real-time functionality to support an enrollee's change in health status or other needs. The real-time capabilities of CareUnify are especially critical for cancer patients, their providers, and our Care Management team.

Care managers work with the enrollee and his or her providers to coordinate hospice or palliative care, especially important for an enrollee with a life-threatening or terminal illness. Our care managers can support enrollees completing advance directives. Aetna will maintain written procedures for enrollee advance directives that address how Aetna will access copies of any advance directives executed by the enrollee. Aetna is in compliance with the language from the Standards for Managed Care Plan Enrollee Records section in Attachment B of the ITN.

Understanding the intense pressure cancer can cause to caregivers and family members, our care managers make referrals for respite care, peer support services, and additional support services. Additionally, our program is designed to elicit changes in enrollees' health-related behaviors, such as tobacco use, diet, and exercise, which positively affect their health and wellness. We aim to improve the enrollee's health status and self-management and reduce or delay complications and mortality associated with cancer. By prioritizing symptom management,

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

we endeavor to decrease the incidence of avoidable ED visits and inpatient admissions. We also monitor and educate providers to follow nationally recognized and evidence-based guidelines for evaluation and treatment of cancer and to collaborate with care management on the enrollee's plan of care.

Aetna's integrated care management model is designed to connect enrollees to all the services enrollees in a particular vulnerable population might need. For example, we link enrollees to the American Cancer Society, which provides enrollees with information on understanding their diagnosis; treatments and side effects; survivorship during and after treatment; children with cancer; end-of-life care; Reach To Recovery® breast cancer support; Look Good Feel Better; and the patient navigator program. We also refer enrollees to the Susan G. Komen breast care help line to speak with a specially trained oncology social worker or specialist.

Aetna collaborates with the Women's Breast & Heart Initiative, Florida Affiliate, Inc., of Miami Lakes to promote health education and screenings for the community. Andrea Ivory, executive director of the Women's Breast & Heart Initiative, provided a letter of support on Aetna's behalf for this ITN. Please refer to Attachment SRC 5 for a copy of this letter.

### **Evidence-Based Guidelines**

Aetna has adopted guidelines from the National Comprehensive Cancer Network as the foundation for cancer management, assessments, and interventions. Clinical practice guidelines assist clinicians and enrollees with appropriate decisions about health care and services.

### **ADVANCING THE AGENCY'S GOALS**

**CRITERION 2:** The adequacy of the respondent's description of how its respective disease management programs will be incorporated into its overall approach to advance the Agency's goals

Our cancer program is incorporated into our overall integrated care management approach to advance the Agency's goals in the following ways:

- Reducing potentially preventable events: Our goal is to support enrollees' management of their symptoms to help prevent hospital utilization. We want to help ensure an enrollee's side effects to chemotherapy or medication are being managed as an outpatient.
- Streamlining processes that enhance the enrollee and provider experience: Our authorizations are for the full course of an enrollee's treatment. We contract with a Florida-licensed oncology vendor staffed with cancer specialists and oncologists. They review chemotherapy regimens and make recommendations to our medical directors to ensure our enrollees are receiving the most clinically appropriate cancer care while aligning with the value-based environment. This process takes the authorization burden off our providers and enables communication between oncology specialists regarding the best treatment modalities for our enrollees.
- Delivering an efficient, high-quality, innovative, cost-effective, and integrated health care delivery model: We contract with eviCore for a pain management program. EviCore provides interventional pain management, which includes epidural injections, nerve blocks, implantable intrathecal drug delivery systems, spinal cord and nerve stimulation,

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

and thermal intradiscal procedures. Additionally, pain management is included in the full course of treatment authorization. We also go beyond the traditional medical model to support the enrollees' biopsychosocial needs with an interdisciplinary approach. We use a streamlined approach to coordinate psychosocial wraparound services for enrollees. For enrollees with a new diagnosis plan, we support them through health care system navigation and coordination of their care. We also facilitate peer support services through organizations like Gilda's Club South Florida. Gilda's Club offers support groups for enrollees with a cancer diagnosis, their family and friends, survivors who are post-treatment, and who have lost someone to cancer.

- Comprehensive, quality-driven provider networks: We have oncology specialists throughout our network and we are planning to expand for 2019 to meet the needs of enrollees in all 11 regions.

### **ALGORITHM**

**CRITERION 3:** The extent to which the respondent's algorithm and risk stratification approach is well defined and describes the data sources that will be utilized

Enrollees are identified monthly for inclusion in the cancer disease management program using our proprietary CORE predictive modeling tool. CORE factors the presence of International Statistical Classification of Diseases and Related Health Problems (ICD)-10 claims for cancer codes from varying dates of service and authorizations for chemotherapeutic treatment regimens completed by our vendor. Predictive modeling also stratifies the enrollee's disease management program risk level. Please refer to the subsection entitled Algorithm and Risk Stratification Approach for a detailed description of CORE. Through our CareUnify population health application, we share risk stratification information with our provider partners to establish care priorities and care coordination activities.

Program identification through organizational utilization includes potentially preventable ED visits and inpatient and observation stays, focusing on enrollees whose ED visit resulted in an inpatient admission. We also identify enrollees using multiple resources: enrollment files; special needs reports; welcome calls; self-referrals (e.g., health appraisal in MyActiveHealth enrollee portal) or family referrals; provider referrals; referrals from internal staff (e.g., Enrollee Services, Provider Services, Utilization Management, concurrent review clinicians); and data from pharmacy, therapeutic, professional, and ancillary services.

Using all of these data sources, as well as others that are unique to an individual, we pursue every opportunity to assess enrollees for care management. Enrollees identified for care management support complete the assessment and risk stratification process with a care management associate or care manager.

### **SYMPTOM MANAGEMENT**

**CRITERION 5.a:** The extent to which the respondent's disease management programs include the following components: (a) Symptom management

Aetna's assessment of an enrollee includes adequate symptom control, treatment adherence, tobacco use/assistance with cessation, and nutrition. Pain management is also a critical component. This is achieved, in part, by ensuring enrollees have access to services such as

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

massage therapy, acupuncture, the eviCore pain management program, and stress management. We also make referrals for medication-assisted treatment (MAT). We endorse MAT as an evidence-based practice and provide coverage for a variety of options for MAT for enrollees with opiate use disorders. Services can be rendered in the office by a trained PCP or psychiatrist or in a facility setting. Care managers make the enrollees aware they have an option to receive MAT treatment and can assist them in accessing an appointment with a MAT provider.

Additionally, we provide enrollee education through care manager interventions, Krames patient education materials, and information and digital coaching on the MyActiveHealth enrollee portal and digital application.

Educational information may include but is not limited to the following:

- Cancer self-care, treatment options, common complications, signs of complications, methods of self- management
- Nutrition guidance
- Importance of physical activity as recommended by enrollee's providers
- Medication management for enrollees
- Details on complications and risks
- Information on how to use the Informed Health Line (a 24-hour nurse line available seven days a week)
- Importance of working with the health practitioner in a partnership toward healthier behavior

### **MEDICATION SUPPORT**

CRITERION 5.b: The extent to which the respondent's disease management programs include the following components: (b) Medication support

Aetna supports enrollees' medication needs in multiple ways. Pharmacy programs include the following:

- Pharmacy Medication Management program (PMMP): The program is designed to engage enrollees and providers to promote the safe and efficacious use of medications. Through a review process, we aim to help simplify and optimize the medications being taken by an enrollee, as well as help ensure an enrollee is taking the correct medications and not having any related symptoms. The PMMP promotes a multidisciplinary approach to medication management as clinical pharmacists, registered nurses, licensed social workers, medical directors, and other members of an interdisciplinary health care team collaborate to support enrollees at risk of negative health outcomes. The PMMP utilizes risk stratification techniques, combining pharmacy and medical claims data with information pertaining to an enrollee's social and behavioral determinants of health, in an attempt to prevent or resolve medication utilization that is not consistent with nationally recognized, evidence-based clinical practice guidelines. Through this proactive approach, the PMMP seeks to divert unnecessary costly health care utilization to more appropriate preventative care and self-management techniques.

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### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Pharmacy Advisor® support: The program monitors enrollees' pharmacy activity and medication usage to help ensure they are receiving optimal treatment for their conditions. Aetna's pharmacy benefit manager, CVS Health, proactively communicates with providers when enrollees stop using prescribed therapies so providers can contact those enrollees, encouraging them to keep taking their medications and explaining why it is important to do so. Improved adherence with medication regimens can help slow disease progression and reduce medical costs. Through retrospective claims review, we will also use Pharmacy Advisor support to identify gaps in medication therapy, turning the prescription benefits plan into a powerful early-warning system for enrollee care. CVS Health will identify enrollees who may need additional medication or are taking an inappropriate or ineffective therapy. Within 72 hours of claims adjudication, CVS Health assesses drug profiles for potential issues or complications. CVS Health communicates in writing the identified opportunities, clinical recommendations, and associated clinical references to the provider.

#### **EMOTIONAL SUPPORT**

CRITERION 5.c: The extent to which the respondent's disease management programs include the following components: (c) Emotional support

Emotional support is vital to the health and well-being of both cancer patients and their caregivers. Enrollees take the lead in their own lives; our role is to support them. Care managers are trained to use motivational interviewing and person-centric language to help enrollees identify what is important to them. Motivational interviewing techniques such as reflective statements and summarizing can help reduce an individual's resistance, resolve patient ambivalence, and support individual autonomy. Through this discovery process, the enrollee and care manager discuss the enrollee's current behavior and stated goals in addition to any discrepancies between them. With the assistance of their care manager, enrollees develop a plan to address these discrepancies and meet their goals. We also help determine the enrollee's readiness for change using the PAM.

It is important for our care managers to know whether an enrollee has shared news of his or her condition with his or her family or circle of support and to know its impact on all parties concerned. Care managers partner with enrollees and their caregivers to identify their emotional needs and provide support through coordination of referrals to services such as the Cancer Support Community (the largest global nonprofit network of cancer support) or Gilda's Club South Florida for support groups as well as respite services. We follow up on referrals to determine whether a service is meeting an enrollee's needs or if an alternate option should be considered.

#### **BEHAVIOR CHANGE**

CRITERION 5.d: The extent to which the respondent's disease management programs include the following components: (d) Behavior change

Key issues with cancer patients are smoking, nutrition, self-care (adequate rest), and mental health. In most cancer programs a nutritionist works with the oncologist to complete a nutritional assessment to identify deficiencies in the patient's diet. Care managers use the assessment information to support the enrollee. For example, the enrollee might have to eat pureed food.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

The care manager helps ensure the enrollee is capable of preparing meals or has assistance, and has the proper equipment to prepare meals. The care managers monitor the enrollee's needs to make sure they are being met.

Additional supports include care manager interventions; service and program referrals and follow-up (e.g., smoking cessation program); patient education materials; and engagement tools on the MyActiveHealth enrollee portal.

### **COMMUNICATION WITH PROVIDERS, INCLUDING THE PCP/SPECIALISTS**

CRITERION 5.e: The extent to which the respondent's disease management programs include the following components: (e) Communication with providers, including the PCP/specialists

Cancer patients may be supported by multiple specialists, making the communication process and coordination of their care can be challenging. Care managers serve as the primary point of contact and advocate for an enrollee in supporting his or her interactions and communication with providers. We can help set up appointments, arrange for non-emergent transportation, coordinate services based on a referral from a provider, and support medication needs and authorization processes.

Care managers have a central role in management of an enrollee's interdisciplinary care team, connecting the enrollee with providers and health plan resources to help ensure the enrollee is maintaining adherence to his or her treatment and medication plans and achieving his or her personal goals. The enrollee's interdisciplinary care teams are composed of an enrollee's preferred professional support system, including his or her PCP, specialists (e.g., oncologist), and anyone they feel is important to their care. Working with our enrollee and the enrollee-selected interdisciplinary participants, we identify barriers and risks that prevent him or her from achieving goals and reaching an optimal level of independence and health.

When the care manager receives information from the interdisciplinary care team about a red flag, new need, or concern, the care manager immediately contacts the enrollee. The care manager assesses the enrollee either over the phone or in person depending on the severity of the concern, reviews the current status of the enrollee, speaks with all providers, reviews current services, and determines the need for additional services and/or referrals that may be necessary to enhance the plan of care. Any changes to the plan of care require an interdisciplinary care team review to discuss the new information and to develop a new plan based on the assessment findings as well as information from the interdisciplinary care team participants.

The interdisciplinary care team is supported by CareUnify, which empowers providers and our care managers with instant access to a complete profile of their patients—including cost, quality, and care coordination activity information—and greater visibility into the entire biopsychosocial complexity of each individual. CareUnify drives all aspects of care coordination with built-in flexibility to support downstream dissemination of information to the entire broader community team engaged with each individual enrollee.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **PERFORMANCE METRICS USED TO EVALUATE EFFICACY**

**CRITERION 6:** The extent to which the respondent has described a methodology for evaluating the impact of the disease management programs and provided results/data based on previous experience that supports the reduction of potentially preventable events

Aetna uses the following performance metrics to evaluate effectiveness:

- Measurement of the impact on potentially preventable events, including relevant experience to provide support for the use of the specific performance metrics: cancer patient ED visits, admission, and readmission rates; chemotherapy inpatient admissions; HEDIS breast cancer screening rates
- Increase in treatment adherence: clinical pathway compliance; documentation of cancer staging; timeliness of treatment (chemotherapy, radiation); symptom management for pain, depression, fatigue, weight loss; shared decision making; palliative care evaluation; enrollees who received therapy within the last 14 days of life; percentage of enrollees who died from cancer and were not admitted to hospice
- Overall costs per enrollee per month
- Enrollee satisfaction surveys

The Mercy Care Advantage (MCA) Dual Eligible Special Needs Plan administered by Aetna used a comprehensive enrollee outreach and communications strategy to achieve 27% improvement in the Colorectal Cancer Screening HEDIS measure. MCA's approach to improve outcomes for more than 18,000 dual-eligible enrollees included:

- Coordination of care via three-way calls among enrollee, provider, and MCA to schedule appointments
- Written reminders to enrollees of appointments that were scheduled during outreach calls
- Automated telephonic reminders to enrollees who may be due for services (e.g., screenings, well visits)
- Written education information and reminders to enrollees about preventive services
- Text messages to enrollees
- Inclusion of information related to preventive services in the enrollee newsletter
- Education to and coordination with providers regarding these services

MCA's successful approach and outcomes serves as a best practice that we can leverage to support our enrollees in Florida.

### **PROPOSED DM PROGRAM: DIABETES**

**CRITERION 1.b:** The extent to which the respondent proposes an innovative and evidence-based approach to disease management for the following conditions: (b) Diabetes

It is estimated that in Florida, over 2.4 million people have diabetes and over 5.8 million have prediabetes, according to the 2017 Florida Diabetes Report. In State fiscal year 2014 – 2015, the estimated cost of diabetes to Medicaid was \$142 million.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Aetna's disease management program for diabetes is designed to help educate enrollees on the risks of diabetes and support changes in enrollees' health-related behaviors that positively affect their health. The program seeks to increase the use of influenza and pneumococcal vaccinations by enrollees and promote improvement in HEDIS measures that relate to diabetes, including cholesterol low-density lipoprotein level, dilated retinal eye exam, HbA1c, urine protein, and blood pressure.

We work with enrollees to improve their health status and self-management and reduce or delay complications and mortality associated with diabetes. Our goal is to decrease the incidence of ED and inpatient visits related to diabetes, when either improved diabetic management could prevent such visits or visits could be provided in a more appropriate setting such as a physician's office.

CareUnify enables us to integrate an enrollee's care among providers and the interdisciplinary care team, using real-time functionality and notifications to enhance care coordination, communication, and data exchanges.

### **Evidence-Based Guidelines**

**CRITERION 1.b:** The extent to which the respondent proposes an innovative and evidence-based approach to disease management for the following conditions: (b) Diabetes

The American Diabetes Association Standards of Medical Care in Diabetes (2016 and 2017) are the clinical practice guidelines adopted as the foundation for diabetes management and used to develop assessments.

### **ADVANCING THE AGENCY'S GOALS**

**CRITERION 2:** The adequacy of the respondent's description of how its respective disease management programs will be incorporated into its overall approach to advance the Agency's goals

Our diabetes program is incorporated into our overall integrated care management approach to advance the Agency's goals in the following ways:

- Improve birth outcomes: Aetna contracts with Optum to provide clinical services to our high-risk obstetrics population. For enrollees newly diagnosed with non-insulin-dependent diabetes, we offer support from an obstetrics registered nurse to help maintain normal blood sugar levels during pregnancy, daily monitoring and clinical evaluation, customized meal planning, and compliance monitoring. For enrollees with insulin-dependent diabetes in pregnancy, we offer daily insulin injections or continuous insulin infusion, in-home assessment and education, nutritional education with assessment and meal planning, dosing and adjustment according to physician parameters, counseling and support by experienced diabetes educators, and comprehensive out-of-range reporting to their physician. For enrollees diagnosed with gestational hypertension or preeclampsia, we offer home-based comprehensive nursing surveillance with device management, an interactive device that guides enrollees in assessment activities, and daily reports on results, including any out-of-range or non-compliance.

## **EXHIBIT A-4-a**

### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Provide identified high-risk enrollees with high-risk pregnancies with our in-home remote monitoring technology package: We contract with national remote monitoring expert Care Innovations, a joint venture between GE and Intel. Enrollees in the program receive a remote monitoring bundle and kit iPad mini™, along with up to four peripheral devices, including a weight scale, pulse oximeter, blood pressure cuff, and glucometer. These devices are 4G-enabled with call center and delivery support both to and from the enrollee's home. The units are designed for simple setup, the iPads are personalized for enrollees (with their names on the landing page), and the devices include easy-to-follow instructions and videos on how to use them, how and when to contact providers and care managers, and how to seek emergency help. The tablets provide educational content on disease management and warning signs of worsening conditions, and they enable our care managers to videoconference using Facetime with enrollees to check in and provide assistance when needed. We use the tablet to send assessments that can be completed in real time, such as our new social determinants assessment to identify enrollee needs such as food insecurity or transportation problems or our mood assessment to monitor emerging or acute mental health issues. Care managers and the care team can then address these challenges as they occur. These plug-and-play devices are easy for enrollees to use with a wireless network. While enrollees do not need any technology or Web access, they do need standard cell tower reception. The enrollee simply attaches a device or stands on the scale and biometric readings will automatically transmit to a secure HIPAA compliant database monitored by the 24/7 Informed Health line. Based on the PCP or other provider's recommendations, devices are programmed to alert the enrollee if a reading is abnormal. Simultaneously, the Informed Health line can enact outreach for any high or abnormal readings so the enrollee can access care and help if needed. Care managers and the enrollee's PCP, care team, or other designated providers can access the device readings and alert notifications to identify an abnormal or critical reading that requires action.
- Reduce potentially preventable events: We support enrollees to self-manage their diabetes and maintain adherence to screenings to help prevent utilization of ED and hospital services.
- Comprehensive, quality-driven provider networks: We have endocrinologists and diabetic educators throughout our network and are planning to expand for 2019 to meet the needs of enrollees in all 11 regions. Enrollees also have access to home health agencies through our network for nurse support and education services.
- Streamline processes that enhance the enrollee and provider experience: Our streamlined process does not require PCPs to receive approvals for referrals to specialists. Diabetic supplies and equipment are authorized as long-term services, reducing the authorization burden on the provider offices.
- Expand benefits targeted to improve outcomes for enrollees: For our first phase of implementation, we will provide identified high-risk enrollees with diabetes our in-home remote monitoring technology package. We contract with national remote monitoring expert Care Innovations, a joint venture between GE and Intel. Enrollees in the program receive an iPad mini and two of four peripheral devices including a weight scale, pulse oximeter, blood pressure cuff, and glucometer. These devices are 4G-enabled with call center and delivery support both to and from the enrollee's home. The enrollee simply attaches the devices or stands on the scale and biometric readings will automatically transmit to a secure HIPAA-compliant database. Devices are programmed to trigger and alert the enrollee if his or her reading is abnormal. The same information is monitored by the Informed Health Line (i.e., Nurse line), from which an immediate follow-up outreach

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

call is made for any high or abnormal readings to ensure the enrollee can access care and help if needed. In addition, our care managers and the enrollee's PCP, care team, or other designated provider can access the device readings, along with alert notifications, to identify an abnormal or critical reading that requires action.

- Deliver an efficient, high-quality, innovative, cost-effective, and integrated health care delivery model: Care managers help take the burden off enrollees by coordinating DME and supplies. We can set up programs for home delivery. We also streamline the approval process for DME for individuals with diabetes. Additionally, we are interested in implementing educational and competency advancement activities for pediatricians and PCPs who work with children with diabetes. Lastly, we will promote the Project ECHO™ model in Florida, offering our telemedicine platform to allow providers to consult directly with each other. This model has been successful in addressing acute or newly diagnosed issues with enrollees in real-time providing access to expert consultation, medical therapy management, and guidance for the PCP/patient-centered medical home team. Our experience with this model shows that PCPs and their teams become increasingly more competent over time. They also become comfortable independently triaging and ultimately treating more complex physical and behavioral health conditions.

### **ALGORITHM**

**CRITERION 3:** The extent to which the respondent's algorithm and risk stratification approach is well defined and describes the data sources that will be utilized

Identification monthly through our CORE predictive modeling tool is based on the presence of diabetes ICD-10 codes claims from multiple dates of service and the use of insulin and/or oral antidiabetic medications. Predictive modeling also stratifies the enrollee's disease management program risk level. Please refer to the subsection entitled Algorithm and Risk Stratification Approach for a detailed description of CORE. In addition, the Algorithm subsection of our cancer program description details the variety of data sources and processes we use to identify enrollees for care management.

### **SYMPTOM MANAGEMENT**

**CRITERION 5.a:** The extent to which the respondent's disease management programs include the following components: (a) Symptom management

Enrollees identified for care management support may have clinical needs such as identified HEDIS gaps in care, access to DME (e.g., glucometer, blood sugar tracking tools), connection to community services, or diabetes education. We conduct telephonic outreach to the enrollee to perform a diabetes assessment for self-monitoring of blood glucose and glucometer availability, dilated retinal exam, appropriate foot care, medication adherence and appropriate lab testing (HbA1c, lipids, etc.), diet and exercise, and completion of SF-10 (children) or SF-12 functional health and well-being surveys.

Educational information through care manager interventions, Krames education materials, the MyActiveHealth enrollee portal, and biannual diabetes-focused newsletter includes the following:

## **EXHIBIT A-4-a**

### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Diabetes self-care, normal progression diabetes, common complications and risks, signs of complications, methods of self-condition management
- Nutrition guidance
- Importance of physical activity as recommended by enrollee's providers
- Appropriate laboratory testing for diabetes management (e.g., HbA1c, fasting glucose)
- Access to a glucometer and a blood glucose monitoring tracking tool, if needed
- Information on how to use the Informed Health line (24-hour nurse line)
- Web based tools such as the Health Appraisal and Self-Management Tools for Diabetes

#### **MEDICATION SUPPORT**

CRITERION 5.b: The extent to which the respondent's disease management programs include the following components: (b) Medication support

Our care managers work closely with enrollees to help them take their medication. We know that enrollees with diabetes often have complicated medication regimens and it may be hard to take all their medications. We also know that many enrollees with diabetes have associated anxiety issues and these issues can interfere with symptom and other diabetes medications. We work with the enrollees to understand any barriers to taking their medication. Additionally, care managers work with Aetna pharmacists to evaluate and help simplify an enrollee's medication schedule, as necessary. The pharmacist also makes sure an enrollee's psychiatric medications do not interfere with the diabetes medications.

#### **EMOTIONAL SUPPORT**

CRITERION 5.c: The extent to which the respondent's disease management programs include the following components: (c) Emotional support

Peer support can be essential for enrollees with diabetes. The MyActiveHealth enrollee portal features social communities that connect individuals with shared experiences. Additionally, our care managers collaborate with enrollees to provide referrals to community-based peer support groups that are aligned with the enrollee's values, beliefs, and culture.

#### **BEHAVIOR CHANGE**

CRITERION 5.d: The extent to which the respondent's disease management programs include the following components: (d) Behavior change

Diet and exercise are focus areas for enrollees with diabetes. Our care managers educate enrollees on the impact on their condition and collaborate with the enrollee to establish personal goals as needed. Care managers also make referrals to dietitians, nutritionists, and exercise resources.

MyActiveHealth features a Healthy Recipes section, as well as videos and audio files on diabetes. Additionally, the Care4life diabetes management program provides support through text messages and videos available on a smartphone available to eligible enrollees for no cost through the Medicaid Lifeline Access program. Care4life features ongoing notifications that provide education and other reminders to engage enrollees in self-care or the care of their

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

family members with an emphasis on wellness, prevention, and early intervention. Care4life has achieved 88% improved diabetes care (reached optimal insulin doses within 12 weeks).

### **COMMUNICATION WITH PROVIDERS, INCLUDING THE PCP/SPECIALISTS**

CRITERION 5.e: The extent to which the respondent's disease management programs include the following components: (e) Communication with providers, including the PCP/specialists  
Our care managers work closely with enrollees to support communication with their providers. For enrollees, we help to ensure their PCP and endocrinologist are in alignment with the treatment plan and that the providers address any identified gaps. The care manager also can coordinate communications between a provider and a dietitian or nutritionist on the enrollee's behalf, as needed.

CareUnify enables providers to digitally share and aggregate actionable data across systems and organizations with the purpose of promoting effective and efficient care coordination.

### **PERFORMANCE METRICS USED TO EVALUATE EFFICACY**

CRITERION 6: The extent to which the respondent has described a methodology for evaluating the impact of the disease management programs and provided results/data based on previous experience that supports the reduction of potentially preventable events

Our care managers, through use of the gaps-in-care report, helped our enrollees to exceed our internal goals for the NCQA, which is in alignment with the Agency's goal of achieving top quality scores. Aetna realized the following HEDIS rates in 2016: Medical Attention for Nephropathy, 94.81% (95th percentile); HbA1c Control (<8%), 53.77% (75th percentile); HbA1c Testing, 87.74% (50th percentile); and Dilated Retinal Eye Exam, 57.08% (50th percentile), respectively.

Aetna uses the following performance metrics to evaluate effectiveness:

- Measurement of the impact on potentially preventable events, including relevant experience to provide support for the use of the specific performance metrics: We analyze reductions in inpatient admissions and preventable ED utilization related to diabetes.
- Increase in treatment adherence: Aetna evaluates improvement in the following HEDIS measures to assess effectiveness of the program, including number of enrollees with dilated retinal exams; number of enrollees obtaining appropriate HbA1c testing; number of enrollees with urine microalbumin testing; and number of enrollees with blood pressure under control. In addition, we evaluate appropriate medication adherence related to diabetes and enrollees receiving influenza and pneumococcal vaccinations.
- Overall costs per enrollee per month

### **PROPOSED DM PROGRAM: ASTHMA**

CRITERION 1.c: The extent to which the respondent proposes an innovative and evidence-based approach to disease management for the following conditions: (c) Asthma

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Approximately 10% of Florida children have asthma, according to the Florida Department of Health. Asthma is more common and more severe among children, women, low-income urban residents, and African American and Hispanic communities.

Aetna's asthma disease management program helps our enrollees understand the risks of living with asthma and support changes in enrollees' health-related behaviors that positively influence their health and wellness, such as eliminating or decreasing tobacco use and increasing flu and pneumonia vaccines. The program seeks to promote improvement in HEDIS measures that relate to asthma, including medication management for asthma control and appropriate spirometry testing. We support enrollees to increase the use of medications correctly (i.e., frequency and dosing) with the aim of decreasing ED visits and hospital admissions. CareUnify integrates our comprehensive support for an enrollee, connecting providers, the Care Management team, and the enrollee to enhance care coordination, communication, and data exchanges. CareUnify's real-time functionality allows for immediate follow-up and care by the interdisciplinary care team if there is a change in the enrollee's health status.

### **Evidence-Based Guidelines**

**CRITERION 1.c:** The extent to which the respondent proposes an innovative and evidence-based approach to disease management for the following conditions: (c) Asthma  
The National Heart, Lung, and Blood Institute guidelines (2007, updated 2008) are the clinical practice guidelines adopted as the foundation to develop asthma-related assessments and interventions.

### **ADVANCING THE AGENCY'S GOALS**

**CRITERION 2:** The adequacy of the respondent's description of how its respective disease management programs will be incorporated into its overall approach to advance the Agency's goals

Our asthma program is incorporated into our overall integrated care management approach to advance the Agency's goals in the following ways:

- Reduce potentially preventable events: Asthma is an ambulatory-care sensitive condition for which effective outpatient treatment can potentially prevent the need for admission to the ED or hospital, or for which early intervention can prevent complications or more severe disease. Care managers assess enrollees to determine appropriate outpatient care is being delivered, the enrollee has a good understanding of his or her condition, and barriers to getting their health care needs are mitigated. Care managers look for root causes in enrollees' lives that result in lack of self-management (e.g., unstable housing). We address those root-cause issues. Care managers make face-to-face visit so they can observe an enrollee's environmental factors (e.g., parents smoking with a child with asthma).
- Improve birth outcomes: Children born prematurely often have underdeveloped respiratory systems. We provide services and support to give children an opportunity to develop their respiratory systems fully.
- Streamlined processes that enhance the enrollee and provider experience: Referrals to a specialist do not require prior authorization, streamlining the care coordination

**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

process. Our medication authorization process is not rigorous as well, providing enrollees easier and quicker access to the medications they need.

\*\*\*\*\*[REDACTED]\*\*\*\*\*

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

\*\*\*\*\*

**ALGORITHM**

3. The extent to which the respondent's algorithm and risk stratification approach is well defined and describes the data sources that will be utilized

Identification monthly through our CORE predictive modeling tool is based on the presence of several asthma ICD-10 codes claims from varying dates of service and the dispensing of multiple asthma maintenance or rescue medications, tobacco cessation therapies, and professional services such as spirometry and lung function testing. CORE helps stratify how urgently we need to connect with and engage enrollees. We also use information about an enrollee's disease status from the PCP to help determine an enrollee's risk level and develop a plan of care.

Please refer to the subsection entitled Algorithm and Risk Stratification Approach for a detailed description of CORE. In addition, the Algorithm subsection of our cancer program description details the variety of data sources and processes we use to identify enrollees for care management.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **SYMPTOM MANAGEMENT**

CRITERION 5.a: The extent to which the respondent's disease management programs include the following components: (a) Symptom management

Care managers work with enrollees to develop an asthma action plan, which assesses and addresses components, including allergens in the home environment, presence of smokers, and instructions on how to use spirometers and evaluate readings to share with providers. Given the high propensity of adolescents with asthma and depression, we also monitor enrollees in that age group for depression and complete screenings as necessary.

We support enrollees through care manager interventions, Krames education materials, and the MyActiveHealth enrollee portal (e.g., digital coaching, videos, audio files). Focus areas include the following:

- Asthma self-care, normal progression asthma, common complications and risks, signs of complications, methods of self-condition management
- Environmental triggers for asthma
- Nutrition guidance
- Importance of physical activity and asthma control as recommended by enrollee's providers
- Appropriate respiratory testing for asthma management (spirometry)
- Medication management for enrollees with asthma for asthma control
- Asthma action plan and use of peak flow meter

### **MEDICATION SUPPORT**

CRITERION 5.b: The extent to which the respondent's disease management programs include the following components: (b) Medication support

Enrollees are educated on the proper use and care of nebulizers, inhalers, and asthma spacers. We have instructional videos that demonstrate how to use an inhaler. Care managers work with an Aetna pharmacist to make sure enrollees are on right medication regimen. If enrollees are using short-acting inhalers for emergency use, we evaluate whether they are being used too often. Enrollees are referred to their PCP for evaluation as needed.

### **EMOTIONAL SUPPORT**

CRITERION 5.c: The extent to which the respondent's disease management programs include the following components: (c) Emotional support

Anxiety is a big risk for enrollees with asthma. By helping enrollees learn to focus on reducing anxiety, teaching them to relax when they start feeling anxious, and encouraging enrollees to practice their breathing equips enrollees to be prepared for an asthma attack with quick-relief processes.

We encourage enrollees to engage in peer support. The MyActiveHealth enrollee portal features social communities that connect individuals with shared experiences (e.g. enrollees with

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

asthma). Additionally, our care managers will work with enrollees to provide referrals to community-based organizations like the South Florida Asthma Consortium, a patient education resource for the medical community, family members, and individuals that live with asthma on a daily basis. South Florida Asthma Consortium maintains a calendar of asthma-related events for families managing asthma.

### **BEHAVIOR CHANGE**

CRITERION 5.d: The extent to which the respondent's disease management programs include the following components: (d) Behavior change

Smoking, nutrition, and environmental factors are focus areas for enrollees with asthma. We educate enrollees on environmental risks such as allergies, insect infestation, and dirty linens. Having enrollees understand the triggers to their condition is part of the plan of care development process. Care managers work with enrollees to establish goals and to address discrepancies in their lifestyle so they can achieve their goals and reduce risk factors. An enrollee's goals, in part, are based on his or her readiness to change. We use the PAM tool to evaluate an enrollee's readiness to change and level of activation.

### **COMMUNICATION WITH PROVIDERS, INCLUDING THE PCP/SPECIALISTS**

CRITERION 5.e: The extent to which the respondent's disease management programs include the following components: (e) Communication with providers, including the PCP/specialists

Care managers collaborate with enrollees to help ensure their needs are being met through coordination of care and communication with their PCP and specialty provider (e.g., pulmonologist, allergist). Care managers coordinate with enrollees' providers to make sure they are taking and refilling their medications and properly using their short-acting inhaler. Additionally, we make sure the enrollees' plan of care goals are aligned with their treatment plan. CareUnify connects an enrollee's providers for easy collaboration.

### **PERFORMANCE METRICS USED TO EVALUATE EFFICACY**

CRITERION 6: The extent to which the respondent has described a methodology for evaluating the impact of the disease management programs and provided results/data based on previous experience that supports the reduction of potentially preventable events

Aetna uses the following performance metrics to evaluate effectiveness:

- Measurement of the impact on potentially preventable events, including relevant experience to provide support for the use of the specific performance metrics: inpatient admissions, readmissions, and preventable ED utilization related to asthma
- Increase in treatment adherence: Aetna uses HEDIS measures to assess the percentage of enrolled enrollees with asthma who had appropriate testing/screening and condition control during the measurement period. Aetna evaluates changes in medication management for people with asthma to help assess effectiveness of the program. In addition, Aetna evaluates number of home assessments for enrollees in intensive care management; number of enrollees obtaining spirometry testing; utilization of peak flow meter; asthma emergency plan (stoplight plan); number of enrollees

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

receiving influenza and pneumococcal vaccination; number of enrollees with tobacco usage and asthma diagnosis; and medication appropriateness and control for enrollees with asthma.

- Overall costs per enrollee per month

In 2017, 64% of Aetna's Medicaid plans were at or above the NCQA 75th percentile for Medication Management for People with Asthma (MMA) HEDIS measures. Likewise, 70% of Aetna's Medicaid plans were at or above the NCQA 75th percentile for the Asthma Medication Ratio HEDIS measure. Both HEDIS rates increased from 2016: MMA by 36 percentage points and AMR by 34 percentage points, respectively. In Florida, we had overall excellent quality scores in 2017 but fell short of achieving our goals for the asthma program. We have adopted organizational best practices aimed at improving our enrollees' outcomes.

### **PROPOSED DM PROGRAM: HYPERTENSION**

CRITERION 1.d: The extent to which the respondent proposes an innovative and evidence-based approach to disease management for the following conditions: (d) Hypertension

Approximately one-third of American adults have high blood pressure, according to the Centers for Disease Control and Prevention. High blood pressure puts individuals at risk for heart disease and stroke, which are leading causes of death in the United States. We recognize Region 2 has the highest major cardiovascular disease age-adjusted mortality rate, based on State data.

Aetna's hypertension disease management program educates enrollees on the risks of living with hypertension and supports changes in enrollees' health-related behaviors that positively influence their health and wellness. The program seeks to promote improvement in HEDIS measures that relate to hypertension, including persistence of beta-blocker treatment after heart attack, statin therapy for patients with cardiovascular disease, and eliminating or decreasing the use of tobacco. Our goal is to decrease the incidence of ED and inpatient visits related to hypertension, when either improved health management could prevent such visits or visits could be provided in a more appropriate setting such as a physician's office.

We use technology to better support enrollees with hypertension, linking our enrollees to their interdisciplinary care teams with remote patient monitoring capabilities and CareUnify.

### **Evidence-Based Guidelines**

CRITERION 1.d: The extent to which the respondent proposes an innovative and evidence-based approach to disease management for the following conditions: (d) Hypertension

The American College of Cardiology Foundation/American Heart Association hypertension guidelines (2015) are the clinical practice guidelines used to develop assessments and interventions.

### **ADVANCING THE AGENCY'S GOALS**

CRITERION 2: The adequacy of the respondent's description of how its respective disease management programs will be incorporated into its overall approach to advance the Agency's goals

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Our hypertension program is incorporated into our overall integrated care management approach to advance the Agency's goals in the following ways:

- Streamlined processes that enhance the enrollee and provider experience: Digital and non-digital blood pressure cuffs are an over-the-counter benefit for enrollees. We encourage enrollees to have blood pressure monitors in their homes for daily checks; we will assist with ordering and educate enrollees on how to use the devices. Additionally, we plan to provide identified high-risk enrollees with hypertension with our in-home remote monitoring technology package. Enrollees in the program receive an iPad mini and two of four peripheral devices, including a weight scale, pulse oximeter, blood pressure cuff, and glucometer. The enrollee simply attaches the devices or stands on the scale and biometric readings will automatically transmit to a secure HIPAA-compliant database. Devices are programmed to trigger and alert the enrollee if his or her reading is abnormal. The same information is monitored by the Informed Health line (24-hour Nurse line), from which an immediate follow-up outreach call is made for any high or abnormal readings to ensure the enrollee can access care and help if needed.
- Improve birth outcomes: We contract with Optum to provide services for enrollees with gestational hypertension or preeclampsia, offering home-based comprehensive nursing surveillance with device management, an interactive device that guides enrollees in assessment activities, and daily reports on results, including any out-of-range or non-compliant.
- Reduce potentially preventable events: We support enrollees with hypertension to self-manage their condition to help prevent ED visits or hospital admissions. High-risk enrollees with diabetes, hypertension, congestive heart failure, and high-risk pregnancies will receive our in-home remote monitoring technology package. We contract with national remote monitoring expert Care Innovations, a joint venture between GE and Intel. Enrollees in the program receive a remote monitoring bundle and kit iPad mini™, along with up to four peripheral devices, including a weight scale, pulse oximeter, blood pressure cuff, and glucometer. These devices are 4G-enabled with call center and delivery support both to and from the enrollee's home. The units are designed for simple setup, the iPads are personalized for enrollees (with their names on the landing page), and the devices include easy-to-follow instructions and videos on how to use them, how and when to contact providers and care managers, and how to seek emergency help. The tablets provide educational content on disease management and warning signs of worsening conditions, and they enable our care managers to videoconference using Facetime with enrollees to check in and provide assistance when needed.

### **ALGORITHM**

**CRITERION 3:** The extent to which the respondent's algorithm and risk stratification approach is well defined and describes the data sources that will be utilized

Identification monthly through our CORE predictive modeling tool is based on the presence of hypertension ICD-10 codes claims from varying dates of service.

Please refer to the subsection Algorithm and Risk Stratification Approach for a detailed description of CORE. In addition, the Algorithm subsection of our cancer program description

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

details the variety of data sources and processes we use to identify enrollees for care management.

### **SYMPTOM MANAGEMENT**

**CRITERION 5.a:** The extent to which the respondent's disease management programs include the following components: (a) Symptom management

Supporting enrollees with hypertension can be a challenge because often they do not have discernible symptoms or feel negative physical effects from their condition. Care managers emphasize the importance of enrollees taking their medications even when they do not feel bad. We support enrollees' symptom management by providing education about the importance of daily blood pressure monitoring, about signs of common complications, about the impact of diet on symptoms, and about when to alert their PCP or specialist. We educate enrollees through telephonic and face-to-face care management interventions, Krames education materials, and the MyActiveHealth enrollee portal.

Additionally, we help identify barriers to improved health outcomes, such as how an enrollee living in a food desert—prevalent in the Pensacola area, for example—can affect his or her goal to adhere to a low-sodium diet.

### **MEDICATION SUPPORT**

**CRITERION 5.b:** The extent to which the respondent's disease management programs include the following components: (b) Medication support

Care managers support enrollees to help ensure they are maintaining medication adherence with diuretics, angiotensin-converting-enzyme inhibitors, and angiotensin II receptor blockers and to identify gaps in fulfillment or issues with prescribed medication. We work with the Pharmacy department to review enrollees' medication profile to make sure they have the correct dosage and schedule. We also help to identify if there are barriers to taking the medication.

### **EMOTIONAL SUPPORT**

**CRITERION 5.c:** The extent to which the respondent's disease management programs include the following components: (c) Emotional support

We complete screenings for anxiety and depression if a risk is identified. Enrollees are referred for behavioral health services as needed. Care managers are an ongoing resource and provide emotional support to our enrollees through regular telephone contact and face-to-face visits.

### **BEHAVIOR CHANGE**

**CRITERION 5.d:** The extent to which the respondent's disease management programs include the following components: (d) Behavior change

We support enrollee self-management in key health areas, including diet, exercise, weight management, smoking cessation, and sleep. Care managers work with enrollees to make sure they are educated on the impact of these areas on their health. For example, weight loss or

## **EXHIBIT A-4-a**

### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

exercise alone can lower blood pressure, which can be motivating for an individual. In addition, we promote a low-sodium diet featuring whole foods and a reduced amount of processed foods as well as providing education about the potential for higher sodium intake by eating at restaurants. Enrollees are encouraged to develop goals and identify discrepancies in their current lifestyle using motivational interviewing and assessing their readiness to change using the PAM tool.

#### **COMMUNICATION WITH PROVIDERS, INCLUDING THE PCP/SPECIALISTS**

CRITERION 5.e: The extent to which the respondent's disease management programs include the following components: (e) Communication with providers, including the PCP/specialists  
Our care managers work with enrollees to make sure their needs are being met through coordination of care and communication with their PCP and specialty provider, as applicable. We confirm the enrollee's treatment plan is aligned with his or her plan of care goals.

CareUnify enables us to communicate directly with the PCP in real time if we receive notification an enrollee's blood pressure is above the expected ranges. We can call the PCP or specialist and request follow-up care.

#### **PERFORMANCE METRICS USED TO EVALUATE EFFICACY**

CRITERION 6: The extent to which the respondent has described a methodology for evaluating the impact of the disease management programs and provided results/data based on previous experience that supports the reduction of potentially preventable events

Our care managers, through use of the gaps in care report, helped our enrollees to exceed our internal goals for NCQA. Aetna achieved the 75th percentile for Controlling High Blood Pressure (63.88%) for 2016 HEDIS measures.

Aetna uses the following performance metrics to evaluate effectiveness:

- Measurement of the impact on potentially preventable events, including relevant experience to provide support for the use of specific performance metrics: inpatient admissions and preventable ED utilization related to hypertension.
- Increase in treatment adherence: Aetna uses HEDIS measures to assess the percentage of enrollees with hypertension who had appropriate testing/screening and condition control during the measurement period. Aetna evaluates changes in the following HEDIS measure to assess effectiveness of the program: controlling high blood pressure; persistence of beta-blocker treatment after heart attack; statin therapy for patients with cardiovascular disease; number of enrollees with appropriate lab work; adherence of enrollees on appropriate hypertension medication; and number of enrollees receiving influenza and pneumococcal vaccinations.
- Overall costs per enrollee per month

#### **PROPOSED DM PROGRAM: MENTAL HEALTH**

CRITERION 1.e: The extent to which the respondent proposes an innovative and evidence-based approach to disease management for the following conditions: (e) Mental health

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Mental health conditions account for nearly 40% of initial hospital admissions that result in a readmission, according to data from the Agency's report, Analyzing Potentially Preventable Healthcare Events of Florida Medicaid Enrollees. Schizophrenia is the leading mental health condition, followed by bipolar disorders and major depression.

Aetna's mental health disease management program educates enrollees on the risks of living with mental health conditions and supports changes in health-related behaviors to improve health outcomes. We aim to improve enrollees' health status, their ability to self-manage their mental health, and reduce or delay morbidity and mortality associated with mental health. The program seeks to decrease the incidence of ED visits and inpatient admissions related to mental health and achieve improvement in HEDIS measures that relate to mental health issues, including medication management and follow-up after hospitalization for mental illness.

During inpatient admissions, we meet with enrollees admitted for mental illness and collaborate with treatment teams for discharge planning to address root causes. We encourage use of depot neuroleptics (long-acting antipsychotic medications), identify comorbid substance use needs, and connect enrollees with the full continuum of system of care services.

CareUnify will enhance integration, communication, and coordination among Aetna's Care Management team, Beacon Behavioral Services (our behavioral health services provider), and the interdisciplinary care team. CareUnify's real-time functionality can be especially critical for enrollees with a mental health diagnosis because of the potential for urgent changes in health status.

### **Evidence-Based Guidelines**

CRITERION 1.e: The extent to which the respondent proposes an innovative and evidence-based approach to disease management for the following conditions: (e) Mental Health

The clinical practice guidelines of the American Psychiatric Association are used to develop assessments and interventions.

### **ADVANCING THE AGENCY'S GOALS**

CRITERION 2: The adequacy of the respondent's description of how its respective disease management programs will be incorporated into its overall approach to advance the Agency's goals

Our mental health program is incorporated into our overall integrated care management approach to advance the Agency's goals in the following ways:

- Improve birth outcomes: We provide support to mothers to help them control their behavioral health conditions. We offer care management interventions and education, and we make referrals to peer support groups and specialists. Additionally, we use the Edinburgh Postnatal Depression Scale (EPDS) to assist in identifying possible symptoms of depression in the postnatal period. EPDS is a screening tool that aims to identify women who may benefit from follow-up care.
- Deliver an efficient, high-quality, innovative, cost-effective, and integrated health care delivery model: We can support coordination of care between an enrollee's PCP and

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behavioral health practitioner. For example, if an enrollee being treated for metabolic syndrome is prescribed an antipsychotic by a behavioral health practitioner, we can share that information with the enrollee's PCP to help ensure the enrollee's treatment plan is aligned with and supporting improved health outcomes. We can also support a measurement-based treatment approach for enrollees who are prescribed antidepressants by their PCP. We will educate PCPs on the use of a measurement tool like Patient Health Questionnaire-9 for depression severity to treat enrollees for full remissions of conditions rather than an initial response. This approach can help prevent avoidable ED utilization.

We also collaborate with Healthy Start Coalition of Miami-Dade (HSCMD) to participate in the Moving beyond Depression program, which provides in-home psychotherapy, and monitoring of depression in pregnant women. Aetna will pay for this service as a value-added benefit for our enrollees. The initiative addresses the need for psychotherapy services for pregnant women who might not reach out for services through their OB/GYN, or who may not attend appointments or follow-up visits because of their behavioral state or comorbidities. HSCMD uses the EPDS to prescreen expectant mothers for evidence of depression. HSCMD care managers also perform a comprehensive evaluation of the enrollee's family and living situation and check for associated maternal morbidity surrounding illness—due to or causing depression. HSCMD care managers notify Aetna care managers of any indicators of a depression so that a trained psychotherapist can intervene with therapy. The EPDS is repeated at each visit and the mother's progress is tracked to a healthy level and when it is safe to discontinue treatment. If at any time the results of the assessment reach a level, which would call for a psychiatric evaluation, we arrange for the assessment in order to keep mother and child safe.

\*\*\*\*\* [REDACTED] \*\*\*\*\*

[REDACTED]

[REDACTED]

[REDACTED]

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**ALGORITHM**

**CRITERION 3:** The extent to which the respondent's algorithm and risk stratification approach is well defined and describes the data sources that will be utilized

Identification monthly through predictive modeling is based on the presence of moderate-to-severe mental health-related ICD-10 codes on claims from various dates of service. These include, but are not limited to the following diagnoses: depression, bipolar disorder, schizophrenia, schizoaffective disorder, delusional disorder, and obsessive-compulsive disorder.

Please refer to the subsection Algorithm and Risk Stratification Approach for a detailed description of CORE. In addition, the Algorithm subsection of our cancer program description details the variety of data sources and processes we use to identify enrollees for care management.

**SYMPTOM MANAGEMENT**

**CRITERION 5.a:** The extent to which the respondent's disease management programs include the following components: (a) Symptom management

Our care managers are trained to support behavioral health disorders using evidence-based job aids for reference tools. Additionally, they can make referrals to behavioral specialists within Aetna for support.

We provide support for enrollees' symptom management through telephonic and face-to-face interventions, Krames education materials, and the MyActiveHealth enrollee portal and mobile applications (e.g., digital coaching, videos, and audio files). Educational information includes the following:

- Signs and symptoms, self-management, and collaboration with provider and behavioral health specialist
- Importance of enrollee supports
- Diet and nutrition
- Importance of physical activity and wellness activities
- Medication management and adherence
- Wellness recovery action plan
- Suicide risk signs
- Substance abuse treatment

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Additional educational information on comorbid conditions

### **MEDICATION SUPPORT**

CRITERION 5.b: The extent to which the respondent's disease management programs include the following components: (b) Medication support

Care managers work closely with enrollees to help ensure they are maintaining adherence to their medication needs and supporting any gaps in fulfillment or adherence. Please refer to the Cancer: Medication Support subsection for details about the Pharmacy Medication Management program and Pharmacy Advisor support program.

### **EMOTIONAL SUPPORT**

CRITERION 5.c: The extent to which the respondent's disease management programs include the following components: (c) Emotional support

We use peer support specialists as an important resource for enrollees' emotional support. Peer support specialists are persons in recovery from a behavioral health condition who have completed specific training that enables them to enhance a person's wellness and recovery. Peer support specialists support the voices and choices of our enrollees. They work in a variety of locations, such as peer support centers, crisis stabilization units, respite programs, psychosocial rehabilitation programs, and psychiatric hospitals. Peer support can be a one-on-one experience or a group of people sharing together.

Objectives of peer support specialists include the following:

- Engagement of enrollees in a person-centered, strengths-based dialogue focused on achieving long-term recovery
- Supporting enrollees with identifying and working toward recovery-centered goals
- Identifying whole-person solutions that meet enrollees where they are on their health journey
- Improving linkages to community supports and services
- Assisting the enrollee in navigating the service delivery system
- Connecting the enrollee to community-based care services

These objectives often lead to enrollees gaining self-efficacy in their recovery, which in turn will result in cost savings, enabling pathways, and increasing adherence to treatment plans since the enrollee's voice is represented.

Additionally, care managers collaborate with enrollees to provide referrals to community-based peer support groups.

### **BEHAVIOR CHANGE**

CRITERION 5.d: The extent to which the respondent's disease management programs include the following components: (d) Behavior change

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We support enrollees in their ability to be independent as well as manage their medications and prevent a relapse.

Care managers use motivational interviewing to help enrollees identify their goals. Using motivational interviewing to engage the enrollee in every contact, we approach the enrollee as having the skills to make changes versus seeing the enrollee as having deficits. We ask open-ended questions, make use of reflections, and find out what the enrollee's values and goals are—letting the enrollee tell his or her story. By eliciting talk of behavior change, we build possibility with the enrollee, assessing his or her readiness to change using Prochaska and DiClemente's stages of change model. We make use of reflections to gently point out and explore discrepancies in an enrollee's behaviors versus his or her stated values and goals (i.e., where internal motivation can build to self-efficacy), and provide targeted education. The enrollee drives action planning with guidance from the care manager, which often happens naturally during the change talk discussion.

### **COMMUNICATION WITH PROVIDERS, INCLUDING THE PCP/SPECIALISTS**

CRITERION 5.e: The extent to which the respondent's disease management programs include the following components: (e) Communication with providers, including the PCP/specialists

Care managers serve as the primary point-of-contact and advocate in supporting an enrollee's interactions and communication with his or her PCP and behavioral health providers. Care managers help make sure enrollees are maintaining adherence to their treatment and medication plans and are achieving their personal goals. They also make certain the enrollee's plan of care is in alignment with his or her treatment plan.

CareUnify drives all aspects of care coordination with built-in flexibility to support downstream dissemination of information to the broader community interdisciplinary team.

### **PERFORMANCE METRICS USED TO EVALUATE EFFICACY**

CRITERION 6: The extent to which the respondent has described a methodology for evaluating the impact of the disease management programs and provided results/data based on previous experience that supports the reduction of potentially preventable events

Aetna collaborates with Beacon Behavioral Services to integrate services for mental health into our care management approach. In 2016, quarterly utilization management data reported by Beacon reflects a downward trend in the number of inpatient mental health days/1,000, from 26.99/1000 (Quarter 1 of 2016) to 14.27/1,000 enrollees (Quarter 4 of 2016). In addition, 2016 utilization data reflects a reduction in average mental health length of stay, from 3.25 to 2.70 days. From Quarter 1 to Quarter 4 of 2016, the number of enrollees who accessed mental health and substance use services increased from 2,771 to 2,964.

Aetna uses the following performance metrics to evaluate effectiveness:

- Measurement of the impact on potentially preventable events, including relevant experience to provide support for the use of specific performance metrics: inpatient admissions and preventable ED utilization related to mental health

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- Increase in treatment adherence: Aetna uses HEDIS measures to assess the percentage of enrollees with a behavioral health diagnosis who had appropriate testing/screening and condition control during the measurement period. Aetna evaluates changes in the following HEDIS measure to assess effectiveness of the program: medication management; follow-up after hospitalization for mental illness; medication appropriateness and adherence for enrollees with mental health diagnosis; improvement on screening assessments; enrollees being followed by behavioral health provider; enrollees enrolled in substance abuse programs; adherence to evidence-based practice; and consistency of behavioral health clinical decision-making.
- Overall costs per enrollee per month

**PROPOSED DM PROGRAM: SUBSTANCE USE**

**CRITERION 1.f:** The extent to which the respondent proposes an innovative and evidence-based approach to disease management for the following conditions: (f) Substance abuse

The Agency's Behavioral Health Services Revenue Maximization Plan cites the following definition of SUDs from the Substance Abuse and Mental Health Services Administration: "The use, abuse, or dependence of alcohol and/or drugs that causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home." Aetna's program supports the broad scope of SUDs.

Florida Governor Rick Scott's official declaration of the opioid epidemic being a public health emergency prioritized treatment of this issue May 2017. Heroin, fentanyl, and oxycodone were directly responsible for the deaths of nearly 3,900 Floridians in 2015 making up 12% of the opioid overdoses in the United States, according to Florida Department of Law Enforcement statistics. The opioid epidemic is symptomatic of substance use challenges facing the State. Region 5 has the highest drug overdose mortality rate.

In response to the nationwide opioid epidemic, Aetna Inc. created an enterprise-wide opioid taskforce chaired by [REDACTED] Aetna's strategy includes data-driven goals that benefit our enrollees by encouraging effective pain management, reducing abuse, and supporting long-term addiction recovery. We aim to reduce inappropriate opioid prescribing by 50%; increase opioid use disorder treatment with MAT and other evidence-based treatments by 90%; and increase treatment of enrollees with chronic pain by evidence-based multi-modal approaches by 50% across all markets.

**Community Support Services Program**

As an example of a specialized clinical program for effectively treating addiction, Aetna's subcontractor Beacon has implemented a community support services (CSP) program in Massachusetts with enrollees who are admitted to acute treatment services for substance use. CSP providers from the recovery community work with enrollees to build social supports and to develop coping skills for psychosocial stressors that create barriers to aftercare and transition planning. The program's primary goal is to increase the overall engagement in aftercare of enrollees discharging from detoxification, thereby decreasing readmissions to acute levels of care. The project aims to connect enrollees to specialty CSP providers from the recovery community with the unique skills and training to meet population needs. The program focuses on creating an individualized service plan focused on the following key areas:

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Assisting with attendance of recommended mental health, substance use, and medical appointments
- Supporting adherence to the enrollee's treatment and service plan
- Building and supporting links with peer and natural supports
- Assisting with obtaining benefits, housing, and community services
- Providing education and assistance with skill building, recovery and rehabilitation
- Promoting wellness and recovery
- Developing crisis prevention plans

The evaluation results associated with CSP follow:

- Among enrollees who were discharged from a detoxification level of care, those who received CSP had 20.2% lower readmission in 30 days and 8.2% lower readmission in 90 days than those who did not
- Among enrollees who were continuously enrolled for the 44 days prior to and following the ATS discharge, those connected to CSP experienced 70.4% higher aftercare in 14 days and 69.7% higher two aftercare visits in 30 days than those who were not connected

### **Medication-Assisted Therapies Bundle Pilot**

In collaboration with community-based providers, Beacon is piloting an innovative program for bundled payment specific to opioid use disorder for enrollees in Massachusetts. Opioid treatment bundles are innovative in that they recognize opioid use disorder as a chronic disease, as opposed to an episodic one, and align payment mechanisms behind this fact. This bundle design includes high-touch, frequent psychotherapy and counseling services to help ensure enrollees remain engaged in treatment and their MAT program.

This program will have an initial six-month assessment period during which treatment services, inclusive of medication visits and therapeutic services, will be reimbursed through a bundled payment rather than through fee-for-service payment for enrollees. The purpose of the program is to reimburse the provider in a manner wherein services are provided based on enrollee need, thus reducing the administrative burden on the provider by simplifying clinical, financial, and other operational processes required by fee-for-service payment, while offering other supportive and oversight mechanisms to ensure efficacy and efficiency. Criteria for eligibility in the program will be assessed by the provider on initiation of treatment. If the enrollee is not eligible for the bundled program, MAT services will be paid on a fee-for-service basis.

An outpatient MAT case rate incorporates outcomes metrics and bonus payments to align financial incentives effectively with high quality treatment. Quality metrics will then be used to award pay-for-performance incentives based on successful care outcomes. Examples of successful outcomes include:

- Reduction in inpatient readmission rates
- Increase in MAT adherence
- Improvement in patient quality of life assessment

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Alcohol is a critical issue in parts of the state. Regions 2 and 10 have the most alcohol-impaired driving deaths, according to State data.

Aetna's substance use program is designed to help our enrollees understand the risks of substance use and support changes in enrollees' health-related behaviors that positively affect their health and wellness. The goal is to increase our enrollees' ability to self-manage their behaviors and reduce or delay morbidity and mortality associated with substance abuse. We enlist family or other support entities to aid in maintenance of wellness and condition management activities; engage the enrollee and enrollees' providers in following nationally recognized and evidence-based guidelines for evaluation and treatment; and assure appropriate use of community resources, substance use professionals, and psychiatrists.

### **Evidence-Based Guidelines**

**CRITERION 1.f:** The extent to which the respondent proposes an innovative and evidence-based approach to disease management for the following conditions: (f) Substance Use

Aetna adopted clinical practice guidelines from Substance Abuse and Mental Health Services Administration and the American Psychiatric Association Practice Guidelines for the Treatment of Patients with Substance Use Disorders (May 2006).

### **ADVANCING THE AGENCY'S GOALS**

**CRITERION 2:** The adequacy of the respondent's description of how its respective disease management programs will be incorporated into its overall approach to advance the Agency's goals

Our substance use program is incorporated into our overall integrated care management approach to advance the Agency's goals in the following ways:

- Reduce potentially preventable events: Aetna is working on adopting Screening, Brief Intervention, and Referral to Treatment (SBIRT) practices into our care model with providers. 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 an SUD. This approach can be used by primary care and other providers. SBIRT consists of three major components: screening quickly assesses the severity of substance use and identifies the appropriate level of treatment; brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change; and referral to treatment provides those identified as needing more extensive treatment with access to specialty care. Our Florida Medicaid plan can use the effective approach of our Illinois health plan as a model. In the Illinois plan's provider network, more than a dozen large federally qualified health centers, patient-centered medical homes, and community mental health centers are trained in SBIRT, as well as smaller, independent PCPs. In 2016, 15 Aetna staff members received train-the-trainer credentials for SBIRT. They can orient PCPs on the importance and benefits of screening enrollees on SBIRT.

## **EXHIBIT A-4-a**

### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Through monitoring of PCP billing, Aetna has seen a steady increase in the number of completed SBIRT screenings.

- Improve birth outcomes: We provide support to mothers to help them control their behavioral health conditions. We offer care management interventions and education, and we make referrals to peer support groups and specialists. Additionally, we use the EPDS to assist in identifying possible symptoms of depression in the postnatal period. EPDS is a screening tool that aims to identify women who may benefit from follow-up care.
- Deliver an efficient, high-quality, innovative, cost-effective, and integrated health care delivery model: We can support coordination of care between an enrollee's PCP and behavioral health practitioner. For example, if an enrollee being treated for metabolic syndrome is prescribed an antipsychotic by a behavioral health practitioner, we can share that information with the enrollee's PCP to help ensure the enrollee's treatment plan is aligned with and supporting improved health outcomes. We can also support a measurement-based treatment approach for enrollees who are prescribed antidepressants by their PCP. We will educate PCPs on the use of a measurement tool like Patient Health Questionnaire-9 for depression severity to treat enrollees for full remissions of conditions rather than an initial response. This approach can help prevent avoidable ED utilization..
- Improve birth outcomes: Our integrated care management goals for expectant mothers include optimizing the health of women during their pregnancies, and specifically outreaching and engaging pregnant women who have significant opiate use or opiate addiction in prenatal care management, providing support through our Neonatal Abstinence Syndrome (NAS) program. With the incidence of maternal opiate use and NAS increasing dramatically in the last decade, Aetna believes it is important to identify and engage expectant mothers with SUD as soon as possible in prenatal care, screen them for co-occurring behavioral health diagnoses, and provide and coordinate appropriate referrals to optimize care for these women and their babies. Our clinical care management team works with expectant mothers throughout their pregnancy to engage them in substance use treatment and help them stay in treatment for the duration of their pregnancy and the year after delivery. They are also screened for other mental health disorders and referred for behavioral health specialty care as needed. Since we know that social determinants of health are critical for these enrollees, we work in a holistic person-centered approach to identify all of their needs and connect them to corresponding community based resources and support systems. The same care manager follows the baby in the hospital and for the first year of life, whether or not the baby has NAS.

#### **ALGORITHM**

**CRITERION 3:** The extent to which the respondent's algorithm and risk stratification approach is well defined and describes the data sources that will be utilized

We identify enrollees for inclusion in the substance use disease management program through our CORE predictive modeling tool, as well as enrollment files; special needs reports; welcome calls; self-referrals (e.g., health appraisal in MyActiveHealth enrollee portal) or family referrals; provider referrals; referrals from internal staff (e.g., Enrollee Services, Provider Relations, Utilization Management, concurrent review clinicians); and data from pharmacy, therapeutic, professional, and ancillary services.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Please refer to the Algorithm and Risk Stratification Approach subsection for a detailed description of CORE.

### **SYMPTOM MANAGEMENT**

CRITERION 5.a: The extent to which the respondent's disease management programs include the following components: (a) Symptom management

Enrollees receive support for symptom management for their conditions from care manager interventions, Krames education materials, and self-management tools on the MyActiveHealth enrollee portal. Educational information may include but is not limited to the following:

- Referral to behavioral health specialist
- Peer support coordination
- Condition-specific self-care, normal progression of a chronic condition, common complications, signs of complications, methods of self-condition management
- Nutrition and diet
- Importance of physical activity as recommended by an enrollee's providers
- Appropriate laboratory or other testing for specific conditions
- The importance of working with the health practitioner in a partnership toward healthier behavior

### **MEDICATION SUPPORT**

CRITERION 5.b: The extent to which the respondent's disease management programs include the following components: (b) Medication support

We endorse MAT as an evidence-based practice and provide coverage for a variety of options for MAT for enrollees with opiate use disorders and alcohol use disorders. Services can be rendered in the office by a trained PCP or psychiatrist or in a facility setting. Our care managers make the enrollees aware they have an option to receive MAT treatment and can assist them in accessing an appointment with a MAT provider. In other cases where the SUD provider is providing the therapies and the PCP is prescribing the MAT medication, we assist with the communication and coordination between the two providers.

Additionally, care managers work with enrollees to help make certain they are maintaining medication adherence and self-management as well as addressing fulfillment issues. We will make referrals to our pharmacy clinicians and behavioral specialists for additional support.

### **EMOTIONAL SUPPORT**

CRITERION 5.c: The extent to which the respondent's disease management programs include the following components: (c) Emotional support

We make sure enrollees that assess for co-occurring mental health conditions and SUD are supported for all of their conditions. We work with enrollees to build sober supports. Typically, this is done with 12-step and other support groups, securing a sponsor, treatment groups including dual-diagnosis issues, sober living arrangements, etc. We assist our enrollees in

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

identifying support group meetings to attend and follow up for their response. Because enrollees with SUDs may require ongoing emotional support, we also make referrals to behavioral health practitioners for therapy services as appropriate.

The MyActiveHealth enrollee portal features social communities that connect individuals with shared experiences.

### **BEHAVIOR CHANGE**

CRITERION 5.d: The extent to which the respondent's disease management programs include the following components: (d) Behavior change

Care managers frame their discussions with enrollees using motivational interviewing to help enrollees discover and develop internal motivations to establish goals and identify discrepancies in their current lifestyle. In some cases, we support a hard reduction in substance use as opposed to total abstinence as an agreed-upon initial, realistic goal for enrollees.

### **COMMUNICATION WITH PROVIDERS, INCLUDING THE PCP/SPECIALISTS**

CRITERION 5.e: The extent to which the respondent's disease management programs include the following components: (e) Communication with providers, including the PCP/specialists

Care managers work with enrollees to make sure their needs are being met through coordination of care and communication with their behavioral health provider and PCP. We confirm that an enrollee's plan-of-care goals align with his or her treatment plan. CareUnify is the integrated hub for communication, coordination, and data among the interdisciplinary care team. CareUnify's real-time functionality enables the interdisciplinary care team to address an enrollee's urgent needs.

### **PERFORMANCE METRICS USED TO EVALUATE EFFICACY**

CRITERION 6: The extent to which the respondent has described a methodology for evaluating the impact of the disease management programs and provided results/data based on previous experience that supports the reduction of potentially preventable events

Aetna works with Beacon to integrate services for SUD into our care management approach. In 2016, Beacon reported a decrease in outpatient visits per 1,000 from 15.89 in Quarter 1 to 12.70 in Quarter 4.

Aetna uses the following performance metrics to evaluate effectiveness:

- Measurement of the impact on potentially preventable events, including relevant experience to provide support for the use of the specific performance metrics: reductions in inpatient admissions and preventable ED utilization
- Treatment compliance rates: Enrollees in the program will be engaged in treatment with community practitioners and providers, Alcoholics Anonymous/Narcotics Anonymous (AA/NA), online and face-to-face support groups, and other resources that will assist the enrollee in attaining sobriety and working their recovery. We will evaluate enrollee willingness to access and utilize community resources for support and continued

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

abstinence from using substances (i.e., negative urine toxicology screens, continued compliance with treatment recommendations, participation in AA/NA programs, etc.).

- Overall costs per enrollee per month

Depending upon the substance used, we will also administer a screening tool to all enrollees identified as appropriate for inclusion in the program. This screening will yield a baseline score at the point of referral and an outcome score at the conclusion of the interventions. When coupled with the enrollee's compliance with treatment and active participation in treatment, these scores will yield an outcomes measure related to the success of the interventions.

In collaboration with Aetna, Beacon uses an SUD track that is funneled through an integrated model of care within Beacon's Care Management department. The referral process facilitates referrals from Aetna, PCPs, providers, and/or practitioners. The substance use track encompasses multiple components to address the needs of enrollees—from identification of an existing substance use clinical issue or diagnosis, through the treatment phase of the interventions, to the abstinence and recovery period. Primary outreach includes five primary goals:

- Successful outreach to enrollees to engage them in treatment: If the enrollee is not engaged in behavioral health treatment (medication management, therapy, and psychosocial rehabilitation), he or she is educated on services available under the Medicaid benefit plan. Beacon will assist in the coordination of available substance use services covered under the enrollee's benefit coverage that meet medical necessity and promote abstinence and sobriety/recovery. The enrollee will also be referred for targeted care management for monitoring of compliance and ongoing linkage to treatment by a psychiatrist, substance use professional, alcohol and substance use programs, and community resources.
- Education on the Healthy Behaviors program: This includes information on available resources, incentives for compliance with treatment (if applicable), and benefits of participation
- Identification of assigned care coordinator or care manager as an added resource for the enrollee: The assigned care manager will complete a screening tool (CAGE, COWS, and DAST). In addition to the targeted care manager in the community, the designated care manager will be responsible for monitoring the enrollee's level of participation and progress.
- Designated staff that contributes to the care plan developed in collaboration with treating practitioners: This staff will also communicate progress to providers with appropriate consent.
- Integration of medical/substance use/mental health care in coordination with Aetna.

A built-in functionality of the substance use program is securing the enrollee's commitment to participate. Upon determining that an enrollee meets the parameters for inclusion in the program, he or she will receive an enrollment packet that includes (but is not limited to):

- Local and community resources that provide support and education regarding addictions, recovery communities, and locations and meeting times for AA/NA within the enrollee's access area
- Consents for the release of information to facilitate effective coordination of care while safeguarding the enrollee's right to privacy

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- A copy of the enrollee's rights and responsibility as they relate to health care and treatment
- An enrollee attestation that they are willingly participating in the program
- A designated Beacon care manager assigned to the enrollee; this designated staff member will be responsible for completing care management assessment to identify the enrollee's readiness and level of functionality necessary to facilitate the development of the care plan. The enrollee will have direct access to this staff member to assist with appointments, coordination efforts, communication with treating practitioners, and more.

Successful participation in these programs will result in incentives for Medicaid enrollees; Aetna will determine what those incentives will be on a yearly basis. Beacon's Care Management department tracks and assigns Healthy Behaviors referrals monthly and reports to Aetna quarterly.

### **Evaluation Criteria:**

1. The extent to which the respondent proposes an innovative and evidence-based approach to disease management for the following conditions:
  - (a) Cancer (Section 409.966, Florida Statutes);
  - (b) Diabetes (Section 409.966, Florida Statutes);
  - (c) Asthma;
  - (d) Hypertension;
  - (e) Mental health; and
  - (f) Substance abuse.
2. The adequacy of the respondent's description of how its respective disease management programs will be incorporated into its overall approach to advance the Agency's goals.
3. The extent to which the respondent's algorithm and risk stratification approach is well defined and describes the data sources that will be utilized.
4. The adequacy of the respondent's description of how its disease management programs will be integrated into case management/care coordination programs.
5. The extent to which the respondent's disease management programs include the following components:
  - (a) Symptom management;
  - (b) Medication support;
  - (c) Emotional support;
  - (d) Behavior change; and
  - (e) Communication with providers, including the PCP/specialists.
6. The extent to which the respondent has described a methodology for evaluating the impact of the disease management programs and provided results/data based on previous experience that supports the reduction of potentially preventable events.

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**Score:** This section is worth a maximum of 75 raw points with each component being worth a maximum of 5 points each.

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**SRC# 6 – HEDIS Measures (Statewide):**

The respondent shall describe its experience in achieving quality standards with populations similar to the target population described in this solicitation. The respondent shall include, in table format, the target population (TANF, ABD, dual eligible), the respondent's results for the HEDIS measures specified below for each of the last two (2) years (CY 2015/ HEDIS 2016 and CY 2016/ HEDIS 2017) for the respondent's three (3) largest Medicaid Contracts (measured by number of enrollees). If the respondent does not have HEDIS results for at least three (3) Medicaid Contracts, the respondent shall provide commercial HEDIS measures for the respondent's largest Contracts. If the Respondent has Florida Medicaid HEDIS results, it shall include the Florida Medicaid experience as one (1) of three (3) states for the last two (2) years.

The respondent shall provide the data requested in **Exhibit A-4-a-1**, General Performance Measurement Tool to provide results for the following HEDIS measures:

- Adults' Access to Preventive/Ambulatory Health Services (Total);
- Child and Adolescent Access to PCPs (all 4 age bands reported as separate rates);
- Medication Management for People with Asthma (75% - Total);
- Controlling High Blood Pressure;
- Comprehensive Diabetes Care – HbA1c Control (<8%);
- Follow-up after Hospitalization for Mental Illness (7 day);
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation – Total);
- Antidepressant Medication Management – Acute Phase; and
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia

**Response:**

Aetna's ability to measure and evaluate how well we are performing against the State's objective is reinforced by mature processes and supported by the concept of continuous process improvement. With continuous quality improvement at the forefront of our efforts, Aetna remains committed to fulfilling the aim of improved health outcomes for all of our enrollees.

Our proven results are evidenced in our consistently high National Committee for Quality Assurance (NCQA) status ratings, as well as across our quality, medical management, and health equity programs. In 2017, Aetna Better Health of Florida (Aetna) received commendable status on its NCQA accreditation based on scores earned on standards, clinical measures, and enrollee satisfaction. Furthermore, we recently received the highest NCQA rating among all Florida Medicaid plans for the second consecutive year, as demonstrated in Attachment SRC 6 in Table SRC 6-1: NCQA Medicaid Health Plan Rating Compared to Health Plans in Florida.

Additionally, we are among the top 15 Medicaid plans in the country as shown in Attachment SRC 6 in Table SRC 6-2: NCQA Medicaid Health Plan Rating Compared to Health Plans in All States.

Our experience implementing, managing, and caring for Medicaid enrollees results in improved access to care, higher quality of care in appropriate settings, and a seamless consumer experience in a culturally competent manner.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **EXPERIENCE ACHIEVING QUALITY STANDARDS**

**CRITERION 1:** The extent of experience (e.g., number of Contracts, enrollees or years) in achieving quality standards with similar target populations, for the HEDIS performance measures included in this submission requirement

With more than 160 years of experience operating in all 50 states, the Aetna organization is among the nation's leading diversified health care benefits companies, serving an estimated 46.7 million individuals with information and resources necessary to help them make better-informed decisions about their health care. In 2007, Aetna Inc. acquired Schaller Anderson, Incorporated (Schaller Anderson), an experienced company in the Medicaid space, founded in 1986. As a leader in Medicaid managed care, Schaller Anderson participated in the nation's first fully capitated statewide managed care programs, the Arizona Health Care Cost Containment System, through its management of health plans serving that program. Schaller Anderson was at the forefront of innovation in Medicaid managed care as states across the nation emulated Arizona's success.

Through a series of name changes, Schaller Anderson's subsidiary, Schaller Anderson of Arizona, L.L.C., became what is currently known as Aetna Medicaid Administrators LLC, which now manages health plans in 14 states, including Arizona, Florida, Illinois, Kentucky, Louisiana, Michigan, New York, New Jersey, Ohio, Pennsylvania, Texas, Virginia, West Virginia, and Maryland. In addition, Aetna will begin operations in California in the coming months. Through these contracts, Aetna serves 3 million Temporary Assistance for Needy Families (TANF); Children's Health Insurance Program (CHIP); aged, blind, and disabled (ABD); dually eligible; and long-term services and supports enrollees. These Medicaid enrollees include high-needs children, pregnant women and families, individuals with disabilities, seniors eligible for Medicare and Medicaid, community-based services, and individuals living in long-term care facilities. We are extremely proud of our time-tested leadership and legacy managing the care of the Medicaid managed care population.

Aetna Life Insurance Company has been licensed to conduct business in Florida since 1892. Aetna currently serves more than 100,000 Medicaid enrollees statewide. We have served Florida TANF and ABD Medicaid populations since September 2002, with more than 56,000 current enrollees in Region 11. Aetna launched its current contract in Florida's Region 11 in January of 2014. As an experienced NCQA-accredited Medicaid contractor, Aetna has developed expertise in each measure included in this SRC in Florida, as well as in other Medicaid plans across the country. This expertise enables us to implement interventions that are proven successful in improving measures locally. Additionally, we leverage our national experience to deploy interventions that have proven successful in other states.

As a nationally accredited managed care plan, our goals align with the Agency's to offer comprehensive, quality-driven provider networks, streamlined processes that enhance the enrollee and provider experience, expanded benefits aimed at improving outcomes for enrollees, stellar quality scores, and high rates of enrollee satisfaction to deliver an efficient, high-quality, innovative, cost-effective, and integrated health care delivery model. We take our responsibility as a steward of public programs seriously.

### **EXPERIENCE IN FLORIDA AND OTHER STATES**

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Aetna has a robust quality improvement program across the country. States that have achieved the NCQA 50th percentile rate or higher on the Healthcare Effectiveness Data and Information Set (HEDIS) performance measures included in the SRC are listed as follows:

**Adults' Access to Preventive/Ambulatory Health Services (Total)**

Met one year: TX, WV

Met two years (or both years): IL, MD, VA

**Children and Adolescents' Access to Primary Care Practitioners (12 – 24 months)**

Met one year: None

Met two years (or both years): KY, MD, TX, VA, WV

**Children and Adolescents' Access to Primary Care Practitioners (25 months – 6 years)**

Met one year: AZ

Met two years (or both years): FL, KY, MD, TX, WV, VA

**Children and Adolescents' Access to Primary Care Practitioners (7 – 11 years)**

Met one year: None

Met two years (or both years): AZ, KY, MD, TX, VA, WV

**Children and Adolescents' Access to Primary Care Practitioners (12 – 19 years)**

Met one year: IL

Met two years (or both years): AZ, KY, MD, TX, VA, WV

**Medication Management for People with Asthma (75% – Total)**

Met one year: FL, IL, LA, VA, WV

Met two years (or both years): AZ, KY, MD, MI, MO, PA

**Controlling High Blood Pressure**

Met one year: KY, WV

Met two years (or both years): FL, MD, PA, VA

**Comprehensive Diabetes Care – HbA1c Control (<8%)**

Met one year: PA, VA

Met two years (or both years): FL, AZ, KY, MD

**Follow-Up after Hospitalization for Mental Illness (7 day)**

Met one year: FL

Met two years (or both years): None

**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation Total)**

Met one year: KY, MO, LA, VA, TX

Met two years (or both years): IL, WV

**Antidepressant Medication Management – Acute Phase**

Met one year: FL, IL, NJ, MI

Met two years (or both years): AZ, KY, LA, MO, PA, TX

**Adherence to Antipsychotic Medications for Individuals with Schizophrenia**

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Met one year: IL, WV

Met two years (or both years): VA

### **QUALITY IMPROVEMENT EFFORTS**

With 30 years of experience in Medicaid in different types of markets serving diverse populations, Aetna's Medicaid organization consistently meets and exceeds contract quality standards. We have been reporting on HEDIS measures for TANF, CHIP, and ABD enrollees in Florida for 23 years. Aetna currently is the highest NCQA-ranked Medicaid managed care company serving Florida Medicaid.

Most recently for calendar year 2016/HEDIS 2017, our quality efforts by our Florida plan exceeded the 50th percentile for the following measures included in this SRC:

- 8% point increase from the prior year with Diabetic HbA1c (<8%) measure, achieving the 75th percentile
- Twenty percentage point increase with the Follow-up After Hospitalization for Mental Health Illness – Seven Days measure, achieving the 50th percentile
- Four percentage point increase with the Controlling High Blood Pressure measure, achieving the 75th percentile

Aetna is continually looking for innovative solutions to improve quality behavioral health services using a variety of methods. For example, in Kentucky many behavioral health measures have shown improved results from insourcing these services. Through Aetna's behavioral health leadership and care coordination, the Kentucky plan improved the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) measure by 9 percentage points between 2015 and 2016, exceeding the national mean. Kentucky also exceeded the mean for additional measures included in this SRC. They improved the Adherence to Antipsychotic Medications for Individuals with Schizophrenia by seven percentage points during that time. Kentucky has used CVS Health (CVS) as its pharmacy benefits manager since its migration from Coventry to Aetna. CVS has many programs and patient management services to improve medication compliance in enrollees with chronic conditions. This is among the contributing factors to Kentucky's 12-percentage point increase in the Medication Management for People with Asthma measure (75% total). Aetna migrated to CVS in 2016 and the health plan is implementing programs to address medication adherence for Asthma and other conditions.

**CRITERION 2:** The extent to which the respondent exceeded the national mean and applicable regional mean for each quality measure reported and showed improvement from the first year to the second year reported

### **General Performance Measurement Tool**

We have completed Exhibit A-4-a-1 for our Florida plan and our two largest contracts in Pennsylvania and Kentucky, respectively, all of which serve populations similar to the Florida Statewide Medicaid Managed Care plan. We have 6 years of experience serving Medicaid enrollees in Kentucky with 251,155 enrollees. In Pennsylvania, we serve 220,516 and have 24 years of experience achieving quality standards. Please refer to Exhibit A-4-a-1, attached.

### **Evaluation Criteria:**

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

1. The extent of experience (e.g., number of Contracts, enrollees or years) in achieving quality standards with similar target populations, for the HEDIS performance measures included in this submission requirement.
2. The extent to which the respondent exceeded the national mean and applicable regional mean for each quality measure reported and showed improvement from the first year to the second year reported.

**Score:** This section is worth a maximum of 160 raw points with component 1 worth a maximum of 10 points and component 2 worth a maximum of 150 points as described below:

**Exhibit A-4-a-1**, General Performance Measurement Tool, provides for seventy-two (72) opportunities for a respondent to report prior experience in meeting quality standards (twelve (12) measure rates, three (3) states each, two (2) years each).

For each of the measure rates, a total of 10 points is available per state reported (for a total of 360 points available). The respondent will be awarded 2 points if their reported plan rate exceeded the national Medicaid mean and 2 points if their reported plan rate exceeded the applicable regional Medicaid mean, for each available year, for each available state. The respondent will be awarded an additional 2 points for each measure rate where the second year's rate is an improvement over the first year's rate, for each available state.

An aggregate score will be calculated and respondents will receive a final score of 0 through 150 corresponding to the number and percentage of points received out of the total available points. For example, if a respondent receives 100% of the available 360 points, the final score will be 150 points (100%). If a respondent receives 324 (90%) of the available 360 points, the final score will be 135 points (90%). If a respondent receives 36 (10%) of the available 360 points, the final score will be 15 points (10%).

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COVENTRY HEALTH CARE OF FLORIDA, INC. DBA  
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## **Attachment SRC# 6**



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SRC# 6: Table SRC 6-1: NCQA Medicaid Health Plan Rating as Compared Other Florida Plans



NCQA Health Insurance Plan Ratings 2017-2018 - Summary Report (Medicaid)

Search for a health insurance plan by state, plan name or plan type (Private, Medicaid, Medicare). Click a plan name for a detailed analysis.

In 2017, NCQA rated more than 1,000 health insurance plans based on clinical quality, member satisfaction and NCQA Accreditation Survey results. This way of rating plans emphasizes care outcomes (the results of care people receive) and what patients say about their care.

Information about the ratings, including how they are calculated, is available [here](#). To license the underlying data, go [here](#).

2017 - 2018

Lower Performance

Higher Performance

Medicaid

Florida

Enter Plan Name

Search

Rating	Plan Name	States	Type	NCQA Accreditation	Consumer Satisfaction	Prevention	Treatment
4.0	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida	FL	HMO	Yes	4.0	3.5	3.5
3.5	AMERIGROUP Florida, Inc.	FL	HMO	Yes	3.0	3.0	3.0
3.5	Humana Medical Plan, Inc. (Florida)	FL	HMO	Yes	2.5	3.0	3.0
3.5	Simply Healthcare Plans, Inc. <i>Special Project / Area: Managed Medical Assistance / Region 11</i>	FL	HMO	No	5.0	3.0	3.5
3.5	WellCare of Florida, Inc. <i>Special Area: Florida</i>	FL	HMO	Yes	3.0	3.0	3.0
3.0	Better Health, Inc. <i>Special Project / Area: Managed Medical Assistance / Region 6 and 10</i>	FL	HMO	No	3.5	3.0	2.5
3.0	Molina Healthcare of Florida, Inc. <i>Special Project: Managed Medical Assistance</i>	FL	HMO	Yes	3.0	2.5	3.0
3.0	Simply Healthcare Plans, Inc. <i>Special Project / Area: Managed Medical Assistance / State-wide</i>	FL	HMO	No	4.5	3.0	2.5
3.0	Sunshine Health Plan, Inc.	FL	HMO	Yes	3.0	2.5	2.0
3.0	UnitedHealthcare of Florida, Inc., dba UnitedHealthcare Community Plan (Florida)	FL	HMO	Yes	3.0	2.5	2.5
2.5	Prestige Health Choice	FL	HMO	Yes (Interim)	2.5	2.5	2.5
2.0	South Florida Community Care Network	FL	HMO	No	3.0	3.0	1.5
Partial Data Reported	Florida MHS Inc. d/b/a Magellan Complete Care	FL	HMO	Yes	I	I	I
Partial Data Reported	Freedom Health Inc.	FL	HMO	Yes	I	0.0	I
No Data Reported	Children's Medical Services Managed Care Plan	FL	HMO	No			

Table SRC 6-1: NCQA Medicaid Health Plan Rating as Compared Other Florida Plans

*Aetna recently received the highest NCQA rating among all Florida Medicaid plans for the second consecutive year.*



**COVENTRY HEALTH CARE OF FLORIDA, INC. DBA  
AETNA BETTER HEALTH® OF FLORIDA**

**SRC# 6: Table SRC 6-2: NCQA Medicaid Health Plan Rating Compared to Health Plans in All States**



**NCQA Health Insurance Plan Ratings 2017-2018 - Summary Report (Medicaid)**

Search for a health insurance plan by state, plan name or plan type (Private, Medicaid, Medicare). Click a plan name for a detailed analysis.

In 2017, NCQA rated more than 1,000 health insurance plans based on clinical quality, member satisfaction and NCQA Accreditation Survey results. This way of rating plans emphasizes care outcomes (the results of care people receive) and what patients say about their care.

Information about the ratings, including how they are calculated, is available [here](#). To license the underlying data, go [here](#).

2017 - 2018

Medicaid  Select All States  Enter Plan Name

Lower Performance Higher Performance  
≤1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0

Rating	Plan Name	States	Type	NCQA Accreditation	Consumer Satisfaction	Prevention	Treatment
5.0	Jai Medical Systems Managed Care Organization, Inc.	MD	HMO	Yes	4.5	4.5	4.0
4.5	Boston Medical Center Health Plan, Inc. (d/b/a Well Sense Health Plan)	NH	HMO	Yes	3.5	3.5	4.0
4.5	Capital District Physicians' Health Plan, Inc. (CDPHP)	NY	HMO	Yes	4.0	4.0	4.0
4.5	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	MD	HMO	Yes	2.5	4.5	4.0
4.5	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Virginia Medicaid)	VA	HMO	Yes	2.5	4.0	4.5
4.5	Kaiser Foundation Health Plan, Inc. - Hawaii	HI	HMO	Yes	4.0	4.5	4.0
4.5	Neighborhood Health Plan of Rhode Island	RI	HMO	Yes	4.0	4.5	4.0
4.5	Priority Health	MI	HMO	Yes	3.5	4.0	4.0
4.5	Tufts Health Public Plans, Inc.	MA	HMO	Yes	3.0	4.5	4.5
4.5	UnitedHealthcare of New England, Inc. dba UnitedHealthcare Community Plan (RI)	RI	HMO	Yes	4.5	4.5	3.5
4.5	Vista Health Plan DBA AmeriHealth Caritas Pennsylvania	PA	HMO	Yes	4.0	4.0	4.0
4.0	Blue Plus (HMO Minnesota dba Blue Plus) Special Project: MN Care	MN	HMO	Yes	3.0	3.0	4.0
4.0	Blue Plus (HMO Minnesota dba Blue Plus) Special Project: PMAP	MN	HMO	Yes	2.5	3.5	4.0
4.0	Boston Medical Center Health Plan, Inc (d/b/a Boston Medical Center HealthNet Plan)	MA	HMO	Yes	2.5	4.5	4.0
4.0	Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida	FL	HMO	Yes	4.0	3.5	3.5

**Table SRC 6-2: NCQA Medicaid Health Plan Rating Compared to Health Plans in All States**

*Aetna was among the top 15 Medicaid plans in the country.*

**EXHIBIT A-4-a-1**  
**SRC# 6 - GENERAL PERFORMANCE MEASUREMENT TOOL (10-2-2017)**

RESPONDENT NAME: Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida							
Group A							
	State #1:		State #2:		State #3:		
HEDIS Performance Measure	CY 2015 Rate	Florida	CY 2015 Rate	Kentucky	CY 2015 Rate	Pennsylvania	CY 2016 Rate
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	57.02	57.43	59.79	66.8	55.34	58.48	
Antidepressant Medication Management - Acute Phase	53.05	53	61.69	58.82	61.46	58.14	
Comprehensive Diabetes Care - HbA1c Control (<8%)	48.91	53.77	53.65	50.73	49.34	46.43	
Controlling High Blood Pressure	59.95	63.88	57.21	51.78	60.63	66.07	
Follow-Up After Hospitalization for Mental Illness - 7 day	27.78	47.52	41.62	40.31	NB	NB	
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Initiation - Total	31.67	27.23	32.77	42.14	NB	NB	
Medication Management for People with Asthma - 75% Compliance - Total	21.77	24.22	39.27	51.27	40.51	42.7	
Children and Adolescents' Access to Primary Care Practitioners - 12-24 months	95.5	95.53	97.28	97.19	94.57	93.96	
Children and Adolescents' Access to Primary Care Practitioners - 25 months - 6 years	90.59	89.91	89.96	91.37	86.79	87.31	

**EXHIBIT A-4-a-1**  
**SRC# 6 - GENERAL PERFORMANCE MEASUREMENT TOOL (10-2-2017)**

Group A						
	State #1:	Florida	State #2:	Kentucky	State #3:	Pennsylvania
HEDIS Performance Measure	CY 2015 Rate	CY 2016 Rate	CY 2015 Rate	CY 2016 Rate	CY 2015 Rate	CY 2016 Rate
Children and Adolescents' Access to Primary Care Practitioners - 7-11 years	90.73	89.68	94.53	95.05	90.4	90.23
Children and Adolescents' Access to Primary Care Practitioners - 12-19 years	85.68	84.58	92.77	93.93	88.4	88.64
Adults' Access to Preventive/Ambulatory Health Services - Total	72.73	74.41	79.79	80.98	73.99	70.34

<b>Total Points</b>	<b>208</b>
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## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **SRC# 7 – HEDIS Measures (Statewide):**

In addition to providing HEDIS measure data, describe any instances of failure to meet HEDIS or Contract-required quality standards for the measures listed below and actions taken to improve performance. Describe actions taken to improve quality performance when HEDIS or Contract-required standards were met, but improvement was desirable.

- Adults' Access to Preventive/Ambulatory Health Services (Total);
- Child and Adolescent Access to PCPs (all 4 age bands reported as separate rates);
- Medication Management for People with Asthma (75% - Total);
- Controlling High Blood Pressure;
- Comprehensive Diabetes Care – HbA1c Control (<8%);
- Follow-up after Hospitalization for Mental Illness (7 day);
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation – Total);
- Antidepressant Medication Management – Acute Phase; and
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia.

#### **Response:**

Aetna embraces and employs a comprehensive strategy to achieve continuous quality improvement. Our responsibility to educate enrollees on health literacy and on how to navigate the health care system successfully is top priority. Passionate and knowledgeable staff are dedicated to helping enrollees to understand and access their benefits; encouraging them to obtain recommended screenings and immunizations, and teaching them to manage their chronic condition better. Whenever our enrollees understand the health care services available to them—including access to these services and their impact on enrollees' overall health and well-being—it benefits Medicaid overall.

Serving as industry role models, our Florida leadership presents best practices to other Aetna Medicaid plans annually. Through our disciplined approach, we met 100% of all HEDIS 2017 hybrid measures at the 50th percentile rate; 64% at the 75th percentile rate; and 80% of our Managed Medical Assistance (MMA) performance measure goals, respectively. This is an increase over HEDIS 2016, where we met 70% of goals, HEDIS 2015 with 62% of goals met, and HEDIS 2014 with 48% met.

While we work to improve all measures, our priority is the critical areas where the measure is indicative of an area that may affect the enrollee's immediate health and well-being, such as controlling high blood pressure or follow-up after hospitalization for mental illness. The intensity of our interventions varies based on the measure and the enrollee's needs, with the goal of helping to ensure enrollees are receiving all appropriate services. Some of our performance measures do not reflect the high level of service and support provided to our enrollees; the strict methodology for many measures does not always capture this due to provider coding errors or other issues. For this reason, data capture and completion are our highest improvement strategies after we confirm an enrollee has indeed received appropriate services.

Aetna offers the State a quality-driven provider network through our value-based purchasing (VBP) agreements that support a high-quality, innovative, cost-effective, and integrated health

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

care delivery model. Our VBP model includes patient centered medical homes and health homes to strengthen our existing integrated care plan and promote alignment between physical and behavioral health. The model drives quality by including both physical and behavioral health quality measures aligned with AHCA's goals. We reward providers for achieving improved performance on a broad spectrum of HEDIS measures based on the State's quality strategy, gaps in care, and demonstrating appropriate utilization metrics for their Aetna enrollee panel. For example, the program includes quality incentives for improvements in key measures.

Other aspects of our strategy to remediate failures, to foster continued improvement on high-performing measures, and to advance ongoing improvements include the following:

- Monthly monitoring of rates to identify issues quickly
- Implementing immediate solutions for prompt mitigation of issues
- Including quality measures in our value-based solution contracts
- Rewarding high-quality providers with Aetna's Awesome Provider program, our MMA Physician Incentive program (MPIP), and our value-based payment models
- Recognizing and leveraging the State's MPIP incentive plan to drive quality behavior
- Engaging, educating, and partnering with providers to provide high-quality service to enrollees and drive improvement of quality performance
- Working with community groups to create a strong community structure to support enrollee needs
- Embracing innovation such as free Lifeline smartphones and telehealth to solve for historic Medicaid enrollees issues, such as lack of correct contact information and lack of transportation, respectively
- Improving completeness and accuracy of data from providers and other sources to ensure accurate reflection of service

Every plan performance measure status is reviewed routinely, usually monthly. Continuous monitoring of our measures gives us insight into deviations, trends, and potential issues early in a measurement year so that we can intervene as needed. While we use the Plan-Do-Study-Act methodology and employ rapid cycle processes as appropriate, the cycle is adapted as needed to help ensure we are constantly reviewing all the elements that affect our performance and take steps to mitigate where needed. We also use information on where we do well and replicate successful interventions in other areas. Whenever we conduct a deep dive, the entire measure is analyzed to determine for gaps in our performance. Aetna conducts in-depth analysis of measures with poor outcomes, as well as on those with good outcomes. We examine enrollee, provider, and geographic differences in addition to data issues that may be affecting performance. For example, with the Initiation and Engagement of Alcohol and other Drug Dependence Treatment (IET) measure, the data showed that the incorrect specialty provider was included on the claim, which led to valid completed services not included in calculation of the measure. Our ongoing analysis allows us to find opportunities for improvement (including those enrollee-, provider-, system-, and data-related) in near real time.

Findings of our analyses are presented to the quality committee and related subcommittees. The subcommittees and workgroups are cross-functional teams that represent system-wide expertise, who assist in understanding our findings and working on improvement, including building a work plan or corrective action plan to fix deficiencies. Our findings are ultimately explained to the Quality Management Oversight Committee with our plan for next steps. With

## **EXHIBIT A-4-a**

### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

our structure and processes, everyone within our organization contributes to organizational and clinical quality improvement.

Aetna recognizes the challenges as our outcomes get closer to 100%. As such, we continuously seek new ways to improve even when our interventions demonstrate success. We never assume a mail campaign will move enrollees to close gaps in care, but we do look forward to having the ability to conduct email campaigns that are more cost effective and have shown success nationally. Aetna conducts live outreach whenever possible, and we find this to be the most effective way to contact enrollees to improve outcomes. Using different interventions for different measures, we learn from our successes and examine their applicability to improving other measures. In addition, successful approaches from Aetna plans in other states are reviewed and evaluated for their applicability to our Florida plan.

Results are assessed for behavioral health-related measures compared to our Aetna Medicaid partners nationwide, and we are continually looking for innovative ways to improve these services and enrollee outcomes. Currently in Florida, Beacon provides all behavioral health services for our enrollees. In the next contract term, we will use our proven integrated approach to behavioral health services to strengthen our care coordination further, based on the success of our plans in other states that led to improvements in outcomes.

Using our person-centered approach, we make calls to enrollees with gaps in care whenever we identify they have not received recommended services or have barriers to receiving them. Through this outreach, we have learned that some enrollees do not understand what is available to them, such as zero copayments, our expansive provider network, available expanded benefits, and transportation options. Our team educates these enrollees to improve their health literacy. We work to build and foster positive relationships with our enrollees and to help them achieve optimal health. Instead of simply addressing their gaps in care, we help them to maximize their covered benefits and arrange for additional assistance when needed.

One important initiative is optimal PCP assignment to accommodate the enrollee's unique characteristics, preferences, and family structure. For example, some families who have parents and children as enrollees are asked whether they prefer a practice where both the parents and children can be served. This saves enrollees time and makes transportation easier. Working with enrollees increases their functional knowledge of their benefits and necessary care, which results in the enduring benefit of an educated, well informed enrollee. Engaged enrollees understand how and when to seek care, which results in improved outcomes, a healthier population, and lower costs—all of which reinforce good stewardship of State resources.

#### **INSTANCES OF FAILURE TO MEET QUALITY STANDARDS AND ACTIONS TAKEN TO IMPROVE**

**CRITERION 1:** The extent to which the described experience demonstrates the ability to improve quality in a meaningful way and to successfully remediate all failures for the HEDIS performance measures included in this submission requirement

For all the measures—whether we failed to meet goal and seek to improve upon it, or we met a goal but seek to improve upon it—our core quality improvement initiatives include, but are not limited to, the provider and enrollee initiatives listed as follows:

## **EXHIBIT A-4-a**

### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

#### **Provider Initiatives**

Quality improvement initiatives in place for providers include the following:

- Gaps-in-care with enrollee non-adherence lists to assist providers in identifying enrollees with gaps in care with information updated on an ongoing basis and providers can access gaps in care ad hoc through the provider portal at any time
- HEDIS coding tools
- Claim analysis and customized provider-specific solutions evaluating claim data to determine whether there are specific training or education needs such as helping a provider understand why they did not meet a HEDIS measure and how they can leverage electronic medical records to close gaps in care
- One-on-one assistance with our provider services liaisons and quality staff meeting one-on-one with providers to answer questions, address concerns, offer education and training, and be available to assist providers to better understand processes, procedures, and how to improve their practices to better serve enrollees' needs
- Provider incentive programs such as our MPIP and VBP that incent providers to improve health outcomes and reduce costs, as well as Aetna's Awesome Provider program, which provides top performing PCPs with prioritized auto-assignment, office awards, publication of their award in the newspaper, and other benefits
- CareUnify (population health system) using Aetna's interactive utilization management system allowing providers to see information in real time, such as claims data, clinical information and notes, and prior authorizations, to serve enrollees better
- Ongoing training and education, which helps providers understand what clinical guidelines and HEDIS requirements are and how to meet them
- Help leveraging electronic medical records to manage enrollees and close gaps in care by reviewing real-time information through CareUnify or monthly gaps-in-care information available through the provider portal
- Toolkits to assist providers' in engaging enrollees and improving HEDIS rates
- Webinars to educate providers on key measures, plan performance, and tools to improve rates
- Medical record review and feedback
- Coding assistance through our experienced Provider Services staff, which can assist with any issues or concerns with claim, payment, or other issues
- One-on-one staff training with our provider services liaisons who meet regularly with providers in their office to help providers understand processes, procedures, and how to improve health outcomes and reduce costs
- Claim analysis to evaluate any gaps or issues that we can assist resolving or provide training or education to mitigate any potential issues or concerns
- Provider Services staff is available to assist with closing gaps or other issues/concerns

Our approach to engage providers involves not only providing them the tools and information to meet HEDIS measures, but also helping them to increase revenue while doing it. For example, Aetna encourages pediatricians to have a blood lead analyzer in their office, which helps ensure that enrollees due for lead screening have point-of-service testing, simultaneously providing a revenue source to the physician and closing a gap in care.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **Enrollee Initiatives**

Quality improvement initiatives for enrollees include the following:

- Live outreach conducted by Quality staff to inform enrollees of services that may be due, help them overcome barriers to care, and assist with other health plan issues
- Automated outreach including automated outbound calls, interactive voice response calls, and enrollee portal information
- Text messages for gaps in care information, health management reminders, general benefit information, appointment reminders, and health tips
- A cellphone at no cost through the Lifeline program providing free calls and text messages to and from the health plan
- Email messages (when available)
- A prescription bag tag with convenient reminders and messaging with refill and/or care reminders
- Birthday cards with preventive care reminders, a pleasant reminder to schedule an annual well care or preventive care visit
- Growth chart for kids with a well-visit and immunization schedule that includes a wall growth chart and crayons that children can use to color and personalize the chart
- Appointment reminders for annual exams and preventive or chronic care
- Educational initiatives based on referrals from the quality team for those individuals needing help managing their condition
- Provider right-sizing to help enrollees find the PCP that is right for them based on cultural and geographic needs and is able to serve the family unit when services are needed
- The Unable to Reach Enrollee program, conducting outreach by letter to attempt to locate and confirm the enrollee's new or current address and contact information, as needed
- My Home Doctor, a Florida-based physician house call program for high-risk enrollees with complex conditions providing convenient 24/7 access to care for the medically fragile, reducing unnecessary urgent care and/or emergency department use
- Incentives are used for some conditions, and preventive care when appropriate, to drive enrollees to close gaps in care and become more self-sufficient in seeking preventive care
- ActiveHealth health coaching and wellness, a free service accessible through the member portal offering health risk assessments, health and wellness information, and resources

### **Measure-Specific Interventions**

In addition to these provider and enrollee initiatives, there are measure-specific interventions that supplement the core interventions. These initiatives are described as follows:

#### **Adult Access to Preventive/Ambulatory Health Services (Total)**

This measure represents ambulatory or preventive care provided to our enrollees ages 21 and over. While the rate for this measure fell below the National Committee for Quality Assurance (NCQA) 50th percentile of 83.8% for Florida, we did increase by two percentage points year over year. We have found that many enrollees who show as non-compliant in this measure

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

have completed visits with their PCP or OB, but were not counted in the measure because we did not receive a claim with coding that meets measure requirements. Data and provider claim submission is an area of focus to help ensure our HEDIS measures accurately reflect the service our providers render to enrollees. In addition to our core initiatives, we are focusing on locating enrollees—who have no outpatient care, three or more emergency department visits, and cannot be reached—with an intense enrollee location campaign. This campaign will specifically use extensive research services to find enrollees and work with them to help ensure they understand their benefits and schedule care. This measure is also included in the Aetna Awesome Provider program and VBP contracting.

We designed our Awesome Provider program to recognize publicly primary care providers with high clinical quality performance and improved HEDIS scores. Qualified providers receive points based on selected HEDIS rates. The top three highest-scoring practices in each category (pediatrician or internal/family medicine/multispecialty) receive our Awesome Provider award. The accomplishment is published in local print media. We also send a press release to the Florida Association of Health Plans and announce the winners on our enrollee website. The provider's office gets a pizza party with special mementos for all staff and a commemorative plaque. Aetna fax blasts a program announcement to all providers.

### **Child and Adolescent Access to PCPs (All Four Age Bands Reported as Separate Rates)**

Similar to the adult access measure, this measure represents ambulatory and preventive care provided to enrollees, but for enrollees under age 21. This measure is included in the Aetna Awesome Provider program and VBP contracting, and it includes an additional focus on data integrity, completeness, and physician coding. As with the adult access measure, our analysis revealed that enrollees completed visits to their PCPs as confirmed by medical record reviews, but the claims were not received. While it is reassuring that enrollees are seeing their PCP according to the child checkup periodicity schedule, this issue needs to be reconciled to be counted for this measure (medical records findings are not included in the measure methodology).

### **Medication Management for Individuals with Asthma**

This measure looks at medication use in individuals with asthma to confirm they have prescriptions to prevent worsening of their condition. In our initial data analysis, we found that many of our non-compliant enrollees had exclusions that could not be counted because they were not found on claims but were in medical records. Some providers have also explained that they gave enrollees medication samples despite free medication under Medicaid because they were unsure of insurance coverage or as a convenience or compliance initiative so the enrollee did not need to go to the pharmacy. We are conducting education of physicians as one strategy to remediate the prescription sample issue. Additionally, a medication compliance program is available through our pharmacy benefit manager, CVS Health (CVS), to remind enrollees to complete timely medication fills. The Quality Outreach team will also address prescription gaps through live calls and referral to care management as appropriate.

### **Initiation and Engagement of Alcohol and Other Drug Dependence Treatment or IET (Initiation – Total)**

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The IET measure unexpectedly declined in the 2016 measurement year from 31.67% in 2015 (HEDIS 2016) to 27.3% in 2016 (HEDIS 2017). The analysis of this decrease led us to discover billing practices inconsistent with HEDIS requirements. Although services were being provided timely and completely, the data did not represent it. An additional strategy to improve this measure relates to incorporating behavioral health services into our integrated care approach. Aetna has had significant success, as can be seen by the excellent performance of our other Aetna Medicaid plans, on behavioral health measures. Through this integrated care approach, we will gain improved oversight and accountability, as well as superior data mining capabilities, which will enable us to locate enrollees in need or enrollees being treated in a primary care setting.

We will incentivize our providers to be Screening, Brief Intervention, and Referral to Treatment (SBIRT)-trained. SBIRT is an evidence-based practice and Medicaid billable service used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. Training includes motivational interviewing techniques designed to help enrollees become motivated to change and help them develop strategies to change. SBIRT helps catch needed intervention early as 70 to 90% of enrollees needing intensive care management have comorbid substance abuse disorder and chronic, disabling physical and mental health conditions. Our integrated care management model includes addressing behavioral health issues by helping enrollees set goals, address readiness to change, take charge of their own health (stop substance abuse), and providing peer support intervention.

### **Antidepressant Medication Management (AMM)**

The antidepressant medication management measure is an indicator of enrollee medication compliance. Although our rate improved slightly from the 2015 to 2016 measurement year, we were one enrollee short of meeting the 50th percentile rate for HEDIS 2017. Similar to our findings on the Medication Management for People with Asthma measure, we found non-compliant enrollees had exclusions that could not be counted because they were not found in the claims (but were in medical records). For example, providers giving enrollees medication samples despite free medication under Medicaid as the enrollee's insurance was unfamiliar to them, or in recognition of transportation barriers Medicaid enrollees face, or as a convenience or compliance initiative so that the enrollee did not need to go to the pharmacy. We are educating physicians as part of our initiatives to remediate the prescription sample issue. Aetna will also implement our pharmacy bag tag program for this measure. Bag tags are messages attached to the enrollee's prescription bag with a customized message focused on the importance of medication adherence. Additionally, the CVS Medication Compliance program reminds enrollees to complete timely medication fills. The Quality Outreach team will also address prescription gaps through live calls and referral to care management as appropriate.

### **Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)**

The SAA measure was just short of the 50th percentile rate in 2016. This was a new measure for the 2016 measurement year under the AHCA contract, and new initiatives are being implemented with more measure experience. SAA measures enrollees' adherence to treatment. As with other medication-related measures, we found many enrollees who should be excluded from this measure in medical records who could not be removed due to NCQA's methodology of inclusion from claims.

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In recognition of transportation barriers that Medicaid enrollees face, providers gave enrollees medication samples despite free medication coverage under Medicaid as a convenience or compliance initiative so enrollees did not have to go to the pharmacy. We are educating physicians as part of our initiatives to remediate the prescription sample issue. Our pharmacy bag tag program will also focus on customized messaging for enrollees receiving antipsychotic medications for schizophrenia. Messages will remind them to take their medications as directed, on time, and to contact their physicians if they experience certain side effects or believe the medication is not working. Additionally, the CVS Medication Compliance program can remind enrollees to complete timely medication refills. The Quality Outreach team will also address prescription gaps through live calls and referral to care management as appropriate.

A benefit to an integrated behavioral health model includes an experienced team that has proven effective in improving the health of Medicaid enrollees with behavioral health needs. Successful interventions include helping non-behavioral health physicians understand the goals of behavioral health treatment, how to support and coordinate it, and what they should have for treatment expectations. Effective strategies for training PCPs include identifying patients at high risk, engaging enrollees in peer support, reducing hospitalizations and emergency department visits by linking enrollees with community treatment and support, helping with medication compliance, and managing comorbidities. The common thread in Aetna's philosophy of helping enrollees reach their ultimate best health is to find the root cause of their treatment challenges, connect them with the providers and services they need, create realistic health goals, and support them so they can meet their goals. The philosophy is supported by a team with significant knowledge and experience and by a desire to meet the enrollee where they are and to support them in the way they need as individuals.

### **ACTIONS TO IMPROVE QUALITY PERFORMANCE WHEN STANDARDS WERE MET**

**CRITERION 2:** The extent to which the described experience demonstrates the ability to improve quality in a meaningful way even when HEDIS or Contract-required standards were met, but improvement was desirable, for the HEDIS performance measures included in this submission requirement

We consider meeting all State measures at least the 50th percentile rate as required by contract, the minimum level we expect to achieve. Year-over-year improvement is considered success. Our goal is to meet percentile rates reflective of the excellent service and care we provide to our enrollees. Our enrollee efforts have resulted in high satisfaction and longevity, and improved performance each year, as represented by our improvement from meeting 48% of our State Medicaid goals in 2013 to 80% in 2016. We use a number of ways to engage with enrollees and providers to improve quality as described in the following paragraphs.

In 2013, Aetna met 48% of our total HEDIS goals (50th percentile rate). Our score increased to 62% in 2014, 70% in 2015, and 80% this year, respectively. We do not limit our interventions to measures that do not meet goals. Rather, we look at gaps in care for all measures and work to remediate with appropriate prioritization for measures that impact enrollees' immediate health.

#### **Follow-Up after Hospitalization for Mental Illness (FUH)**

Aetna met the FUH measure at the 50th percentile rate in the 2016 measurement year. We increased our rate by over 17 percentage points in one year with our focused interventions and

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

work with our behavioral health vendor and providers. For the 2016 measurement year, we were able to make gains in our performance as our deep dive analysis found that we were providing timely service after an enrollee was discharged from hospitalization for mental health issues, but the claims did not comply with HEDIS specifications.

Through work with our behavioral health vendor and providers, we were able to improve our HEDIS rate. Additional interventions to increase the rate included intensive enrollee outreach prior to discharge from the facility, care management services, and work with providers to identify enrollees who needed service. Additional improvements are expected when we move behavioral health services into our plan. Measurable improvements have been attained by insourcing behavioral health for our Medicaid plans in other states. These plans have experienced improved outcomes and management of enrollees.

### **Comprehensive Diabetes HbA1c (<8%) (CDC)**

Aetna met the Comprehensive Diabetes HbA1c (<8%) measure at the 50th percentile rate goal in the 2015 measurement year; however, as with all critical measures, we push to raise our rates every year regardless of our performance compared to goal. Through focused enrollee and provider interventions including live enrollee outreach, provider education, gaps-in-care reports, and enrollee reminders (by text message and by mail), that allowed us to improve our performance to the 75th percentile rate this year, with an increase of approximately five percentage points over the prior measurement year.

### **Controlling High Blood Pressure**

Aetna met the 75th percentile rate for Controlling High Blood Pressure for the 2016 measurement year, with an increase of almost four percentage points from the prior measurement year. Although HEDIS methodology in 2016 (HEDIS 2017) decreased the number of enrollees that could be considered measure compliant, we offset that by improving compliance to blood pressure requirements in our population through enrollee and provider interventions. Additional interventions are being tested for inclusion, including blood pressure medication compliance programs with CVS. Although our performance on this measure is high, we perform ongoing monitoring and analysis to help ensure we are identifying opportunities for improvement throughout the measurement year. Because this measure is a medical record measure, claim data is not sufficient to meet the measure requirements. Care management and other touchpoints provide opportunities to ensure enrollees are well managed and medication compliant. CareUnify will also allow real-time data to be reviewed for treatment course corrections during the measurement year.

Aetna strives continuously to improve our quality scores and outcomes for all enrollees. Our efforts have resulted in improvements year over year, even in cases where we have not yet exceeded the national mean. These long-term sustained gains lead to better health for our enrollees while teaching them how to stay healthy.

### **Evaluation Criteria:**

1. The extent to which the described experience demonstrates the ability to improve quality in a meaningful way and to successfully remediate all failures for the HEDIS performance measures included in this submission requirement.

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2. The extent to which the described experience demonstrates the ability to improve quality in a meaningful way even when HEDIS or Contract-required standards were met, but improvement was desirable, for the HEDIS performance measures included in this submission requirement.

**Score:** This section is worth a maximum of 10 raw points with each component worth a maximum of 5 points each.

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## EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

### **SRC# 8 – Vignette (Statewide):**

The respondent shall review the below case vignette, which describes potential Florida Medicaid recipients. Note: The vignette included below is fictional.

*Robert, a 50-year-old man, was diagnosed with chronic obstructive pulmonary disease (COPD) five (5) years ago. His symptoms have been worsening recently, and he has presented at the emergency department three (3) times during the past thirty (30) days. Robert previously smoked twenty-five (25) cigarettes per day for thirty (30) years, but cut down to ten (10) cigarettes per day after his first COPD exacerbation two (2) years ago. He has attempted to quit smoking on several occasions without any success. Robert is prescribed several regular medications for his COPD, as well as for hypertension and hypercholesterolemia. He is pre-diabetic and obese with a BMI of 35. His last appointment with his specialist was ten (10) months ago. Robert has difficulty taking his medications regularly, as he is sometimes unable to get his prescriptions in his rural community and he lacks transportation. After his last visit to the emergency department, Robert was prescribed oxygen treatments and a new medication; however, he has not filled these orders. Robert lives with his 15-year old son and is a single parent. Robert and his son have been on Medicaid for the last four (4) years since he lost his job. Robert has been a member of the plan since December 2016.*

The respondent shall describe its approach to coordinating care for an enrollee with Robert's profile, including a detailed description and workflow demonstrating notable points in the system where the respondent's processes are implemented:

- a. New Enrollee Identification;
- b. Health Risk Assessment;
- c. Care Coordination/Case Management;
- d. Service Planning;
- e. Discharge/Transition Planning;
- f. Disease Management;
- g. Utilization Management; and
- h. Grievance and Appeals.

Where applicable, the respondent should include specific experiences the respondent has had in addressing these same needs in Florida or other states.

### **Response:**

Robert is representative of 11 million Americans living with chronic obstructive pulmonary disorder (COPD), a progressive lung disease that over time makes it hard to breathe, according to the American Lung Association. In Florida, COPD treatment is the most expensive among chronic conditions, accounting for \$250 million in Medicaid spending in State fiscal year 2014 – 15, according to the Florida Diabetes Advisory Council. Additionally, COPD was the leading cause for inpatient admissions among Medicaid enrollees for the period August 2014 to July 2015, representing 10% of admissions, according to the Agency for Health Care Administration report, "Analyzing Potentially Preventable Healthcare Events of Florida Medicaid Enrollees," published in spring 2017.


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Robert's case reflects the issue of high utilization and aligns with the State's goal of reducing potentially preventable events. On the surface, Robert's physical challenges are not uncommon; however, like all Medicaid enrollees, his profile is unique and complex given he is a single parent of a 15-year-old son, long-time unemployed, a smoker, lacks transportation in a rural community, and not adherent to his medication and oxygen treatments. To achieve his goals and improve his health outcomes, Robert requires a biopsychosocial approach for his care and a fully integrated system of support from his providers, Aetna's integrated care management, service providers, and community resources, among others.

**STRATEGIES THAT RESULTED IN IMPROVED HEALTH OUTCOMES**

**CRITERION 5:** The extent to which the respondent demonstrates experience in providing services to enrollees with complex medical needs and provides evidence of strategies utilized that resulted in improved health outcomes

To support enrollees like Robert with complex medical needs, Aetna implemented a strategy in 2015 to reduce preventable ED visits and increase enrollee involvement in self-management of acute and chronic conditions. Our multifaceted approach focuses on enrollees with high utilization (i.e., three visits in a quarter).



Aetna's integration with the Event Notification Service (ENS), a system of the State's health information exchange, is a key to our strategy for reducing potentially preventable events. ENS provides secure, real-time notice of patient encounters from over 200 participating hospitals to subscribing organizations like Aetna. This includes emergency department visits, inpatient admissions, and observation stays in the hospital setting. The notification enables our care managers to contact the enrollee and provide proactive follow-up care. We share utilization information with providers, who contact the enrollees and schedule follow-up appointments, enhancing care coordination efforts and improving the provider/enrollee relationship.

Additionally, Aetna's disease management program is designed to address enrollees like Robert who are most likely to have high emergency department utilization related to their diagnosis and severity of illness. Our program targets enrollees with specific chronic conditions, such as COPD, depression, obesity, smoking, and diabetes for care management interventions. These interventions are specifically aimed at helping enrollees like Robert improve their self-management and reduce avoidable utilization of ED and in-patient services.

Our approach also provides increased access to care in multiple ways:

- Offer incentives to Robert's providers, and make certain that they offer extended weekday (after 6 p.m.) and weekend hours.
- Provide Robert with information on our Informed Health Line and behavioral health crisis line, which offer 24-hour support. For example, if Robert does not require emergency department services, our health line clinicians can assist him on how he can self-manage his condition prior to seeing his primary care physician or specialist. The behavioral health crisis line is staffed by behavioral health clinicians who are experienced and trained to assist enrollees requiring support or in urgent or emergent

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

situations. Our clinicians will make sure that Robert is stable during the call, and transfer him to the appropriate clinician. They will also document the call in our electronic care management system so that the care manager can follow up with any calls to the Informed Health Line team.

- Review the location of urgent care centers in Robert's area and discuss with Robert when to use them. In Miami-Dade County, we have over 40 urgent care centers that can provide services to our enrollees. As a standard practice, our outreach calls to the enrollees with high utilization of emergency department services include education about which facilities are within their ZIP code. We will provide Robert with addresses and contact information for nearby urgent care centers. When enrollees call with inquiries about emergency departments or urgent care centers, Aetna's Enrollee Services representatives are trained to ask why they are calling and if they can assist. Our goal is to make sure enrollees go to their primary care providers first and get referrals as needed.

### **Approach**

The role of our care managers is to serve as advocates and incorporate Robert's personal goals and desires into a concrete care and service plan. In supporting Robert, we help to shape a life plan, as opposed to simply a plan of care—a collaborative and supportive partnership that results in real health transformation through better self-management of his chronic diseases. Aetna provides comprehensive care management support and an individual plan of care that prioritizes the goals that are most important to Robert (not all of which may have to do with health) and addresses underlying root causes that are either driving adverse outcomes or creating barriers to improvement.

In partnering with Robert to help him achieve his goals, his profile raises multiple questions:

- What triggered three visits to the ED in the past 30 days?
- What are the dynamics of his relationship with his son? How is his son's health? How is his son doing in school? Does his son smoke?
- Where is his son's mother? Are any of her family members involved with Robert's son? What are the dynamics here?
- What is Robert's social situation? How does he manage his daily life? Is he isolated or does he have a support network such as a partner, friends, faith-based circle of support, etc.?

Through an evidence-based assessment process, the Aetna care manager will begin to form a partnership with Robert and collaborate with him to develop a care plan that addresses his various needs. Together, they will address his relationship with his PCP and specialists, along with how to ensure he has a successful relationship with them in addition to incorporating medication adherence, oxygen treatments, access to care (e.g., transportation or telemedicine/telemonitoring), social support, and healthy behaviors (e.g., smoking cessation). Our care managers are licensed clinicians with various credentials, including registered nurses, clinical social workers, professional counselors, marriage and family therapists, and nurse practitioners. The plan of care would also consider the needs of Robert's son. We would arrange for Robert and his son to have the same care manager to enhance continuity of care and communication.

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Our focus is joining Robert on his health journey, serving him as he wants to be served, and living up to the Aetna theme: You don't join us. We join you.

### **NEW ENROLLEE IDENTIFICATION**

CRITERION 1.a: Identification processes for enrollees with complex health conditions or who are in need of care coordination

CRITERION 7: The extent to which the respondent describes innovative and evidence-based strategies to integrate information across all systems/processes into its workflows

Robert's name would appear on a new enrollee file in Aetna's system beginning December 2016. Within 30 days of his enrollment, Aetna would make a welcome call to Robert that includes a brief health screening with questions about specific physical conditions, history of behavioral health treatment, smoking, ED utilization, and scheduled appointments with a primary care provider. Confirmative responses prompt a referral and warm transfer to a care management associate with Robert's consent. Aetna reports daily on enrollees identified for receiving care management through survey triggers. If an enrollee does not disclose conditions in the survey, Aetna has multiple ways to identify enrollees such as Robert for care management support.

Innovative and evidence-based strategies that integrate information across all systems include the following mechanisms:

- CareUnify: Robert's information is entered into our Web-based population health management platform that integrates data from multiple internal sources such as claims, CORE risk stratification, and assessments data, and external resources such as the State's health information exchange (HIE) and providers' electronic health electronic health records (EHR) to create a comprehensive, tailored profile and dashboard. This information can be used to create a single source of truth that all members of the interdisciplinary care team (e.g., care manager, medical director, pharmacy director, and providers) can use to coordinate care around a common plan of care.
- ENS: Aetna would receive from the State's HIE a real-time notification that Robert was in the ED each time he was there. Aetna currently receives admission, discharge, and transfer (ADT) data that is incorporated into our discharge planning process. The ADT information will be used in CareUnify for our care management team and our provider partners to begin discharge planning upon day one of admission or immediately following an ED visit or stay to help ensure all needed care is quickly aligned to enrollees like Robert. Additionally, our team will contact Robert's PCP, or the PCP would receive an electronic notification directly into the EHR from CareUnify, after an enrollee's ED visit. Following notification, we recommend a follow-up call to the enrollee with notice of any open Healthcare Effectiveness Data and Information Set (HEDIS) gaps or medication reconciliation to be completed. This information would be updated in the enrollee's CareUnify profile.
- Concurrent review: If Robert were admitted to the hospital as an inpatient or for observation, our concurrent review clinicians would review the admission medically and identify behavioral, social, or other contributing factors for root causes of the admission. This information gathering enables us to understand and prevent discharge planning failures that can lead to readmission (e.g., not repeating the same discharge plan if there is a readmission). The concurrent review clinician makes a referral to care management

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if it is determined the enrollee would benefit from integrated care management and disease management support.

- Our experience indicates an enrollee like Robert with his risk factors is likely to be hospitalized for COPD exacerbation. We work hard to mitigate hospitalizations through our monitoring process described as follows. In the event he is hospitalized, Robert's discharge to home would be coordinated by Aetna's transition of care clinician, our concurrent review clinicians, care managers, and hospital discharge planners, and providers to identify root causes of admission and shape the discharge plan accordingly.

Additionally, we have multiple fail-safe mechanisms to identify Robert:

- Quarterly ED High Utilizers Report: Identifies Robert as an enrollee with three or more ED visits in a quarter. We can also use CareUnify to identify high ED utilizers and have our population health specialists work directly with PCPs and hospital systems using CareUnify workflows to handle post-discharge care and care coordination for the enrollee and all participating in the care.
- Inpatient Census: Our electronic care management system has triggers that notify the Care Management and Utilization Management departments of all inpatient admissions. This enables the enrollee's care manager and a Utilization Management care manager to begin working directly with the enrollee during hospitalization.

### **HEALTH RISK ASSESSMENT**

**CRITERION 1.b:** Description of the sources of data/information that would be utilized in the assessment process, including timeframes for completion

Based on Robert's utilization history and high utilizers report, we review his claims info including diagnoses and medications. Then, a member of our care management team outreaches Robert for the HRQ. The five data elements of the HRQ include:

- Perceived health status
- Perceived control over disease state/health status
- Residential instability
- Alcohol use (adults only)
- History of treatment for drug, alcohol, mood, or stress (adults only)

We would work with Robert to ensure completion of the assessment process to maintain compliance with the Agency's 30-day period. Self-reported data, such as that elicited in our HRQ, is a critical component of our integrated care model. Our model addresses physical, behavioral, and social health, which is necessary for managing our most vulnerable, highest-risk enrollees like Robert. Many of the most serious behavioral and social issues (e.g., housing instability or unemployment) cannot be captured in claims data. We developed a standardized set of biopsychosocial questions that help us to identify high-risk enrollees either in the absence of or as a supplement to claims data. For example, the HRQ includes the question: "How many different addresses have you had in the last 12 months?" The question would relate to the stability of Robert's home environment.

Our HRQ includes several questions to identify the possibility of a mental health or a substance use disorder. A positive response to any question about mental health or substance use leads

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to several more focused screening tools. We recognize anxiety and depression are common for individuals with COPD. We would provide any support Robert needs through referrals to behavioral health practitioners or peer support understanding anxiety and depression can make it difficult for him to follow his treatment plan. This could make his symptoms worse and make his condition progress more quickly.

The questionnaire covers the enrollee's demographic information; language preference; providers; recent or pending medical services; medicines and adherence; emergency room and hospital utilization; dental health; physical and mental health self-assessments; drug, alcohol, and tobacco use; diagnosed conditions; mobility; cognitive and communication ability; home stability; home- and community-based services; and activities of daily living.

We would also speak directly with Robert's son, his PCP, and previous care managers, and anyone else in his circle of support.

Based on Robert's needs, a care manager would complete a comprehensive assessment along with condition-specific assessments and plan of care interventions for COPD, obesity, smoking cessation and pre-diabetes to assist him with chronic condition management, thereby including traditional disease management within the integrated care management process rather than as a separate program. The comprehensive assessment includes questions about Robert's daily activities including employment status, home stability, living environment, and the occurrence of domestic violence in his life. We would work with Robert to ensure completion of the assessment process to maintain compliance with the Agency's 30-day period.

All chronic condition assessments include triggers to screen for behavioral health disorders (especially depression and anxiety) and substance use disorders. Enrollees diagnosed with depression are identified by our HRQ, care management assessments, concurrent review/prior authorization referral, as well as by enrollee and provider referrals. Our assessments, including a specialized depression assessment, are focused on understanding the enrollee's abilities and readiness to engage in self-management of a chronic condition, understanding the individual's barriers to good self-management, educating about each chronic condition, and coordinating appointments, referrals, durable medical equipment, and community supports that will further benefit the enrollee. All assessments can be made available on CareUnify so that results can be shared with the interdisciplinary care team.

We also have developed a social determinants questionnaire that assess an enrollee's status with food and housing security or need with access to other resources, such as transportation as noted with Robert. If services are needed, a notification through CareUnify will be sent to the care manager. For service referrals, our care managers utilize Florida 2-1-1, which is a free, confidential service that connects enrollees with local, community-based organizations across the state. Florida 2-1-1 provides assistance with food, housing, employment, health care, counseling, and more. All of the above services are focused on empowering Robert and his son to manage his care safely and effectively at home and on preventing further use of the ED.

### **CARE COORDINATION/CARE MANAGEMENT**

CRITERION 1.c: Application of the respondent's case management risk stratification protocol

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Three primary mechanisms are used to identify enrollees for care management stratification: CORE, HRQ, and surveillance. Based on these factors, Robert initially stratifies for intensive care management and he will be further evaluated for ongoing care management based on our comprehensive assessment. Robert's risk stratification will change as his care and service needs change and as he makes progress on his goals toward improved health status and self-management.

We developed Medicaid-specific, proprietary algorithms based on International Classification of Diseases (ICD)-10 codes from medical, behavioral, and pharmacy claims, diagnoses, impact scores, and our clinical and informatics expertise, ranking all plan enrollees from highest to lowest risk. Identification through predictive modeling is based on the presence of COPD ICD-10 codes claims from varying dates of service, the dispensing of multiple anti-cholinergic or inhaled steroid medications, and a minimum age of 40 years of age.

Inpatient and ED risk scores are produced using logistical regression models to predict the probability of an occurrence in the next 12 months. CORE predicts both financial and clinical performance. Indicators include prior year ED, inpatient, and specialist utilization, comorbidities, and pharmacy complexity. Specific behavioral health risk indicators include behavioral health admissions with readmissions, presence of serious emotional disturbance, polyprescriber and polypharmacy activity for behavioral health medications, and concurrent use of multiple medications from the same behavioral health therapy class.

### **SYSTEM OF COORDINATED HEALTH CARE INTERVENTIONS**

**CRITERION 6:** The extent to which the respondent demonstrates a system of coordinated health care interventions designed to achieve cost savings through the organized and timely delivery of high quality services

We compile a 360-degree view of Robert through our internal systems, external systems of care, and outcome management. We review and develop recommendations to engage and activate Robert in his health care. Additionally, we will address Robert's gaps in care and provide case formulation and case rounds. Our goal is to educate Robert and help him achieve self-sufficiency in the management and maintenance of his health care goals and chronic conditions. This allows us to achieve cost savings through prevention and timely intervention and the delivery of high-quality services and care.

Because Robert is assigned to our intensive level of care management, his case is reviewed in our clinical rounds with a clinical pharmacist at least monthly and he receives a telephonic and face-to-face to discuss any concerns we discover in the rounds. The interdisciplinary rounding also includes any traditional and non-traditional providers with which Robert is engaged. This allows the care manager to ensure that all providers are working together on the plan of care that includes Robert's personal goals, self-management, medications, and any specific information from his PCP or specialist.

After identifying Robert for intensive care management support, Aetna would schedule a face-to-face visit in Robert's home. We make every effort to meet with enrollees within one week of their stratification to intensive care management. The visit will provide an opportunity for the care manager to meet Robert (and possibly his son) for the first time, beginning relationships based on trust and compassion and focused on Robert achieving his health goals. Seeing

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Robert's living environment will provide the care manager with insight into Robert's overall status, evaluating his home for cleanliness, maintenance, and organization, observing interaction with his son, etc. During the visit, Robert will complete a comprehensive, evidence-based assessment, which gives us a deep understanding of who Robert is and what his needs are from a medical, behavioral, social, functional, and cognitive standpoint. The comprehensive assessment includes questions about Robert's medications and provides the care manager an opportunity to educate Robert about the importance of adherence and identify any barriers. Robert's interdisciplinary care team will also include a pharmacist who participates in care management rounds and will review his medications with the care manager to identify and address any issues and concerns.

Aetna's comprehensive assessment instrument is based on best practices and clinical guidelines and it contains a biopsychosocial scope with elements of root-cause analysis that includes social determinants. We meet Robert where he is at in physical, mental, emotional, and social terms; we listen to what Robert is saying; and we use all of our resources and training to help ensure our approach is individualized.

Robert's care manager engages him in conversation about the goals that are most important to him, about his strengths and available resources, and about the things in his life that make it harder to take better care of himself. We put it all together into a case formulation that tells a story in terms that make sense to Robert and that he verifies. This case formulation becomes the basis for identifying the root causes of Robert's current and recent challenges and identifies his priorities and goals that are most important to him. The care coordinator and Robert will finalize his plan of care within five days of the initial home visit, in accordance with Attachment B of the Invitation to Negotiate.

Robert is also asked about services he receives, such as nutrition classes, Supplemental Nutrition Assistance Program (SNAP), adult day care, pain management, etc. The assessment provides us with the information necessary to create the framework for Robert's care plan and for formation of the interdisciplinary care team.

Robert's preliminary plan of care addresses any immediate, urgent needs he may have and describes how the care manager and other members of the care team and circle of support will work with him to mitigate the impact of the most important root causes. This work is not complete until Robert agrees that it makes sense and commits to the activities in the care plan. For example, the care manager works with Robert to determine whether he is interested and capable of working or if he should apply for disability benefits. Ongoing support will be facilitated through CareUnify where Robert, his circle of support, and members of his interdisciplinary care team can track progress, meet virtually, or send notifications and updates on his plan of care—all in one place where coordination can be optimized and aligned to Robert's goals.

The care manager works with Robert to define and prioritize both short- and long-term goals, translate those goals into achievable steps, and implement the plan of care in phases according to their activation level. This phased approach will enable Robert to meet short-term goals quickly, gain trust with his care manager, and to increase his confidence level early on.

## **EXHIBIT A-4-a**

### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

#### **APPLICATION OF COORDINATION PROTOCOLS**

CRITERION 1.g: Application of coordination protocols utilized with other insurers (when applicable), primary care providers, specialists, other services providers, and community partners particularly when referrals are needed for non-covered services

If Robert is in need of non-covered services, we have experience coordinating the financial and medical management responsibilities for specific carved-out benefits for enrollees. It is not unusual for enrollees to receive services through the Statewide Medicaid Managed Care program's comprehensive benefit package, as well as non-covered services from a variety of programs and community resources. We coordinate care regardless of the source. For example, Robert might be referred to one of the state employment services such as the Office of Reemployment Assistance or People First, the State's self-service, Web-based human resource information system with job listings by region. The services Robert receives are included in his plan of care and our care manager facilitates communication, consultation, and information sharing among the service providers.

To facilitate effective coordination of care with providers of non-covered or community-based services, our programming includes activities such as:

- Connecting Robert to physical and behavioral health providers and resources that support his ability to reach his health care goals, as we described above with our subcontractor, Beacon
- Securing urgent or emergency care if Robert is experiencing a crisis, including notification of any behavioral health or specialty provider who may be involved
- Coordinating benefits by collaborating with contracted and non-contracted partners and providers to determine benefit eligibility and coordination of covered benefits
- Involving community or provider-based care managers who offer unique or specific services or insight Robert may need
- Making referrals for health-related services, which are outside the benefit package, through external programs or community resources and organizations (e.g., SNAP)
- Reporting (internal and external), including monitoring and reporting referrals, authorizations, and outcomes according to internal health plan requirements and external agreements
- Coordinating care with the PCP and patient-centered medical home or health home team and other interdisciplinary care team participants to facilitate referrals for needed services that may not be covered under the Statewide Medicaid Managed Care program
- Robert's care manager and other Aetna staff members networking and developing relationships with community partners to learn about non-covered benefits to assist him with his needs and to make referrals to those services

#### **ASSESSMENT OF PROVIDER CAPACITY**

CRITERION 1.h: Description of the assessment of provider capacity to meet the specific needs of enrollees

Aetna's goal would be to maintain continuity of care with Robert's providers and patient-centered medical home or health home after he joined our plan. During the initial assessment process completed with the care manager, Robert would be asked about his current providers and whether he wanted to continue with his current PCP and specialists. If Robert expressed

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

concerns or issues that keep him from seeing his providers, the care manager would assist him with selecting different providers that could meet his needs, and arrange referrals, appointments, and transportation. The care manager would discuss providers that have experience working with Robert's complex needs, as well as practices that offer after-hours, weekend or walk-in availability, on-site lab or supports that Robert might need, or one that has the capacity to take care of both Robert and his son. The care manager would also consider the same capacity for Robert's specialty providers, including wait time for an appointment. As clinicians, our care managers are uniquely qualified to understand the specialty needs of an enrollee like Robert and they would take lead in assisting the enrollee in obtaining the physician services that he would require to meet his unique needs.

When transferring into our plan, Robert can maintain his existing providers for 90 days. For providers who are not currently in our network, our Provider Services department can facilitate letters of agreement or single-case agreements with Robert's providers. Our aim will be to include all of Robert's providers in our network. As part of Robert's service transition to Aetna, we would make a request for his medical records and clinical information from practitioners in relinquishing health plans.

Aetna's proven and rigorous provider credentialing process will help ensure Robert is being treated by the most qualified providers. We consider the following factors in our credentialing process and secure primary source verification as required, including:

- Licensure and/or certification that is verified through State licensing boards in geographical areas where network practitioners care for our enrollees
- Board certifications (when applicable)
- Loss of/limitation of hospital admitting privileges (when applicable)
- Current professional liability coverage
- Drug Enforcement Agency (DEA) and State-controlled drug substance registration, when applicable, through verification by the U.S. Department of Commerce National Technical Information Service (when applicable)
- Disciplinary history or adverse actions related to licensure and DEA registration queried through State licensing boards and the National Practitioner Databank
- Malpractice insurance claim history to examine any possible trends and look for evidence that might suggest any probable substandard professional performance in the future
- Mental and physical health to determine whether the practitioner's history might suggest any probable substandard professional performance in the future
- Participation in government programs such as Medicare or Medicaid
- Professional education and training through verification by the American Medical Association Masterfile, American Osteopathic Association, and specialty board or specific residency/training program (highest level of education, depending on practitioner type)
- Work history:
  - We review hours of operation ensuring that his providers have after hours capacity, walk in availability, labs, etc.
  - We also review the proximity to Roger's home to his PCP and specialists, review his transportation needs, knowledge of how to get to his appointments, and review the PCP and specialist appointment availability

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **COMMUNICATION AMONG PROVIDERS AND INTEGRATION OF INFORMATION**

CRITERION 3: The extent to which the respondent demonstrates innovative and evidence-based processes that it has in place to enhance communication among all service providers and subcontractors (for delegated functions)

CRITERION 1.k: Application of strategies to integrate enrollee information across the plan and various subcontractors when the respondent has delegated functions

CRITERION 1.e: Description of the interventions and strategies that would be used to facilitate compliance with the plan of care, including use of incentives, healthy behavior programs, etc.

Robert or his care manager would share Robert's plan of care with his PCP. Additionally, the care manager may escort Robert to his initial PCP visit for reinforcement following a 10-month absence from seeing his specialist.

The care manager would then also share Robert's plan of care with the interdisciplinary care team (which includes Robert and his circle of support) in advance of its initial meeting and be a focal point of our discussions throughout the course of its support for Robert. The interdisciplinary care team meetings provide an opportunity to review Robert's plan of care and his current clinical status to make sure all of his biopsychosocial needs are being met. The care manager takes the lead on the assignment and follow-up of all action items that result from the meetings.

Aetna accomplishes exceptional levels of care collaboration by using our electronic care management system, which is composed of two components:

- Our internal care management system, which drives internal care management workflows and tracks key enrollee engagement events and the longitudinal care management record for our care management team
- Our external population health management system, CareUnify, which would support Robert's interdisciplinary care team with external data sharing around key clinical events that includes real-time notifications and detailed enrollee and panel information

Aetna's technology system protocols and consent process enable Robert's care manager to have access to all of Robert's records within our systems so he or she can stay updated on key care management components such as Robert's medications, prior authorization requests, and utilization management processes. Aetna is able to support Robert better through our systems that provide essential departments access to our primary enrollee support system (e.g., enrollment, claims processing, service authorization) and care management system.

As the leading cause of COPD, according to the National Institutes of Health, cigarette smoking is a primary risk for Robert's condition. To encourage Robert to quit smoking, Beacon would assist Robert with the following services:

- Beacon would provide a referral to smoking cessation through its Healthy Behaviors program. Beacon provides linkage to an individual therapist who can assist in identifying barriers to making a change. Robert may also be a good candidate for Therapeutic Behavioral on Site (TBOS services) for adults.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- In addition, if Robert were amenable, Beacon would provide linkage to a therapist to assist him regarding weight management.

### **Healthy Behaviors: Smoking Cessation**

Smoking cessation is not easy and may require several attempts with active engagement and participation. Many times, smokers relapse because they experience withdrawal symptoms (i.e., anxiety, irritability, cravings, increased appetite, or difficulty concentrating), stress, and/or weight gain. In collaboration, Aetna and Beacon offer a smoking cessation program funneled through an integrated model of care. The smoking cessation track has multiple components to address Robert's needs from a treatment perspective. Robert may benefit from a combination of counseling and medication, which evidence has shown provides the greatest likelihood of successful treatment. Medications that do not contain nicotine (Zyban, Wellbutrin, and Clonidine) paired with behavioral/supportive therapy increase the likelihood of success in this program. Robert's participation in the smoking cessation program is voluntary. Robert will receive an enrollment packet, which includes the following:

- Consent for the release of information to facilitate effective coordination of care while safeguarding Robert's right to privacy
- Copy of Robert's rights and responsibilities as they relate to health care and treatment
- Attestation that Robert is a willing participant in the program

Robert will also benefit from having a designated Beacon care manager assigned to him. This designated staff member will be responsible for identifying Robert's readiness and level of functionality and facilitating coordination of care for the smoking cessation program.

To participate in the Healthy Behaviors Smoking Cessation initiative, Robert will engage in therapy to discuss his desire and goal to stop smoking. His care manager will be responsible for monitoring Robert's level of participation, progress in treatment and needs. If Robert is successful in the program, he will receive a monetary incentive yearly as determined by Aetna. Beacon tracks and assigns Healthy Behaviors referrals monthly and reports to Aetna quarterly.

### **Therapeutic Behavioral Onsite Services**

Robert's case would be evaluated by a licensed Beacon clinician to determine whether he could also benefit from adult TBOS services. An intensive treatment intervention, TBOS is delivered where Robert is living, working, or participating in educational activities and designed to stabilize functioning and preserve Robert's living situation within his community. Service components include comprehensive assessment of his current living situation, crisis intervention, service coordination, and the teaching, accessing tangible resources. Intensity of treatment depends upon Robert's clinical needs.

We will collaborate with Robert and Beacon to develop a plan to address Robert's smoking. The care manager can also make a referral to our clinical pharmacist to speak with Robert over the phone or virtually on our telemedicine platform about smoking cessation aides. The care manager would educate Robert on the \$25 monthly benefit for over-the-counter items like nicotine patches. Additionally, we would educate Robert on the flammability of oxygen equipment and the risk at which he is putting himself and his son by smoking in its proximity.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Robert would have the opportunity to enroll in our tobacco cessation program as it aligns with his personal goals.

The overarching goal of the tobacco cessation program is to help Robert understand the health risks of tobacco use and to elicit changes in his health-related behaviors that positively affect his current and future health and wellness. This will be accomplished through collaboration with Beacon, which will encourage Robert's engagement in this program, identify Robert's strengths such as prior times he stopped or reduced his smoking, and leverage those strengths to enhance his ability to reduce his smoking successfully. We follow our integrated, evidence-based guidelines from the Centers for Disease Control and Prevention and the Surgeon General to develop assessments and interventions.

The following are the goals of the tobacco cessation intervention:

- To increase Robert's ability to self-manage tobacco use with the goal of cessation
- To promote correct use of nicotine replacement therapy, in both frequency and dosing
- To reduce or delay morbidity (complications) and mortality associated with tobacco use
- To teach wellness and better overall management of tobacco use, resulting in healthier lifestyle choices
- To refer Robert for tobacco cessation support programs
- To enlist family or other support entities as possible to aid in achieving and sustaining a tobacco-free lifestyle
- To engage Robert's PCP in following nationally recognized and evidence-based guidelines for evaluation and treatment of tobacco use
- To track outcomes to identify opportunities to improve the interventions

Robert also has the option of participating in Aetna's text messaging condition-support program. Aetna works with the Wellpass, Inc. (formerly Voxiva) platform to deliver evidence-based health text messaging programs to enrollees for multiple conditions including smoking cessation (Text2quit) and diabetes management (Care4life) if Robert were to receive a diabetes diagnosis. These programs feature ongoing notifications that provide education and other reminders to engage enrollees in self-care or the care of their family members, with an emphasis on wellness, prevention, and early intervention. Text2quit has achieved a twofold increase in smoking abstinence for enrollees and Care4life has achieved 88% improved diabetes care (reached optimal insulin doses within 12 weeks).

Additionally, we will provide weight management support for Robert through care management interventions focusing on healthy eating and access to healthful foods, a referral to a dietitian or nutritionist, and self-management tools on the MyActive Health enrollee portal. We will also educate Robert on the importance of having flu and Pneumovax® 23 vaccines to mitigate risk with COPD. He will receive newsletters for his chronic conditions that include reminders about having flu vaccines. Along with providing education to Robert, the care manager makes a call to Robert's PCP to discuss gaps in care and ask them make a note to discuss flu vaccines with Robert on his next visit.

### **SERVICE PLANNING**

CRITERION 1.d: Identification of service needs (covered and non-covered) and a description for service referral processes

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

The care manager works closely with Robert to educate him on his enrollee benefits and to help facilitate provision of services to meet his needs. In addition to identifying Robert's needs, the care manager assists Robert with arranging the delivery of his oxygen treatment, develops a plan for his transportation needs, supports scheduling appointments with his PCP, and arranges for a 90-day fill of medications. Robert's PCP would provide referrals for specialist services and ensure that Robert knows who the specialist is, knows why he is seeing a specialist, and has transportation. We would also follow up with Robert after his PCP and specialist visit to make certain he understands the medical instructions and has the appropriate medications and refills and to review any other associated referrals from the PCP and or specialist. Additionally, the care manager schedules an environmental assessment of Robert's home to check on dust, bugs, and vermin, which can affect his breathing. The care manager also checks to determine whether Robert is eligible for supplemental security income and/or SNAP.

Robert can stay connected to his providers, care manager, and essential resources using a smartphone at no cost through the Medicaid Lifeline Access program. The enrollee benefit is available through our partnership with Wellpass, Inc., offering enrollees a data, talk, and text package at no cost to him.

### **STRATEGIES FOR SELF-MANAGEMENT AND TREATMENT ADHERENCE**

**CRITERION 1.i:** Identification of strategies that promote enrollee self-management and treatment adherence

The care manager will also check to see whether Robert is eligible for our remote patient monitoring program with the iPad mini and specific devices to check his vital signs regularly. For select enrollees like Robert who have specific chronic conditions like COPD that can be monitored from home, we place our remote monitoring bundle in the home if we find that he has hypertension, which is common in obesity and COPD enrollees. For Robert, we might place a pulse oximeter and blood pressure cuff to help him understand his own health better. The monitoring devices are 4G-enabled and are plug-and-play, making them easy for enrollees to use. Our Call Center Support team monitors for high or abnormal values and will call Robert when a clinical reading is triggered.

Moreover, the iPad has an innovative camera that allows a telehealth/virtual in-person visit with the care manager or PCP who can check in with Robert to check on his status or review the plan of care. The device will also send information directly to CareUnify, from which notifications for abnormal values will be forwarded to the PCP and made available to the entire interdisciplinary care team. Further, the devices will help Robert self-manage his care, reinforcing positive behavior. The iPad will also send daily notifications to check his vital signs and will provide tailored educational content on the device on not only how to use it, but also on how to manage his condition and tips tied to prevention and wellness.

Robert will be supported by Aetna's comprehensive integrated care model, which includes, but is not limited to the following:

- All the services a particular vulnerable population might need, including covered services managed by Aetna

## **EXHIBIT A-4-a**

### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Physical and behavioral health services not managed by Aetna and/or not covered by the contract
- School-based services and clinics
- Block grant services
- Wraparound treatments, services, and supports available from government agencies or offered by community-based organizations

Additionally, within our integrated care management model, service providers, agencies, and organizations work together based on a mutual understanding of and commitment to each other's roles and responsibilities. As a result, Aetna's integrated care model ensures the right resources are available, organized, and coordinated to enable Robert to achieve those goals that matter most to him. The model also allows enrollees like Robert to live in the least restrictive and most integrated setting compatible with their preferences, treatment efficacy, and safety, which helps to minimize preventable use of high-intensity, high-cost health services such as inpatient hospitalization, long-term residential/institutional care, and ED visits.

Aetna is partnering with the 2-1-1 organization to connect enrollees with community resources in their area for supplemental food and nutrition programs, shelter and housing options and utilities assistance, emergency information and disaster relief, employment and education opportunities, addiction prevention and rehabilitation programs, support groups for individuals with mental illnesses or special needs, and a safe, confidential path out of physical and/or emotional domestic abuse.

Aetna promotes collaboration, communication, and data sharing among Robert's providers by including them on an interdisciplinary care team. The interdisciplinary care team is supported by CareUnify, which gives providers and our care managers real-time access to a complete profile of their patients and offers enhanced visibility into the entire biopsychosocial complexity of each individual. Complementing the internal component of our care management platform, CareUnify provides an industry-leading population health tool to drive all aspects of care coordination with built-in flexibility to support downstream dissemination of information to the broader community interdisciplinary team.

#### **DISCHARGE/TRANSITION PLANNING**

**CRITERION 1.f:** Application of discharge and aftercare planning protocols that facilitate a successful transition

**CRITERION 4:** The extent to which the respondent describes an approach that supports care delivery in the most appropriate and cost-effective setting and avoids unnecessary institutionalization (i.e., hospital or nursing facility care) or emergency department use>

Aetna focuses on enrollees like Robert who have a pattern of high utilization, in his case having been to the ED three or more times in a quarter. Our care management team sends written notification to the PCP communicating the number of visits made in the quarter. In addition, our care manager would reach out to Robert to determine the root cause of the ED visits and provide education on the benefits of visiting his PCP instead of the ED to enhance the continuum of care. The care manager would also discuss Robert's most recent ED visit with his PCP.

## **EXHIBIT A-4-a**

### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

#### **Care Delivery in the Most Appropriate and Cost-Effective Setting**

Aetna's overarching goal is to prevent all avoidable inpatient admissions. COPD is among the leading causes for admissions and readmissions in the State. Our strategy for reducing hospital admissions includes real-time identification via the ENS of any enrollee with an inpatient stay, observation stay, or ED visit. Those enrollees are treated as the highest risk for readmission. From the outset (day one) of an inpatient stay, our concurrent review clinicians and care managers review the admission medically and also identify behavioral, social, or other contributing factors or root causes of the admission, which enables us to understand and prevent discharge planning failures that can lead to readmission (e.g., not repeating the same discharge plan if there is a readmission).

Aetna's transition of care clinician collaborates with our concurrent review staff and care managers, hospital discharge planners, clinical pharmacists, and providers to offer assistance and connect with enrollees who have trigger diagnoses, including COPD. The transition of care clinician attends daily rounds with the medical director and concurrent review clinician, which allows the transition of care clinician to identify enrollees that are pending discharge and will require assistance with transition. The transition of care clinician reaches out to the hospital discharge planner to identify the enrollee's needs upon discharge. Relying on the orders from the attending physician, the hospital discharge planner's assessment, and the concurrent review clinician's clinical notes, the transition of care clinician assesses whether the enrollee is appropriate for a safe discharge to home with or without support services or if the enrollees requires discharge to an alternative setting.

The transition of care clinician completes face-to-face visits with the enrollee and his/her responsible parties in the acute care setting and in other care settings as needed, including the home environment. One of the goals of our face-to-face visits is to provide patient education about his/her condition and plan benefits, ensuring the enrollee is appropriately educated about what to expect after discharge and what his/her responsibilities are to support a successful transition of care.

Effective transitions of care are critical to maintaining and improving enrollees' quality of care, quality of outcomes, and most importantly, quality of life. We recognize the need to help ensure a seamless transition of care with a goal toward improved health and recovery, coordination of care, and a reduction in readmissions. Because enrollees can be at significant risk when transitioning between care settings, effective care transitions are vital to decreasing potentially preventable events. Our integrated care management model uses a strengths-based approach to empower the enrollee to achieve his or her own optimal level of functioning.

Robert's utilization increased, suggesting a change in health status, which indicates something changed in the preceding period. We would explore the following root causes:

- Did Robert stop all his medications because he could not afford them when a new demand became more important or because he became acutely depressed, etc.?
- Did his son start smoking cigarettes or marijuana?
- Has his son's behavior become disruptive or threatening?
- Is Robert's living environment not healthy, e.g., dirty, cluttered, etc.?

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

The care manager will work with Robert to mitigate social issues and to complete referrals for behavioral health services including substance use concerns. The goal of PCP notification is so the physician can outreach the enrollee and attempt to schedule visits in lieu of ED visits.

Robert will receive care management support until he is capable of self-managing his plan of care. The care manager meets with him on a mutually agreed-upon schedule—at least monthly—and together they review Robert's progress toward achieving his plan of care goals and any barriers he is facing.

### **DISEASE MANAGEMENT**

**CRITERION 1.i:** Identification of strategies that promote enrollee self-management and treatment adherence

Aetna's disease management program focuses on enrollees like Robert with specific chronic conditions, such as COPD, and includes patient education, smoking cessation program, care management interventions, coordination with PCPs and specialists, and regular follow-up with Robert to ensure adherence to his treatment plan. Aetna has designed our disease management program to address those enrollees most likely to be high ED utilizers related to their diagnosis and severity of illness.

Robert would receive mailings of Krames patient education materials specific to COPD as well as COPD-specific newsletters twice a year. He also would be supported by the MyActiveHealth enrollee portal with information on COPD available in multiple formats: digital coaching, videos, and audio files, to name a few. The following are educational focus areas for COPD:

- COPD self-care, normal progression of COPD, common complications, signs of complications, methods of self-condition management
- Environmental triggers for COPD
- Smoking cessation
- Nutrition, where applicable
- Importance of physical activity and COPD control as recommended by enrollee's provider(s)
- Appropriate in-office respiratory tests
- Medication management, including inhalers, for enrollees with COPD
- COPD action plan
- Alternate breathing techniques
- Oxygen usage when needed
- Details on COPD complications and risks
- Additional educational information on specific complications and conditions for enrollees with special risks or complications
- Information on how to use the Nurse line (available 24/7)
- The importance of working with health practitioner in a partnership toward healthier behavior

Additionally, we would educate Robert on his pre-diabetes condition using materials on weight management, nutrition, and exercise, in addition to care management interventions. As appropriate, we would also make a referral to a dietitian or nutritionist for counseling services.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

We would encourage Robert to do the following:

- Consult with his PCP about preventing or delaying the development of type-2 diabetes
- Complete a diabetes screening
- Eat healthful foods such as lean meats or protein substitutes, fresh vegetables, high-fiber starches, and healthful fats
- Reduce toxic stress levels with coping techniques such as exercise and meditation
- Exercise—gradual to moderate aerobic exercise for 30 minutes five days a week
- Manage his medication

### **UTILIZATION MANAGEMENT**

CRITERION 1.j: Application of utilization management protocols (i.e., identification of the criteria that will be utilized, processes to ensure continuity of care, etc.)

Our utilization management program is designed to ensure Robert receives the most medically appropriate, cost-effective health care to improve his physical and behavioral health outcomes and to improve access to preventive services. Using an interdepartmental approach, our Utilization Management and Care Management team members work in concert to educate providers regarding covered services and to help ensure Robert receives the services he needs—when and where he needs them. Utilization Management staff collaborates and consults with Robert's interdisciplinary care team, including through peer-to-peer calls, so that we reach consensus rapidly on the most appropriate course of Robert's care.

The scope of utilization management activities covers all clinical aspects of preventive, diagnostic, and treatment services in both the inpatient and outpatient settings, which include physical health, behavioral health, and pharmacy. These programs are all inter-related and integrate physical and behavioral health components to assure Robert receives consistent access to care and services across the service network, as well as quality, cost-effective care in a timely manner.

Our utilization management program incorporates utilization management decision-making criteria using appropriate evidenced-based clinical settings and services to treat co-occurring behavioral and physical disorders. Integrated with our quality management program, Aetna's utilization management program pursues the common principle of providing optimal clinical practices in all settings by balancing behavioral/physical health management, operations, and finance components.

Utilization management's goals for Robert include the following:

- Assuring he receives continuing care through his established, current providers within the first 60 days, allowing for further assessment of needed services
- Practicing fully integrated utilization processes with care management and pharmacy to provide seamless access for Robert

Our qualified and trained staff members are guided by established medical necessity criteria, but ultimately make determinations based on clinical judgement in the best interest of the enrollee, including consideration to specific and unique characteristics such as the local delivery system and the enrollee's age, comorbidity, complications, progress in treatment, psychosocial

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

situation, and home environment. If prior authorization is necessary, the following criteria and guidelines are utilized:

- Florida Medicaid contractual requirements and limitations
- MCG (Milliman Care Guidelines)
- Aetna Clinical Policy Bulletins (CPB)
- Other (e.g. specialty society guidelines)

Aetna will provide standard authorization decisions within seven days and within 48 hours for an expedited review following receipt of the request for service, in compliance with Attachment B of the Invitation to Negotiate. We provide expedited authorization decisions within 48 hours after receipt of the request for service.

### **INTEGRATION OF INFORMATION ACROSS ALL SYSTEMS**

**CRITERION 7:** The extent to which the respondent describes innovative and evidence-based strategies to integrate information across all systems/processes into its workflows

Our program integrates systems for managing, monitoring, evaluating, and improving the utilization of the care and services enrollees receive, including automated synchronization of prior authorization decisions with claims processing. Robert's providers can view prior authorization status in real time using the provider portal. The system facilitates care by informing providers of whether a request has been approved, denied, or downgraded. A provider can request a peer-to-peer review based on an authorization decision. Additionally, Aetna fully facilitates the integration of the physical and behavioral health care services contracted providers render.

Aetna's Utilization Management Prior Authorization staff manages authorizations for all services and procedures as well as non-emergent/elective hospitalizations before an enrollee like Robert receives the service. Prior authorization confirms that requested services are for eligible enrollees, making sure they are:

- Included in the defined benefits
- Provided at an appropriate level of care and place of service
- Appropriate, timely, and cost-effective
- Documented accurately to facilitate timely reimbursement and reporting
- Coordinated with medical management and communicated to applicable operations areas (e.g., Finance, Enrollee Services, Provider Services) or per contractual requirement with external vendors

Aetna has made a significant commitment to decreasing the administrative burden of the prior authorization process on our providers and enrollees. Based on a continuous evaluation process, we recently identified more than 500 codes that will be removed and more than 300 codes have been identified for eventual movement from prior authorization to reduce the administrative burden.

Aetna utilizes national policies and processes for adopting and updating evidence-based clinical practice guidelines and preventative services guidelines from recognized sources that follow NCQA standards.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Aetna uses drug utilization review to analyze enrollee and practitioner drug utilization patterns to identify educational and/or intervention opportunities that promote enrollee safety and appropriate utilization, monitor quality outcomes, and to drive cost-effective drug therapy.

Additionally, our pharmacy benefit manager, CVS, proactively communicates with providers when enrollees stop using prescribed therapies so that providers can contact those enrollees, encourage them to keep taking their medications, and explain why it is important to do so. Improved adherence with medication regimens can help slow disease progression and reduce medical costs. Through retrospective claims review, we will also use Pharmacy Advisor® Support to identify gaps in medication therapy, turning the prescription benefits plan into a powerful early warning system for enrollee care. CVS will identify enrollees who may need additional medication or are taking an inappropriate or ineffective therapy. Within 72 hours of claims adjudication, CVS assesses drug profiles for potential issues or complications. CVS communicates in writing the identified opportunities, clinical recommendations, and associated clinical references to the provider.

### **Delegated Providers and Subcontractors**

Should Robert's PCP or specialists order diagnostic studies, such as a CT scan or an MRI, they can contact our delegated subcontractor, eviCore. EviCore completes prior authorization for specific tests and interventional pain management. Aetna delegates this procedure review to eviCore to ensure quality and appropriateness of services. Providers can make their requests directly to eviCore using their provider portal, by facsimile, or by telephone. EviCore complies with the Agency turnaround time requirements for review and authorization and their physician reviewers are available to speak with Robert's provider if he or she wants to know why a service was not authorized. Aetna's Utilization Management staff works closely with eviCore to ensure that any provider or enrollee issues are resolved quickly. Our care managers expedite authorizations as needed to ensure that there are no delays or gaps in care. In addition, Aetna provides oversight to our delegated subcontractors through regular joint operating meetings, monthly reporting, and monitoring of performance measures.

Another provider to which Robert may be referred is Beacon, which employs Utilization Management staff members that are embedded in the health plan and working side by side with Aetna's care management staff, collaborating on root cause analysis and shaping the enrollee's plan of care. Aetna utilizes Beacon's network of behavioral health specialists to treat enrollees with behavioral health conditions utilizing collaborative care, Project ECHO™, and psychiatric consultation.

Aetna provides oversight of Beacon through weekly joint case rounds and regular reporting and monitoring of performance measures. If Robert was to have a behavioral health-related hospital admission, Beacon's Utilization Management staff would immediately inform Aetna's care management staff using Beacon's Utilization Management business application's census report. Beacon and Aetna collaborate on the root cause analysis of the current admission, on discharge planning, and on engaging members in care management.

### **Grievances and Appeals**

Although grievance and appeals is not directly addressed in this vignette, Aetna places great importance on helping to make sure enrollees like Robert are appropriately educated on their

**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

health care and their rights as enrollees. The care manager would work closely with Robert to provide thorough and accurate information regarding complaint, grievance, and appeal processes and procedures. Our goal is to make enrollees' lives easier and not burden them with undue administrative challenges.

Enrollee education includes availability of assistance in the filing process, the procedure for filing a grievance or appeal, the right to representation (self, legal counsel, relative, friend, provider); procedures for exercising the rights to request a State Fair Hearing within a specified time frame; the requirement that internal appeals must be exhausted before requesting a State Fair Hearing; the right to continue benefits at the current level if the appeal or State Fair Hearing is requested within the specified time frame; and that the enrollee may be required to pay the cost of services furnished if the final decision is adverse to the enrollee.

Aetna will resolve complaints by close of business on the business day following receipt, in compliance with Attachment B. We will review grievances and provide written notice of results to the enrollee within 90 calendar days from the receipt date of the grievance. State Fair Hearings must be requested in writing. Grievances may be requested at any time, appeals must be requested within 60 calendar days of the initial denial, and State Fair Hearings must be requested within 120 calendar days of the appeal decision letter.

Enrollees may continue to receive services during an appeal or State Fair Hearing process whenever they meet required conditions.

**ACTUAL ENROLLEE EXPERIENCE**

**CRITERION 5:** The extent to which the respondent demonstrates experience in providing services to enrollees with complex medical needs and provides evidence of strategies utilized that resulted in improved health outcomes

[REDACTED]

[REDACTED]

[REDACTED]

**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
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**WORKFLOW**

CRITERION 2: The extent to which the respondent's workflows/narrative descriptions include timeframes for completion of each step in the care planning process

Our narrative includes a detailed description and timeframes for each step supporting Robert's care planning and care coordination process. Robert has significant biopsychosocial needs that will be supported with extensive coordination of care among his care manager, providers, service providers, and wraparound resources. Support for Robert includes the following timeline:

- Robert's name would appear on a new enrollee file in Aetna's system beginning December 2016.
- Aetna would identify Robert as a high-risk enrollee likely to benefit from care management through at least one of the following methods:
  - Within 30 days of receiving Robert's 4 years of claims from the State, Aetna would run a CORE report that could identify Robert as high risk.
  - Upon notification of his second ED visit within 30 days, Aetna would identify him high-risk and refer him to care management.
  - Within 30 days of his enrollment, Aetna would make a welcome call to Robert that includes a brief health screening. Confirmative responses would prompt a referral and warm transfer to a care management associate with Robert's consent.
- We would make every effort to meet with Robert to complete a comprehensive assessment and begin developing his plan of care within one week of being stratified for intensive care management.
- The care manager and Robert will finalize his plan of care within five days of the initial home visit.
- Aetna will authorize and initiate services identified on Robert's plan of care within 14 days of plan of care development, or sooner if necessary.
- Aetna will provide standard authorization decisions within seven days following receipt of the request for service. We will provide expedited authorization decisions within 48 hours after receipt of the request for service.

Figure SRC 8-1: Continuum of care for Robert in Attachment SRC 8 provides an illustration of a detailed workflow demonstrating notable points in the care management and care coordination processes for Robert. Our support begins with identification of Robert. We learn about Robert through a comprehensive assessment process in which we partner with him to develop a plan of care. We support Robert with an integrated care management approach focused on achieving personal goals as determined by Robert.

**Evaluation Criteria:**

1. The adequacy of the respondent's approach in addressing the following:

**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
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- a. Identification processes for enrollees with complex health conditions or who are in need of care coordination;
  - b. Description of the sources of data/information that would be utilized in the assessment process, including timeframes for completion;
  - c. Application of the respondent's case management risk stratification protocol;
  - d. Identification of service needs (covered and non-covered) and a description for service referral processes;
  - e. Description of the interventions and strategies that would be used to facilitate compliance with the plan of care, including use of incentives, healthy behavior programs, etc.;
  - f. Application of discharge and aftercare planning protocols that facilitate a successful transition;
  - g. Application of coordination protocols utilized with other insurers (when applicable), primary care providers, specialists, other services providers, and community partners particularly when referrals are needed for non-covered services;
  - h. Description of the assessment of provider capacity to meet the specific needs of enrollees;
  - i. Identification of strategies that promote enrollee self-management and treatment adherence;
  - j. Application of utilization management protocols (i.e., identification of the criteria that will be utilized, processes to ensure continuity of care, etc.); and
  - k. Application of strategies to integrate enrollee information across the plan and various subcontractors when the respondent has delegated functions.
2. The extent to which the respondent's workflows/narrative descriptions include timeframes for completion of each step in the care planning process.
  3. The extent to which the respondent demonstrates innovative and evidence-based processes that it has in place to enhance communication among all service providers and subcontractors (for delegated functions).
  4. The extent to which the respondent describes an approach that supports care delivery in the most appropriate and cost-effective setting and avoids unnecessary institutionalization (i.e., hospital or nursing facility care) or emergency department use.
  5. The extent to which the respondent demonstrates experience in providing services to enrollees with complex medical needs and provides evidence of strategies utilized that resulted in improved health outcomes.
  6. The extent to which the respondent demonstrates a system of coordinated health care interventions designed to achieve cost savings through the organized and timely delivery of high quality services.
  7. The extent to which the respondent describes innovative and evidence-based strategies to integrate information across all systems/processes into its workflows.

**Score:** This section is worth a maximum of 85 raw points with each of the above components being worth a maximum of 5 points each.

**EXHIBIT A-4-a**  
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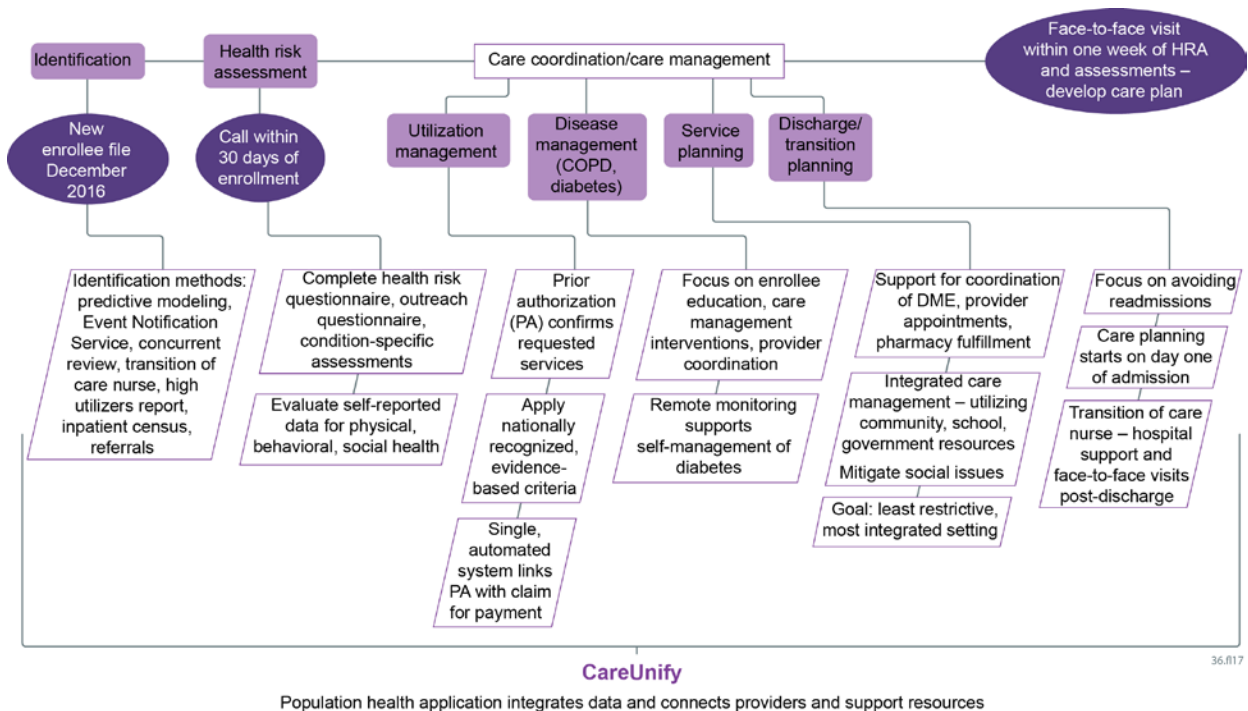
## **Attachment SRC# 8**



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SRC# 8: Figure SRC 8-1: Continuum of care for Robert



**Figure SRC 8-1: Continuum of care for Robert**

*Robert is supported by our integrated care management model encompassing enrollee assessment, care coordination, utilization management, disease management, and discharge planning. CareUnify technology enhances data integration and communication among Robert's providers and supports.*



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**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**C. RECIPIENT EXPERIENCE**

**SRC# 9 – Expanded Benefits (Regional):**

Based upon the expanded benefits listed in **Exhibit A-4-a-2**, Expanded Benefits Tool, the respondent shall identify the benefits it proposes to offer its enrollees for all eligible populations (TANF, ABD, dual eligible, and LTC populations). **Exhibit A-4-a-2**, Expanded Benefits Tool outlines specific expanded benefits, including category, procedure code descriptions and procedure codes. When electing to offer expanded benefits included in **Exhibit A-4-a-2**, Expanded Benefits Tool, the respondent must offer the benefit in its entirety, including all procedure codes (and minimum quantity limits) listed in **Exhibit A-4-a-2**.

**Response:** The respondent shall select the following expanded benefits it will offer, as listed in **Exhibit A-4-a-2**, Expanded Benefits Tool (Respondent shall check all that apply):

- ☒ Dental benefits for adults
- ☒ Over-the-counter benefits
- ☒ Occupational Therapy benefits for adults
- ☒ Physical Therapy benefits for adults
- ☒ Hearing benefit for adults
- ☒ Vision benefit for adults
- ☒ Prenatal benefit
- ☒ Respiratory Therapy benefit for adults
- ☒ Speech Therapy benefit for adults
- ☒ Additional Primary Care services benefit
- ☒ Newborn Circumcision benefit

**Evaluation Criteria:**

**Score:** This section is worth a maximum of 190 raw points as outlined below.

- |            |   |        |
|------------|---|--------|
| <b>(a)</b> | Election of the Dental benefit for adults:                | 50 pts |
| <b>(b)</b> | Election of the Over-the-counter benefit:                 | 25 pts |
| <b>(c)</b> | Election of the Occupational Therapy benefits for adults: | 20 pts |
| <b>(d)</b> | Election of the Physical Therapy benefit for adults:      | 20 pts |
| <b>(e)</b> | Election of the Prenatal benefit:                         | 20 pts |
| <b>(f)</b> | Election of the Hearing benefit for adults:               | 10 pts |
| <b>(g)</b> | Election of the Vision benefit for adults:                | 10 pts |
| <b>(h)</b> | Election of the Respiratory Therapy benefit for adults:   | 10 pts |
| <b>(i)</b> | Election of the Speech Therapy benefit for adults:        | 10 pts |
| <b>(j)</b> | Election of the Additional Primary Care services benefit: | 10 pts |
| <b>(k)</b> | Election of the Newborn Circumcision benefit:             | 5 pts  |

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**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**SRC# 10 – Additional Expanded Benefits (Regional)**

The respondent shall identify each additional expanded benefit that it proposes to offer its enrollees by eligible population (TANF, ABD, dual eligible, and LTC populations). For the purposes of this SRC, the respondent must not select expanded benefits that are included in **Exhibit A-4-a-2**, Expanded Benefits Tool described in SRC# 9. The respondent shall include the name of the benefit, procedure code descriptions, procedure codes and any limitations (frequency/duration, etc.).

The respondent shall submit documentation that includes the calculations used to determine the per-member-per-month (PMPM) cost and the data source used for the calculations (e.g. previous SMMC experience, commercial experience). The submitted PMPM cost must be developed on a “total member” basis, rather than a “per user” or “per benefit eligible” basis (e.g., if the benefit is for adults only, do not submit the expected monthly cost per adult but rather the expected cost per member; or, if the benefit is for the household, its expected monthly cost must be converted to the expected cost per member) and should exclude administrative costs. The respondent shall submit **Exhibit A-4-a-3**, Additional Expanded Benefits Template (Regional).

**Response:**

Please refer to Exhibit A-4-a-3, attached.

**Evaluation Criteria:**

- a. The extent to which the respondent identifies the expanded benefits it will provide and the information included in **Exhibit A-4-a-3**, Additional Expanded Benefits Template (Regional).

**Score:** This section is worth a maximum of 5 raw points with the above component being worth a maximum of 5 points.

**Note:** Pursuant to Section 409.966(3)(c)6., Florida Statutes, response to this submission requirement will be considered for negotiations.

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**Exhibit A-4-a-3**  
**SRC# 10 - ADDITIONAL EXPANDED BENEFITS TEMPLATE (REGIONAL)**

Benefit Category	Procedure Code Description	Procedure Code	Min Age	Max Age	Current Florida Medicaid Coverage (Adults)	Expanded Benefit Coverage (Units)	Co-payment Requirements	PM/PM Cost	Eligible Populations	Rationale for Offering this Benefit
Home Health Care Home visit services provided home health aide or nurse	HOM HLTH AIDE/CERT NURSE ASST PROV CARE HOM;-HR S9123 S9124 T1030 NURSING CARE THE G0155 HOME; REGISTERED NURSE PER HOUR S9347 NURSING CARE IN THE T1021 HOME; BY LPN PER HOUR NURSING CARE THE HOME REGISTERED NURSE PER DIEM SRVC CLINICAL SOCIAL WORKER HH/HOSPICE EA 15 MIN HIT UNINTRPED LNG- TERM CNTRL RATE IV/SUBQ;-DIEM HOME HEALTH AIDE/CERTIFIED NURSE ASST PER VISIT	S9122 S9123 S9124 T1030 G0155 S9347 T1021	21	No Max	Not Covered	Unlimited/ PA Required	No Copay	\$0.04	TANF/ABD/Dual Eligible Non-Pregnant Members	Will help to enable adult members regain maximum function, preventing ER visits, readmits and physicians visits resulting from deterioration of conditions or lack of condition improvement due to imposition of contractual home health visit limitation. This expanded home health services benefit is "in lieu" of admissions in a nursing home. Prior authorization process will ensure that services are only provided when they can be impactful and not for the convenience of the Enrollee.
	Medically Related Lodging & Food Max \$150 per day for travel/food for medically necessary services over 200 miles from service area	LODGING PER DIEM NOT OTHERWISE SPECIFIED S9994 LODGING COSTS CLINICAL S9975 TRIAL PRTCP&ONE S9977 CAREGIVR S9996 TRANSPLANT REL LODG MEALS & TRNSPRT PER DIEM MEALS PER DIEM NOT OTHERWISE SPECIFIED	No Min	No Max	Not Covered	Max \$150 per day/ PA Required	No Copay	\$0.01	TANF/ABD/Dual Eligible	Helps to ensure members receive necessary services which may be difficult to obtain when experienced, appropriate and more cost effective providers are not in the service area. May reduce costs for members who would otherwise need to receive services from non-par provider

**Exhibit A-4-a-3**  
**SRC# 10 - ADDITIONAL EXPANDED BENEFITS TEMPLATE (REGIONAL)**

Benefit Category	Procedure Code Description	Procedure Code	Min Age	Max Age	Current Florida Medicaid Coverage (Adults)	Expanded Benefit Coverage (Units)	Co-payment Requirements	PMPM Cost	Eligible Populations	Rationale for Offering this Benefit
Nutritional Counseling  Unlimited nutritional counseling by health plan network providers	NUTRITION CLASSES NON- PHYSICIAN PER SESSION NUTRITIONAL COUNSELING DIETITIAN VISIT MED NUT TX; REASSESS FLW 2 REF YR W/PT EA 15 MIN MED NUT TX REASSESS FLW 2 REF YR GRP EA 30 MIN MED NUTR THER 1ST ASSMT&IVNTJ INDIV EA 15 MIN MED NUTR THER GRP2/> INDIV EA 30 MIN	S9452 S9470 G0270 G0271 97802 97804	No Min	No Max	Not Covered	Unlimited/ PA Required for non- participating providers or at home place of service	No Copay	\$0.02	TANF/ABD/Du al Eligible	Allows members to achieve optimum nutritional support in order to improve health, healing, and immune response; should reduce costs associated with conditions resulting from poor nutrition including dehydration, obesity, vitamin deficiencies, and excess sugar intake
	Physician Home Visits	All visit related codes  POS = 12 & provider type = PCP or physician	21	No Max	Not Covered	Physician Home Visits - One (1) additional PCP home visit per month; One (1) additional specialist home visit per month.	No Copay	\$0.01	TANF/ABD/Du al Eligible	Will help close gaps in care and provide medical care to those unable to leave their home due to physical or geographical barriers. Should reduce ER utilization and medical complications resulting from deficiencies in care due to member's refusal to leave their home
	Post-Discharge Meals	HOME DELIV MEALS INCLUDING PREPARATION; PER MEAL	21	No Max	Not Covered	Ten (10) home delivered meals after hospital discharge; Limit – two (2) discharges per year. PA is required for non-par	No Copay	\$0.02	TANF/ABD/Du al Eligible	Will assist members in achieving post discharge stabilization and recovery; will reduce readmissions associated with members not receiving adequate nutrition post-hospitalization

**Exhibit A-4-a-3**  
**SRC# 10 - ADDITIONAL EXPANDED BENEFITS TEMPLATE (REGIONAL)**

Benefit Category	Procedure Code Description	Procedure Code	Min Age	Max Age	Current Florida Medicaid Coverage (Adults)	Expanded Benefit Coverage (Units)	Co-payment Requirements	PMPM Cost	Eligible Populations	Rationale for Offering this Benefit
Adult Influenza Vaccine	FLU VACCINE ADJUVANT IM INFLUENZA VACCINE PRSV FREE ID USE ADMINISTRATION OF INFLUENZA VIRUS VACCINE	90653 90654 G0008 90660 90661 Q2034 90673 90664 90666 90668 90672 90685 90686 90687 90688 Q2035 Q2036 Q2037 Q2038 Q2039	21	No Max	Not Covered	Two (2) vaccinations per year  Two (2) vaccinations per year.	No Copay	\$0.01	TANF/ABD/Dual Eligible	Will remove financial barriers in achieving maximum vaccination coverage; will reduce serious complications from influenza illness and resulting PPEs (e.g. ER visits, hospitalizations, and preventable physician and specialist visits)
	FLU VACCINE NASAL INFLUENZA VACCINE CELL CULT PRSRV FREE IM FLU VIRUS VAC SPLIT VIRUS INTRAMUSCULAR AGRIFLU RIV3 VACCINE PRESERVATIVE FREE FOR IM USE INFLUENZA VACCINE PANDEMIC LIVE INTRANASAL USE INFLUENZA VACCINE PANDEMIC SPLIT PRSRV FREE IM INFLUENZA VACCINE PANDEMIC IM USE FLU VACCINE 4 VALENT NASAL									
Adult Shingles Vaccine	VARICELLA-ZOSTER IMMUNE GLOBULIN HUMAN IM ZOSTER SHINGLES VACCINE LIVE SUBCUTANEOUS	90396 90736	21	No Max	Not Covered	One (1) vaccination per lifetime; prior authorization required for enrollees less than sixty (60) years old	No Copay	\$0.01	TANF/ABD/Dual Eligible	Will remove financial barriers in achieving maximum Shingles vaccination coverage; will reduce incidence of debilitating and painful complications from Shingles disease and resulting PPEs (e.g. ER visits, hospitalizations, and preventable physician and specialist visits)

**Exhibit A-4-a-3**  
**SRC# 10 - ADDITIONAL EXPANDED BENEFITS TEMPLATE (REGIONAL)**

Benefit Category	Procedure Code Description	Procedure Code	Min Age	Max Age	Current Florida Medicaid Coverage (Adults)	Expanded Benefit Coverage (Units)	Co-payment Requirements	PMPM Cost	Eligible Populations	Rationale for Offering this Benefit
Adult Pneumonia Vaccine	PNEUMOCOCCAL CONJ VACCINE 13 VALENT IM PNEUMOCOCCAL POLYSAC VACCINE 23-V 2 YR + SUBQ/IM ADMINISTRATION OF PNEUMOCOCCAL VACCINE	90670 90732 G0009	21	No Max	Not Covered	One (1) vaccination every five (5) years; subject to prior authorization	No Copay	\$0.01	TANF/ABD/Dual Eligible	Will remove financial barriers in achieving maximum Pneumonia vaccination coverage; will reduce serious complications and death resulting from Pneumococcal Pneumonia and resulting PPEs (e.g. ER visits, hospitalizations, and preventable physician and specialist visits)
Waived Copayments - Copayments waived on all covered services and enhanced benefits	All applicable services	All applicable procedure codes	21	No Max	Not Covered	Copayments are waived for services specified under Medicaid Payment Policy PA is required for non-par	No Copay	\$0.20	TANF/ABD/Dual Eligible	Copayments are a barrier to necessary care that could prevent ER visits and hospitalizations; they are also difficult and costly to administer

**Exhibit A-4-a-3**  
**SRC# 10 - ADDITIONAL EXPANDED BENEFITS TEMPLATE (REGIONAL)**

Benefit Category	Procedure Code Description	Procedure Code	Min Age	Max Age	Current Florida Medicaid Coverage (Adults)	Expanded Benefit Coverage (Units)	Co-payment Requirements	PMPM Cost	Eligible Populations	Rationale for Offering this Benefit
Bed Hold	ASSISTED LIVING WAIVER; PER MONTH	T2030	21	No Max	Not Covered	21 bed day hold for ALFs and AFCHs No prior authorization All eligibles	No Copay	\$0.00	LTC/Dual Eligible	Covering bed days will ensure members in ALFs and AFCHs do not lose their slot in the facility due to hospitalization. Losing a bed in an ALF or AFCH can cause enrollees to suffer medical and psychological harm from such an upheaval. The prospect of facing a new bed and a new room each time an Enrollee returns from a brief leave can be confusing – and ultimately put that enrollee's health at risk. This coverage will also help prevent HCBS members from lapsing into a nursing facility post hospitalization.

**Exhibit A-4-a-3**  
**SRC# 10 - ADDITIONAL EXPANDED BENEFITS TEMPLATE (REGIONAL)**

Benefit Category	Procedure Code Description	Procedure Code	Min Age	Max Age	Current Florida Medicaid Coverage (Adults)	Expanded Benefit Coverage (Units)	Co-payment Requirements	PMPM Cost	Eligible Populations	Rationale for Offering this Benefit
Transition from nursing home to community	Maximum two thousand and five hundred dollars (\$2500) per enrollee per lifetime to assist with transition costs and/or moving expenses when moving from Skilled Nursing Facilities into a community setting; may be used in conjunction with the Emergency Financial Assistance benefit; however, the total amount for both benefits shall not exceed two thousand and five hundred dollars (\$2500) cumulatively; subject to prior authorization.	N/A	21	No Max	Not Covered	Up to \$2,500 per lifetime for deposits, household furnishings/supplies, and moving expenses for your own home from a skilled nursing facility	No Copay	\$1.08	LTC/Dual Eligible	Helps LTC members in nursing homes transition to the community by providing funds to obtain services such as electricity (money used for deposit) or furniture which are necessary for a member to move to the home setting.

**Exhibit A-4-a-3**  
**SRC# 10 - ADDITIONAL EXPANDED BENEFITS TEMPLATE (REGIONAL)**

Benefit Category	Procedure Code Description	Procedure Code	Min Age	Max Age	Current Florida Medicaid Coverage (Adults)	Expanded Benefit Coverage (Units)	Co-payment Requirements	PMPM Cost	Eligible Populations	Rationale for Offering this Benefit
Emergency Financial Assistance	Maximum of two hundred and fifty dollars (\$250) per community-based enrollee per year to assist with a health crisis, personal loss, rent, housing or utilities after the managed care plan has attempted to assist the enrollee with other avenues of funding; funds shall be paid directly to vendors; benefit may be used in conjunction with the Support to Transition out of a Nursing Facility benefit; however, the total amount for both benefits shall not exceed two thousand and five hundred dollars (\$2500) cumulatively; subject to prior authorization.	N/A	21	No Max	Not Covered	Maximum of two hundred and fifty dollars (\$250) per community-based enrollee per year	No Copay	\$0.24	LTC/Dual Eligible	Helps to ensure that LTC members in the home and community setting are able to stay in that setting and are not forced to move to a nursing facility due to resource issues.
Shelf-stable Meals w/water	HOME DELIV MEALS INCLUDING PREPARATION; PER MEAL	S5170	21	No Max	Not Covered	Ten (10) shelf-stable meals with (2) cases of water prior to a hurricane or other disaster for enrollees at significant nutritional risk.	No Copay	\$1.32	LTC/Dual Eligible	Helps ensure that LTC members in the home and community based setting are able to stay in that setting during a disaster and are not forced to move to a nursing facility or have an ER admission due to lack of food. Lessens the anxiety of preparing for a storm when stores are no longer adequately stocked.





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## **Exhibit A-4-a-3**

### **Supporting Documentation**



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Benefit Category	PMPM Cost	Data Source	Calculations
Home Health Care Home visit services provided home health aide or nurse	\$0.04	2016 ASR, paid through 3/31/17 Coventry, Region 11	<i>Note: PMPM cost provided is relative to total MMA population.</i> Total CY 2016 expense for this benefit = \$26,342 CY 2016 MMA member months = 690,842 Cost PMPM = \$0.04
Medically Related Lodging & Food Max \$150 per day for travel/food for medically necessary services over 200 miles from service area	\$0.01	Actuarial Judgment	<i>Note: PMPM cost provided is relative to total MMA population.</i> Total CY 2016 expense for this benefit per ASR = \$0. Assuming \$0.01 PMPM, consistent with cost projection when benefit was first added.
Nutritional Counseling  Unlimited nutritional counseling by health plan network providers	\$0.02	2016 ASR, paid through 3/31/17 Coventry, Region 11	<i>Note: PMPM cost provided is relative to total MMA population.</i> Total CY 2016 expense for this benefit = \$16,313 CY 2016 MMA member months = 690,842 Cost PMPM = \$0.02
Physician Home Visits	\$0.01	2017 ASR, paid through 6/30/17 Coventry, Region 11	<i>Note: PMPM cost provided is relative to total MMA population.</i> Total 1Q 2017 expense for this benefit = \$269 1Q 2017 MMA member months = 44,185 Cost PMPM = \$0.01
Post-Discharge Meals	\$0.02	2017 ASR, paid through 6/30/17 Coventry, Region 11	<i>Note: PMPM cost provided is relative to total MMA population.</i> Total 1Q 2017 expense for this benefit = \$798 1Q 2017 MMA member months = 44,185 Cost PMPM = \$0.02
Adult Influenza Vaccine	\$0.01	2017 ASR, paid through 6/30/17 Coventry, Region 11	<i>Note: PMPM cost provided is relative to total MMA population.</i> Total 1Q 2017 expense for this benefit = \$251 1Q 2017 MMA member months = 44,185 Cost PMPM = \$0.01



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Benefit Category	PMPM Cost	Data Source	Calculations
Adult Shingles Vaccine	\$0.01	Actuarial Judgment	<i>Note: PMPM cost provided is relative to total MMA population.</i> Total CY 2016 and 1Q 2017 expense for this benefit per ASR = \$0. Assuming \$0.01 PMPM.
Adult Pneumonia Vaccine	\$0.01	2017 ASR paid through 6/30/17 Coventry, Region 11	<i>Note: PMPM cost provided is relative to total MMA population.</i> Total 1Q 2017 expense for this benefit = \$377 1Q 2017 MMA member months = 44,185 Cost PMPM = \$0.01
Waived Copayments - Copayments waived on all covered services and enhanced benefits	\$0.20	Coventry's MMA Expanded Benefits Template provided to the Agency on 3/27/17	<i>Note: PMPM cost provided is relative to total MMA population.</i> Total Jan - Jun 2016 expense for this benefit = \$67,309 Jan - Jun 2016 MMA member months = 330,633 Cost PMPM = \$0.20
Bed Hold	\$0.00	Actuarial Judgment	<i>Note: PMPM cost provided is relative to total LTC population.</i> Cost is included in underlying base data. Unable to separate from standard ALF capitation payments.
Transition from nursing home to community	\$1.08	Internal Coventry data on Transition payments made from Jan - Jun 2017, paid through Jun 2017	<i>Note: PMPM cost provided is relative to total LTC population.</i> Total Jan-Jun 2017 expense for this benefit = \$25,671 Nursing Home member months Jan - Jun 2017 = 12,226 Nursing Home Member Cost PMPM = \$2.10 Assumed Nursing Home member months as % of total LTC member months in RY 18/19 (all 11 regions) = 51.5% Total Cost PMPM = (\$2.10 x 51.5%) + (\$0 x 48.5%) = \$1.08
Emergency Financial Assistance	\$0.24	Internal Coventry data on Emergency Financial Assistance payments made from Jan - Sep 2017, paid through Sep 2017	<i>Note: PMPM cost provided is relative to total LTC population.</i> Total Jan-Sep 2017 expense for this benefit = \$10,620 LTC member months Jan - Sep 2017 = 45,120 Cost PMPM = \$0.24



Benefit Category	PMPM Cost	Data Source	Calculations
Shelf-stable Meals	\$1.32	Meals: Internal Coventry data for payments made in 2017  Water: Estimated	<p>Note: PMPM cost provided is relative to total LTC population.</p> <p>Cost of 10 meals paid for all enrollees at significant nutritional risk in 2017 = \$80,673</p> <p>Estimated cost of 2 cases of water for each eligible enrollee = \$15,000</p> <p>Estimated CY 2017 HCBS member months = 35,200</p> <p>Anticipated # incidences = 1</p> <p>HCBS Member Cost PMPM = <math>[(\\$80,673 + \\$15,000) \times 1] / 35,200 = \\$2.72</math></p> <p>Assumed HCBS member months as % of total LTC member months in RY 18/19 (all 11 regions) = 48.5%</p> <p>Total Cost PMPM = <math>(\\$2.72 \times 48.5\%) + (\\$0 \times 51.5\%) = \\$1.32</math></p>

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**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**SRC# 11 – Online Provider Directory (Statewide):**

The respondent shall describe the provider search function for the online provider directory, including submission of:

- a. A description outlining the transparency and accessibility of the online provider directory, including the parameters upon which enrollees may search. Include whether or not the online provider directory is mobile friendly.
- b. Screen shots for each mouse click required from the start of the respondent's home page to actual search results for a provider, using durable medical equipment providers and zip code as the search elements.
- c. A list of performance indicators the respondent will include for each provider type listed in its provider directory.
- d. A description of the respondent's process for verification of provider information in the online provider directory, including delegated subcontractor provider information, and the method(s) the respondent uses to ensure the weekly network file submission to the Agency is accurate.

**Response:**

Finding and selecting the right providers—in a transparent and straightforward manner—is critical. Aetna recognizes that a key factor in assisting enrollees in making informed provider choices and accessing care is the ease of use and accuracy of provider directories. Aetna accomplishes this objective through the implementation of proven processes. We confirm and update provider listings, rosters, and directories frequently to make sure enrollees have the most current and accurate information at their disposal.

**PROVIDER SEARCH FUNCTION PROVIDES TRANSPARENCY AND ACCESSIBILITY**

**CRITERION 1:** The extent of the respondent's search functions for the respondent's online directory and ease of access for enrollees' navigation of the online provider directory, including whether or not the online directory is mobile friendly

Our goal is make online directories easy to use by and readily accessible to enrollees searching for a provider (in only two mouse clicks). Our online directory is available to anyone through the Aetna Better Health of Florida website or through our mobile-friendly application accessible by tablet or phone. We currently maintain thousands of online and hard-copy directories across our many lines of business. While maintaining such volume can be challenging, Aetna applies continuous process improvement strategies and best practices aimed at ensuring listings are accurate, available, and easily accessible.

Aetna's online search parameters are built for ease of use and accessibility by connecting the enrollee to the information they need in as few clicks as necessary. By simply visiting our website or mobile-friendly application, anyone (enrollees or potential enrollees) can search for providers through computers, tablets, or smartphones. Through drill-down and fill-in-the-box

## **EXHIBIT A-4-a**

### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

tools, enrollees can search for a provider based on location, type, ZIP code, specialty, facility name, and distance.

On the homepage of the Aetna Better Health of Florida website, enrollees can click on "Find a Provider/Pharmacy" and fill in basic information, such as health plan, ZIP code (or other geographic parameters like city, county, etc.), and specialty or facility name to set search parameters. A search can be also widened based on the number of miles from the enrollee's home. Standard search parameters are five miles, but that can be expanded to locate a wider range of providers. Searches can be refined further by provider gender, ages served, special needs, hospital affiliation, provider language, board certification, and whether the provider is handicap accessible through the "Refine Search" box. Once parameters are entered, all an enrollee needs to do is simply click "Search" and the online directory begins to filter for the required results. Visitors to the site are only two mouse clicks away from finding a provider or pharmacy.

Search results are returned giving the name, provider type, address, and phone numbers, along with the option to view more details for that provider. The results box shows the various providers that meet the search parameters, allowing enrollees to quickly review results and determine the provider that best fits their needs. Enrollees can easily learn more about the provider by clicking on the "View Details" box, which provides more information on language, accessibility, hours, accepting new patients, board certification, handicap accessibility, and easy access to public transportation. Within the search function, enrollees can enter their home or work address to get directions to the provider.

We provide transparency by allowing users to evaluate providers based on performance indicators. The online directory also offers enrollees an option to rate a provider so they can provide feedback and rate their satisfaction with a provider's performance. The enrollee is asked to rate the provider on a scale from one to five, with one being the lowest score and five being the highest. Responses are averaged, and performance ratings are displayed by stars next to the provider's name. Aetna will also introduce the Awesome Provider program in 2018, providing another type of performance rating system to give enrollees transparency and access to the most information possible. Detailed information on these programs is provided in the Performance Indicator section at the end of our response to this SRC.

#### **Mobile-Friendly Application**

Aetna Better Health of Florida, along with many of our sister plans across the country, recently launched a mobile-friendly application that enables enrollees to do the following:

- Find a provider
- Change a primary care provider (PCP) designation in real time
- View the handbook
- Check claims
- Order a new ID card
- View current medications

This mobile-friendly application is easy to use and conveniently accessible by cellphone or tablet. Our application provides on-demand access to the tools enrollees need to stay healthy. Enrollees can search for medical, behavioral health, dental, or vision providers or search for the

## **EXHIBIT A-4-a**

### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

nearest pharmacy location. The application is available as a free download from the Apple App Store or Google Play.

Our website follows mobile-friendly guidelines to ensure accessibility—no matter whether accessed by computer, tablet, phone, or other mobile device. With these guidelines, our website:

- Loads quickly (the site is not overly busy with information)
- Is easy to read (takes into consideration that mobile phone screens are 1/5 the size of desktop computers)
- Is easy to navigate with menus that fit the limited space available on mobile devices
- Requires minimal scrolling, both horizontally and vertically
- Does not use Flash, which Apple products do not support

#### **SCREEN SHOTS**

**CRITERION 2:** The extent to which the number of clicks it takes recipients to access the search results, as indicated by the screen shots provided, is less than five (5)

Aetna's online provider directory provides easy access to help enrollees find the right provider for medical equipment or services. Using only two mouse clicks, enrollees can evaluate the results of their search to find the closest provider that meets their needs. For example, a search starting at the home page for a durable medical equipment provider in ZIP code 33155 returns 15 results. We also provide the address, phone number, provider rating (if available), and information on whether the provider is handicap accessible and easily accessible via public transportation.

Figure SRC 11-1: Aetna Better Health of Florida Home Page in Attachment SRC 11 shows the Aetna Better Health of Florida home page. The Find a Provider/Pharmacy link is clearly marked at the top of the screen for easy access.

Figure SRC 11-2: Provider Directory Search Page in Attachment SRC 11 depicts the ease of use in finding providers. Users simply select the appropriate categories using the pull-down menus and add the ZIP code or other geographic parameters. With the second mouse click, the provider search begins.

Figure SRC 11-3: Provider Directory Results Page in Attachment SRC 11 shows the provider search results along with the provider rating (if available), and other parameters to help the enrollee find the right provider to meet their needs. In this case, the actual results for a durable medical equipment provider, as requested in the Invitation to Negotiate (ITN), are displayed.

#### **PERFORMANCE INDICATORS**

**CRITERION 3:** The extent and relevance of the performance indicators available in the respondent's provider directory for each provider type listed

Aetna will provide several performance indicator programs on our website offering enrollees the ability to find and evaluate the provider that best fits their needs. For example, the option to rate a provider is available for all provider types, allowing enrollees to rate a provider based on their

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

experience with the provider's performance. The enrollee is asked to rate the provider on a scale from one to five, with one being the lowest score and five being the highest. Responses are averaged, and performance ratings are displayed by stars next to the provider's name. Beginning in 2018, we will also offer an Awesome Provider program rating. The program rates PCPs based on performance under several HEDIS indicators. We are also looking into adding other performance indicator functionality in the future, such as incorporating Centers for Medicare & Medicaid Services rankings or other identified performance ratings.

The Awesome Provider program offers increased transparency into the provider selection process and celebrates Medicaid Managed Medical Assistance PCPs that demonstrate high clinical quality performance. The program consists of PCPs with at least 100 assigned enrollees and a minimum of 5 enrollees in each quality measure denominator (if more than one sub-measure) and with scores within the 50th percentile rate in 75% of applicable program measures. The top three scoring practices in each category will receive the award of Aetna Awesome Provider, which will be communicated in Aetna's online provider directory and among other providers to promote a competitive atmosphere. With one of Aetna's Awesome Providers, enrollees will have the satisfaction of knowing they are choosing a provider that meets and/or exceeds standards.

The Awesome Provider program provides reports on HEDIS quality measures for adults (an asterisk symbol [\*] indicates a HEDIS measure that is also one of the State's required measures):

- Adults' Access to Preventive/Ambulatory Health Services (AAP)\*
- Cervical Cancer Screening (CCS)
- Comprehensive Diabetes Care – Eye Exam (CDC DRE)\*
- Medication Management for People with Asthma\*

HEDIS reporting measures for children (pediatrics) include the following (an asterisk symbol [\*] indicates a HEDIS measure that is also one of the State's required measures):

- Children and Adolescents' Access to Primary Care Practitioners (CAP) between 12 to 24 months, 25 months to 6 years, 7 to 11 years, and 12 to 19 years\*
- Childhood Immunization Status (Combo 3) (CIS)
- Lead Screening in Children (LSC)
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
- Immunizations for Adolescents

Not only will this provide valuable quality information to enrollees, it will also give providers visibility into the recognized performance of their competitors in the region, further driving competition toward quality improvement.

Aetna strives to provide our enrollees with as much information as possible when selecting a provider. We offer several indicators through our online directory to assess a provider's ability to fulfill an enrollee's needs, such as accepting new patients, access to afterhours care, board certifications, hospital affiliations, languages spoken, and available interpreter services. These indicators are available (as applicable) across all provider types, including the ITN-designated specialty providers. For long-term care, home health, nursing care, and home and community-based providers, we offer several additional categories that include indicators, such as NPI

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

number (if applicable), state license number, Website (if available), handicap accessibility, special training, and geographic service area. These indicators are helpful to ensure the enrollee selects the right provider for the right service and in the right setting.

In our provider directory, we will inform enrollees of which providers meet quality standards by putting designation symbols next to the provider's name. For example, for providers qualifying as patient-centered medical homes (PCMHs), we may put a gold star or a trophy symbol. Providers who qualify for quality bonuses, for example, would be notated with another symbol. All of these symbols will be explained in an easily identified legend in the directory. We will recognize providers meeting the following performance programs: Awesome Provider, PCMH, value-based quality performance, and Managed Medical Assistance Provider Incentive program enhanced payment qualifications.

### **PROCESS FOR VERIFICATION OF PROVIDER INFORMATION**

**CRITERION 4:** The extent of the respondent's efforts to ensure information in the respondent's online provider directory is accurate, including type and frequency of monitoring activities, and delegated subcontractor provider information. Include the frequency of outreach efforts to remediate incorrect provider demographic information and accepting new patient status

Aetna follows standardized policies and procedures to update provider listings, rosters, and directories based on the contract requirements of the plan. We use several methods to verify and update provider information, including provider rosters, delegated subcontractor provider file updates, on-site visits, phone calls, and routine communications, call trend reporting, access gap logs, and access and availability studies.

#### **Provider Rosters**

We require and receive current provider rosters weekly, biweekly, or monthly depending on the contractual arrangement and frequency of changes to their provider rosters. Rosters are loaded within 30 days in compliance with State law and standards, but we currently exceed that standard by loading rosters at the frequency they are received. The health plan conducts monthly reviews of an active provider report that lists any provider who does not have any Aetna enrollees to determine whether they want to remain in the network; if not, we remove him or her from the directory.

#### **Delegated Subcontractor File Updates**

All of our delegated subcontractors provide weekly files that we upload to our system and add to our provider directory. Provider Services conducts periodic reviews of provider data of all providers (including delegated subcontractors) to verify accuracy of the information provided.

#### **On-site Visits/Routine Communication**

We also confirm the accuracy of our provider listings and directories during regular on-site visits, ongoing monitoring, and through routine communication with providers making note of any changes.

## **EXHIBIT A-4-a**

### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

#### **Phone Calls and Call Trend Reporting**

Enrollee Services monitors phone calls for trend reporting, as well as enrollee concerns about inaccuracies in the provider directory. Upon discovering a discrepancy, we take immediate action to correct it and we give the enrollee assistance in finding a replacement provider.

Access Gap Logs: Working collaboratively with Medical Management, Network Management, or other departments using our access gap log, we log, monitor, and review provider and access issues. We monitor the log to review any patterns or trends that may be occurring and to identify any areas of concern. For instance, if an enrollee contacts us about not being able to find a provider, the issue is noted in the log for review and follow-up to ensure the issue was resolved and to help us identify any trends or additional action needed to mitigate any future issues.

Access and Availability Studies: Additionally, we conduct network access and availability studies for hospitals and for providers of obstetrics/gynecology (pre- and postnatal care), high-volume specialty, emergent, urgent, home health, dental, and behavioral health services. Status changes are logged in our system and result in a system update in less than 24 hours. Changes can be processed as often as necessary, with no restrictions as to how many can be logged daily. Audits are conducted to confirm providers have either an after-hours service or offer a message directing callers to an emergency department or other options, such as an urgent care center or another provider based on plan-specific information, as appropriate.

Open Panel/New Patient Status: At a minimum, on quarterly basis, Provider Services reviews PCP panel reports to review assignment levels. Providers with a high volume of enrollee assignments are contacted to ensure they continue to remain open to receiving new membership. At this time, providers must not exceed more than a total of 2,500 enrollee assignments. In the event a provider is nearing capacity or is closed to new patients, we conduct outreach to find providers in the same geographic area and/or specialty to add to our network. We also review the panel status of other similar providers in the area to make sure they are open to accepting new patients in the event a referral or provider change is needed. During provider services liaison site visits, our standard process also includes the discussion of provider panels. We request updates on a monthly basis or more often as needed. By reviewing open panel status to confirm where new enrollees can be assigned, we identify providers who have reached their capacity or referral limits so that our directories indicate which practitioners are accepting new patients. We also conduct survey calls on a monthly basis to assess several factors: verifying demographic information, timely access, and panel status.

**CRITERION 5:** The extent to which the respondent's online provider directory updates are performed daily and the extent to which the updates are communicated to the Agency as required to ensure the information the respondent displays on its website align with the Agency's information

#### **Daily Updates to the Agency and Verifying Accuracy**

Aetna communicates provider information to the Agency, including daily updates to the online file directory through the claims management system. We submit a Provider Network Verification file directly to the Agency twice weekly, exceeding the weekly requirement. To verify the accuracy of this information, we perform audits comparing the information against what is in the Agency's system through our quality improvement audit process. If there are any significant

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

changes to enrollees, we work with the Agency to create any communication pieces or materials as needed.

### **Streamlining the Verification Process**

Availity is a national clearinghouse and provider data management company. Aetna retains Availity to improve the accuracy, streamline the data collection processes and reduce administrative burden for our Florida providers. Availity's provider data management option enables providers to seamlessly update, validate, and attest to the accuracy of their demographic information. This speeds our verification process, as well as improves the accuracy of the data we provide to enrollees, providers, and the State.

### **Ensuring Accurate Directory Listings are Readily Available**

To ensure the most accurate directory listings are readily available (by either print or online through the Web-portal), we apply continuous process improvement strategies. Nightly updates to provider information are made in the system, pushed to the online directory, and published to the website. Aetna meets the requirement to provide Web content using accessibility guideline-compliant, machine-readable formats. Aetna currently exceeds the contractual requirements to submit updates to the hard-copy provider directory no later than 30 business days after receipt of the updated provider information. A copy of the hard-copy directory can be downloaded from the portal at any time.

Aetna's provider directories contain all of the following information, at minimum: provider's name, group affiliation (if applicable), and type (e.g., physician, specialist, hospital, pharmacy); street addresses; telephone numbers; Web address (as appropriate); specialty; and gender. It also indicates whether the provider is accepting new enrollees; the provider's cultural and linguistic capabilities including languages spoken by provider or skilled medical interpreters at the practitioner's office; whether the provider has completed cultural competence training; whether Spanish language or other staff is available; and accessibility for persons with disabilities.

### **Evaluation Criteria:**

1. The extent of the respondent's search functions for the respondent's online directory and ease of access for enrollees' navigation of the online provider directory, including whether or not the online directory is mobile friendly.
2. The extent to which the number of clicks it takes recipients to access the search results, as indicated by the screen shots provided, is less than five (5).
3. The extent and relevance of the performance indicators available in the respondent's provider directory for each provider type listed.
4. The extent of the respondent's efforts to ensure information in the respondent's online provider directory is accurate, including type and frequency of monitoring activities, and delegated subcontractor provider information. Include the frequency of outreach efforts

**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

to remediate incorrect provider demographic information and accepting new patient status.

5. The extent to which the respondent's online provider directory updates are performed daily and the extent to which the updates are communicated to the Agency as required to ensure the information the respondent displays on its website align with the Agency's information.

**Score:** This section is worth a maximum of 25 raw points with each of the above components being worth a maximum of 5 points each.

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## **Attachment SRC# 11**



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SRC# 11: Figure SRC 11-1: Aetna Better Health of Florida Home Page

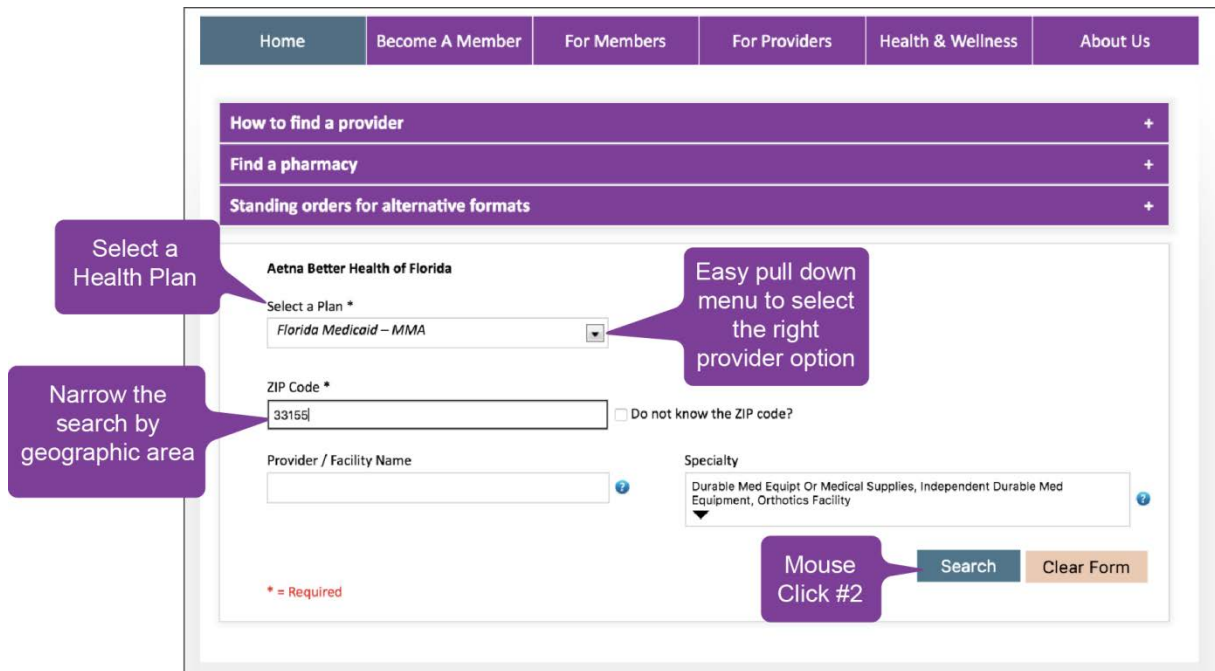


**Figure SRC 11-1: Aetna Better Health of Florida Home Page**

*Enrollees enter Aetna in the search bar (Google, Explorer, etc.), from which they are directed to the homepage. Enrollees simply click on Find a Provider/Pharmacy at the top of the page (first mouse click) to begin their provider search.*

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# SRC# 11: Figure SRC 11-2: Provider Directory Search Page



The screenshot shows the Aetna Better Health of Florida website's provider directory search page. At the top is a navigation bar with links: Home, Become A Member, For Members, For Providers, Health & Wellness, and About Us. Below this is a section titled 'How to find a provider' with three expandable options: 'Find a provider', 'Find a pharmacy', and 'Standing orders for alternative formats'. The main search area is titled 'Aetna Better Health of Florida' and contains several input fields: 'Select a Plan \*' (a pull-down menu showing 'Florida Medicaid - MMA'), 'ZIP Code \*' (a text box with '33156' and a checkbox for 'Do not know the ZIP code?'), 'Provider / Facility Name' (a text box), and 'Specialty' (a pull-down menu showing 'Durable Med Equipmt Or Medical Supplies, Independent Durable Med Equipment, Orthotics Facility'). At the bottom right are 'Search' and 'Clear Form' buttons. A red asterisk indicates required fields. Four callout boxes provide instructions: 'Select a Health Plan' points to the plan selection menu; 'Narrow the search by geographic area' points to the ZIP code field; 'Easy pull down menu to select the right provider option' points to the specialty menu; and 'Mouse Click #2' points to the Search button.

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**Figure SRC 11-2: Provider Directory Search Page**

*Enrollees follow the convenient pull-down menus to select a plan, find a provider by name or location (city, county, ZIP code, and distance parameters), and specialty. Enrollees simply click Search (second mouse click) to begin filtering for results.*

SRC# 11: Figure SRC 11-3: Provider Directory Results Page

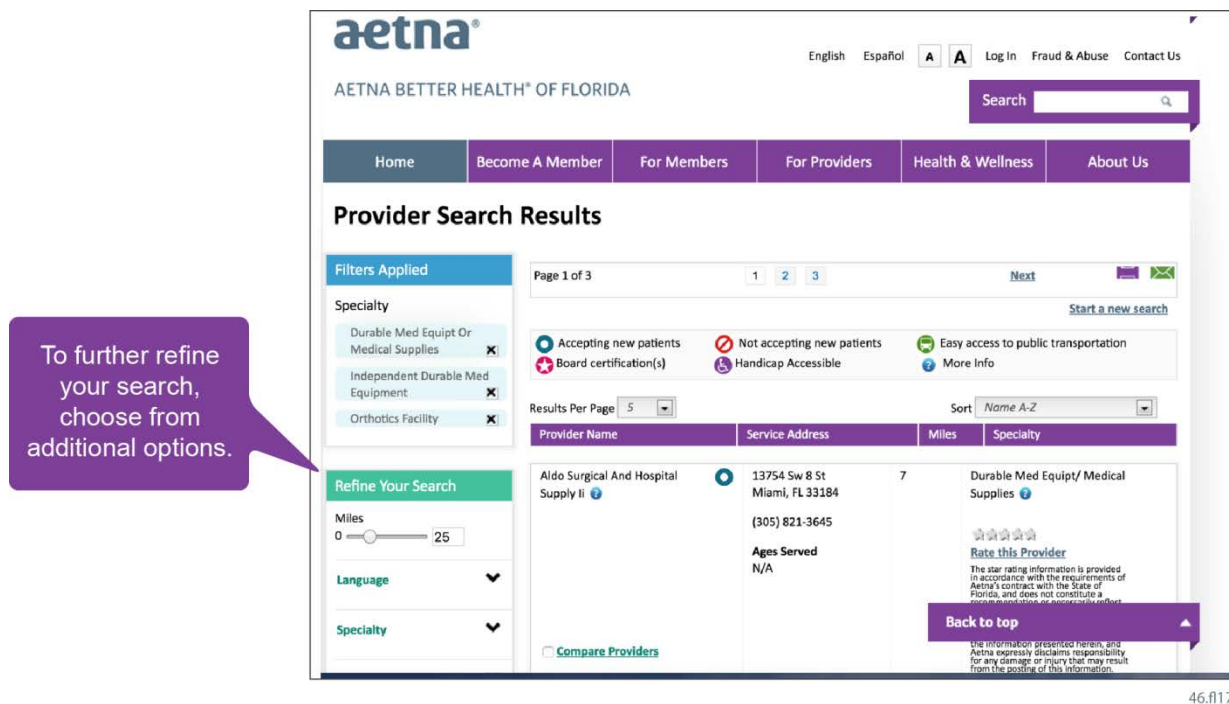


Figure SRC 11-3: Provider Directory Results Page

The first page of the search results for the required category for a durable medical equipment provider are shown in this figure and are just two mouse clicks away from the home page. If the enrollee wants to refine or revise the search further, he or she may do so using the easy-to-use pull-down menu on the left side of the screen. The enrollee can also Rate this Provider by simply clicking on the link on the right hand side of the page.



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**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**SRC# 12 – Enrollee Grievance and Appeal System (Statewide):**

The respondent shall provide a flowchart and written description of how the respondent will execute its enrollee grievance and appeal system, including identifying, tracking and analysis of enrollee complaints, grievances, appeals and Medicaid fair hearing data. The respondent shall include in the description detail regarding how data resulting from the grievance and appeal system are used to improve the operational performance of the respondent.

**Response:**

Aetna employs a comprehensive enrollee grievance and appeal system that is inclusive of complaints, grievances, appeals, and State Fair Hearings based on our Medicaid best practices in 14 states. The objectives of our enrollee grievance and appeal system are to do the following:

- Protect and promote enrollee education regarding complaints, grievances, appeals, and State Fair Hearings rights
- Provide the opportunity to reconsider original clinical or administrative determinations made by a second reviewer that did not originally take part in the original review
- Verify that enrollee complaints, grievances, and appeals are acknowledged and addressed in a manner that supports an equitable outcome
- Facilitate the resolution of issues that potentially impact access to services, quality of care, enrollee choice, and safety
- Facilitate compliance with contractual requirements and National Committee for Quality Assurance standards, including applicable federal and State laws and rules
- Support effective management of enrollee complaints, grievances, and appeals
- Provide accurate maintenance of required documentation
- Comply with State and federal compliance reporting requirements

At any time during the complaint, grievance, and appeal process, the enrollee can authorize a representative, such as a family enrollee, friend, attorney, or provider to act on his or her behalf. Authorization must be in writing and signed by the enrollee. Enrollees or their authorized representative have the right to examine the enrollee's case file, including medical records and any other documents and records considered during the complaint, grievance, and appeal process. They may present supporting documentation or evidence by phone, in person, or in writing on or before the date of the grievance or appeal meeting date by contacting the grievance and appeal manager. The parties to the grievance or appeal include the health plan, the enrollee, and his or her representative or the representative of a deceased enrollee's estate. All cases are documented in our grievance and appeal application inclusive of those received through the Agency or subcontractor. 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 complaints, grievances, appeals, and State Fair Hearings are maintained in accordance with the applicable record retention policies and in strict compliance with HIPAA standards to protect enrollee privacy.

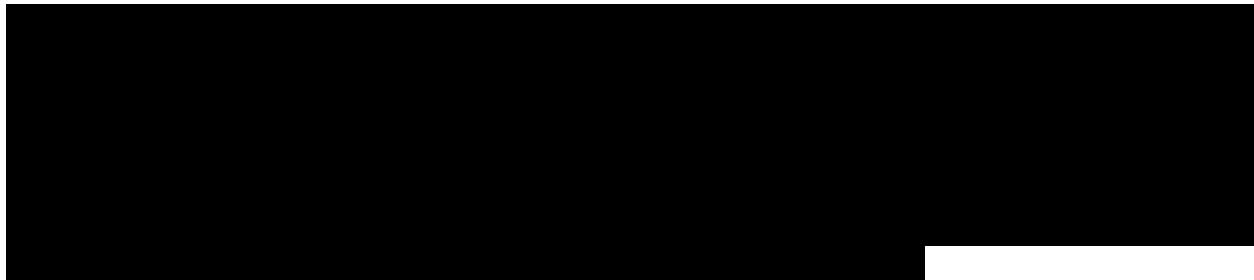
We make sure that no punitive action is taken against enrollees for filing a complaint, grievance, appeal, or State Fair Hearing; providers who request a complaint, grievance, appeal, or State Fair Hearing; and designated representatives who support an enrollee's complaint, grievance, appeal, or State Fair Hearing.

**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**EASE OF ACCESS IN EXECUTING THE ENROLLEE GRIEVANCE AND APPEAL SYSTEM**

**CRITERION 1:** The extent to which the respondent's grievance and appeal system flowchart reflects ease of access for individuals with complaints, grievances and appeals, including ease of access for persons with disabilities or who speak other languages

The grievance and appeal processes is designed to be simple and user-friendly, affording enrollees the opportunity to voice their issues and concerns in a non-threatening manner. Our process is available to our enrollees and our approach to identify and resolve grievances and appeals timely helps to ensure our enrollees from all racial, ethnic, and cultural backgrounds receive equitable and effective treatment in a culturally and linguistically appropriate manner. The grievance and appeal system responds to and supports all enrollee requests for state fair hearings and conforms to all applicable State and federal laws and regulations. We do not delegate complaints, grievances, or appeals processing to any subcontractors. Aetna retains responsibility for all complaint, grievance, and appeal case resolution/decisions.



Grievance and appeal staff members (located in Florida and exclusive to our Florida enrollees) maintain accountability for processing all complaints, grievances, and appeals relating to our enrollees, providers, subcontractors, and health plan. This allows our enrollees or their designated representatives (including providers who have been authorized to represent the enrollee, in writing) to contact us directly for a timely resolution of issues.

Whenever an enrollee or his/her 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 enrollee appeal process.

If enrollees or their designated representatives are dissatisfied with service or other concerns unrelated to an appeal, the review is conducted in accordance with our enrollee complaint and grievance process.

Figure SRC 12-1: High-Level Complaint and Grievance Process in Attachment SRC 12 illustrates an overview of our complaint and grievance process.

Figure SRC 12-2: High-Level Appeal Process in Attachment SRC 12 illustrates an overview of our appeal process.

Figure SRC 12-3: High-Level Tracking, Trending, and Reporting Process in Attachment SRC 12 illustrates an overview of our tracking, trending, and reporting process.

## **EXHIBIT A-4-a**

### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

#### **DESCRIPTION**

We maintain and disseminate internal policy and procedure documents, as well as provide role-specific training for Grievance and Appeal, Enrollee Services, and Clinical Review staff members to help ensure they are fully educated on the complaint, grievance, and appeal processes. We thoroughly train all our staff to identify potential complaints, grievances, and appeals. We emphasize the importance of enrollee confidentiality and privacy throughout the grievance and appeals process. Clinical and health information is not shared beyond a need to know basis and consents are obtained as necessary to facilitate the process of resolution. Our goal is to make enrollees' lives easier, making the process of filing and appeal or grievance as uncomplicated as possible by removing and reducing any undue administrative challenges. We provide enrollees with thorough and accurate information regarding complaint, grievance, and appeal processes and procedures. We communicate with enrollees proactively, respectfully catering to addressing the individuality of each enrollee. Enrollees with special needs or disabilities are provided with additional assistance to be able to access the grievance and appeal process; this includes translation, sign language, in-person translation, and additional educational resources related to the process and timeframes.

All complaint, grievance, and appeal documents are written at a fourth-grade reading level to facilitate accessibility and understanding for all enrollees. Each document has a notification about the availability of the document in other languages and other formats. We also provide oral interpretation services, available through our Enrollee Services department, and for select languages through the Grievance and Appeal department, as well as alternative forms of communication such as audiotapes, sign language, and additional reasonable accommodations. There is never a cost to enrollees for these services.

Enrollees are provided with written complaint, grievance, and appeal policy and procedure information in the enrollee handbook and on our website. Our enrollee services representatives, in tandem with Language Line Solutions interpreters, are trained to assist enrollees, including those with language or special health care needs, to navigate the complaint, grievance, and appeal process.

Specific guidelines are used to verify that we are communicating with our enrollees in a clear, effective, and accurate manner for both language and reading level requirements. We use bulleted lists and shorter sentence structures and do not include health care jargon when creating enrollee materials. Technical or unfamiliar terms are explained in plain language to promote accuracy and comprehension. All written materials are clearly legible with a minimum font size of 12 points with the exception of enrollee ID cards. Our grievance and appeal procedures are reviewed at least annually, amend them upon receiving the written prior authorization from AHCA, and then provide the updated procedures to the Agency.

#### **Identification**

**CRITERION 2:** The extent to which the respondent's timelines for acknowledging and responding to complaints, grievances and appeals are less than those specified in federal and State requirements

Upon receipt of a verbal enrollee grievance or appeal, our team logs the concern and assigns it to a representative for review. A Grievance and Appeal coordinator reviews all of the facts to

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

determine whether the case should be processed as an inquiry, grievance, or appeal; general questions are processed as an inquiry and are resolved within the call tracking system. Cases related to an adverse benefit determination where we denied, reduced, suspended, or terminated an item or service are classified and processed as an appeal. Cases not related to an adverse benefit determination are classified first as a complaint. If the complaint cannot be resolved by the close of the following business day, it is transferred to the grievance process and processed as a grievance. When the complaint or grievance is about the service or care they received from a provider, we always secure enrollee permission to utilize their name to investigate the complaint or grievance.

### **Enrollee Assistance and Education**

Aetna places high value on helping ensure enrollees are appropriately educated on their health care and their rights as enrollees. Enrollees are educated about the grievance and appeal system, along with any changes through written materials (e.g., enrollee handbook, website). Enrollee education includes the availability of assistance in the filing process, the procedure for filing a grievance or appeal, the right to representation (self, legal counsel, relative, friend, provider); procedures for exercising the rights to request a State Fair Hearing within a specified timeframe; the requirement that internal appeals must be exhausted before requesting a State Fair Hearing; the right to continue benefits at the current level if the appeal or State Fair Hearing is requested within the specified timeframe; and communication that the enrollee may be required to pay the cost of services furnished if the final decision is adverse to the enrollee. If needed, a Grievance and Appeal coordinator or other staff member assists enrollees with completing forms and taking other procedural steps. Aetna provides information in alternative formats (e.g., interpreter services, translation services, audio tapes, sign language, large font, TTY Relay Florida), as well as makes other reasonable accommodations available to all enrollees, including those with special needs at no cost. Both the enrollee handbook and our website include information on complaints, grievances, and appeals policies, procedures, and timeframes, including:

- Definitions of a complaint, a grievance, and an appeal
- How to file a complaint, grievance, or appeal
- Timeframes for resolving complaints, grievances, and appeals
- Communication required for complaint, grievance, and appeal resolutions
- The limited time available to present evidence or allegations
- Requirements and timeframes for filing a complaint, grievance, or appeal
- Availability of assistance during the filing process
- Toll-free numbers that the enrollee can use to file a complaint, grievance, or appeal by telephone
- Information detailing the options for self-representation or the use of a designated representative
- Regulations that support or provide the change in federal or State law that requires action
- Enrollees' right to request a State Fair Hearing: State Fair Hearings do not apply to grievances. In cases of actions required due to change in law, we describe circumstances under which a State Fair Hearing is granted
- Notification of the following: Benefit continuation if the enrollee files an appeal or a request for a State Fair Hearing within the timeframes specified for filing (applies to pre-service appeals only); Potential enrollee responsibility to pay the cost of services

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

furnished while the appeal is pending, and/or if the final decision is adverse to the enrollee

### **Filing a Grievance or Appeal**

Enrollees or their authorized representatives may file a complaint, grievance or appeal verbally or in writing. Complaints, grievances, and appeals may also be filed through AHCA. The Agency forwards any cases received for resolution as a standard or expedited case as appropriate. Unless the enrollee is requesting an expedited appeal resolution, a verbal appeal request must be followed by a written, signed appeal. State Fair Hearings must be requested in writing. Grievances may be requested at any time, appeals must be requested within 60 calendar days of the initial denial, and State Fair Hearings must be requested within 120 calendar days of the appeal decision letter.

### **Continuation of Benefits**

Enrollees may continue to receive services during an appeal or State Fair Hearing process whenever they meet all of the conditions that follow: the enrollee requests an appeal or State Fair Hearing within 10 calendar days of the mailing of the denial/notice of adverse benefit determination or appeal decision letter, respectively (the intended effective date of the proposed denial); the enrollee files the appeal or State Fair Hearing and the appeal or State Fair Hearing involves the termination, suspension, or reduction of a previously authorized course of treatment; services were ordered by an authorized provider; and the original period covered by the original authorization has not expired; and the enrollee requests extension of benefits.

Enrollees continue to receive benefits during a pending appeal or State Fair Hearing until the enrollee withdraws the appeal or State Fair Hearing, or until 10 calendar days pass after the appeal or State Fair Hearing decision letter is mailed. If the final resolution of the appeal or State Fair Hearing is adverse to the enrollee (the decision upholds our adverse benefit determination), we may recover the cost of the services furnished to the enrollee while the appeal or State Fair Hearing is pending to the extent they were furnished solely because of the requirements of this section. The enrollee is informed that he or she may be financially liable for services rendered during this process.

### **Grievance or Appeal Acknowledgment**

A Grievance and Appeal coordinator documents the receipt date of the verbal grievance or appeal to establish the earliest possible filing date in the grievances and appeals application. Verbal appeals are acknowledged at the time of receipt and enrollees are asked to submit a written, signed appeal. Verbal grievances are acknowledged at the time of receipt. All grievances and appeals received in writing are acknowledged within five business days in writing. Requests for State Fair Hearings are acknowledged by AHCA and are acknowledged through eligibility letters within five calendar days of receipt.

### **Resolution of Complaints**

Aetna resolves complaints by the close of the following business day of the receipt of request. If the complaint cannot be resolved by the close of the following business day, it is transferred to a standard grievance. Complaints may be resolved by the Enrollee Services representative and

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

documented in the call tracking system. Complaints are forwarded to the Grievance and Appeal department to be documented and reported as a complaint in the grievance and appeal application.

### **Resolution of Grievances and Appeals**

The date of receipt is used to calculate automatically the due date for completion of the case.

Grievances: Aetna resolves all standard grievances within 90 days based on State and federal timeframes from receipt of a request. However, we strive for a quick resolution to ensure our enrollee's satisfaction and currently, we average 55 calendar days for 2017, exceeding the 90 day standard. For expedited grievances, we render a decision within 72 hours from receipt of request. Grievances are processed in an expedited timeframe whenever the grievance is the result of the denial of expedited processing on an appeal, or whenever Aetna takes an extension on an appeal decision-making timeframe.

If the enrollee's grievance involves a confirmed or validated quality of care issue, we forward the details of the grievance to our Quality Improvement department to initiate an internal review. Florida statute 766.101 prohibits us from disclosing any findings, recommendations, evaluations, opinions, or other actions arising from its review of quality-of-care issues.

Appeals: Aetna resolves all standard appeals within 30 calendar days of receipt of a request with an average of 20 calendar days in 2017, exceeding the 30-day standard. For expedited appeals, we notify the enrollee within 24 hours of any additional information needed and render a decision within 72 hours from receipt of the request. If the information is not received within 72 hours from receipt of request, Aetna requests an extension, as it is in the enrollee's best interest to have the additional time to submit the information.

Appeals are processed in an expedited timeframe whenever the standard timeframe could seriously jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function. If the provider or enrollee requests expedited processing, neither written confirmation nor the enrollee's written consent is required for the provider to act on the enrollee's behalf and request an expedited appeal.

We immediately conduct an initial review outreach to review the urgency of the issue to determine whether the issue meets the criteria of an expedited appeal as documented in policy and procedure documents, the website, the enrollee handbook, the provider handbook, and as dictated by our contract, or the Agency. A key part of this review includes an assessment of the enrollee's current health condition by a clinical reviewer. The majority of the expedited appeal and grievance requests are submitted to the plan verbally. If the issue fails to meet the expedited appeal criteria, we transfer it to the standard appeal process and maintain the original received date. If a request meets the expedited criteria listed above, an appropriate licensed clinical reviewer in the same or similar specialty—who typically treats the medical condition, was not involved in the initial determination, and is not a subordinate of any persons involved in the initial decision—renders a decision as quickly as the enrollee's health requires not to exceed 72 hours from receipt of the request. If the enrollee requested expedited processing and we deny the enrollee's request for an expedited decision, Aetna makes a good faith attempt to give prompt oral notification of the decision to transfer the case to the standard timeframe and a written notice is sent within two calendar days.

## **EXHIBIT A-4-a**

### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

The enrollee or authorized representative may present supporting evidence in person or in writing, either on or before the appeal meeting date. During this time, the enrollee or their representative may contact us to request a copy of the enrollee's file or clinical records that are reviewed during the appeals process. There is no cost to the enrollee for this service.

The Grievance and Appeal department or its designee compiles the appeal case. When a request is received and additional clinical information is needed to render the decision, Grievance and Appeal staff members outreach the enrollee and the provider in an effort to obtain the missing information. Staff members make a minimum of three attempts on different days, times, and through different media such as telephone, email, and surface mail.

In the event additional clinical information is received with the request, 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 part of an Appeal Committee for review. If the deciding health care professional does not meet the same or similar specialty requirements, the case is forwarded to an external appropriately licensed doctor or clinical peer reviewer with expertise in the same or similar specialty to review the case to make a determination.

Complex appeal requests that involve multiple departments may be reviewed by the committee. This Appeal Committee is called to order as needed, on a case by case basis, and includes staff from multiple departments. The committee also includes an appropriately licensed doctor or clinical peer reviewer who was not involved in the initial determination process and is not a subordinate of any person involved in the initial decision-making process. Appeal Committee members must sign a confidentiality and conflict of interest statement, agreeing to hold all information confidential in alignment with HIPAA requirements and to excuse themselves when a case is being reviewed where they have a potential conflict of interest.

The resolution period may be extended up to 14 calendar days if the enrollee requests an extension or if we show there is a need for additional information and that the delay is in the enrollee's best interest. Upon request, Aetna provides documentation to the Agency that the delay is in the enrollee's interest. If the resolution timeframe is extended, we provide written notice of the delay within the original processing time. When we accept the extension, the written notice informs the enrollee that he or she may file a grievance if he or she disagrees with the decision for the extension.

Complaints, grievances, and appeals received through AHCA are processed according to the standard or expedited timeframe as appropriate. The Agency may also specify a different decision or resolution processing time at their discretion.

#### **Written Notification**

Enrollees and their authorized representative receive a grievance resolution or appeal decision letter that explains the resolution/decision and the reason within two calendar days of the decision and with the applicable standard or expedited processing time. Decision letters on State Fair Hearings are sent by those reviewers to all parties. The written grievance resolution or appeal decision notice includes these items: results of the process and the date it was completed; right to request assistance filing grievances and appeals, right to request a State Fair Hearing and the processes involved to request a hearing for appeals not resolved wholly in

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

favor of the enrollee; right to request a continuation of benefits while the State Fair Hearing is pending and how to make such requests; notification that the enrollee may be held liable for the cost of those benefits if the hearing decision upholds our adverse benefit determination; reference to the benefit provision, guideline, protocol, or other similar criterion on which the appeal decision was based; notification that the enrollee can obtain, at no cost upon request, 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.

The Grievance and Appeal manager forwards any adverse decisions to the Agency for further review or action upon request by AHCA or our enrollee. The enrollee may request a State Fair Hearing within 120 calendar days from the appeal decision letter.

### **State Fair Hearings**

The State Fair Hearing process provides enrollees 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 enrollee, and his or her authorized representative or the representative of a deceased enrollee's estate. An enrollee or his or her authorized representative, including a provider, may file a request for a State Fair Hearing upon completion of the health plan appeal process within 120 calendar days of the appeal decision letter. If the hearing officer reverses a 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 enrollee'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.

Implementing and maintaining appropriate processes and personnel: All enrollee grievances and appeals materials are submitted to the Agency for approval prior to being made available to our enrollees. Aetna employees are empowered to help enrollees with all aspects of the grievances and appeals system processes to minimize frustration, improve resolution timeframes, and verify that the enrollees receive the care they need. Personnel include the following: an enrollee services representative responsible for processing and resolving complaints or for transferring to a grievance when the issue cannot be resolved within one business day; a Grievance and Appeal coordinator who is responsible for processing and resolving grievances and appeals; a Grievance and Appeal manager who reports to the director of operations and is responsible for disseminating information to enrollees about their grievance and appeal rights, managing the processing, resolution, reporting, and identification of trends for all complaint, grievance, and appeal scenarios, including requests for State Fair Hearings; and a director of operations who reports to the chief operating officer and is authorized to engage other departments, as necessary, and to implement improvement activities and execute corrective action plans as needed. Other departments may also support case investigations with researching. As necessary, Provider Services, Enrollee Services, Claims, Medical Management, Utilization Management, and other departments, depending on the specific case, may contribute to the resolution process.

Medical Directors, who must hold a valid medical license in the State of Florida, are the only personnel who may conduct a medical necessity review and render a denial of authorization for payment. Physicians who render a decision on a grievance or appeal are 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 (as determined by AHCA) in

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

treating a enrollee'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 around the clock for our enrollees 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.

### **Tracking**

**CRITERION 5:** The extent to which the respondent is able to ensure all complaints (including those submitted to the respondent by the Agency or respondent's subcontractors) are tracked and resolved as part of the respondent's established complaint, grievance and appeal process

Aetna maintains records of all complaints, grievances, appeals, and State Fair Hearings within our internal, proprietary application, including the date of receipt of the complaint, grievance, appeal, or State Fair Hearing; the enrollee identification number; a short, dated summary of each issue; the AHCA-specific category, the name of the person filing the complaint, grievance, appeal, or State Fair Hearing, including the enrollee, their authorized representative, or the Agency; the date of decision; the resolution for complaints and grievances; the date of decision for appeals and hearings; and the criteria used in rendering the decision and the date of communication of the resolution/decision. This documentation allows us to maintain and track all cases from origination through resolution/decision.

The application contains a standard suite of reports and queries by case type of complaint, grievance, appeal, or State Fair Hearing that are utilized to track cases throughout the process. 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. The application is all-inclusive, housing all correspondence, letters created, and staff actions taken on the case. All follow-up actions such as enrollee or provider 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 identification of cases and work to be completed. The Grievance and Appeal manager utilizes standard queries and reports within the application to monitor cases throughout the process, to monitor timeliness and accuracy and to identify and report upon trends for potential opportunities for improvement.

We maintain this data for seven years from the date of resolution. Complaint, grievance, and appeal data is reported monthly internally and to the Agency at least quarterly in the format required.

### **ANALYSIS**

**CRITERION 3:** The extent to which the respondent's complaint, grievance and appeal and Medicaid Fair Hearing data are aggregated so that results are actionable, protect enrollee privacy and are reviewed by the appropriate staff or committee for analysis and prioritization of corrective action and/or improvement initiatives

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

CRITERION 4: The extent to which the respondent's complaint, grievance and appeal process imposes deadlines on completion of corrective action plans implemented as a result of verified complaints, grievances or appeals and have set quality controls in place to review outcomes Aetna has programmed its grievance and appeals application to calculate the due date automatically (pursuant to Agency requirements) for completion of the case; and this due date is used to calculate automatically the actual turnaround time on the case. Upon resolution, the application automatically marks the case as timely or untimely. Aetna uses multiple standard reports to monitor aging of cases in real time to make certain of timely resolution. These reports are monitored daily; if we see any evidence of an issue requiring escalation, we act on it immediately.

The Grievance and Appeal manager utilizes standard queries and reports within the application to monitor cases throughout the process, to monitor timeliness and accuracy, and to identify and report trends for potential opportunities for improvement. The Grievance and Appeals manager also conducts daily and monthly audits to help ensure consistency and quality standards. Aetna identifies discernable trends and aggregates data that represent opportunities for improvement. The data is aggregated to protect enrollee privacy. Consistent evaluation of grievances and appeals trend data allows for compliance and executive staff, in conjunction with Quality Management, to improve on medical, network, operations, and management areas identified through grievance and appeal tracking that requires additional focus.

Data from health plan experience, results of oversight activities, and the need for any corrective action plans identified internally or by the Agency are presented to our Service Improvement and Quality committees. These committees include cross-functional representatives from Enrollee Services, Provider Services, Compliance, Care Management, or other departments as needed. Participants on the Service Improvement Committee and the Quality Management Oversight Committee include senior leaders at the health plan. This validates 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 enrollee satisfaction and provider satisfaction, to stabilize trends within the delivery system as a whole, and to meet performance standards. These individuals hold involved departments to deadlines and actions specified in the corrective action plan and ensure completion within the timeframes specified.

### **Operational Improvements**

CRITERION 6: The extent to which the respondent's grievance and appeal system data resulted in operational improvements of the respondent

Our Grievance and Appeal system facilitates operational performance improvements to our operations, airtight and comprehensive tracking and analysis, and timely resolution. We have the infrastructure in place in Florida to collect and analyze operational data to enable positive change in this new contract.

Through the systematic review of our complaint, grievance, and appeal data trends, we identify opportunities and implement rapid interventions for improvement. Aetna considers this data a valuable source of information for improving the enrollee and provider experience. The following represent examples of trends identified, actions taken, and the resulting improvements:

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- A recent review of complaint and grievance data found a trend of enrollees being balanced billed. The trend involved several different provider types; root causes included, enrollees not carrying their identification cards at the time of service and providers not understanding that balanced billing is prohibited. Several corrective actions were implemented. Targeted outreach to the providers identified through data analysis was performed by provider services. In addition, a provider alert was sent and posted on the Aetna website. Member focused reminders were also deployed. The enrollee newsletter was used to highlight that balance billing is prohibited and that presenting an identification card during the registration process for medical appointments is critical to avoid being charged for services. We have seen an overall decrease of balance billing complaints and grievances as a result of these interventions.
- Appeal report data demonstrated a high trend of denials for adult physical therapy. A provider educational bulletin was created to address physical therapy benefit qualifications and limitations for adults. The bulletin was sent to all providers and was posted on our website. Provider services took the list of providers with the highest number of denials and outreached to ensure their receipt and understanding of the bulletin. Since the bulletin was distributed and outreach was conducted, the number of denials and appeals has significantly decreased.
- A trend of enrollees having difficulty locating in-network specialists was identified during a recent review of complaint and grievance report data conducted by our Service Improvement Committee. There was no pattern that pointed to a specific provider type. There appeared to be several root causes. As part of the corrective actions undertaken Aetna conducted a review the composition of network to determine gaps and the need for further recruitment efforts. We reviewed of our enrollee directory update process to make sure that updates were being made regularly. We also implemented a more in-depth enrollee assistance process. This process involves enrollee service representatives outreaching to provider offices with the enrollee on the line in order to facilitate appointments, provider services proactively outreaching providers to remind them of their participation in the Medicaid network, and instituting a process for case management involvement on complex cases; case where multiple specialists are needed and extensive services must be coordinated. As a result of these steps taken we have seen a decrease in enrollee complaints pertaining specialist availability.

### **Evaluation Criteria:**

1. The extent to which the respondent's grievance and appeal system flowchart reflects ease of access for individuals with complaints, grievances and appeals, including ease of access for persons with disabilities or who speak other languages.
2. The extent to which the respondent's timelines for acknowledging and responding to complaints, grievances and appeals are less than those specified in federal and State requirements.
3. The extent to which the respondent's complaint, grievance and appeal and Medicaid Fair Hearing data are aggregated so that results are actionable, protect enrollee privacy and are reviewed by the appropriate staff or committee for analysis and prioritization of corrective action and/or improvement initiatives.

**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

4. The extent to which the respondent's complaint, grievance and appeal process imposes deadlines on completion of corrective action plans implemented as a result of verified complaints, grievances or appeals and have set quality controls in place to review outcomes.
5. The extent to which the respondent is able to ensure all complaints (including those submitted to the respondent by the Agency or respondent's subcontractors) are tracked and resolved as part of the respondent's established complaint, grievance and appeal process.
6. The extent to which the respondent's grievance and appeal system data resulted in operational improvements of the respondent.

**Score:** This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.



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## **Attachment SRC# 12**



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SRC# 12: Figure SRC 12-1: High-Level Complaint and Grievance Process

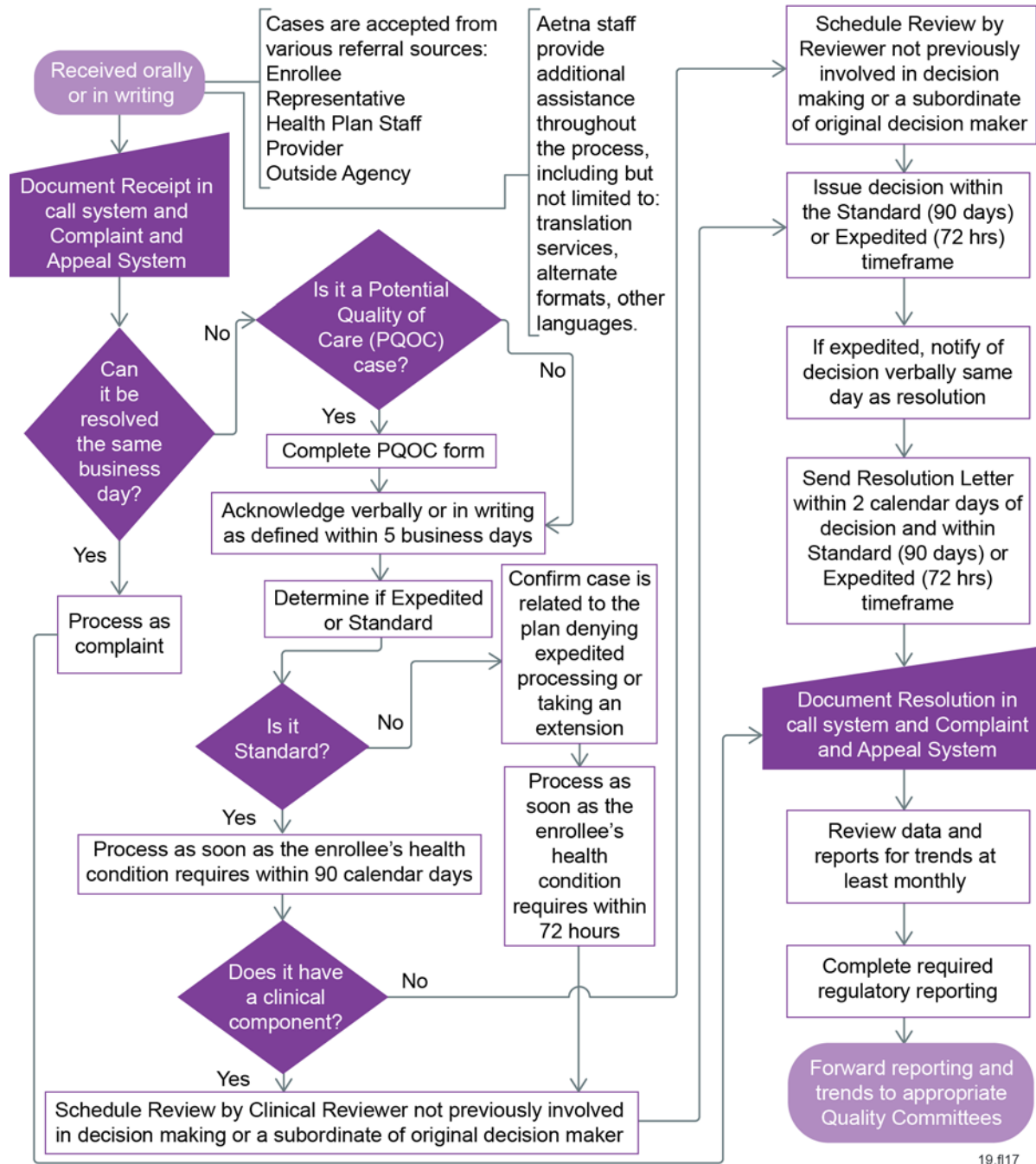
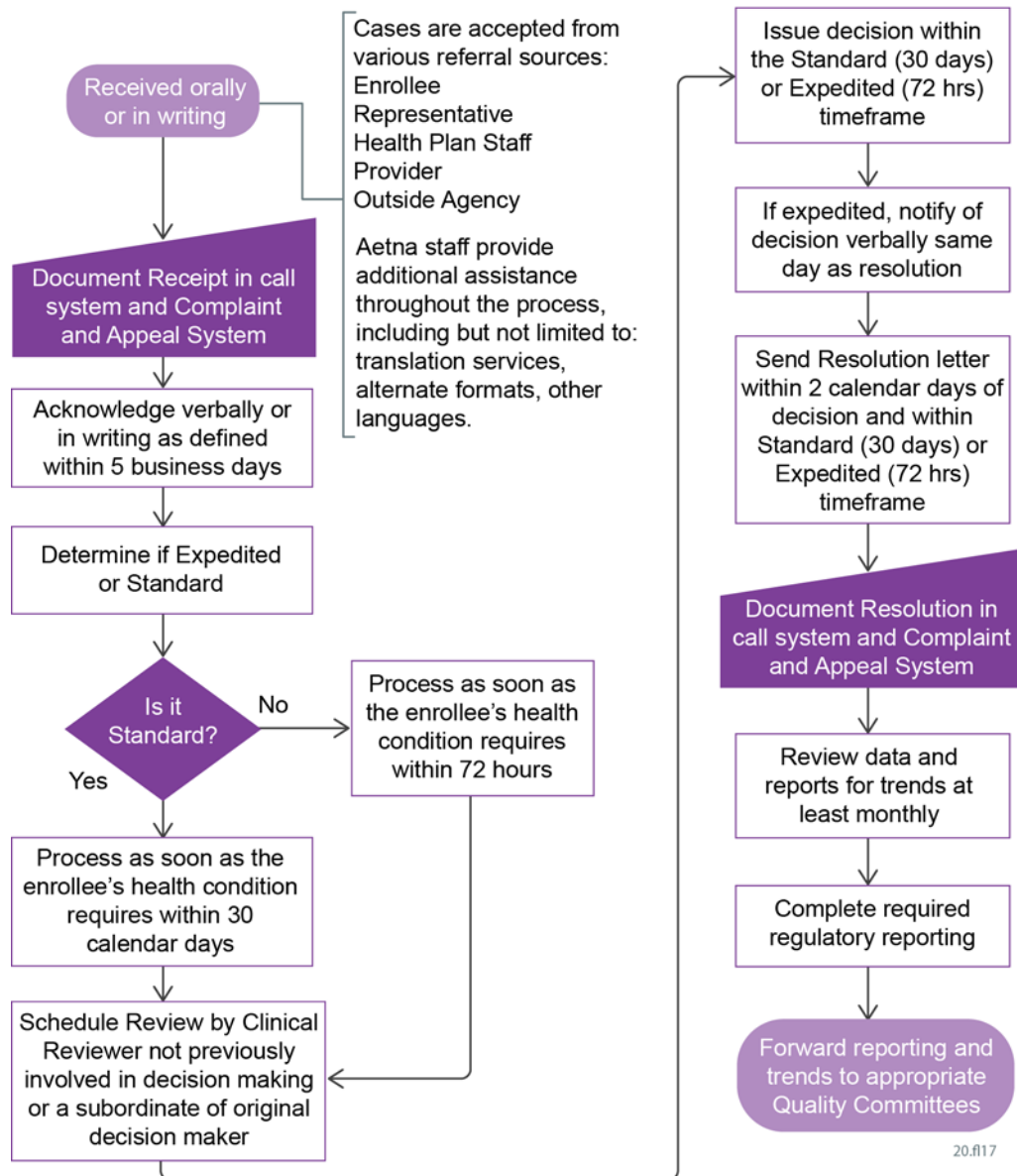


Figure 12-1: High-Level Complaint and Grievance Process

*Aetna's complaint and grievance process provides enrollees with easy access to file complaints and grievances as issues arise.*

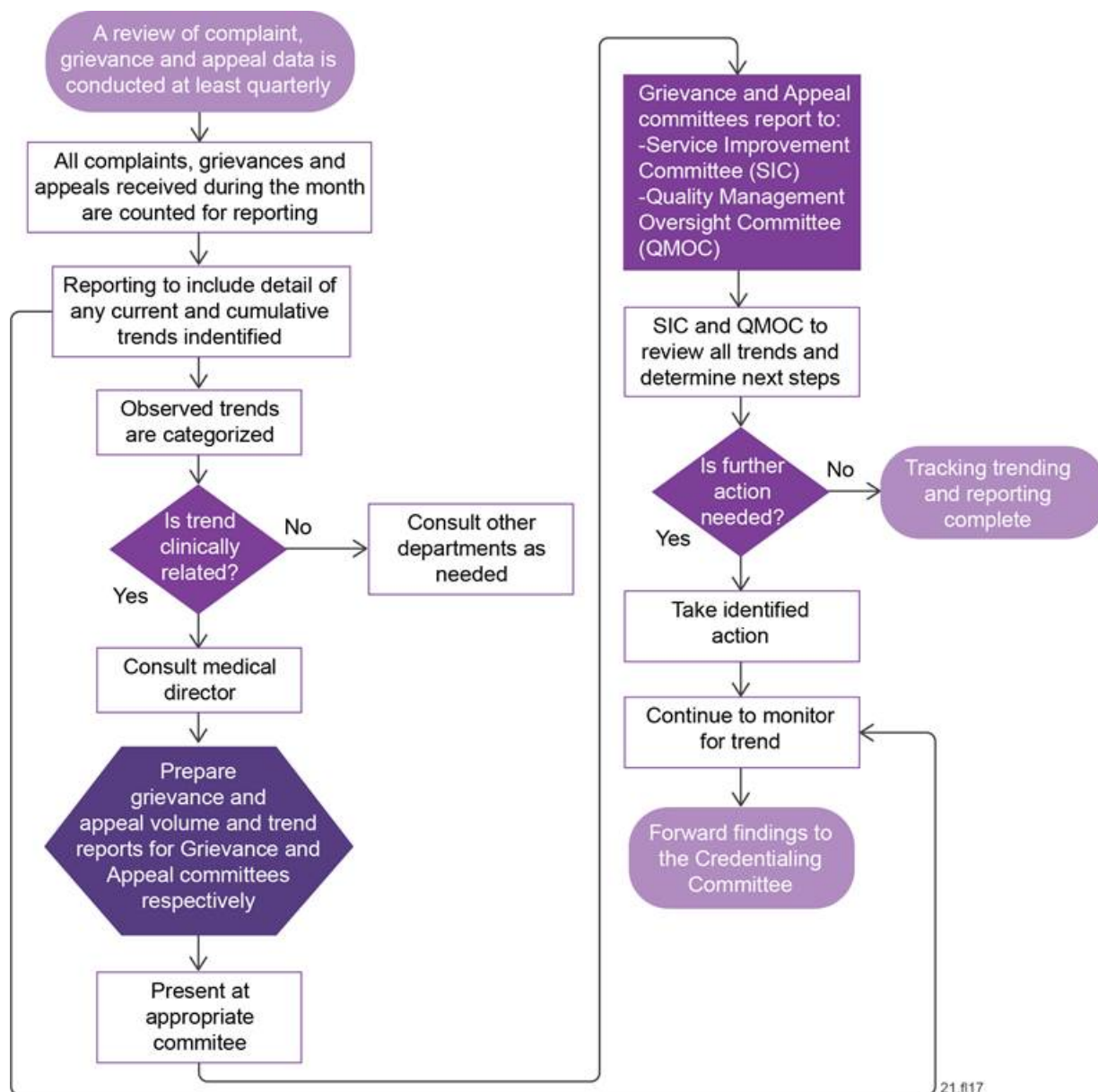
**SRC# 12: Figure SRC 12-2: High-Level Appeal Process**



**Figure SRC 12-2: High-Level Appeal Process**

*Aetna's appeal process provides enrollees with easy access to request appeals as issues arise.*

**SRC# 12: Figure SRC 12-3: High-Level Tracking, Trending, and Reporting Process**



**Figure SRC 12-3: High-Level Tracking, Trending, and Reporting Process**

*Aetna's tracking, trending, and reporting process provides us actionable data to analyze and enact improvements.*



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**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
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**SRC# 13 – Social Media (Statewide):**

The respondent shall describe its approach for engaging enrollees by using innovative communication methods and technologically advanced resources, including, but not limited to the use of social media, texting and smartphone application platforms.

**Response:**

While still relatively new as a digital tool to drive health outcomes, social media continues to garner mainstream acceptance as a way to share ideas, provide education, network with family and friends, and even measure or monitor health status. Aetna was an early adopter and champion of the use of social media as a means to promote enrollee engagement, with an ongoing and active national presence on sites such as Facebook, Instagram, LinkedIn, Twitter, Tumblr, and YouTube. We found early success using these popular sites to outreach, inspire, educate, and empower our enrollees, their circles of support, and their communities by sharing ideas about how to remain healthy and achieve health goals. Aetna recognizes that social media serves as an excellent tool for communicating with difficult-to-locate enrollees such as those who are homeless. Social media also helps us meet the needs and preferences of an upcoming generation.

Consumer engagement is critical to positive outcomes—social media technology provides an opportunity to reach consumers in personal ways at any time—dynamically, interactively, and threaded within everyday communication. We fully embrace the use of mobile and social media tools to share ideas in the context of our enrollees' daily lives by sending care reminders, providing educational resources, networking with family and friends, and measuring and monitoring health status.

Aetna also views the use of advanced digital platforms such as telehealth, in-home remote monitoring devices, and smartphone applications, and text messaging to offer multiple channels for our care managers and the primary care team to reach and engage our enrollees to help them manage their care proactively. As part of our digital portfolio to connect enrollees to their care teams, we also provide our innovative CareUnify population health platform. An industry-leading, Web-based application to aggregate data and break down the walls of interoperability and data silos, CareUnify enables enrollees of different organizations to use a single platform to coordinate care and to communicate effectively with all members of an enrollee's integrated care team.

We continue to examine unique ways our digital tools can help our enrollees navigate their daily experiences in their Florida communities and to help ensure they have access to necessary services beyond traditional health care. For example, we use texting and mobile applications to deliver information to address social determinants of health, such as housing and food security, particularly for enrollees who reside in rural and underserved urban areas. One of our primary design approaches for technology is that an enrollee's ZIP code should not define the services he or she receives. Whether an enrollee resides at the end of a rural gravel road in Immokalee or on a city block in Miami, we empower every enrollee with information at the swipe of a fingertip to access and receive optimal care.

While technology will not solve all of the communication challenges that exist within our complex health care system, innovative interactive technologies can serve as a way to build and foster

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

trusting relationships with our enrollees and their families. A key part of our innovation strategy is to find new opportunities with our digital portfolio to offer personally tailored information focused on activation and early intervention, with an emphasis on wellness and prevention. New digital technologies offer new opportunities to improve the enrollee care experience and, ultimately, reduce costs.

### **TECHNOLOGY TO IMPROVE HEALTH LITERACY AND PROMOTE IMPROVED HEALTH OUTCOMES**

**CRITERION 1:** The extent to which the respondent described how these technology investments will be used to improve health literacy and promote improved health outcomes

Aetna uses a variety of applications to promote next-generation models of care delivery to improve health literacy and promote improved health outcomes.

#### **Social Media**

Aetna was an early champion of the use of social media as a way to promote engagement effectively, with an ongoing and active national presence on Facebook, LinkedIn, Tumblr, Twitter, and YouTube. On these sites, we publish content and engage with our enrollees and communities to inspire, educate, and empower them to achieve their health goals.

Aetna currently uses Facebook and Twitter to promote enrollee engagement in healthy behaviors, posting daily messages that promote healthy choices and wellness activities or incentives to achieve health, including exercise or nutrition recommendations. We also use these platforms for broader messaging to enrollees and the community about the importance of preventive care, immunizations, medication adherence, and scheduling visits with their physicians to receive important annual screenings or regular check-ups for chronic conditions. By leveraging these sites, health literacy is improved while also creating localized information that can be consumed and acted upon quickly and in the context of our enrollees' daily lives.

Figure SRC 13-1: Examples of Aetna posts on Facebook in Attachment SRC 13 illustrates two examples of Aetna's Facebook posts, which promote healthy behaviors.

In 2016, Aetna launched the #TakeaMoment social campaign to raise awareness and increase social conversation around the positive health benefits of practicing mindfulness. This campaign significantly increased engagement and positive sentiment, generating 99% positive consumer sentiment regarding the published content. By the fourth quarter of 2016, Aetna achieved the industry-leading social reputation score, which evaluates volume and sentiment of social conversation.

This approach—the use of social media to identify a consumer health concern and providing relevant, useful content to empower individuals to live healthier lives—can be applied to a broad variety of audiences and help Florida's Statewide Medicaid Managed Care enrollees achieve improved health outcomes and optimal well-being.

**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

Utilizing Emerging Social Media Opportunities

Unique opportunities continue to emerge to engage our enrollees, particularly those in underserved or rural areas where social media can deliver important health messages and make local and meaningful connections regardless of geographic location. For example, we use YouTube at our Ohio Medicaid health plan as a social media platform to educate enrollees and their families about Aetna and the many services we offer. The page includes a series of videos about the Aetna MyCare Ohio Medicare-Medicaid program, which captures powerful enrollee testimonials on how the benefits and services we provide have significantly improved the quality of the enrollees' lives and their health and well-being.

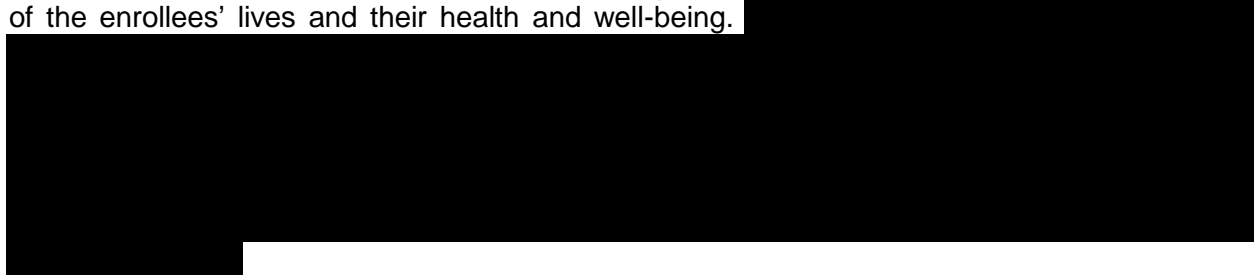


Figure SRC 13-2: Ohio YouTube Video in Attachment SRC 13 represents a screen shot from our Ohio YouTube videos. Our Kentucky plan also uses videos, and we have some in production for our Virginia and West Virginia plans. In Florida, we use this unique approach with social media platforms to connect our enrollees to one another, the health plan, and services within their local communities. Aetna will create YouTube educational videos in English, Spanish, Haitian, Creole, and other languages commonly spoken by our Florida enrollees.

TEXT MESSAGING

CRITERION 3: The extent to which the respondent describes how social media, texting and smartphone app(s) will be mobile friendly and made available on all operating systems (iOS, Android, Windows, etc.) and interoperable with other technologies currently used by the Medicaid population (e.g., Lifeline)

CRITERION 2: The extent to which the respondent provides data that supports the efficacy of the proposed approach in achieving the intended goals/health outcomes (e.g., increase in appointment compliance) for the target population

Aetna has used smartphone technology for several years, and experience indicates that text messaging is an efficient and important way to remain digitally connected with an enrollee's circle of support and community. When joining our plan, enrollees learn about their option to receive text messages from our Enrollee Services staff, the enrollee handbook, and our website. If an enrollee consents to receive texts on his or her personal phone, Aetna sends a text message outlining the programs we offer, including a link to download our mobile application. Enrollees may also receive text messages in their preferred language. We also use text messages for notifications and reminders such as for medication refills, appointments, and for disease management education to support and empower enrollees to self-manage their care.

Aetna also works with the Wellpass, Inc. (formerly Voxiva) platform to deliver evidence-based health text messaging programs to enrollees. Programs are tailored for enrollees based on disease, condition, or key clinical or life events. These programs feature ongoing notifications

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

that provide education and other reminders to engage enrollees in self-care or the care of their family members with an emphasis on wellness, prevention, and early intervention. While the programs support a variety of conditions, we have experienced success with maternal health (Text4baby), diabetes management (Care4life), and smoking cessation (Text2quit). These programs demonstrate improved outcomes; for example, Text4baby has shown a 26% increase in well-baby visits; Care4life has shown an 88% improved diabetes care (reached optimal insulin doses within 12 weeks); and Text2quit has shown a twofold increase in smoking abstinence. (Voxiva and Sense Health Merge to Launch Wellpass Messaging Platform for Healthcare, April 4, 2017, retrieved from the Internet September 15, 2017.)

### **Achieving Intended Goals and Health Outcomes with Text Messages**

Additional successful outcomes supporting the efficacy of our texting programs in improving health literacy and promoting health outcomes include the following:

- Improved glucose levels in pregnancy
- 8% increase in medication adherence
- 40% improvement in appointment attendance
- 82% pregnant moms report attending well-baby visits
- 2 times increase in flu shot utilization
- 18% increase in well-child visits
- 44% increase in dental visits

In addition, Aetna enrollees who participated in the Care4life diabetes management program report the following:

- 96% were engaged with the program (indicated by setting a health-related goal)
- 100% said Care4life improved their knowledge of diabetes and how to manage it
- 73% said the program helped them remember to take medications and attend doctor appointments
- 82% said the program helped them set health goals and work toward achieving them

In Florida, Aetna had 1,570 active users of Text4Health, Text4Kids, and Text4Baby in 2016. Florida Connect4Health users reported the following as of September 2017:

- Txt4Health (based on 416 users): 100% of respondents would recommend the program to a friend; 71% reported attending or intention to attend their appointment; and 89% reported scheduling or intention to schedule their annual adult well exam.
- Txt4Kids (based on 212 users): 87% reported scheduling or intention to schedule a well-child visit; and at follow-up, 70% reported they attended their well-child visit.

### **MOBILE APPLICATIONS AND SMARTPHONES**

**CRITERION 3:** The extent to which the respondent describes how social media, texting and smartphone app(s) will be mobile friendly and made available on all operating systems (iOS, Android, Windows, etc.) and interoperable with other technologies currently used by the Medicaid population (e.g., Lifeline)

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Aetna offers a comprehensive mobile application (at no cost) to our enrollees with iOS and Android smartphones; this application works on all operating systems, including Windows. The application provides access to their personal profiles and the ability to communicate directly with our team—all in the palm of the enrollee's hand. Using our mobile application or website, enrollees can perform the following self-service tasks in real time:

- Search for a physician, dentist, or provider facility and urgent care providers by ZIP code
- Use mapping software to get directions and navigate to a provider's facility directly
- Log in to the secure enrollee site to view the following: claims, coverage, benefits, prescriptions and primary care providers, image of the ID card, secure messages, and the enrollee's individual plan of care
- Send secure communication requests to Enrollee Services department
- Send a secure message to the care management team requesting a meeting or other direct service
- Link to our website and to other useful community resources
- View their plan of care or other provider and community service referral links

We will be offering a social determinants risk assessment tool that will enable enrollees to complete a form and receive a real-time response on how to access resources or contact information for local community services, such as housing or food pantries, tied to their home ZIP code.

Figure SRC 13-3: Enrollee Mobile Application Sample in Attachment SRC 13 displays screenshots from our mobile application.

In addition, Aetna offers the federal government's Lifeline program, which provides free smartphones for those who qualify. With success offering Lifeline in 11 of our health plans including Florida, we understand that nearly two-thirds of Americans are now smartphone owners; for many, these devices are their only entry point to the Internet. By offering and promoting the free phone service, we provide a natural extension to support and empower enrollees with their care. The program promotes healthy behaviors and self-health management resources by offering talk time minutes, texting (unlimited), and data. Access to free smartphones not only fosters enrollees having a reliable phone number where they can be reached, but literally places in their hands a no-cost solution with access to important information such as health tips and health education through text messaging. It also delivers timely reminders on important care management actions like getting an annual flu shot or picking up prescription refills. A no-cost smartphone with minutes and data per month can make a significant difference to anyone struggling to make ends meet, helping to connect with jobs, emergency services, and family. In 2016, 1,700 of our enrollee households had Lifeline phones.

In our experience, more and more enrollees engage with us electronically. One way we improve outcomes is by getting enrollees access to the care. Our transportation vendor collaborates with us to accomplish this goal. The vendor offers a smartphone application and portal to schedule transportation. We cover on-demand transportation, to provide the most appropriate, most accessible transportation for our enrollees, including a Lyft-like, on-demand ridesharing solution to dramatically improve service, quality, and accessibility. Enrollees, care managers, and discharge planners arrange transportation through an approved vendor via phone or through a mobile application.

## **EXHIBIT A-4-a**

### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Our vendor uses an on-demand rideshare service as part of its full-service transportation network. Whenever our enrollees utilize this service, the vendor has a mobile application or Trip Care portal that:

- Allows care managers or enrollees to order trips easily
- Creates an automated and accurate method to track provider location and time
- Reduces potential vendor/enrollee no-shows
- Reduces enrollee uncertainty by connecting driver and enrollee
- Enables enrollees to communicate more effectively with drivers and transportation providers using their mobile device

#### **OTHER CHANNELS**

CRITERION 3: The extent to which the respondent describes how social media, texting and smartphone app(s) will be mobile friendly and made available on all operating systems (iOS, Android, Windows, etc.) and interoperable with other technologies currently used by the Medicaid population (e.g., Lifeline)

#### **Enrollee Web-Portals for Self-Service**

We designed our website so enrollees can easily obtain the information they need when they need it so that they become empowered to assume accountability for their health and well-being from anywhere. It is available on all common operating systems, including iOS and Windows. Our website has advanced capabilities to detect the type of device accessing the site and automatically adapt to provide the best format for that type of device. The enrollee website, also available in Spanish, uses a WCAG 2.0 AA screen reader to read website content aloud to enrollees living with visual disabilities. Additionally, videos posted on our websites are closed-captioned, provide written transcripts, and are WCAG-compliant. We recognize that there are other prominent languages among our enrollees, such as a growing Portuguese-speaking population in Region 10 (Broward County) and a growing Hindi-speaking population in Region 7, which includes the Orlando area. Accordingly, we will make the website available in additional languages to serve our enrollees better.

Our website provides secure access to the enrollee and enables him or her to perform the following tasks:

- View claims status, coverage and benefits, prescriptions and primary care providers, an image of the ID card, secure messages, the enrollee's individual plan of care, personal health history, and track health goals
- View enrollee newsletters, health and wellness information, and our non-discrimination notice
- Search for a physician, dentist, or provider facility and urgent care providers by ZIP code
- Use mapping software to get directions and navigate to a provider's facility
- Update contact information
- Find forms or get new enrollee ID cards
- Download a copy of the enrollee handbook
- Learn about the difference between emergency care and urgent care
- Learn how to file complaints and appeals
- Report suspected fraud or abuse

## **EXHIBIT A-4-a**

### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Send secure communication requests and questions to Enrollee Services for a response within 24 hours
- Access links to community resources

#### **Aetna: We Join You**

To drive engagement with Aetna's enrollees and their communities, we developed "We Join You", a digital experience that enables consumers to engage with content that delivers an emotional connection between Aetna and health outcomes. Through articles, videos, infographics, and questions and answers, the content covers a broad range of health topics, evokes inspiration, and highlights reasons to believe in Aetna. Content throughout the site is intended to resonate with one or more of our target audience groups: mothers with children under age 18 and matures (defined as ages 60 to 69). For example, an Aetna care manager, Kevin, is featured as he helps enrollees through their individual health journeys.

As an active member of the communities we serve, Aetna participates in making our communities better. The Aetna Foundation provides support to community organizations in Florida and around the country. Our community outreach teams in partnership with local organizations and our employees make significant, positive improvements.

In September of 2017, Aetna launched the American Health Ambitions series, which shows how we are helping individuals improve their health literacy and achieve improved health outcomes by working with communities to address the social determinants of health and our most vulnerable enrollees. This work brings together the Aetna Foundation, our employees and community-based organizations to achieve positive results. The series is promoted on CNN and other social media sites. The first story focused on how Aetna is working with the Food Trust in Philadelphia to provide access to healthy food and nutrition education in underserved communities.

The American Health Ambitions program to be launched in October focuses on Aetna's work in the Jacksonville, Putnam County area of Florida with 2nd Mile Ministries in the Brentwood neighborhood. According to the USDA Food Access Research Atlas, there are 29 areas designated as food deserts in Jacksonville. Lack of access to fresh, healthy food or food deserts is a prevalent issue in Northern Florida. Many residents of the Brentwood area do not have easy access to grocery stores, and the area instead is served by convenience stores that do not have fresh produce. High rates of food insecurity have a larger impact including high obesity rates, prevalence of diabetes, for example. Children with poor diets cannot focus in school; this affects the workforce over the long term. Solving the problem of food deserts means a holistic answer. It is not just about the food, but about empowering young people with what they need: nutrition education, job skills, and more. The community garden 2nd Mile Ministries manages is helping to meet some of these needs. Through additional services such as daycare, leadership development, summer camps, and affordable housing support the organization seeks to help residents of the Northside of Jacksonville in tangible and practical ways.

Programs in Atlanta and Houston will debut on CNN and Aetna We Join You during October and November. The American Health Ambitions series highlights just a few of the programs Aetna supports. We are deeply committed to serving the enrollees in our communities.

## **EXHIBIT A-4-a**

### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

The American's Health Ambitions series directs viewers to Aetna's We Join You site. The site is designed to do the following:

- Position Aetna as a health company partner in each enrollee's personal journey to well-being
- Demonstrate an understanding of today's evolving and holistic definition of health
- Differentiate Aetna from our more transaction-focused competitors
- Improve health literacy
- Inspire enrollees to take health actions leading to improved outcomes

Our enrollees can access useful, timely information for themselves and their families anywhere they use their smartphone or computer.

#### **Remote Patient Monitoring**

Aetna will offer remote monitoring to specific high-risk enrollees with the following conditions: diabetes, hypertension, chronic heart failure, asthma, and high-risk pregnancies. Remote patient monitoring has been shown to be effective in preventing hospitalization and health regression with early detection and intervention. We contract with a national remote monitoring expert, which is the joint venture of two Fortune 50 companies. Enrollees in the program receive an iPad mini™ and up to four peripheral devices, including a weight scale, pulse oximeter, blood pressure cuff, and glucometer. These devices are 4G-enabled with call center and delivery support both to and from the enrollee's home. The unit is designed for a simple setup, with the iPad personalized for each enrollee, listing his or her name on the landing page with easy-to-follow instructions and videos on how to use the devices, how and when to contact the provider and care manager, and how to seek emergency help.

The tablet also includes individually tailored educational content on disease management and warning signs of worsening conditions based on the enrollee's condition and needs. We send quick reminder and check-ins to ensure the enrollee is checking his or her vital signs, and ask if the enrollee needs assistance. In addition, we send assessments requesting whether enrollees need assistance with specific social determinants of health. For example, we ask about housing risk, food insecurity, or safety concerns of individuals living alone to ensure they have access to services and daily essentials needed to live safely in the community. Further, we use the tablet technology for pre-scheduled virtual visits with our care managers to video conference and FaceTime with enrollees to check in and provide assistance when needed. We have found value using these virtual visits post-discharge to conduct key assessments, complete medication reconciliation, have an enrollee provide a return demonstration, get a visual on the enrollee to address a worsening condition, or check on safety issues in the living environment.

Enrollees simply attach the devices or stands on the scale and biometric readings will automatically transmit to a secure Health Insurance Portability and Accountability Act-compliant database monitored by practitioners. Devices are programmed to trigger and alert the enrollee if the reading is abnormal. The same information is monitored by the Informed Health line, where an immediate follow-up outreach call is made for any high or abnormal readings to ensure the enrollee can access care and help if needed. In addition, our care managers and the enrollee's PCP, care team, or other designated provider can access the device readings using CareUnify, along with alert notifications, to identify an abnormal or critical reading that requires action and early intervention.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Remote patient monitoring engages enrollees by empowering them to manage their health proactively. Enrollees learn how to manage their conditions to avoid preventable admissions and emergency department visits. We use remote patient monitoring in several states where the technology is preventing hospitalizations, avoidable readmissions, and health regression by focusing on early detection and intervention. Early outcomes from our pilot program in Michigan include:

- Enrollee appointments to their PCP reduced by 54%
- Enrollee appointments to a physician who is not their PCP reduced by 40%
- Number of emergency department visits reduced by 65%
- Number of inpatient admissions reduced by 37%
- Almost all of the participating enrollees (96%) found the equipment easy to use
- Enrollee confidence in managing their conditions after 30 days was 93%, while 96% of participating enrollees said the program made them more comfortable caring for themselves at home

### **CareUnify**

As previously noted, CareUnify is our highly innovative population health management tool that connects providers and enrollees on a single Web-based platform to data and information when they need it. CareUnify creates a 360-degree view with a panel-level view or an individual enrollee view with key data, including the best of our claims, analytics and risk data and other information such as admission, discharge and transfer data from Florida's Health Information Exchange. The driving strategy behind CareUnify is the ability to create collaborative relationships tied to actionable information on one platform to promote effective and efficient care coordination, particularly for complex, high-risk enrollees. By creating this connected community, enrollees become a pivotal part of driving their own enrollee-centered plan of care. CareUnify has a mobile application that is now live for providers with an enrollee application to be launched in the fourth quarter of 2017.

CareUnify also pushes secure email or text notifications to remind enrollees of the integrated care team or the enrollee that a particular action or intervention is required. CareUnify has specific care paths built into the system that can be tailored to drive care coordination for all members of the care team around specific key events. For example, after an enrollee is discharged, a care path can be implemented aligned to evidence-based approaches to ensure the enrollee receives medication reconciliation and referrals for all follow-up care. The system will send text or email reminders on key actions that need to be taken to prevent breakdowns and promote clean hand-offs between organizations (e.g., between a PCP and a behavioral health provider). The system also ensures the enrollee and their family can access their care team 24/7 with real-time text or email notifications being sent to the care team. Further, each enrollee is able to direct and access the entire care team with access to their personal health records, education tools, appointments, transportation requests, as well as initiating a telehealth visit on the system and accessing healthy lifestyle campaigns.

With the enrollee mobile app, CareUnify can push out secure email or text notifications to an enrollee's smart phone application to remind enrollees that a particular action or intervention is needed. An enrollee might receive a message to complete an annual exam, pick up a medication, or make sure he or she completed a specific gap in care such as a specific blood test. In addition, specific care paths are built into the CareUnify system with targeted messages

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

to take specific actions to drive care coordination for all enrollees of the care team around specific key events. For example, after an enrollee is discharged, a care path can be implemented that is aligned to best practices for medication reconciliation to ensure the enrollee receives medications and all follow-up care. The system will send reminders through the mobile application or via CareUnify on key actions that need to be taken to prevent breakdowns and to promote clean hand-offs between organizations, such as between a PCP and a behavioral health provider. The system also ensures the enrollee and his or her family can access his or her care team 24/7, with the ability to send real-time notifications to their care team.

Furthermore, each enrollee can direct and access the entire care team with access to his or her personal health records, education tools, appointments, transportation requests, as well as initiate a telehealth visit on the system, and access healthy lifestyle campaigns. For example, an enrollee can send a message through the enrollee mobile app to their PCP or care manager requesting an appointment. The request for an appointment can also be tracked in the CareUnify system to ensure that the referral is completed and ensure transportation other associated care activities—such as posting lab work in the system for review—can be completed prior to the scheduled appointment. Enrollees can also send a message to their care manager or the provider with a request for transportation assistance. The enrollee app also allows them to view their medications or benefits, request a PCP change, see their care plan, or request an ID card.

### **Informed Health Line (24-Hour Nurse Line)**

Our Informed Health line (24-hour Nurse Line) offers enrollees round-the-clock advice from a nurse. Enrollees can ask about a condition or symptoms and get advice regarding whether they should go to the emergency department, go to urgent care, or see their provider. We survey enrollees who call the Informed Health line to measure enrollee satisfaction. For 2016, the response rate was 30%. Highlights include the following:

- 89% reported being satisfied or very satisfied overall with the service.
- 90% were satisfied with the nurses' medical knowledge.
- 89% were satisfied with the nurses' understanding of their medical complaint.
- 93% were comfortable speaking with a nurse by phone.
- 73% of those who followed the nurse recommendation reported their medical condition was resolved.

### **MONITORING USE**

**CRITERION 2:** The extent to which the respondent provides data that supports the efficacy of the proposed approach in achieving the intended goals/health outcomes (e.g., increase in appointment compliance) for the target population

**CRITERION 4:** The extent to which the respondent is able to provide routine performance data to support enrollee usage trends

### **Social Media**

Aetna has a mature social listening and community management practice utilizing several industry-leading platforms. We leverage these platforms in several ways:

**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

- Aetna has a highly rated social media servicing team that is staffed 24/7 for any social media complaints from enrollees, with a 10-minute average response time. Aetna community managers typically engage in up to 100 conversations each week with consumers; we engage in proactive conversations beyond mentions of the Aetna brand to increase engagement with our enrollees.
- Aetna leverages social listening as part of our community management practice to engage with users on our own social channels in unique, competitively differentiating ways to demonstrate how Aetna educates, empowers, and inspires you to achieve your health goals.
- Social listening is also used to observe and monitor online conversations, allowing us to track brand mentions as well as specific events, campaigns, keywords, and topics.



The use of valuable social media information, content tracking and outreach all helped identify the need to educate the community about the dangers of the Zika virus. We collaborated with The Lotus House, a homeless shelter for women, youth, and children in the Overtown area of Miami-Dade County. In one of the first areas affected by the Zika virus, the Outreach team had our medical director, Dr. Darwin Caraballo, present Zika prevention training to the residents of Lotus House. Dr. Caraballo showed the women how to identify the virus in adults, children, and newborns. He also provided detailed information on the symptoms, including what to do if infected. Dr. Caraballo discussed how to prevent the virus and provided tips on how to protect their children and unborn babies. The residents were engaged and many had questions and concerns, which the doctor addressed. Several participants told us they found the presentation and training useful in understanding how to curb the spread of the virus.

#### Website and Mobile Application

Our enrollee Web-portal is designed specifically with accessibility and outcomes in mind. Enrollees may contact us directly through our secure Web-portals or mobile application. Enrollee Services representatives are trained to recognize and promptly respond to enrollee issues and concerns. Each inquiry or complaint is logged and resolved. Following resolution, we analyze complaints for trends and opportunities, and we share this information with various stakeholders and committees to take action. Our enrollee Web-portal, mobile application, and Lifeline smartphones provide multiple platforms that enable us to share messages with enrollees about reminders to close gaps in care by getting flu shots, mammograms, and HgA1c

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

tests, as well as to schedule well-child visits—all of which tie directly to Consumer Assessment of HEDIS results and outcomes.

Aetna monitors our website constantly to identify usage trends and opportunities for continuous improvement. Our Security team monitors our website for breaches or piracy to protect our enrollees. We created a dashboard that shows trends in daily visits, unique visitors, pages used, length of time spent on site, type of device used to access website, and more. By reviewing popular downloads and page hits, we learn how we can enhance the enrollee experience. We also monitor reports that make it possible to review media effectiveness and impact of online campaigns. In July 2017, more than 3,000 visitors used the site for five minutes or less. This indicates visitors are finding what they need quickly. Some of the additional performance data on enrollee use from July 2017 follows:

- More than 3,800 users visited the Find a Provider page on our website and 1,364 visited the page from our mobile application. This page is one of the most viewed.
- Over 2,800 went to the Enrollee Login page to access the enrollee portal on our website.
- Monitoring of most popular downloads shows enrollees download the enrollee handbook, while providers are downloading prior authorization forms and the Provider Manual.
- Use of mobile phones and tablets to access the site is growing among our enrollees.

We analyze this data to identify opportunities to improve our website to give our enrollees the best possible experience and publish the most useful information. We utilize our Enrollee Advisory Committee to be able to obtain feedback about our website, our on-line applications and all member facing materials and communications. The committee provides valuable feedback on how to improve how we provide information to our enrollees.

Aetna also tracks requests received through the website. For the period March 2017 through June 2017, the top three types of requests were 1) to change PCP; 2) request ID card; and 3) to change enrollee information (e.g. new address). We respond to all requests within one to three days. The number of requests received from our website for this period were 106 (March), 91 (April), 83 (May), and 88 (June).

### **Evaluation Criteria:**

1. The extent to which the respondent described how these technology investments will be used to improve health literacy and promote improved health outcomes.
2. The extent to which the respondent provides data that supports the efficacy of the proposed approach in achieving the intended goals/health outcomes (e.g., increase in appointment compliance) for the target population.
3. The extent to which the respondent describes how social media, texting and smartphone app(s) will be mobile friendly and made available on all operating systems (iOS, Android, Windows, etc.) and interoperable with other technologies currently used by the Medicaid population (e.g., Lifeline).

**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

4. The extent to which the respondent is able to provide routine performance data to support enrollee usage trends.

**Score:** This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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COVENTRY HEALTH CARE OF FLORIDA, INC. DBA  
AETNA BETTER HEALTH® OF FLORIDA

## **Attachment SRC# 13**



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AETNA BETTER HEALTH® OF FLORIDA

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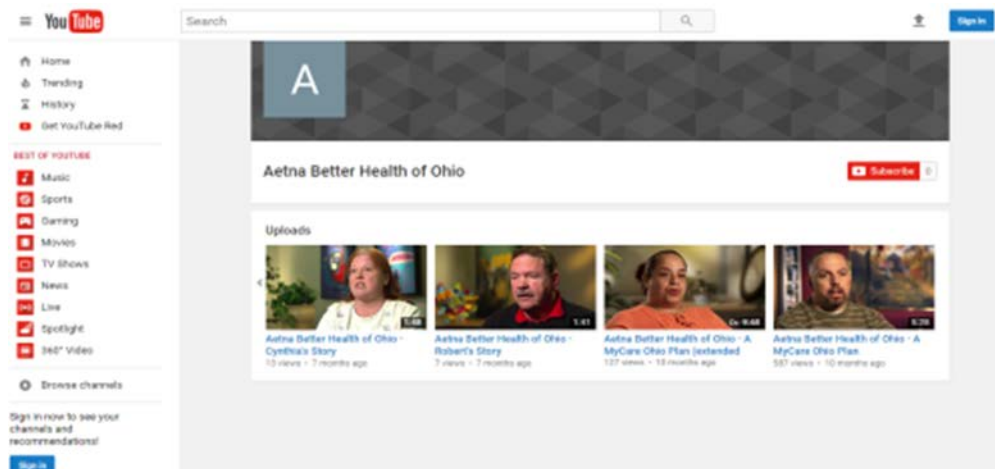
COVENTRY HEALTH CARE OF FLORIDA, INC. DBA  
AETNA BETTER HEALTH® OF FLORIDA

**SRC# 13: Figure SRC 13-1: Examples of Aetna posts on Facebook**



**Figure SRC 13-1: Examples of Aetna posts on Facebook**  
*Aetna's Facebook posts promote healthy behaviors.*

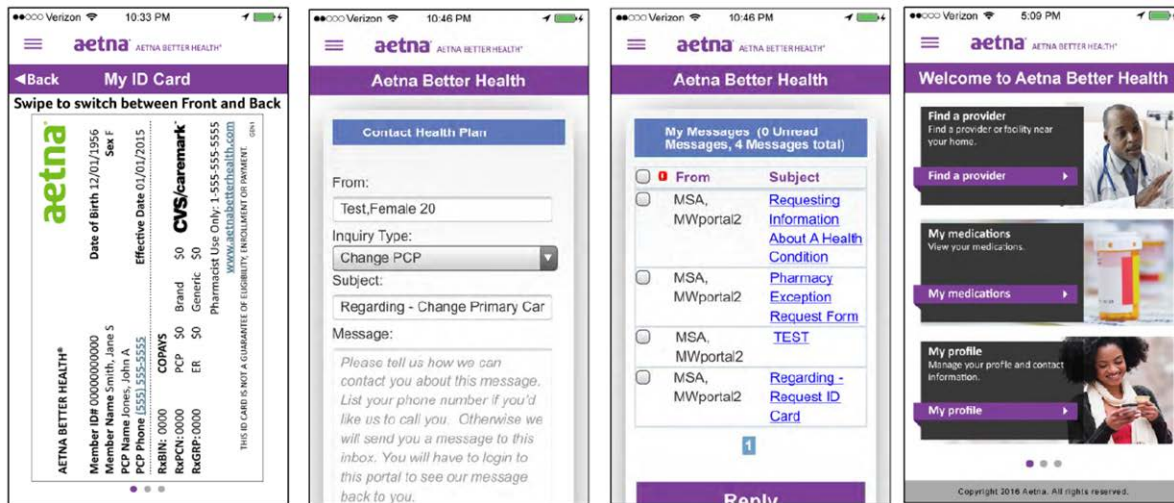
**SRC# 13: Figure SRC 13-2: Ohio YouTube Video**



**Figure SRC 13-2: Ohio YouTube Video**  
*Our Ohio YouTube video connects enrollees to each other, the health plan, and services within their local community.*

COVENTRY HEALTH CARE OF FLORIDA, INC. DBA  
AETNA BETTER HEALTH® OF FLORIDA

### SRC# 13: Figure SRC 13-3: Enrollee Mobile Application Sample



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**Figure SRC 13-3: Enrollee Mobile Application Sample**

*Our enrollee mobile application offers easy access to secure enrollee information and extends Enrollee Services capabilities to the palm of the user's hand.*

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **SRC# 14 – CAHPS Results (Statewide):**

The Respondent (including respondents' parent, affiliate(s), or subsidiary(ies)) shall include in table format, the target population (TANF, ABD, dual eligible) and the respondent's results for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) items/composites specified below for the 2017 survey for its adult and child populations for the respondent's three (3) largest Medicaid Contracts (as measured by number of enrollees). If the Respondent does not have Medicaid CAHPS results for at least three (3) states, the respondent shall provide commercial CAHPS results for the respondent's largest Contracts. If the Respondent has Florida Medicaid CAHPS results, it shall include the Florida Medicaid experience as one (1) of three (3) states reported. Respondents shall provide the data requested in **Exhibit A-4-a-4**, Standard CAHPS Measurement Tool, to provide results for the following CAHPS items/composites:

- a. Health Plan Rating;
- b. Health Care Rating;
- c. Getting Needed Care (composite);
- d. Getting Care Quickly (composite); and
- e. Getting Help for Customer Service (composite).

#### **Response:**

CRITERION 1: The extent to which the respondent exceeded the national Medicaid mean for each CAHPS survey item/component reported

Exhibit A-4-a-4 includes our CAHPS results for Florida, along with our two largest contracts in Kentucky and Pennsylvania.

#### **Evaluation Criteria:**

1. The extent to which the respondent exceeded the national Medicaid mean for each CAHPS survey item/component reported.

**Score:** This section is worth a maximum of 20 raw points as described below.

**Exhibit A-4-a-4**, Standard CAHPS Measurement Tool, provides for thirty (30) opportunities for a respondent to report prior experience in providing desirable experiences with health care (five (5) measures, three (3) states each, adult population for each, and child population for each). For each of the five (5) measures, a total of six (6) points are available.

The respondent will be awarded 1 point if their reported plan rate exceeded the national Medicaid mean, for each available state, for adults and for children, respectively. An aggregate score will be calculated and respondents will receive a final score of 0 through 20 corresponding to the number and percentage of points received out of the total available points. For example, if a respondent receives 100% of the available 30 points, the final score will be 20 points (100%). If a respondent receives 27 (90%) of the available 30 points, the final score will be 18

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points (90%). If a respondent receives 3 (10%) of the available 30 points, the final score will be 2 points (10%).

**EXHIBIT A-4-a-4**  
**SRC#14 - STANDARD CAHPS MEASUREMENT TOOL**

**RESPONDENT NAME:** Coventry Health Care of Florida, Inc. dba Aetna Better Health of Florida

	State #1: 2017 Adult	Florida 2017 Child	State #2: 2017 Adult	Kentucky 2017 Child	State #3: 2017 Adult	Pennsylvania 2017 Child
<b>CAHPS Item/Composite</b>						
<b>Rating of Health Plan</b> (the percentage of respondents rating their plan an 8, 9, or 10 out of 10)	78.21	83.06	73.56	81.17	68.03	79.77
<b>Rating of Health Care</b> (the percentage of respondents rating their health care an 8, 9, or 10 out of 10)	80.43	91.36	73.06	86.34	69.34	84.06
<b>Getting Needed Care Composite</b> (the percentage of respondents reporting it is usually or always easy to get needed care)	82.01	85.19	83.17	89.44	78.73	88.13
<b>Getting Care Quickly Composite</b> (the percentage of respondents reporting it is usually or always easy to get care quickly)	86.63	93.15	84.63	91.39	83.80	90.40
<b>Getting Help from Customer Service Composite</b> (the percentage of respondents reporting it is usually or always easy to get help needed from customer service)	86.09	90.97	88.07	90.74	80.20	86.92

<b>Total Points</b>	<b>18</b>
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**D. PROVIDER EXPERIENCE**

**SRC# 15 – Provider Engagement Model (Statewide):**

The respondent shall describe in detail its provider engagement model. The respondent shall include the following elements in its description, at a minimum:

- a. The respondent's staff that play a role in provider engagement;
- b. The presence of local provider field representatives and their role;
- c. The mechanism to track interactions with providers (electronic, physical and telephonic);
- d. How the respondent collects and analyzes utilization data and provider feedback, including complaints received, to identify specific training needs;
- e. The metrics used to measure the overall satisfaction of network providers with the respondent; and
- f. The approach and frequency of provider training on respondent and Agency requirements.

**Response:**

Aetna's passion for and dedication to serving Florida's Medicaid population translates to authentic and meaningful provider relationships that result in our ability to make a significant and positive difference in the lives of our enrollees. In our view, it is never enough to serve simply as a payer to our providers—we must serve as the bridge that anchors these unique and collaborative relationships, and the critical link that joins our enrollees and providers.

An integral part of improving enrollees' health outcomes is our strong provider relationships that begin at the top of our organization and extend to every staff member. The Aetna Medicaid organization has strengthened our approach to engaging, educating, and supporting providers by using a deliberate and thoughtful approach to working with provider communities, particularly those transitioning to managed Medicaid. This approach uses a technological, hands-on, and collaborative strategy to help make sure all types of providers fully understand their responsibilities in a managed care environment and their requirements under the contract. Additionally, our approach includes an overview of the State's goals, information on where to seek assistance, access to the provider portal, how to bill for services or how to seek answers regarding claims, how to request prior authorizations, criteria for Medicaid eligibility, and our integrated care management model.

**STAFF ROLE IN PROVIDER ENGAGEMENT**

**CRITERION 1:** The extent to which plan leadership are involved in provider engagement

Our Florida team is fully dedicated to meeting the needs of the enrollees we serve. From senior management to every member of our staff, we are actively engaged with the provider community in every step of the way. Our Chief Medical Officer (CMO) Jorge Cabrera, M.D., Chief Executive Officer Heidi Garwood, and Chief Operating Officer Claudia Lamazares meet regularly with stakeholders, community groups, and associations to work collectively to serve our enrollees and help them achieve optimal health outcomes.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

To accomplish this objective, it is critical that we build long-term, strong relationships with providers throughout the integrated system of care, including PCPs, LTC facilities, home- and community-based services (HCBS), specialists, hospitals, community agencies and resources, and the various providers and facilities that are crucial to fostering improved health outcomes for our enrollees. Our provider relations team is committed to developing these crucial relationships through face to face visits and by assigning each provider with a field-based liaison who can assist the provider in addressing needs and connecting them to other resources at the health plan. The integrated system of care coordinates health care and related services in collaboration with each enrollee and the important people in his or her life. We build on the enrollee's strengths and remove barriers to care so that each enrollee can pursue the goals that are most important to him or her. Our integrated system of care includes physical, behavioral, and oral health services, as well as those services that address the social determinants of health and well-being. The mix of services will vary to reflect the various needs of the enrollees we serve.

### **Senior Leadership Provider Engagement**

Aetna's mission is not just to improve enrollee health, but to improve lives. We are constantly engaged with the community to achieve this mission. Our senior leadership conducts regular community action forums to glean thoughts, observations, advocacy, and input from our community partners that interact with Medicaid enrollees. Our goal is to place our enrollees' welfare at the forefront of all we do. The forum comprises 8 to 12 community partners and providers that share their views and opinions in a confidential setting. Invitees include health care professionals, community leaders, Aetna staff, community advocates, and providers. Forums are held quarterly to discuss specific topics of interest, to solicit feedback necessary to help us understand our partners and providers in the community (including at minimum pediatricians, hospitals, PCPs, and obstetricians (OBs) that routinely engage with the Medicaid community), and to learn how we can serve our enrollees' needs better. While each forum has a preliminary list of topics to discuss, these may change as new topics are brought to our attention. Recent topics include challenges with engaging membership, operational challenges that may affect enrollees or providers, and how to provide messaging to enrollees more effectively. We are confident these collaborative and inclusive forums serve a vital, ongoing role as we continue to evolve and expand our program to serve our enrollees better.

One example of a recent partnership between senior leadership and the provider community to improve health services and quality was a recent symposium at which Dr. Cabrera, our CMO, worked with the Dade County Florida Healthy Start Coalition to help develop and organize a prematurity symposium to address concerns related to reducing the rate of premature births within the State. This year's symposium was held on August 24 and 25, 2017 and included keynote speaker Kelli Wells, MD, Deputy Secretary for Health at the Florida Department of Health and other well-known local leaders in the health care community. The symposium attendees included OBs and gynecologists (GYNs) and the full complement of pediatric and pediatric subspecialty practitioners. Care managers; mental health professionals; clinical social workers; and maternal, infant, and child health community workers also attended. The symposium's sole purpose was to provide education and information on ways to improve care and outcomes for pre-term babies and their mothers. It is through these meaningful events that Aetna contributes to the sustained improvement of care in the communities we serve. The symposium was well attended and providers offered extensive praise for our level of commitment, contribution, and evident partnership with the provider community.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Another example of our leaders engaged in community and provider initiatives is our recent grassroots event with Jessie Trice Community Health Center, which is the oldest federally qualified health center in the State and is comprised of a series of large medical facilities located across Miami-Dade County in low-income cities and communities. Aetna sponsored and participated in one of the center's diabetic nutrition workshops, in which participants received a diabetic-friendly cooking demonstration and cookbooks filled with healthy, low-sugar recipes. Approximately 2.4 million Floridians have diabetes, and individuals with poorly managed diabetes may develop serious complications that can lead to disability and work loss, which can potentially reduce their overall quality of life. Therefore, grassroots efforts by providers to help enrollees with diabetes manage their disease are essential in improving community health.

Our CMO routinely meets with primary care provider practices to gain a better understanding of challenges that our network providers face and to share strategies to help manage care in more effective and efficient ways. As a result of these visits, our CMO developed a primary care practice resource tool that has practical suggestions for our network providers and their respective practices. We post this tool on our Website, and it is part of provider orientation materials.

### **Staff Roles in Provider Engagement**

Every member of the Florida Medicaid team understands that providers are critical to the success, health, and well-being of our enrollees. Every individual of our team who interacts with a provider receives the training, education, and support to provide the most satisfactory provider experience including staff members in the enrollee services, provider services, medical management, care management, clinical, quality, claims, grievances and appeals, and IT Support departments. All of these individuals are critical to our provider engagement strategy. Our staff includes a cross-functional team of both field representatives and back office support to meet provider and enrollee needs, including:

- Senior leadership on the Florida team is fully engaged with the provider community as well as with other stakeholders to learn more about how we can better serve our enrollees, improve membership, improve quality, and educate and inform on innovative programs to integrate health care better. Senior leadership conducts onsite visits and develops and conducts symposia and other educational initiatives. Additionally, leadership is instrumental in building relationships with stakeholders, community resources, and government agencies to develop programs, resources, and educational initiatives. Furthermore, leadership gathers feedback and information on how we can meet both provider and enrollee needs best on an ongoing basis and is always available to assist our provider staff with any issues or concerns.
- Quality staff members develop and oversee informational and educational initiatives for the provider community, handle and oversee grievances and appeals and the oversight and advisory committees, and perform other duties, as necessary.
- Provider Services representatives are dedicated to educating and advocating for the providers. Their advocacy efforts include, but not limited to, resolving provider issues about eligibility, billing, and benefits. Our provider services representatives typically receive the first call from providers whenever they have a question or concern. These discussions serve to inform the training, education, and support in handling provider questions. Through these representatives, we address questions related to contracting, credentialing, and claims. Our goal is always first-call resolution.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Provider Services liaisons conduct face-to-face provider office visits monthly and quarterly and serve as our primary contacts for the provider community. They visit hospitals, other facility provider types, physician and other practitioner types, community agencies, and other stakeholders to build long-term relationships, provide training and education, as well as conduct outreach to bring new providers into the network. Additionally, these liaisons track all provider inquiries using the call tracking system.
- Provider Network staff is responsible for contracting all provider types, ensuring compliance with network contractual requirements and adequacy needs, mitigating network gaps, and determining future network needs.
- Credentialing staff members support the Florida plan in providing credentialing and re-credentialing services.
- NICU and post-discharge clinicians work collaboratively with our providers to assist in transition planning, provide guidance to enrollees/enrollees' parents on benefits and resources, and facilitate any necessary care coordination to sustain the gains made during the inpatient stay. They collaborate with providers closely to extend the capacity of their teams.

### **PRESENCE AND ROLE OF LOCAL PROVIDER FIELD REPRESENTATIVES**

**CRITERION 2:** The extent to which local provider field representatives are incorporated into the model, including the ratio of local provider representatives to providers

Face-to-face contact is critical to creating strong relationships with providers. Provider Services liaisons are a critical component of our provider engagement model. They visit provider offices throughout the State to provide education, answer questions, and resolve issues and concerns. Aetna has a strong presence in Florida; through our Florida Healthy Kids contract and Medicare and commercial programs, and we are able to leverage our geographic footprint to expand our community relationships. In addition, Aetna has a sizeable employee base of over 300 Medicaid staff in the State, offering the flexibility to shift resources as needed to maintain service levels.

Upon award, we will have at a minimum one Provider Services liaison who will be hired from the local community with a deep understanding of the local system of care, located in each region to ensure ready access to contracted providers. Currently, we serve 50,000 Managed Medical Assistance members, 2,000 LTC members, and 500 Florida Healthy Kids members. Our 23 local staff members support providers and as many as 25 additional national support staff members are available to assist with a variety of functions. Upon contract award and consistent with our historical practice, we will hire experienced staff that is knowledgeable about the communities and system of care in their respective areas. Our ratio of 1 provider field liaison per 250 provider practices ensures we have sufficient staff to meet the needs of the provider community. For any regions we are awarded, we will provide sufficient staff to reflect needs, including adding provider services representatives, provider services liaisons, provider network staff members, and others to support provider needs.

Aetna bases staffing ratios on anticipated enrollment using workforce management software to forecast adequate staffing. We will continuously reevaluate and revise staffing levels to ensure consistent delivery of services. Our extensive experience with the Florida Healthy Kids contract, MMA, and LTC as well as our commercial and Medicare business within the State, will guide us to expand our Medicaid staff into other regions. Aetna's approach to determining appropriate staffing levels for provider outreach is flexible, and it will grow based on changes in the number

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of enrollees, special needs of the enrollees served, geography, and the number and type of contracted providers required to fill the educational and training needs.

We hire staff based on their experience in the marketplace and who have solid customer service and provider experience. Our comprehensive training curriculum for provider services staff and liaisons includes a variety of topics including, but not limited to, the most important information and areas of concern for providers such as contract requirements, program requirements, claims, billing, prior authorizations, grievances and appeals, how to handle provider concerns effectively and timely, and, most importantly, cultural competency.

New team members will shadow experienced Provider Services personnel. They are not assigned to the field until they demonstrate sufficient effective problem-solving skills. The provider relations manager regularly reviews issues with the network team to identify trends, provider billing concerns, and opportunities for ongoing training and retraining. As we staff to meet the needs of the contract, Aetna's reputation as an employer of choice enables us to attract the best-qualified candidates, with experience in provider relations/services to serve our provider community best. Aetna's reputation is evidenced by the recognition we received from a variety of organizations. Aetna Inc. was recently recognized as a best place to work by the United States Business Leadership Network and the American Association of People with Disabilities for our disability inclusive-business practices, and we were included for the tenth time since 2001 on Diversity Inc.'s list of the Top 50 Companies for Diversity.

### **MECHANISM TO TRACK INTERACTIONS**

**CRITERION 3:** The extent to which the method the respondent uses to track interactions with providers is capable of producing meaningful data the respondent will use to address both clinical and administrative problem areas

To effectively monitor, manage, and maintain an effective network, it is necessary to effectively track, trend, and analyze data obtained through provider interactions and contacts. This data provides valuable information about clinical and administrative performance gaps and opportunities for improvement. Provider contact that occurs by phone, web-portal, webinars, and educational seminars or through provider collaborations is tracked and documented in a formal manner and reviewed through our Network Engagement and Strategy Committee at least quarterly. Each method of interaction offers a mechanism to track and provide meaningful data including the following:

- **Face-to-Face Visits:** Provider services liaisons track all interactions with providers in the provider database, including updating demographic information; entering feedback, complaints, issues or concerns; training completed and needed; provider issues or problems; and any training or educational needs to assist the provider with resolving the issue. We also track questions answered; specific provider needs; and any other notes or concerns the liaison wishes to note in the system. Reports can be pulled monthly, quarterly, or annually primarily for the use of the provider services team to determine training needs, mitigate issues, and identify potential network gaps or other needs. Reports are also provided to leadership, committees, or other operational teams as needed or requested. Sub-capitated providers are equipped with a suite of reports such as PCP reconciliation, utilization and encounter data, and HEDIS reports. These reports

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### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

are reviewed during on-site visits and provided through the provider portal on a weekly and monthly basis (aggregated data).

- **Telephone:** All provider calls that come into our call center are tracked in real time using call center recording and tracking software. All calls (100%) are recorded for monitoring and tracking as well as training purposes. Calls that come directly into our provider services team are tracked in the call tracking system described in the provider services information that follows. Data gathered from these encounters are reported at several intervals: real-time, hourly, daily, weekly, monthly, quarterly, and annually for assessment by operational teams, leadership, provider services, grievance and appeals, and various committees and management. Data and information collected is used to determine, monitor, and resolve issues and complaints as well as to indicate training or educational needs and assess provider satisfaction.
- **Grievance and Appeals Telephone/Email/Letter/Web:** All complaints that come into our Grievance and Appeals department (no matter the source) are logged in the system using their call tracking module and/or grievance and appeal software. Data gathered on grievances and appeals are reported to the State and are monitored and managed for productivity and quality improvement, including reporting to Aetna's various quality committees. Data is reported on a monthly, quarterly, and/or annual basis, and it is used to identify trends and opportunities for improvement and to assist in developing corrective actions, as well as helping us to improve provider satisfaction. Data is also used in redesigning processes and procedures, applying lessons learned, and helping to improve outcomes such as providing education and training on claims submission, prior authorization processes, etc.
- **Web-portal:** We track the use of the provider portal in real time and on a daily basis to determine its effectiveness for our provider services team. Using analytical software, we can track the number of providers using the portal and the various uses of the portal (e.g., claims, questions, prior authorization, complaints, etc.). Through our Medicaid Web-portal, user reports can be generated easily, showing all accounts within the portal along with activation and activity reports. These reports also reflect the different activities used in the portal during a designated timeframe. Users can also generate secure message reports to identify aging of unanswered messages from providers or enrollees. Other reports are also available regarding use of the various applications through the Web-portal and can be provided to management and various committees (as needed) at any requested frequency. These reports enable us to determine trends, whether changes are needed to increase use, whether providers are having issues with the system to resolve or mitigate any problems, and to determine any training needs such as assisting providers with claims submissions, payments, prior authorizations, updates to their demographic information, etc.
- **Webinars/Educational Sessions:** We track attendance at each webinar (using Web-based software), or at each educational session (either through manual data collection or electronically using an iPad or computer using a common software application). Data can be reported on a monthly, quarterly, or annual basis or immediately after the event. This information is used to determine which providers have completed training and helps us assess those who remain outstanding. Additionally, the information assists with developing and conducting outreach to those who could not attend, and evaluate effectiveness of and/or satisfaction with the training.
- **Provider Database:** Aetna's Provider Services team tracks all encounters (phone, face-to-face, Web, and email) using the provider database; but reports can be provided to leadership, other departments, and committees as needed. The database collects

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### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

provider demographic information, notes on provider interactions, completion of training (including required trainings such as orientations, cultural competency, and/or other specialized training needs). Information is gathered in real time by Provider Services staff and can be reported on a daily, monthly, quarterly, or annual basis and can be used to determine provider training needs, trends, potential issues or problems, potential gaps or network needs, provider satisfaction, issues and complaints, and provider demographic information updates needed.

#### **TRAINING OF FIELD REPRESENTATIVES**

**CRITERION 4:** The extent to which the method the respondent uses to track interactions with providers addresses potential provider field representative training needs

All provider services liaisons receive extensive training and education at the time they are hired to help them become effective educators in the field and understand the needs of providers. We also provide staff with all of the data and tools available to assist providers to improve quality and reduce avoidable. Our liaisons are effective communicators with the skill and experience necessary to address provider concerns and assist providers in deploying Aetna resources to improve health outcomes. Staff training focuses on increasing and continually improving the skill, experience, and knowledge of the individuals who work directly with our providers. Liaisons receive information on an ongoing basis through staff meetings, updates, memos, and additional training to make certain they stay abreast of current topics and trends, as well as to assure they have the information, tools, and resources they need to deliver effective training and communication to our providers. We train our staff interpreting data and on how to identify trends, issues, concerns, or problems in the field in a proactive manner. When collecting and analyzing data shows a trend or uncovers a need to educate our provider team members through evaluating data, we conduct special training using our regular staff meeting as an efficient method of delivery.

New team members undergo formal training to make certain they have the skills and information necessary to fulfill their roles from their first day interacting with providers. They are not assigned to the field or required to answer provider questions until they are fully trained. On an ongoing basis, the provider manager regularly reviews issues with the network team to identify trends, provider billing issues, and opportunities for training and ongoing retraining to make sure the team is effective on the job.

Provider services liaisons conduct monthly onsite meetings for large provider groups and organizations to address any concerns, discuss quality metrics, and review new initiatives. For mid-sized provider organizations, they conduct visits at least quarterly. Liaisons visit small provider groups at least annually. Prior to these visits, a thorough review of agenda items is conducted to make certain that the liaisons are well prepared to cover the proposed agenda items or identified issues in a comprehensive way during their site visits. After the liaison visits with the provider, he or she inputs an assessment of the visit (including needs, concerns, issues, informational and educational needs, etc.) into the provider services database. Aetna's provider services team monitors and tracks these interactions in the system to determine trends, identify educational needs, and provide information and feedback to management about provider concerns. By reviewing and monitoring the information gathered during onsite visits or through telephone encounters, Aetna's provider services team identifies trends, educational and informational needs, and issues or areas of concern that need to be addressed and

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

implemented. Provider Services liaisons review utilization reports, as well as grievance and appeal reports, call center tracking and trending analysis, Web portal reports, and feedback from educational sessions. They also review other interactions including data gathered from regular provider monitoring tools to determine any training or potential training needs. In order to understand the results of these reports best, they are paired with subject matter experts as a resource to assist them to interpret the reports accurately.

On a weekly basis, the director of provider relations facilitates a field operations review meeting that includes all field liaisons and provider relations staff. During this meeting, a systematic review is conducted of all open provider issues, upcoming projects, reviews of provider visits, and provider education and training meetings. Through the review of these items, an assessment is conducted to survey the team to identify the need for training on specific topics pertaining to the current trends, issues, and upcoming assignments. On a quarterly basis, the director of provider relations conducts a formal training survey. The results of the survey are compiled and reviewed in the weekly team meeting. The training topics are then ranked to determine whether they are critical, essential, or helpful. Trainings that are critical become the focus of our training resources and become priority trainings.

Whenever providers raise concerns, whether through onsite visits, phone calls, or other sources, we work with them directly to address the concerns they have. We also proactively work with our team to ensure that they are equipped with knowledge and tools to address the issues or concerns. Addressing provider concerns often requires face-to-face meetings, regularly scheduled meetings by telephone, detailed reviews of outstanding account receivables, or time educating the provider's office staff. The tools and trainings that are provided for our liaisons to be successful are detailed, targeted, and designed to assist them in managing a broad spectrum of issues.

Aetna trains our provider liaisons to better address provider concerns and needs. For example, a new participating provider joined the network and its billing and preauthorization department filed a complaint about specific services being denied for payment and not receiving the assistance needed to determine which services required prior authorization. While the provider services liaison had attempted to assist the provider, it was apparent the liaison required additional training, as she was experiencing difficulty using the reference tools that delineate the services requiring authorization. After the liaison was re-trained, she was able to assist the provider in using the online tool and in searching for the claim status. The provider was satisfied with the assistance and requested to withdraw the complaint formally.

### **MEASURING OVERALL NETWORK PROVIDER SATISFACTION**

**CRITERION 5:** The extent to which the metrics used produce actionable data for measuring provider satisfaction, increasing provider performance, improving the provider engagement model, and identifying areas of improvement for provider related communications or written materials

Provider satisfaction is dependent on a solid partnership between the health plan and the provider, so we work to ensure we proactively address providers' concerns and needs. We obtain feedback from our provider community related to new programs and initiatives on an ongoing basis. As such, we conduct semi-annual provider advisory forums to discuss and

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

review satisfaction ratings, new programs, and initiatives to obtain immediate provider feedback that enable us to make adjustments as needed.

We work collaboratively with providers to understand their issues and determine opportunities for improvement, including incorporating provider feedback into Aetna's committees, as appropriate, to improve processes and procedures. A recent example of how we use provider feedback to implement change is demonstrated by the addition of lab services that can be performed appropriately in an office setting. We met with providers and listened to their suggestions to add specific in-office lab tests including finger/heel sticks for newborns, lead testing, hemoccult test, fecal occult blood, cholesterol screening (lipid test), and mononucleosis tests. The feedback was taken back to our clinical leadership and the codes were effectively implemented. As a result, we received positive provider feedback. Our goal is to collaborate with our providers and to remain flexible and amenable to making changes and adopting new processes to improve care for our enrollees. Allowing the aforementioned STAT lab procedures to be performed by our practitioners, and not limiting them to our contracted labs, improves the ability of our physicians to diagnose and provide prompt treatment.

Aetna is committed to developing innovative ways to improve the provider experience. Technology based solutions is a significant part of our strategy, and most recently, we began a project to streamline the ability for providers to submit requests for authorization in any format as a direct upload of data into our clinical system. This project decreases the turnaround time for processing authorization requests. Our goal is to simplify requirements so providers can focus on providing quality care while decreasing administrative work.

Our strategy of implementing value-based contracting will make a positive impact to provider engagement and satisfaction. In value-based contracting, we collaborate providers to align goals and incentivize performance. Real-time reports and member engagement tools are made available to facilitate the improved health outcomes for enrollees. In complementing provider efforts through our own care management resources and program, we build strong partnerships that ultimately lead to highly effective collaboration.

We collect information about the satisfaction level of our provider community through several communication forums, including the following:

- Regular provider site visits and/or scheduled telephonic meetings
- Annual provider satisfaction surveys
- Monthly provider pulse surveys
- Monthly post-site visit survey
- Feedback from our Community Action Forums
- Feedback from the QM/UM Committee, which includes representatives from the provider community
- Feedback from provider training sessions
- Review of data outcomes from our provider claims inquiry team
- Feedback from care management staff
- Grievances and appeals
- Community meetings

Aetna uses an NCQA-certified survey vendor to conduct an annual provider satisfaction survey to assess how well we meet provider expectations and needs. We survey PCPs, specialists,

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hospitals, and providers of ancillary services through this method. The results from the survey summarize satisfaction through ratings, composites, and attribution rates. The survey assists with identifying plan strengths and opportunities for improvement.

Enrollee feedback is a crucial component of assessing provider quality of care and clinical outcomes. Our Quality Management and Utilization Management programs include processes to monitor the provision of services delivered to enrollees, including evaluating outcomes, adequacy of care, and access to services.

Our Provider Services department has three types of representatives who obtain provider feedback. Each position within the department collaborates with other team members to communicate individual concerns and systemic trends identified regarding provider satisfaction.

- Provider services representatives with claims management backgrounds handle provider calls on our provider line, answer questions placed on our general provider services phone line, handle department email, and monitor and incorporate any feedback into the system. Provider services representatives attempt to resolve any issues or concerns and to escalate any unresolved issues to provider services liaisons or management.
- Provider services liaisons travel to assigned provider practices to listen to concerns, address questions, and receive feedback about how to improve services or operations. Our liaisons also host office manager events and forums to be able to disseminate important information and gain additional clinical and administrative front office insight. Many of these individuals have backgrounds in provider services and claims submissions, so they can relate to the challenges raised by providers. Our provider services liaisons present provider feedback at network meetings attended by all provider services and contracting staff. Any feedback requiring follow-up is identified and an action plan is developed. During provider conferences, provider services liaisons receive direct feedback from attendees, including office managers and practitioners. Common themes include consistent and timely communication of health plan updates and resolution of any issues that arise.
- Contracting managers and negotiators meet with prospective and contracted providers to listen to concerns, address questions related to the contract and the contracting process, and receive feedback about how to improve the process. These seasoned recruiters and negotiators purposely look for opportunities to improve access and quality through innovative collaboration with providers and community organizations on an ongoing basis.

### **Collecting Feedback through Network Management Processes**

Our provider network management process integrates a focus on provider satisfaction through evaluating, monitoring, and implementing improvements with the ultimate goal of improving the provider experience through the following methods:

- Interacting with providers to gain real-time feedback, using this face-to-face time to share proactively claims, utilization management, and patient-specific metrics; feedback regarding policy changes; and likes and dislikes; we use provider feedback to help streamline internal and programmatic policies, processes, and procedures to improve the provider and enrollee experience.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Implementing improvements on an individualized basis to include assigning provider services liaisons to all participating providers so each practice becomes familiar with and forms a solid working relationship with its dedicated representative, as well as providing field service and ongoing training across our provider network; improvements may apply to all providers or across certain provider types.
- Evaluating feedback from all monitored sources to develop implementation plans to improve our services to providers.
- Monitoring provider appeals and grievances for trends and problem areas and leveraging committees, seminars, and surveys for feedback' annual provider seminars are conducted in various regions throughout the State for provider education and outreach. We perform post-seminar satisfaction surveys that generate data and analysis for the Quality Management Oversight Committee and annual provider satisfaction surveys to identify issues or barriers that require immediate resolution. By constantly evaluating the satisfaction level of our provider community, we target and identify providers we can work more closely with to strengthen our relationships.

Corrective Action When Dissatisfaction is Identified:

When we determine that providers are not fully or highly satisfied with an aspect of our provider services, we implement an improvement action plan. This plan details the following:

- Summary of issues discovered
- Root cause(s) of issues / dissatisfaction
- Objectives and goals of the improvement action plan
- Specific action steps and timeline
- Staff and management responsible for completion of the plan
- Date of implementation and target date for completion

Monitoring provider complaints revealed that independent personal care attendants and providers new to HCBS Medicaid services were receiving a high volume of claims denials. Upon further research, we determined they were struggling to complete claims forms accurately. An action plan was implemented that included claims monitoring for denials for HCBS providers, additional regionally located on-site training classes specifically for providers to learn how to effectively complete and submit claims forms, and follow-up review of claims to determine which providers required continued outreach and additional one-on-one assistance.

### **APPROACH TO AND FREQUENCY OF PROVIDER TRAINING**

**CRITERION 6:** The extent to which the training includes service coverage guidelines, service authorization requirements, billing procedures, claims processing, payment timeframes, and respondent's dispute resolution process and timeframes, including corresponding requirements in scope of services

Training for our providers begins with an initial orientation and continues on an ongoing basis through regularly scheduled site visits from our provider services liaisons. The initial site visit is conducted within 30 days of contracting and then on an ongoing schedule depending on their specialty. Training frequency is reflected as follows:

- PCP, family physicians, pediatricians, and OB/GYNs: annually

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- PCPs with value-based purchasing contracts: monthly (for large groups)
- Managed long-term service and supports providers: annually
- Specialists: annually
- Dentists: annually
- Clinics: annually
- Hospitals: quarterly
- FQHCs: bi-annually
- Large groups: monthly
- Provider forums: semi-annually

Training during orientation consists of an overview of the State's goals for care delivery transformation, information on where to seek assistance, access to the provider portal, how to bill for services or how to seek answers on claims, how to request prior authorizations, eligibility criteria for Medicaid eligibility, and Aetna's integrated care model. Providers can attend orientation/training meetings by various means, including convenient, regionally located provider seminars, webinars, and one-on-one education in provider offices. Provider Services liaisons follow up after orientation with all providers to address any questions and to ensure they know how to reach us for assistance.

During implementation, such as will occur with a statewide or multi-region implementation under a new contract award, we will provide monthly training for all providers using webinars and/or regional forums or meetings. These educational sessions will provide information on the contract, program benefits, how to submit claims, use the Web-portal, sign up for electronic funds transfers, and various other topics of interest. Existing office locations in Boynton Beach, Jacksonville, Miami, Orlando, Sunrise, Tallahassee, and Tampa will also be utilized as educational and provider resource centers at which providers can visit in person or call to have their questions or concerns addressed by local staff.

We work closely and actively with HCBS providers and nursing facilities to educate and assist with training about their roles and on what is necessary for success in a managed care environment. Education and training for HCBS and institutional providers (e.g., nursing and assisted-living facilities) are a key responsibility of our Provider Services liaisons.

Orientation/Training: During the initial contracting period (within 30 days of contracting), we offer multiple ways for providers to attend orientation/training meetings, including convenient, regionally located provider seminars, webinars, and one-on-one education in provider offices, and rural communities. We are flexible, and we will work to accommodate the availability of the provider within State requirements. Aetna conducts orientation and training for newly contracted providers within 30 days of their effective date with the plan. Training includes, but is not limited to, the following:

- Contract requirements, along with any amendments
- Special needs of the enrollees the provider serves
- Service coverage guidelines
- Prior authorization requirements
- Billing procedures
- Claims submission and processing (including payment timeframes and requirements),
- Dispute resolution process and timeframes
- Grievance and appeals process and timeframes

## **EXHIBIT A-4-a**

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- Other items required under the contract's scope of services
- How to access information through our website or provider portal
- Any other region-specific issues or concerns to assist providers in meeting enrollee needs

Following orientation, Provider Services liaisons follow up directly with all providers to address any questions and to ensure they know how to reach us for assistance. To reinforce providers' billing knowledge, we offer a worksheet-based claims filing simulation for smaller offices as part of their training. For large provider offices, groups, or systems, we work to arrange a test-claims submission.

During orientation, each provider receives a link to the online provider handbook that includes the following information:

- A description of Medicaid and the Florida Statewide Medicaid Managed Care program
- Emergency service responsibilities
- Provider responsibilities
- Background screening requirements
- Credentialing process requirements
- How to obtain service-specific coverage requirements and medical necessity criteria
- How to obtain prior authorization and referral procedures including the required forms
- Quality programs
- Enrollee record standards for providers
- Claims submission protocols and standards including instructions and all information required to submit a clean or complete claim
- Protocols for submitting claims data
- Marketing activity requirements and prohibitions
- Provider complaint procedures including how to contact the plan to file a complaint, complaints about claims issues, and the complaint review process
- How to identify and report abuse, neglect, and exploitation of enrollees, including identifying victims of human trafficking
- Enrollee rights and responsibilities
- Enrollee grievance process, including address, telephone number, and office hours of the grievance staff; enrollee right to request continuation of benefits while utilizing the grievance and appeal system; and information about SAP

Aetna's provider handbook is available online for quick and convenient access for all provider staff. We regularly distribute bulletins, announcements, alerts, and similar information through fax blasts, email, and our website. We update the handbook as needed. In addition to new provider orientations, we utilize a variety of communication modalities to update providers on an ongoing basis, such as monthly newsletters, Webinars, the provider website, and fax blasts. All of our Provider Services liaisons are able to address any issues that arise.

#### **Ongoing Training:**

We recognize that the provider community is critical to our success, so we make provider engagement and collaboration a cornerstone of our processes. Depending upon the size of the provider practice and enrollee volume, our Provider Services liaisons meet with providers in

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

their offices for regularly scheduled (typically annually, but more often as needed) visits to answer questions, mitigate issues or problems, and educate providers on the following:

- Medicaid managed care
- Billing
- Prior authorization requirements
- Claims submission and payment, including timeframes
- The grievance and appeals process
- All contract requirements required in the scope of services
- Specific issues facing their enrollee population

Training or educational opportunities are developed to address specific needs across the network. During a total system migration during 2017, we conducted town hall training sessions for providers across the State to answer questions, mitigate issues and concerns, and let our providers know that we were readily available to help them during this change. Due to the proactive training, we found there were far fewer provider issues than we normally would have experienced during a migration of this magnitude.

Provider education meetings are held to discuss recently issued amendments, regulations, or emergency notifications. These meetings are generally well attended and well received. Providers appreciate our efforts that lead to a better understanding of upcoming needs and/or changes. Ongoing training is conducted throughout the year on changes to our system and processes, such as recent enhancements. We utilize a variety of methods to communicate this information securely and as efficiently as possible, including using fax blast training.

For the top five specific provider types identified by through claims volume, and the monitoring and quality improvement process, we conduct quarterly education and training on topics that include the following:

- Documentation and appropriate coding, including common claims submission errors and the best ways to avoid them
- How to identify and report abuse, neglect, or exploitation among the enrollees they serve
- Any other topic pertinent to the provider, such as regional trends or issues
- Cultural competency
- How to meet the needs of special needs patients
- Prematurity issues
- How to improve practice performance
- Demographic and roster information verification, appointment availability, and compliance with the Americans with Disabilities Act

Training will be conducted using webinars or in person throughout the various regions. We will publicize all trainings and educational opportunities through marketing materials, on our provider Web portal, and through fax blast communications.

For large provider groups and organizations, Provider Relations liaisons conduct monthly and quarterly Joint Operating Committee meetings onsite to address any concerns, discuss quality metrics, and review any new initiatives. For mid-sized providers and organizations including specialists and ancillary providers, we will conduct visits quarterly. For small provider groups and organizations, we meet at least annually. In addition to onsite visits, we offer technology-

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

based solutions such as webinars, provider notices, and online tutorials in addition to phone contact with the Provider Services liaison. These visits provide foundational support to our provider partners, and one of the cornerstones of our success in the community is our willingness to accommodate individual requests for information and training.

We work closely and actively with HCBS providers and nursing facilities to educate and assist with training on their roles and on what is necessary for success in a managed care environment. Education and training on billing issues and how to obtain assistance or file an appeal for HCBS and institutional providers (e.g., nursing and assisted-living facilities) are a key responsibility of our provider liaisons.

### **Aetna Requirements**

Aetna follows contract requirements that by January 1 of each contract year (and within 90 days after initial contract execution), we present a survey tool to the Agency for approval. The survey tool uses a four-point Likert scale to measure provider relations and communications; authorization processes (including denials and appeals); timeliness of claims payment and assistance with claims processing; complaint resolution process; and care coordination/care management support. Survey results and any action plans are presented to the Agency by July 1 of each contract year.

Aetna uses the SPHA provider satisfaction survey to monitor provider satisfaction levels. Our 2017 provider satisfaction survey template was designed to assess the practitioner's experience and their continuity and coordination of medical care across the delivery system providing a quantitative analysis of data and feedback. Results of the survey are presented by summary rates (the sum of the proportion of respondents who selected the most positive response options ["Well above Average," or "Somewhat above Average"; "Completely Satisfied" or "Somewhat Satisfied"; or "Always" or "Sometimes"; or "Yes" for the attribute]). Composite scores are calculated by taking the average summary rates of the attributes specified in the section.

Aetna reviews all survey results and assesses what we can do better—not just to increase scores, but also to improve provider satisfaction, processes and procedures, and everything we do to improve enrollee engagement and provider satisfaction. Always seeking improvement in our ratings and provider satisfaction, we use this survey as a means to develop more innovative solutions, further refine our processes to make it easier for providers to serve our enrollees, and garner feedback from providers to see what we can do to increase provider satisfaction. Aetna's overall provider satisfaction increased this year by approximately three percentage points.

### **Agency Requirements**

We will submit the annual provider satisfaction survey in advance to the Agency for written approval within 90 days after initial contract execution and by January 1 of each contract year thereafter. The survey tool will use a four-point Likert scale, and it will measure provider relations and communications; authorization processes (including denials and appeals); timeliness of claims payment and assistance with claims processing; complaint resolution process; and care coordination/care management support. The plan will conduct the survey, compile and analyze results, and provide results along with an action plan to the Agency by July 1 of each contract year.

**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**Evaluation Criteria:**

1. The extent to which plan leadership are involved in provider engagement.
2. The extent to which local provider field representatives are incorporated into the model, including the ratio of local provider representatives to providers.
3. The extent to which the method the respondent uses to track interactions with providers is capable of producing meaningful data the respondent will use to address both clinical and administrative problem areas.
4. The extent to which the method the respondent uses to track interactions with providers addresses potential provider field representative training needs.
5. The extent to which the metrics used produce actionable data for measuring provider satisfaction, increasing provider performance, improving the provider engagement model, and identifying areas of improvement for provider related communications or written materials.
6. The extent to which the training includes service coverage guidelines, service authorization requirements, billing procedures, claims processing, payment timeframes, and respondent's dispute resolution process and timeframes, including corresponding requirements in scope of services.

**Score:** This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **SRC# 16 – Dispute Resolution (Statewide):**

The respondent shall describe in detail its provider dispute resolution process.

**Note:** Pursuant to Section 409.966(3)(c)6., Florida Statutes, response to this submission requirement will be considered for negotiations.

#### **Response:**

Aetna and our contracted providers are responsible for timely resolution of any disputes between both parties. Contracted providers may also dispute any administrative functions or policies of the health plan. Aetna refers to an expression of dissatisfaction as a complaint and classifies expression of dissatisfaction as a complaint and issues related to claim payments or denials as an appeal. Both contracted and non-contracted health care providers may file appeals related to claim payments or denials or complaints related to dissatisfaction with any Aetna staff, vendors, or enrollees. Cases classified as complaints and appeals are combined on the provider complaint report for reporting to the Agency.

The provider dispute process includes resubmitted claims for reconsideration, provider complaints, and appeals. Aetna helps to ensure no punitive action is taken against a provider who files a dispute, complaint, or appeal. A dispute between a provider and Aetna does not disrupt or interfere with the provisions of services to the enrollee. We administer an equitable, timely, and balanced review of provider disputes. Upon completion of the Aetna dispute process, providers may request review by a resolution organization within 12 months of the final health plan resolution as defined in Title XXIX, Section 408.7057 (2) (b) (7) (d). Additionally, we meet the Florida Statutes as outlined in Section 409.966 (3) (c) (6) as stated in the Invitation to Negotiate.

Aetna's goal is to help ensure providers understand their dispute rights. We inform providers through the provider handbook and other methods, including newsletters, training, provider orientation, the website, and by the provider calling their Provider Services representative about the provider dispute process. Dispute data from complaints and appeals are reviewed daily to monitor timeliness and address cases as quickly as possible. The data is also reviewed at least monthly for trends and presented to the appropriate committees for identification and implementation of improvement actions. Aetna plans to submit to AHCA any updates and/or changes to currently approved provider dispute processes prior to implementation of the changes.

#### **INTEGRATING ALL COMPLAINTS, REGARDLESS OF REFERRAL SOURCE**

**CRITERION 4:** The extent to which the respondent integrates all complaints, regardless of the complaint referral source (e.g., Agency, third party)

We take provider feedback seriously and strive to improve processes in an effort to increase provider satisfaction. Our Grievance and Appeal department has overall responsibility for the integration and oversight of all provider complaints in the provider dispute process regardless of the complaint referral source. The referral source includes, but is not limited to, the provider, their office staff, the Agency, any State or federal department and any political office. This includes the following:

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Documenting individual complaints, appeals, and resolution organization reviews
- Coordinating resolutions of complaints and appeals within required timeframes
- Documenting the resolutions of resolution organization reviews
- Ensuring timely effectuation of overturned claims in whole or in part
- Tracking, trending, and reporting data
- Identification of opportunities for improvement
- Maintaining the appeal and grievance records

Providers may file a complaint or appeal verbally or in writing. In the case of a claim dispute, the provider may be asked to complete and submit the provider dispute form and any appropriate supporting documentation to Aetna's Provider Services manager. The provider dispute form is accessible on Aetna's website, by fax, or by mail. Provider issues may be received directly from the provider or AHCA or through the resolution organization. All issues are reviewed, documented, tracked, and processed within our internal, proprietary grievance and appeal application.

Aetna maintains records of all complaints, grievances, appeals, and resolution organization reviews, including the following:

- Date of receipt of the complaint, appeal, resolution, and organization review
- Provider identification number
- A short, dated summary of each issue
- AHCA-specific category
- The name of the person or entity filing the case, including the enrollee, his or her authorized representative
- Date of decision
- Resolution for complaints
- The date of decision for appeals and resolution organization reviews
- Criteria used in rendering the decision
- The date of communication of the resolution/decision

This documentation allows us to maintain and track all cases from origination through resolution/decision. This data is maintained for seven years from the date of resolution. The application we use allows us to look at data across all sources, trend the information and pull the necessary data to identify patterns of opportunities or operational problems. The ability to look at full historical data at the provider level, category of complaint level, service type, and specific time period allows Aetna to use the data in a meaningful way. We produce valuable reports used to integrate the data and information into our review processes and quality improvement projects and to look at similar complaints by type and source.

Provider Complaints: Both contracted and non-contracted providers may file a complaint verbally or in writing within 45 calendar days of when they became aware of the issue.

The Grievance and Appeal department is designated to receive provider claim complaints, documenting the substance of individual complaints, coordinating resolutions, tracking data, and reviewing complaints for trends in quality of care or other service related issues. The Grievance and Appeal manager assumes primary responsibility for coordinating and managing provider complaints and for disseminating information to the provider about the status of the complaint.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Aetna acknowledges all verbal requests verbally at the time of receipt and acknowledges all requests in writing within three business days. The acknowledgment includes instruction on how to do the following:

- Revise the complaint within the timeframe specified in the acknowledgement letter
- Withdraw a complaint at any time until the complaint is resolved

Updates are provided every 15 calendar days. If the complaint requires research or input by another department, the grievance and appeal manager forwards the information to the affected department and coordinates with the affected department to thoroughly research each complaint using applicable statutory, regulatory, and contractual provisions; Aetna's written policies and procedures; and pertinent facts from all parties. The complaint with all research is reviewed and resolved. If needed, the complaint is presented to the Grievance Committee for review and resolution. All information related to the case is considered part of the resolution. The complaint is resolved within 90 calendar days. The appeals and grievances manager sends written notification within three business days of the resolution.

The grievance and appeal manager reviews all data monthly for trends and reports trends to the Grievance Committee for review. All complaint data, including volumes, categories, and trends are summarized and reported at least quarterly to Service Improvement Committee (SIC) and Quality Management Oversight Committee (QMOC) for identification of opportunities for improvement, as well as follow-up on identified actions to address those opportunities.

Provider Appeals: Both contracting and non-contracting providers may file an appeal verbally or in writing within 45 calendar days of the claim denial or payment.

The Grievance and Appeal department is designated to receive provider claim appeals, documenting the substance of individual appeals, coordinating reviews and decisions, tracking data, and reviewing appeals for trends. The grievance and appeal manager assumes primary responsibility for coordinating and managing provider appeals, and for disseminating information to the provider about the status of the appeals.

Aetna acknowledges all verbal requests verbally at the time of receipt and acknowledges all requests in writing within three business days. The acknowledgment includes instruction on how to do the following:

- Revise the complaint within the timeframe specified in the acknowledgement letter
- Withdraw a complaint at any time

Updates are provided every 15 calendar days. The appeal with all research is reviewed and decided. If the appeal requires research or input by another department, the Grievance and Appeal department forwards the information to the affected department and coordinates with the affected department to research each appeal thoroughly using applicable statutory, regulatory, and contractual provisions, where appropriate, collecting pertinent facts from all parties, and applying Aetna's written policies and procedures. If needed, the appeal is presented to the Appeal Committee for review and decision-making. All information related to the case is considered part of the decision. The appeal is resolved within 90 calendar days. The grievance and appeal manager sends written notification within three business days of the resolution.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **IDENTIFYING CLAIMS-RELATED DISPUTE TRENDS AND INITIATING IMPROVEMENTS/ SYSTEM ENHANCEMENTS**

**CRITERION 1:** The extent to which the respondent's process identifies claims related dispute trends and initiates process improvement activities/system enhancements

Trends or patterns in the data may be identified through multiple means from a review of denied claims, including but not limited to the provider, coding, and completion documentation that results in grievances or appeals, a review of similar grievances, or appeals within the period under review. At least quarterly, our grievance and appeal data is analyzed to identify trends and opportunities for improvement. Data from health plan experience, results of oversight activities, and the need for any corrective action plans identified internally or by the Agency are presented to our Grievance and Appeal and Quality committees. These committees include cross-functional representatives from Enrollee Services, Provider Services, Compliance, Care Management, or other departments (e.g., Claims) as needed. Participants on the SIC and the QMOC include senior leaders at the health plan. This helps ensure that individuals with authority take corrective action and participate in the decision-making. The Committee focuses their discussion on issues that have the potential to affect compliance, enrollee care, operational inefficiencies, clinical trends, and rapid-cycle process improvement opportunities. They must prioritize trends, opportunities for improvement, and corrective actions. This process is necessary to address issues affecting individual enrollee satisfaction and provider satisfaction and to stabilize trends within the delivery system as a whole and meet performance standards.

During a recent review of provider appeal report data, a number of trends were identified:

- Providers billing for immunizations incorrectly
- Appeals for physical therapy, which is not a covered Managed Medical Assistance benefit for adults over the age 21
- Lack of clarity regarding prior authorization requirements
- Lack of clarity about certain policies and procedures

To address the trends, a review of the most common provider communications was facilitated by our Provider Services team to identify opportunities for improvement within the communications. As a result, changes were made to a number of documents, including the policy on physical therapy for adults and limited benefits, instructions for how to bill with appropriate modifiers, the prior authorization list, and instructions for how to request radiology authorizations (through eviCore). The team modified the documents and communicated them to our providers through a fax blast and publication on our website. We have received positive feedback, and we are currently monitoring and continue to work with our providers to ensure continuous process improvements.

### **ENSURING APPROPRIATE DETERMINATIONS, PAYMENT TIMELINESS, AND DISPUTE RESOLUTION**

**CRITERION 2:** The extent to which the respondent's process includes oversight to ensure appropriate plan dispute determinations are made, timely payments are made, and claims disputes are resolved within required timeframes

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Aetna has programmed its grievance and appeal application to calculate the due date automatically (pursuant to AHCA requirements) for completion of the case. This due date is used to calculate the actual turnaround time on the case automatically. Upon resolution, the application automatically marks the case as timely or untimely. Aetna uses multiple standard reports and queries to monitor aging of cases in real time to assure timely resolution. The Grievance and Appeal manager utilizes standard queries and reports within the application to monitor cases throughout the process, monitor timeliness and accuracy, and identify and report trends for potential opportunities for improvement. The application provides for both data driven and visually driven queues regarding age of cases. Those cases that are past due display in red, those cases due within 48 hours display as blue, and those cases due in greater than 48 hours display in black. The aging report displays all cases by case class (enrollee or provider) and age in days. Cases in red status are prioritized for resolution and are reviewed by the chief operating officer or designee and the compliance officer to determine root cause of non-compliance in order to implement rapid-cycle improvements and corrective action, as necessary.

The Grievance and Appeal manager also conducts daily and monthly audits to help ensure consistency and quality standards. Reminders are sent as necessary for cases that are near the deadline in order to stay in compliance. In the course of performing an audit, we check that the grievance or complaint has been appropriately adjudicated. Consistent evaluation of grievance and appeal trend data allows for compliance and executive staff, in conjunction with Quality Management to improve on medical, network, operations, and management areas that require additional focus.

### **TIMELY RESPONSE TO AGENCY REQUESTS RELATED TO COMPLAINT RESOLUTION**

**CRITERION 3:** The extent to which the respondent's process incorporates timely response to Agency requests related to complaint resolution in accordance with the scope of services

All cases are documented in our grievance and appeal application inclusive of those received through the Agency or as part of the resolution review organization program. All requests from AHCA are processed as standard or expedited requests, as appropriate, unless the Agency specifies a different timeframe. All cases received through AHCA are processed according to the timeframe specified by the Agency depending on the severity of the case.

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 each case is maintained in accordance with the applicable record retention policies and in strict compliance with HIPAA standards to protect enrollee privacy.

Complaint, grievance, and appeal reports and data are generated monthly, quarterly, and annually. These reports include all case types for monitoring and managing productivity and application of continuous quality improvement. We can review trends within each case type or for a particular case type such as resolution organization reviews. Our quality improvement process uses grievance and appeal data to improve staff and provider performance, and to improve performance in functional areas (e.g., appeal and grievance, medical management, provider network, and subcontractors).

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

A recent review of provider claims appeals provided valuable insight to a system configuration mistake that was inappropriately applying patient responsibility when claims were reprocessed due to Agency retro-rate changes. The information obtained from our provider claims appeals allowed us to correct the configuration mistake quickly, provide notification to all impacted providers, and reprocess to correct claims.

### **PARTICIPATION IN AGENCY CLAIMS DISPUTE RESOLUTION PROGRAM**

**CRITERION 5:** The extent to which the respondent's resolution process includes the respondent's participation in the Agency's claims dispute resolution program authorized in Section 408.7057, Florida Statutes

**CRITERION 5.a:** Responding to requests for information from the State contracted independent dispute resolution organization

**CRITERION 5.b:** A global process for analysis of arbitrated cases for possible identification of process improvement/system enhancements

**CRITERION 5.c:** Prompt payment of final orders issued by the Agency related to claims arbitration case determinations

Aetna appreciates the opportunity the Agency provides for an external review alternative to dispute resolution through MAXIMUS. We are supportive of this process, will cooperate with it, and will provide any information, data, or records that will help facilitate it. Management and staff are trained on the availability of this option, along with providers, when appropriate. So far, we have managed escalated disputes through our own internal policies and processes, and we have not required the use of this resource. However, we would use the State's resolution organization in any instance in which it would be conducive to expediting issue resolution and avoiding litigation.

Aetna informs providers of the alternative dispute resolution process through outreach materials and other methods, including the provider handbook, newsletters, training, provider orientation, the website, and provider forums. Aetna devotes the necessary resources to support the resolution organization review process and to comply with all the required timeframes and processes stipulated in Title XXIX Section 408.7057. Our objective is to seek an unbiased and fair determination from the Agency's claim dispute resolution program.

Both participating and non-participating providers may file a request with AHCA. All parties submit resolution organization reviews within 12 months of the Aetna final decision. All parties submit any supporting documentation inclusive of the original decision and all information considered as part of the decision-making to the resolution organization within 15 calendar days of the request. Aetna also provides any additional information requested by AHCA or the independent review organization. Failure to submit documentation within specified timeframes will result in default and the claim in dispute will be considered approved in accordance with Title XXIX Section 408.7057(2)(b)(7)(f). The resolution organization sends a written recommendation to AHCA within 60 calendar days from the receipt of the supporting documentation, not to exceed 90 calendar days from receipt of the request for review. The Agency issues the final resolution within 30 days of receipt of the resolution organization recommendation.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

All cases are documented in our grievance and appeal application inclusive of those received through AHCA or as part of the resolution organization review process. 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 each case is maintained in accordance with the applicable record retention policies and in strict compliance with HIPAA standards to protect enrollee privacy.

Complaint, grievance, and appeal reports and data are generated monthly, quarterly, and annually. These reports include all case types for monitoring and managing productivity and application of continuous quality improvement. These reports are reviewed for trends including but not limited to types of cases; particular case types such as resolution organization reviews; provider involved; specific coding involved; internal decision-makers; and root causes for denial such as lack of prior authorization for services requiring one. Our quality improvement process uses grievance and appeal data to improve staff and provider performance as well as to improve performance in functional areas (e.g., grievance and appeal, medical management, provider network, and subcontractors).

The review of provider claims dispute trend data provides critical insight into various operational area of our organization, such as Claims, Utilization Management, Appeals, and Provider Services. Trend reports and data allow us to identify opportunities to improve our processes, determine the need for internal or external education, and determine whether overturned appeals could have been avoided by authorizing and processing claims and/or configuring our system differently. Aetna's Service Committee reviews complaint, appeal, State Fair Hearing, and external review outcome data in order to determine trends. As a result of data trends, Aetna may redesign processes, apply lessons learned to reduce the number of overturned appeals, or make other improvements to produce optimal outcomes. Aetna has not had a significant volume of Fair Hearings; however, after every hearing the Medical Management team conducts an end-to-end review to determine whether there exists any opportunity for improvement or the need for any clinical retraining.

In the case of MAXIMUS, if the final orders overturn our decision in whole or in part, Aetna will authorize and reprocess the claim within 15 calendar days. We understand that if we do not prevail in the resolution organization review process, we must pay the review cost determined by the resolution organization within 35 calendar days of the order or we are subject to a penalty of not more than \$500.00 per day until it is paid in accordance with Title XXIX Section 408.7057 (2) (h) (6). Aetna has a rigorous audit process that examines final determination, including notification and payment of disputed claims. Audits look at end-to-end processing, timeframes, response quality, and final claims payment turnaround times. Our goal is to pay providers as expeditiously as possible to maintain positive provider relationships and honor our legal and contractual commitments.

### **Evaluation Criteria:**

1. The extent to which the respondent's process identifies claims related dispute trends and initiates process improvement activities/system enhancements.

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**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

2. The extent to which the respondent's process includes oversight to ensure appropriate plan dispute determinations are made, timely payments are made, and claims disputes resolved within required timeframes.
3. The extent to which the respondent's process incorporates timely response to Agency requests related to complaint resolution in accordance with the scope of services.
4. The extent to which the respondent integrates all complaints, regardless of the complaint referral source (e.g., Agency, third party).
5. The extent to which the respondent's resolution process includes the respondent's participation in the Agency's claims dispute resolution program authorized in Section 408.7057, Florida Statutes, as well as includes the following:
  - (a) Responding to requests for information from the State contracted independent dispute resolution organization;
  - (b) A global process for analysis of arbitrated cases for possible identification of process improvement/system enhancements; and
  - (c) Prompt payment of final orders issued by the Agency related to claims arbitration case determinations.

**Score:** This section is worth a maximum of 35 raw points with each of the above components being worth a maximum of 5 points each.

**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**SRC# 17 – Claims Processing and Payment Process (Statewide):**

In a manner suitable for the provider community, the respondent shall submit key components of its claims processing and payment process, addressing both paper and electronic claims submissions for both participating and non-participating providers.

The response shall include detailed information on the metrics to be employed by the vendor to track timeliness and accuracy of claims adjudication and payment for claims submitted by participating providers and how these metrics will be used by line level and management staff to improve processes and provide for rapid cycle improvement.

The response shall also include a detailed description of how the respondent will make data and metrics regarding claims and payment available to the Agency and will ensure that network providers have access to real-time and trend data regarding claims processing and payment by the respondent and all applicable proposed subcontractors.

**Note:** Pursuant to Section 409.966(3)(c)6., Florida Statutes, response to this submission requirement will be considered for negotiations.

**Response:**

Transparency, accuracy, and timeliness—all of which are decidedly interwoven with claims processing and payment—are paramount to maintaining strong relationships with enrollees and providers alike, and directly align with the Agency’s objectives to enhance both the enrollee and provider experience.

**KEY COMPONENTS OF CLAIMS PROCESSING AND PAYMENT PROCESS**

**CRITERION 1:** The extent to which the respondent has described key components of its claims processing and payment process in a format suitable for the public, including a description of the processes for claims submitted both on paper and electronically

Aetna’s claims adjudication system is a HIPAA-compliant, rules-based information processing system. It includes 28 integrated modules that maintain and process health care administration data, allowing us to increase administrative efficiency, improve the quality of care, and position ourselves for compliance with the International Classification of Disease, 10th Edition. Our claims and payment processes apply to both participating and non-participating providers.

The system contains every data element required by Statewide Medicaid Managed Care (SMMC) contractual requirements as well as requirements relating to claims payment timelines in the Florida Statutes as outlined in section 409.966(3)(c)(6) for claims data submission. The provider module contains the unique provider identification number generated by the system, plus all billing and tax reporting information. The claims module shows the date of receipt, the history of actions taken on each claim, and the date of payment, including the check number. The system accumulates claims by specific benefit limits and lifetime benefit rules. It scrubs and edits this data for accuracy during claims processing and payment for both participating and non-participating providers.

## **EXHIBIT A-4-a**

### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

To maximize the quality and correctness of our claims process, our system uses several techniques to review and edit claims data. These include the following:

- Duplicate billing logic
- ClaimCheck® edits
- Coding accuracy
- Procedure code guidelines
- Procedure code definition policies
- Technologies to detect questionable billing practices

Aetna uses a management information system to process enrollee claims. This rules-based system enables us to set multiple edits in a format suitable for the public to test claims validity, customize the edits, and pay or deny claims in accordance with AHCA claims adjudication requirements. Key components of our system edits include (but are not limited to) the following:

- Verification of enrollee eligibility
- Verification of covered services
- Determining whether services are within the scope of a provider's specialty
- Valid prior authorization
- Submission of required documentation
- Excessive or unusual services based on the enrollee's age or gender (e.g., vaginal delivery by someone over age 55 or under age 10)
- Duplication of services
- Invalid procedure codes
- Duplicate claims

Based on one or more of these edits, unusual items result in the claim being denied or pended for further review (e.g., claims for a vaginal delivery for an enrollee who is less than 10 years old or older than 55 years old). The system also automatically pends for further review any claims over \$50,000 in billed charges and requires that certain codes be accompanied with supporting medical records to determine the appropriateness of the service provided.

Figure SRC 17-1: The Life of a Claim in Attachment SRC 17 illustrates our claims adjudication process flowchart, which depicts the flow of claims from receipt to payment in three phases: origination, adjudication, and post-adjudication.

#### **Clinical System Data Edits in Support of Meeting Claims Processing Requirements:**

Our system has over 400 business rules that our Configuration Standards Reimbursement Administration department configures to enforce claims-related policies and procedures. The application of specific conditions, restrictions, and validation criteria promotes the accuracy of claim processing against relevant and established state standards. The edits can result in claims pending or denying depending on the editing logic. For example, if the enrollee is not eligible on the date of service, our system automatically denies the claim. If a claim requires an authorization, and the system does not detect one that fits the criteria on the claim, the claim pends for manual review.

Our claims edit functionality is easily configured to accommodate Agency directives and changes in benefits. The following are examples of data edits and activities that demonstrate

## **EXHIBIT A-4-a**

### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

flexibility yet also provide the functionality required to meet the State program requirements specific to our system:

- **Benefits Package Variations:** The claims adjudication system automatically analyzes Current Procedural Terminology (CPT), revenue, and Healthcare Common Procedure Coding System (HCPCS) codes to determine whether specific services are covered under the contract or benefit rules. If services are not covered, the system automatically denies the respective claim line. The claim line denies with the appropriate HIPAA remittance remark on the Explanation of Benefits (EOB).
- **Data Accuracy:** The claim adjudication system is continually updated based on the most current code sets available (HCPCS, Revenue, CPT, NDC, ICD codes) by year. As new codes are added, terminated, or changed, we update the codes in the system 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 claims adjudication system is configured to enforce the supporting documentation requirements of certain services. In addition, it has the ability to configure prior authorization by code, provider type, and place of service. The system is configured to identify certain types or authorizations for medical director review automatically. Claim edit rules are set to validate the claim against the network provider, enrollee, dates of service, services rendered, and units authorized.
- **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 lends additional support in this regard, reviewing any claim line set to "Pay" for billing appropriateness by specialty. The claims adjudication system checks other provider-specific items as well, verifying, for example, each provider has obtained the requisite NPI or its equivalent, included the identifier on all claims submissions, and is registered with the State with a valid Medicaid ID.
- **Enrollment Eligibility and Enrollment:** The claims adjudication system validates the date of service against the enrollee's enrollment segment to determine if the enrollee was eligible on the date of service. If the enrollee was not eligible on the date of service, the system automatically denies the claim using the appropriate HIPAA-approved remittance comment.
- **Duplicate Billing Logic:** The claims adjudication system uses a robust set of edits to determine duplication of services (e.g., same enrollee, same date, same network provider, same service, or any combination of these criteria). In addition, claim lines set to pay are subjected to Cotiviti's duplicate logic. This logic protects against payment for services rendered by the same physician or other physicians within the same provider group.

Other claims processing edits and tools utilized to maximize accuracy throughout the adjudication process include the following:

- **ClaimCheck® Edits:** ClaimCheck is a comprehensive code auditing solution that supports the claims processing system by applying expert industry edits from a provider-

## **EXHIBIT A-4-a**

### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

recognized knowledge base to analyze claims for accuracy and consistency with relevant policies and procedures. ClaimCheck clinical editing software identifies coding errors in the following categories: procedure unbundling, mutually exclusive procedures, incidental procedures, medical visits (same date of service), bilateral and duplicate procedures, pre- and post-operative care, assistant surgeon, modifier auditing, and medically unlikely services.

- Cotiviti Edits: 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. The system uses algorithms from Cotiviti to detect potential claims up coding, with follow-up procedures for chart audits as appropriate. Cotiviti clinically edits claims to assist Aetna to assist the Agency in promoting proper and fair payment of claims. Examples of applied edits include coding accuracy, durable medical equipment (DME) editing, and procedure code guidelines:
  - Coding Accuracy: If services are up-coded or unbundled, Cotiviti alerts the Claims department to deny the claim line, along with the specific clinical editing policy justification for the denial. The claim line denies with the appropriate HIPAA remittance remark on the EOB.
  - Durable Medical Equipment (DME) Editing: Cotiviti performs edits related to select DME payment policies that align with Florida Medicaid's respective covered service policies. These edits include, but are not limited to, 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 American Medical Association (AMA) CPT-4 Book and CMS HCPCS Book, which provide instructions regarding 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 coding based on industry standards. According to the AMA CPT Book, this vaccination must be reported in addition to the vaccine and toxoid codes.
- Procedure Code Definition Policies: Cotiviti supports correct coding based on the definition or nature of a procedure code or 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 re-code procedures based on the appropriateness of the code selection. For example, if a provider attempts to unbundle procedures, Cotiviti applies editing logic that bundle all of the procedures billed into the most appropriate code. Additionally, if a provider bills an office visit and bills separately for heart monitoring with a stethoscope at the same visit, Cotiviti rebundles the service into the appropriate Evaluation and Management or office code.

Utilizing the edits and tools listed above, 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 and comply with the Agency's coverage and payment policies.

When we deny claims at the time of submission, configuration is added to align with AHCA's guidelines. In such instances, we require providers or subcontractors to resubmit the claim with valid information to receive payment. Following adjudication and payment, we export claims data into the encounter management system twice per week, which provides the State with the most current encounter data to meet timeliness and completeness standards.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **Paper Claims/Electronic Claims**

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. It is also used in 14 other Medicaid health plans that Aetna manages.

The system contains every data element required for claims data submission. The provider module contains the unique provider identification number generated by the system, plus all billing and tax reporting information. The claims module shows the date of receipt, the history of actions taken on each claim, and the date of payment, including the check number. The system accumulates claims by specific benefit limits and lifetime benefit rules. It scrubs and edits this data for accuracy during claims processing and payment.

To maximize the quality and correctness of our claims process, our system uses several techniques to review and edit claims data. These include duplicate billing logic, ClaimCheck® edits, coding accuracy, procedure code guidelines/definition policies, and technologies to detect questionable billing practices.

Aetna has systems, technology, processes, and analytical staff in place to comply with current and future requirements. We have established written policies and procedures that are used for the processing of all Medicaid claims submitted. These policies and procedures are reviewed and updated as requirements change, but no less than annually. These detailed procedures are used to ensure the timely and accurate payment of claims.

### **Procedures for Receipt and Adjudication of Claims**

While Aetna strongly encourages electronic filing of claims, we accept claims submitted in both electronic and paper form from our providers (both participating and non-participating).

### **Origination**

The provider validates the enrollee's enrollment, obtains any prior authorizations (as needed), delivers covered services, and prepares either a paper or an electronic claim. He or she then submits the claim to a clearinghouse. Aetna encourages electronic filing, and our claims system accepts HIPAA-compliant electronic claim transactions in standard 837-format data files. Additionally, we accept claims on paper (forms CMS-1500 and UB-04) through the mail. Paper claims are received by the imaging vendor, scanned and converted to electronic claims, then loaded to our claims processing system. In accordance with State regulations and our provider contract, participating providers must submit claims within 6 months from the date of service. Non-participating providers must submit claims within 365 days from the date of service.

### **Adjudication Logic**

During this phase, Aetna loads the claims into our claims system for processing, the claim enters adjudication (during which we apply a series of edits), and the system determines the claims as pay, pend, or deny. To maximize the quality and correctness of our claims process, our system uses both clinical edits and edits to detect and prevent fraud and abuse. Additionally, Aetna will adhere to the State and federal guidelines, as applicable.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

If the claim fails edits and has a status of pend, it routes to an analyst for further review and final adjudication. The system can deny claims for multiple reasons (e.g., an enrollee was not active at the time of service or more information is required for payment). The system captures all adjudication reasons and notes them for reconciliation purposes using standard reason codes on the provider's electronic remittance advice.

### **Clinical Edits**

Aetna collaborates with industry leaders such as McKesson ClaimCheck, and Cotiviti Healthcare for front-end automation of correct-coding and medical-policy decisions specific to Medicaid and Medicare and for supporting the detection of coding irregularities, conflicts, or errors while making recommendations for correction. Our claim system and editing vendors perform edits for the following: enrollee data (e.g., age, gender), provider data, current coding protocol, assistant surgeon, place of service, type of bill, medical visit logic, medical unlikelihood, DME, new visit frequency, and professional, technical, and global services.

### **Edits to Detect Fraud and Abuse**

Our claim editing software edits both professional and institutional claims reaching an adjudicated status of pay. Automatically undergoing review against nationally recognized standards such as enrollee eligibility, third-party liability, prior authorization; coverage of services; ordering, referring, and rendering providers licensed to do so and contracted with the Florida Medicaid program; appropriateness of services in amount, duration, and scope; and required documentation. Additionally, Aetna employs a Special Investigations unit senior investigator who focuses on detecting fraud, waste, and abuse. This individual is located within the Florida plan and interfaces with providers to offer feedback and correct behaviors related to proper billing, as well as to initiate recoveries for outlier providers.

### **Requirements**

We have established written policies and procedures that are used for the processing of all Medicaid claims submitted. These policies and procedures are reviewed and updated as requirements change, but no less than annually. These detailed procedures are used to validate the timely and accurate payment of claims. To help ensure adherence to these policies and procedures, Aetna uses a suite of tools, scheduled and ad hoc reports to monitor claim receipts, automated claims processing, manual claims adjudication, and check and remittance advice production/distribution on a daily, weekly, and monthly basis. These tools and reports include the pended claims report, which includes all claims that fail auto adjudication and/or are suspended for manual review; the non-final claims report, which identifies all claims in any status other than those finalized through the finance payment process; and claims performance, which monitors turnaround time for clean claims.

The standard and ad hoc reports help us to manage claims workflow proactively. Based on this analysis, our Operations department takes appropriate action to address any trends that indicate a potential issue, such as turnaround times or inventory levels for aging claims. Our approach is to identify the root cause of the problem and to develop and implement the appropriate action plan immediately.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **Post-adjudication**

If the claim passes all edits, the provider receives payment for services rendered on a payment cycle that runs at least weekly. Our system records each financial adjustment to each claims payment, including third-party liability adjustments, interest, and copayments. Providers can track the status of claims online and can contact Aetna representatives for resolution of claims questions. Our system stores claims information as specified by the Agency.

### **METRICS/TRACKING TIMELINESS AND ACCURACY**

**CRITERION 2:** The extent to which the respondent has included detailed metrics to be employed by the respondent to track timeliness and accuracy of the claims processing and payment process

**CRITERION 3:** The extent to which the respondent has included a detailed description of how metrics from the claims processing and payment process will be used throughout its organization to provide for rapid cycle improvement

Aetna depends on key performance standard metrics extracted via a statistically significant random claims sample as global references to our claims system's timeliness and accuracy of the claims processing and payment process. We also utilize ongoing systems reports to assess performance standard metrics. Aetna complies with any claims based performance standards established by AHCA. Examples of some of our performance measures related to claims are illustrated in Figure SRC 17-2: Financial Accuracy Calculation, Figure SRC 17-3: Payment Accuracy Calculation, and Figure SRC 17-3: Payment Accuracy Calculation (all located in Attachment SRC 17), respectively. The systematic review of our claims metrics enables us to identify issues in a timely manner; we can quickly identify the root cause of any unmet benchmark goals and institute rapid cycle improvements. One example of a rapid cycle improvement pertains to the processing of skilled nursing claims for one of our largest providers. We identified an issue with patient spend being applied incorrectly and inconsistently. Our claims reports indicated an accuracy process issue, and we were able to identify the source of the issue to correct it. In this example, we added new claims staff to production who had limited experience with processing these claim types. These new claims processors were provided with additional training and were removed from production until a post-training review indicated they were ready to continue to process claims.

A dedicated claims analysis team, working under the direction of the chief operations officer (COO), reviews all audit results and systems performance metrics to provide rapid cycle improvement and to determine what proactive changes need to be made related to claims system accuracy or performance. This team provides a claims performance dashboard to the COO and senior leadership, along with recommendations for process or systems adjustments that enhance efficiency and accuracy efforts. All claims reports and metrics are reviewed daily by our claims management team; this allows them to provide feedback and targeted oversight to any areas that are not meeting standard performance measures. The COO facilitates a weekly operations call and these performance metrics are reviewed, analyzed, and discussed. Actionable items and follow up activities related to outcomes are documented and tracked, and if necessary, separate workgroups are established to work through issues that require further review, discussion, or system changes. All open issues are tracked, reported on, and monitored until resolution. The review of claims performance dashboards permits health plan operations to

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

take appropriate action to address trends that indicate a potential issue such as turnaround times or inventory levels for aging claims. It is our standard process to immediately determine a root cause and develop and implement the appropriate action plan. In the past, these plans have included one or more of the following:

- System reconfiguration
- Implementing system enhancements
- Deploying robotic tools to automate manual functions
- Staff overtime
- Workload balancing
- Training of staff and providers
- Hiring and training temporary workers to assist with the reduction of claim inventories

### **Financial Accuracy**

The financial accuracy calculation (Figure SRC 17-2: Financial Accuracy Calculation) measures the accuracy of dollars paid to providers. It is generally measured by evaluating dollars overpaid and underpaid in relation to total paid amounts taking into account the dollar stratification of claims.

### **Payment Accuracy**

The payment accuracy calculation (Figure SRC 17-3: Payment Accuracy Calculation) shows the percentage of claims paid or denied correctly. It is generally measured by dividing the number of claims paid/denied correctly by the total claims reviewed.

### **Processing Accuracy**

The processing accuracy calculation (SRC# 17: Figure SRC 17-4: Processing Accuracy Calculation) shows the percentage of claims accurately processed in their entirety from both a financial and non-financial perspective (i.e., claim was paid/denied correctly and all coding was correct, business procedures were followed, etc.). All figures can be found in Attachment SRC 17.

## **AVAILABILITY AND ACCESSIBILITY**

Aetna is committed to transparency and collaboration with both participating and non-participating providers and the Agency. Part of this transparency is focusing on developing relevant, accurate, and accessible data reports. Our analytics team, both from a local and corporate perspective, are engaged in continuous evaluation and improvement of our capacity to leverage technology, enterprise-wide best practices, and the collective experience we have in Florida. Our online provider portal provides valuable claims and clinical data that help our network providers make more informed decisions in the management of their practices and in their clinical treatment plans. Providers only require access to the Internet to view their claims through the provider portal. There is no need to download any applications or programs, configure systems, or purchase software of any kind. Access and use of the portal to view current claims, historical claims information, and remittances is a seamless process that requires minimal training to use. Portal navigation training is part of the provider orientation process and available assistance is offered at any time thereafter.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **AVAILABILITY OF DATA AND METRICS TO THE AGENCY**

CRITERION 4: The extent to which the respondent has included a detailed description of its process to make data and metrics regarding the claims processing and payment process available to the Agency and that the described process provides sufficient opportunity for the Agency to access this data

Aetna submits via the Agency's SMMC secure file transfer protocol (SFTP) site the required claims lag reports and claims aging reports as specified by AHCA's reporting guide. In addition to the contractual reports, we can produce ad hoc reports at the Agency's request. Reports are available to AHCA, as requested, and may be submitted directly AHCA representatives or through the Agency's SMMC SFTP. Our system and our analytics department have the capacity to develop reports on any data elements included in claims processing and payment. The requirement necessary to report on all aspects of the claims processing and payment is passed down to any vendors who are delegated claims payment and is monitored through claims audits. Some examples of the claims reports available to AHCA on demand are the following:

- Processing accuracy reports
- Payment accuracy reports
- Timeliness reports
- Inventory reports
- Claims lag reports
- Claims status reports
- Payment reports by provider and/or service category

Aetna can accommodate Agency requests for ad hoc reports that include any aspects of our claims processing program; this includes claim utilization data at the provider and service level. One example of a recent claims report requested by the Agency is for newborn screenings claims processed from the beginning of the SMMC program since 2014. The report included provider and claims-level details that reported on payment amounts, applicable claim denial codes, volumes, turnaround times, and trending over time. Whenever we receive a data request from the Agency, we confirm the purpose of the request to help ensure we are accurately capturing requirements and specifics. Once confirmed, a request is made to our local Analytics department, which then writes a specific query and retrieves the data for reporting. Once the data is retrieved, our director of analytics reviews the results against the original request and sign off. The report is then sent to the Agency. Uncomplicated, single source reports (i.e., reports only requiring one query from one data source) are turned around with two business days or less. Urgent requests are processed and reports delivered within one business day.

### **ACCESSIBILITY FOR NETWORK PROVIDERS**

CRITERION 5: The extent to which the respondent has included a detailed description of its process to make data and metrics and trend data regarding claims processing and payment process available to network providers on a real-time basis and that the described process provides sufficient opportunities for network providers to access this data

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

It is our priority to help ensure both participating and non-participating network providers have real-time access to view the status of their claims. Our provider portal provides real-time data on the status of their claims and payments. It also has trending history remit and payment data. The portal offers our network providers the data and information necessary to manage their account receivables more effectively. In addition to the provider portal, our Claims Inquiry/Claims Research department and Provider Services teams receive incoming claims inquiry calls. Our plan staff answers questions about the status of these claims, reviews payment issues or inquiries, and provides general information about claims submission processes. We provide monthly utilization and diagnosis reports to our providers as well. These reports provide a breakdown of information pertaining to claims and payment submitted at the enrollee level; they can also track services and payments.

### **PROPOSED SUBCONTRACTORS**

**CRITERION 6:** The extent to which the respondent has included its applicable proposed subcontractors in its response, with each component addressed for each applicable proposed subcontractor

Aetna monitors vendors' and subcontractors' delegated claims through various systematic mechanisms. One such mechanism is through regular mandatory reports that include timeliness, accuracy, financial accuracy, volume, and denial rates. Through regular joint Operations meetings, vendors and subcontractors are required to review operational metrics that include claims processing reports. Aetna monitors provider and enrollee comments, complaints, and feedback that may indicate a pattern of claims processing problems or non-compliance with turnaround times. Aetna holds vendors and subcontractors to the same Agency prescribed claims performance processing timeframes.

FirstSource is a subcontractor that processes overflow claims for and on behalf of Aetna Medicaid Operations. It is assigned overflow claims that do not require extensive or complex handling. The processing is performed in the claims processing system, the same system Aetna Medicaid staff uses. Claims finalized by FirstSource are then audited by the claims quality team. These claims must pass the same quality standards and audit as an Aetna Medicaid analyst. The FirstSource analyst follows the same processes and procedures as the Aetna Medicaid analyst. The Medicaid claims management team sends claims to FirstSource daily (on average, FirstSource processes 2000 claims per day).

Subcontractors that are delegated to claims payment are all required to submit claims data and encounters. These files are imported into our system and used to report on claims adjudication and payment. All vendors that are delegated to claims payment are required to manage their claims payment processes and comply with claims reporting and turnaround times in compliance with AHCA's standards. Vendors are audited periodically to assure they are meeting standards, which includes a review of all provider complaints pertaining to vendor-delegated claims. All vendors and subcontractors undergo an annual formal audit that includes end-to-end review of all claims and encounter processing.

### **Evaluation Criteria:**

**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

1. The extent to which the respondent has described key components of its claims processing and payment process in a format suitable for the public, including a description of the processes for claims submitted both on paper and electronically.
2. The extent to which the respondent has included detailed metrics to be employed by the respondent to track timeliness and accuracy of the claims processing and payment process.
3. The extent to which the respondent has included a detailed description of how metrics from the claims processing and payment process will be used throughout its organization to provide for rapid cycle improvement.
4. The extent to which the respondent has included a detailed description of its process to make data and metrics regarding the claims processing and payment process available to the Agency and that the described process provides sufficient opportunity for the Agency to access this data.
5. The extent to which the respondent has included a detailed description of its process to make data and metrics and trend data regarding claims processing and payment process available to network providers on a real-time basis and that the described process provides sufficient opportunities for network providers to access this data.
6. The extent to which the respondent has included its applicable proposed subcontractors in its response, with each component addressed for each applicable proposed subcontractor.

**Score:** This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

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COVENTRY HEALTH CARE OF FLORIDA, INC. DBA  
AETNA BETTER HEALTH® OF FLORIDA

## **Attachment SRC# 17**



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SRC# 17: Figure SRC 17-1: The Life of a Claim

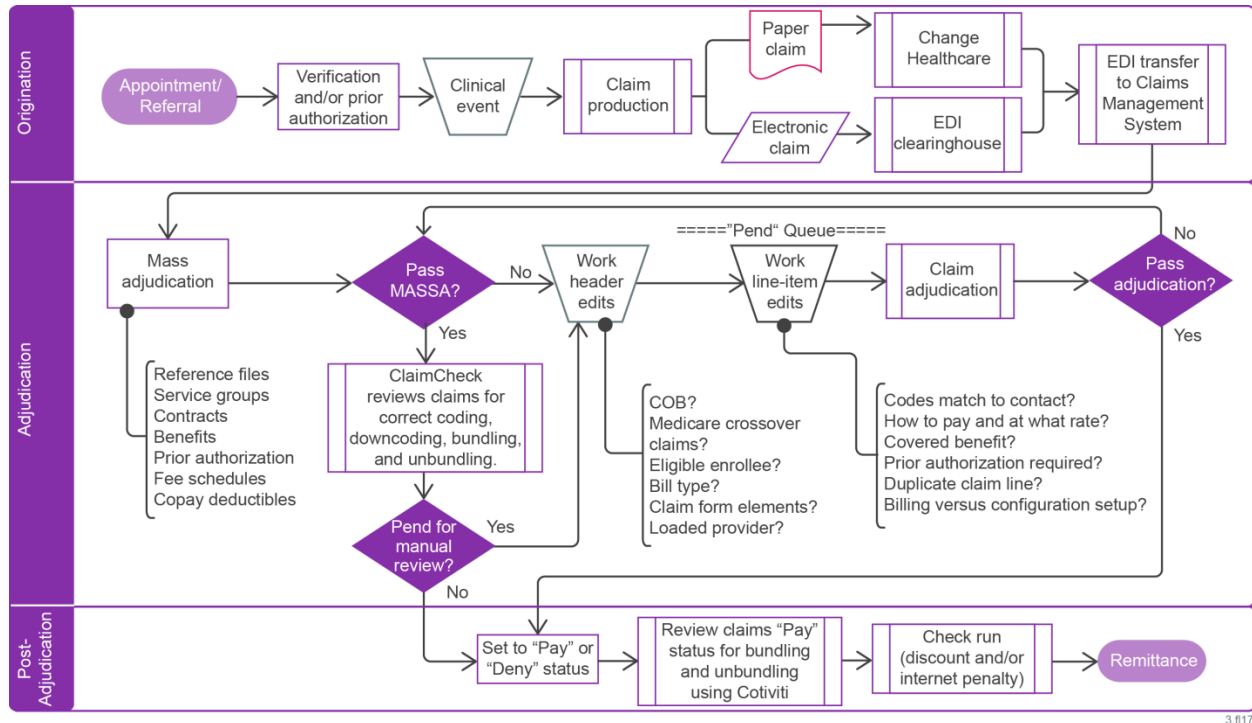


Figure SRC 17-1: The Life of a Claim

*Our claims system manages the life of a claim to maximize efficiency, accuracy, and timeliness to meet AHCA's requirements.*

COVENTRY HEALTH CARE OF FLORIDA, INC. DBA  
AETNA BETTER HEALTH® OF FLORIDA

**SRC# 17: Figure SRC 17-2: Financial Accuracy Calculation**

<b>Calculation:</b>	$\frac{(\text{Total dollars paid} - \text{Total dollars paid in error})}{\text{Total dollars paid}}$
<b>Standard:</b>	99%

4.f.17

**Figure SRC 17-2: Financial Accuracy Calculation**

*Calculation measures the accuracy of dollars paid to providers.*

**SRC# 17: Figure SRC 17-3: Payment Accuracy Calculation**

<b>Calculation:</b>	$\frac{(\text{Total number of claims audited} - \text{total number of claims containing payment errors})}{\text{Total number of claims audited}}$
<b>Standard:</b>	98%

5.f.17

**Figure SRC 17-3: Payment Accuracy Calculation**

*Calculation shows the percentage of claims paid or denied correctly.*

**SRC# 17: Figure SRC 17-4: Processing Accuracy Calculation**

<b>Calculation:</b>	$\frac{(\text{Total number of claims audited} - \text{total number of claims containing procedural errors})}{\text{Total number of claims audited}}$
<b>Standard:</b>	95%

6.f.17

**Figure 17-4: Processing Accuracy Calculation**

*Calculation shows the percentage of claims accurately processed.*

**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**E. DELIVERY SYSTEM COORDINATION**

**SRC# 18 – Utilization Management (Statewide):**

The respondent shall describe the following related to its utilization management (UM) approach:

- a. A description of the process used to determine whether a service should be prior authorized and that the UM criteria for each service have been evaluated to determine their appropriateness for administering a Medicaid benefit.
- b. A description of how the respondent will ensure consistent application of the review criteria for authorization decisions.
- c. A description of how the respondent will ensure that services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope.
- d. A description of the approach used to determine whether a service will be needed short-term vs. long-term (i.e., maintenance therapy) for an enrollee, specifically highlighting any differences in the respondent's service authorization approach (if any exists) based on the length of time that the service will be needed.
- e. To the extent that a service is needed long-term, a description of the strategies that the respondent utilizes to ensure continuity of care and safeguards that are in place to reduce gaps in authorization.
- f. A description and example of how the respondent will detect, monitor and evaluate under-utilization, over-utilization and inappropriate utilization as well as processes to identify and address opportunities for improvement.

**Response:**

In our view, medically appropriate care is cost effective—and promotes the highest quality of care in the most appropriate setting with a biopsychosocial model that integrates enrollees' physical, behavioral, and oral health, along with social determinants of health, illness, and disability. With 30 years of experience in utilization management (UM), Aetna's program directly aligns with the Agency's objectives to deliver efficient, high-quality, cost-effective, and integrated health care. Our program extends beyond the review of requested services to identify ways to empower our enrollees to lead healthier lives and ultimately improve their quality of life and well-being.

Our Medical Management staff members coordinate covered services, carved out services, and work with community resources and Agency programs such as the Child Health Service Targeted Case Management (TCM) program. Aetna's UM program integrates systems for managing, monitoring, evaluating, and improving the utilization of care and services enrollees receive. It incorporates UM decision-making criteria using appropriate evidenced-based clinical settings and services to treat co-occurring behavioral and physical disorders. Integrated with our quality management (QM) program, Aetna's UM program pursues the common principle of

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

providing optimal clinical practices in all settings by balancing behavioral/physical health management, operations, and finance components. The program is under the administrative and clinical direction of our chief medical officer, and is reviewed and approved at least annually by the QM/UM Committee and forwarded to the board of directors for approval.

Our utilization management program goals directly align with the Agency's UM criteria and include:

- Assuring care is medically necessary, provided in the least restrictive and most appropriate setting, and consistent with nationally accepted practice guidelines
- Assuring new enrollees receive continuing care through their established, current providers within the first 90 days, allowing for further assessment of needed services
- Monitoring and evaluating services for accessibility, timeliness, and over- or under-utilization of medical services
- Identifying quality, risk, and utilization issues and developing follow-up measures (including action plans) to resolve issues
- Using quality of care, clinical guidelines, and UM outcomes data to identify underutilization, gaps in care, and other opportunities for care management support, as well as readmission reduction and ED diversion
- Practicing fully integrated utilization processes with care management and pharmacy to provide seamless access for enrollees
- Identifying and intervening to reduce waste, duplication, delays, and miscommunication in medical services provided
- Reviewing trends of approvals and denials to identify services most appropriately managed by prior authorization requirements
- Reviewing trends of complaints, grievances, and appeals to identify opportunities for improved care for our enrollees

### **PROCESS TO DETERMINE WHETHER A SERVICE SHOULD REQUIRE PRIOR AUTHORIZATION**

**CRITERION 1:** The extent to which the respondent describes the process and data sources utilized to determine whether a service should be prior authorized, including reviewing complaints or feedback from providers regarding burdensome or unnecessary prior authorization criteria

Prior authorization enables us to monitor utilization of defined outpatient services and procedures and non-emergent/elective hospitalizations before the enrollee receives the service. It confirms requested services are for eligible enrollees included in the defined benefits; appropriate, timely, and cost-effective; coordinated with medical management, and when applicable, coordinated with contracted vendors; and documented accurately to facilitate timely reimbursement and reporting. Our utilization management program and processes facilitate the provision of targeted and medically necessary care for our enrollees.

Decisions to require prior authorization for certain services are based on data, such as utilization data that identifies services that are likely to be over utilized or to trigger collaboration and communication as appropriate for the coordination of enrollees' care among practitioners and to engage other departments such as Care Management, QM, Concurrent Review, Provider Services, and Enrollee Services.

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Our goal is to provide quality care to our enrollees and, whenever possible, avoid the risks associated with overuse, underuse, and misuse of health care interventions while removing barriers to accessing care. Every decision regarding medical necessity at Aetna is based on a combination of the clinical expertise of our medical directors, established determination criteria, and any extenuating factors in the clinical presentation. To support these decisions, Aetna uses data from nationally recognized, evidence-based criteria, which are applied based on the needs of individual enrollees and characteristics of the local delivery system as well as NCQA health plan accreditations standards. We have standard workflows for processing and review of our authorizations to help ensure a consistent, high-quality prior authorization process. Our medical management clinical criteria policies and procedures define eligible criteria sources and the process for adoption, review, and approval of clinical criteria.

Our threshold requirements for requiring prior authorization of a service, device, supply, or treatment are:

- If prior authorization is deemed necessary, what criteria will be applied?
  - Florida Medicaid contractual requirements and limitations
  - MCG (formerly Milliman Care Guidelines)
  - Aetna Clinical Policy Bulletins (CPB)
  - Other (e.g. specialty society guidelines)
- Does that service, device, supply, or treatment require management? If so, why?
  - To fulfill a contractual or regulatory requirement as specified in State or federal law/regulations, State contract and/or provider contracts
  - Because a service, device, supply or treatment is considered experimental/investigational (E/I), cosmetic, or primarily for convenience
  - Because the service, device, supply or treatment has significant patient safety implications
  - Because there is significant potential for waste, fraud and/or abuse
  - Because our data has shown wide variation in use and opportunities to improve appropriate utilization
- If a rationale for management of a specific service, device, supply, or treatment can be articulated, what is the least burdensome method of management?
  - System limits such as quantity or frequency limits
  - E/I edits if permitted by contract/regulation
  - Post-service review
  - Prior authorization

Based on this process, the Aetna Medicaid organization is in the process of removing the prior authorization requirement from more than 500 codes. An additional 300 codes have been identified for eventual movement from prior authorization to a less burdensome form of management. This is a staged process that began during the spring of 2017. We conduct regular reviews of prior authorization requirements and remove prior authorization requirements for services that we received feedback on, are consistently approved and for which no denials are being made. As an example, we met with a large provider group during one of our joint operating committee meetings. The providers noted that prior authorization requirements for select radiology procedures ordered in the outpatient hospital setting was causing an administrative burden on their office. We researched the procedures and recognized that the procedures resulted in a very small number of denials and we were limited in our ability to redirect pediatric enrollees to less costly freestanding facilities. As a result, we removed the

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

authorization requirements for pediatric enrollees for a list of radiology procedures to be provided in the outpatient hospital setting.

Our behavioral health subcontractor's (Beacon Health Option's) UM program encompasses management of care from the point of entry through discharge for all Managed Medical Assistance enrollees. Using its Florida Medicaid Level of Care Criteria (LOCC) for mental illnesses and ASAM criteria for substance use disorders, Beacon manages behavioral health care with objective, scientifically based clinical criteria and treatment guidelines in its service authorization process. Intensive UM is reserved for high-cost, highly restrictive levels of care and cases that represent potential clinical complexity and risk. Licensed behavioral health clinicians base their reviews on clear and concise criteria developed specifically to guide level of care, treatment, and length of stay determinations.

Clinicians are trained to match the needs of individuals to appropriate services, levels of care, and community supports. This requires a careful consideration of the intensity and severity of clinical data presented with the goal of quality treatment in the least restrictive environment. The clinical integrity of Beacon's UM program helps to ensure that enrollees who present for care are appropriately monitored and that comprehensive reviews of care are provided. Those cases that appear to be outside of best practice guidelines are referred for specialized reviews. These may include evaluation for intensive care management, clinical rounds, physician advisor review, or more frequent clinician review. As a result, Beacon has designed a system of care that is based upon principles of quality care, and that is flexible in meeting the needs of diverse populations, communities, and customers.

Additionally, Beacon's UM program is committed to and embraces the integration of physical, social, and behavioral health care. Whenever possible, UM strategies are aimed to ease providers' administrative burden so that they can spend more time providing that care. Beacon's UM program delivers innovation on three important fronts:

- Use of Informatics: Beacon uses informatics to help drive threshold-based authorizations and performance-based metrics. Threshold-based authorizations, for example, ensure that the right care proceeds because it flags potential conditions that will help design the best treatment plan to meet an individual's needs.
- Measurement of provider performance on specific UM indicators: Measuring provider performance improves the network—from both a quality and operational perspective.
- Development of diversionary and alternative services: A system of diversionary services is essential to prevent avoidable readmissions, execute an effective discharge, and avoid unnecessary costs. To provide the most appropriate care in the least restrictive settings, Beacon collaborates with community-based providers to either expand or create a continuum of rehabilitative services to address enrollees' unique needs.

### **Incorporation of Feedback from Providers**

In our process of determining whether a service should require prior authorization, and in continuous improvement of our processes, we value and incorporate all feedback from enrollees and providers regarding burdensome or unnecessary prior authorization criteria. Our QM/UM committee advises and makes recommendations to the chief medical officer (CMO) on matters pertaining to the quality of care and service provided to enrollees including the oversight and maintenance of the UM program. Members of the QM/UM committee include a cross

## **EXHIBIT A-4-a**

### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

representation of network providers, including PCPs, specialists, pediatricians, obstetricians/gynecologists (OB/GYN), and behavioral health providers/practitioners and they provide direct information about the prior authorization process. We engage with the providers directly through the community action forums and JOCs where we hear directly from the providers about our UM process. Our CMO is also available to speak directly to any provider who has concerns or questions.

We ensure our providers have full transparency into our process in order to provide us this type of feedback. One method is through our prior authorization search tool named ProPat, in which providers can easily determine whether a service requires an authorization for a specific treatment or service. ProPat has been designed to ensure there are no delays in authorization or gaps in care for the enrollee. It is available through our provider Website and portal where providers can input up to six Current Procedural Terminology (CPT), revenue, and Healthcare Common Procedure Coding System (HCPCS) codes and ProPat tells them if the treatment or service requires an authorization.

The system also allows them to know whether Aetna has a delegated vendor to provide the service by referencing the variance detail, including benefit limits or extra information about the authorization requirements. If a delegated vendor is identified, ProPat provides the name and contact information for that vendor; thus reducing the administrative burden for the providers' office staff.

The availability of ProPat minimizes administrative burden on network providers and enrollees, eliminating the need to request an authorization for services that do not require one. Claims pay accordingly; if no authorization is required, the claim pays without searching for one.

Providers benefit directly by signing up for and using our provider portal because it enables them to submit authorization requests electronically. Providers can check the real time status of an authorization request in the portal throughout the process, which allows for transparency and saves the provider from the burden of unnecessary phone calls to us. Service approvals, denials, and reductions are available through our portal. In addition, Aetna has a FaxComm system that allows the UM staff to communicate with the provider offices through call tracking, which is built into FaxComm. For example, if a provider faxes in a request without clinical information, the UM staff can simply return the request via fax and track the request in keeping with timeliness requirements.

UM staff is available to answer questions and support our providers and enrollees 24 hours a day, seven days a week, with a toll-free telephone line and telefax numbers with language assistance and telecommunications device/teletypewriter (TDD/TTY) services for deaf or speech-impaired enrollees. Telephone lines are staffed with professionals who will answer practitioner, provider and enrollee questions about the UM program and authorization of care, as well as resolve provider complaints. The UM department staff conduct outgoing communications with practitioners and providers regarding authorizations seven days a week. Providers can share their feedback with our UM staff, as well as with our provider services and through our peer-to-peer process. Providers can also share literature and data about services that can be incorporated in our utilization criteria.

**ENSURING CRITERIA SELECTED ARE APPROPRIATE AND CONSISTENT WITH POLICY REQUIREMENTS FOR A MEDICAID BENEFIT**

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

CRITERION 2: The adequacy of the processes used by the respondent to determine whether the utilization management criteria selected are appropriate and consistent with policy requirements for a Medicaid benefit

UM criteria selected are appropriate and consistent with specific contract requirements as well as federal and State regulations, including the policy requirements for a Medicaid benefit and the EPSDT program. Criteria is reviewed and updated as needed, for any additions and changes as described above no less than annually through our UM Steering Committee for evaluation, voting and approval. The criteria are regularly reviewed for consistency with Medicaid policy and any changes in Medicaid policy are incorporated in our criteria.

While qualified and trained staff members are guided by these requirements and criteria, the ultimate determinations is based on clinical judgement the best interest of the enrollee, including consideration to specific and unique characteristics, such as the local delivery system and the enrollees' age, comorbidity, complications, progress in treatment, psychosocial situation, and home environment.

The established hierarchy of referenced criteria is:

- Medicaid Contract/Policy Guidelines: Florida Medicaid Coverage and Limitations Handbook, Coverage Policies and associated Medicaid Fee Schedules, AHCA contract, State Medicaid Director letters, CMS informational bulletins and the Florida Agency for Health Care Administration policy statements
- MCG (formerly Milliman Care Guidelines): National evidence-based clinical guidelines, best practices, and care planning tools across the continuum of care to support clinical decision-making
- Aetna Clinical Policy Bulletins: Aetna's proprietary medical necessity guidelines are based on objective, credible sources, such as scientific literature, guidelines, consensus statements, behavioral health criteria, including LOCUS/CASII Guidelines and American Society of Addiction Medicine (ASAM) and expert opinions.
- Aetna Clinical Policy Council: Team of clinical experts responsible for the review of new and emerging technology; this council also provides consultation to Aetna's medical directors.

When criteria are present but unclear in relation to the situation, the reviewing medical director may contact the requesting provider to discuss the case or consult with a board-certified physician from an appropriate specialty area before making a determination of medical necessity. Evidence-based medical necessity guidelines used by Aetna are reviewed annually, as outlined in Aetna's policy, "Process for Approving and Applying Medical Necessity Criteria."

Beacon's behavioral health clinical practice guidelines are used in collaboration with providers to help guide appropriate and clinically effective care for a variety of complex behavioral health conditions. These guidelines represent standards of best practice for treating complex conditions and are references for clinicians and physician advisors during clinical reviews to ensure effective care delivery. Beacon develops and adopts clinical practice guidelines that have undergone significant re-evaluation by national professional organizations including the American Medical Association (AMA) and the Institute of Medicine.

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With an eye toward increasing rigor and improving transparency, these organizations have articulated principles that form the foundation for new standards of guideline development. The American Psychiatric Association (APA) and the American Academy of Child and Adolescent Psychiatry (AACAP) have both published statements on their websites in support of these new standards. Related to the continued evolution of clinical practice guideline development calling for higher standards of evidence, the industry currently has maintained or produced a limited number of guidelines that meet the new standards for guideline rigor and transparency. Beacon has reviewed and adopted the following guidelines that meet those standards:

- The APA Practice Guideline on the Use of Antipsychotics to Treat Agitation or Psychosis in Patients with Dementia
- The APA Practice Guidelines for the Psychiatric Evaluation of Adults
- The ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use
- The Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain – United States, 2016 (adopted by Beacon as treatment recommendation for primary care or pain specialty practitioners)

### **Requests for Additional Information**

The requesting practitioner or provider is responsible for complying with our prior authorization requirements, policies, and request procedures, and for obtaining an authorization number to facilitate reimbursement of claims.

A prior authorization request must include the following:

- Current applicable codes, which may include:
  - Current Procedural Terminology (CPT)
  - International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) effective October 2015
  - Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) codes
  - National Drug Code (NDC)
- Name, date of birth, sex, and identification number of the enrollee
- Primary care provider or treating practitioner
- Name, address, phone and fax number and signature, if applicable, of the referring practitioner or provider
- Name, address, phone and fax number of the consulting practitioner or provider
- Problem/diagnosis, including ICD-10
- Reason for the referral
- Presentation of supporting objective clinical information, such as clinical notes, laboratory and imaging studies, and treatment dates, as applicable for the request

All clinical information should be submitted with the original request. If a prior authorization request does not contain sufficient information to make a determination, and that information is not readily available after outreach to the provider, the timeframe for standard authorization decisions can be extended up to seven additional days if the enrollee or the provider requests extension or Aetna justifies the need for additional information and how the extension is in the enrollee's interest. Aetna can extend the timeframe for an expedited authorization decision by

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

up to two additional business days if the enrollee or the provider requests an extension if it is determined the extension is in the enrollee's interest.

### **Denial of Prior Authorization Requests**

Any service requests that do not meet applicable medical necessity criteria are forwarded to the CMO or designated medical director for review. The CMO or a designated medical director must review any request that does not clearly meet criteria for coverage. Only a medical director may decide to deny, suspend, or reduce service authorization based on medical necessity and appropriateness.

If requested services are not approved, we provide written notification to the requesting practitioner/provider and enrollee of the decision to deny, suspend, or reduce services within the applicable timeframe. The Notice of Adverse Benefit Determination is written at a fourth-grade reading level using language that is easily understood. The notice includes:

- Action that Aetna has or intends to take
- Specific reason for the action, customized to the enrollee's circumstances and in easy to understand language
- Reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision was based
- Notification that the provider or enrollee (upon request) may obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the denial decision was based
- Notification that providers have the opportunity to discuss medical and behavioral health care UM denial decisions with a physician or other appropriate reviewer
- Description of appeal rights, including the right to submit written comments, documents, or other information relevant to the appeal
- Explanation of the appeals process, including the right to enrollee representation (with the enrollee's permission) and the time frames for deciding appeals
- Description of the next level of appeal, either within the organization or to an independent external organization, as applicable, along with any relevant written procedures
- For Medicaid Managed Care, the enrollee's or practitioner/provider's (with written permission of the enrollee) right to request a Medicaid Fair Hearing and instructions about how to request a Medicaid Fair Hearing
- Description of the expedited appeals process for urgent pre-service or urgent concurrent denials
- Circumstances under which expedited resolution is available and how to request it
- Enrollee's right to request continued benefits pending the resolution of the appeal or pending a Medicaid Fair Hearing, how to request continued benefits and the circumstances under which the enrollee may be required to pay the costs of these benefits
- Translation service information
- Procedures for exercising the rights specified in this section

Denial decisions are documented in the prior authorization module of our UM/claims business application system.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **Prior Authorization for Out-of-Network Providers**

Medical services for the treatment of an emergency condition are permitted to be delivered out of network without obtaining prior authorization. Aetna requires coverage of emergency services in the following situations:

- To screen and stabilize the enrollee, 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.

Aetna will not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. Payment will not be withheld from practitioners/providers in or out of network. However, notification is encouraged for appropriate coordination of care and discharge planning.

Prior authorization for out-of-network providers is a two-part process: 1) review of medical necessity for the requested service and 2) verification that 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. Whenever a request is received, the clinician applies medical necessity criteria per the clinical guideline hierarchy. The UM clinician reviews network adequacy to provide the requested service. The UM clinician may approve the request when medical necessity and network deficiency are determined. However, the UM clinician forwards the request to the medical director for a determination when the clinician cannot determine medical necessity or network deficiency.

If an adverse determination based on network adequacy for a service that is considered medically necessary is rendered after review by the medical director, our care management staff work with the provider and enrollee 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 to help ensure the provider is paid promptly and enrollees receive their requested services. We regularly review utilization of out of network services to identify gaps for network expansion.

### **CONSISTENT APPLICATION OF REVIEW CRITERIA FOR ALL AUTHORIZATION DECISIONS**

**CRITERION 3:** The adequacy of the respondent's approach to ensure the consistent application of review criteria for authorization decisions (e.g., inter-rater reliability studies, and training for plan staff and network providers)

Appropriate and consistent application of medical necessity criteria is an important step in making sure that enrollees receive clinically appropriate care in the most appropriate setting. UM clinicians have easy access to online medical necessity criteria, policies, and procedures to reference when making review determinations. We promote consistency by employing appropriately licensed clinical professionals and providing comprehensive training on UM policies and procedures, and the application of evidence-based criteria.

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For example, through our spinal fusion initiative, our orthopedic surgeon consultant provides expert review of spinal cases. The Aetna Spine Surgery Precertification process maximizes consistency of medical necessity determinations for both inpatient and outpatient spinal procedure cases to avoid costly and avoidable spinal surgery. Recent statistics have shown greater than 20% avoidance of avoidable surgery resulting in redirection to care that is more appropriate and conservative.

### **Inter-Rater Reliability (IRR) Studies**

In order to assure consistency and integrity in the clinical decision-making process Aetna uses medical necessity criteria that are evidence-based and nationally accepted. Annually, clinical staff reviewers are tested to verify consistency and accuracy in the application of the criteria. The IRR test is a valuable process used to determine consistency in the application of medical necessity clinical guidelines as well as for the identification of educational opportunities within UM operations. Monitoring compliance with medical necessity clinical guidelines helps identify areas where departmental performance can be improved.

Aetna conducts annual IRR testing of all physician and non-physician review staff in the application of medical necessity criteria. All licensed clinical review staff, which include prior authorization, concurrent review (CRN), and retrospective medical audit (MAU) are trained to apply medical necessity criteria. Our IRR assessment utilizes nationally recognized MCG standardized testing to evaluate staff members, medical directors, and external reviewer objectivity and consistency in the application of medical review criteria. IRR results enable us to identify educational opportunities within UM operations and to improve the quality of care delivered to enrollees. The managers/supervisors of our medical management departments are responsible for developing corrective education plans for their staff members who score less than the 85% of standard. They monitor the education plans of staff members until the required target is met.

In 2016, a review of departmental, prior authorization, CRN, and MAU, as well as individual results showed that all scores exceeded the 85% threshold for the IRR. Participant scores on the health care services categories were 96%.

### **Case Audits**

We also use case audits to monitor consistency of the UM decisions. The manager of UM conducts monthly quality review case audits of UM staff members to assess decision-making related to applying medical necessity criteria and adherence to policies to audit appropriate use of medical necessity criteria, adherence to plan policies, and other NCQA and contractual timeliness standards. A benchmark of at least 90% compliance with standard per quarter is required. In this way, we know immediately if staff are having challenges and are able to provide targeted coaching, training, and support.

### **Training for Staff**

Aetna maintains sufficient UM staff with clinical expertise and training to apply medical management criteria and practice guidelines. Individuals who conduct clinical utilization review are health professionals and possess a Florida active professional relevant license. Each staff has a required training plan, with learning modules that can be accessed 24/7.

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Upon hire, all UM staff members are required to participate in a comprehensive training program including the prior authorization criteria and UM business application system. They are paired with a seasoned UM mentor, and then train with our medical directors to help ensure uniformity within the application of the UM program. They must demonstrate a full understanding the process prior to conducting a review unsupervised.

Each member of our UM staff is required to take regular refresher trainings, as well as targeted trainings when there are updates and changes to the criteria. We conduct department-wide and ad hoc trainings as needed. We hold monthly joint staff meetings in which we conduct grand rounds and discuss challenging cases across disciplines with the care managers. We regularly host vendors who provide overviews of services and clinical issues related to UM, including hospice and housing providers.

If an area of improvement is identified for a staff member, we have most often been successful with retraining and support through ongoing coaching. However, should the areas identified not improve, we place our staff on a correct action plan, and supervisors closely monitor adherence to the goals. Should the staff performance still not improve, they are placed on a performance improvement plan, which leads to formal disciplinary action up to termination should the goals not be met.

### **Education for Providers**

To ensure providers can easily and correctly utilize our UM processes, our provider services team, prior authorization staff, and outreach team work in a closely aligned manner to help providers comply with authorization requirements as simply and efficiently as possible. These staff and processes are overseen by our CMO, vice president of clinical health services, provider services director, and pharmacy director.

Our Provider Services team works diligently to educate providers to ensure consistent application of review criteria. Our outreach team regularly attends joint operating committee meetings with large medical groups and hospitals and any providers that request support for their efforts. Working collaboratively, these two teams communicate prior authorization requirements to practitioners and providers using a variety of tools and answer any questions.

Aetna also communicates prior authorization requirements and procedures to practitioners and providers through the provider manual, on the provider website and portal, in provider newsletter articles, via practitioner and provider contracts as well as fax blasts. We also make these resources available to network practitioners and providers upon request.

### **ENSURING SERVICES ARE NOT ARBITRARILY OR INAPPROPRIATELY DENIED OR REDUCED**

**CRITERION 4:** The adequacy of the review processes (data collection and analysis) deployed by the respondent to ensure services are not arbitrarily being denied or reduced

Aetna works to minimize medical necessity denials resulting from lack of information through strong collaboration among our UM and provider services teams. We review the case thoroughly, identify areas that lack sufficient documentation, and then contact the provider

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

directly to complete the authorization to ensure coverage determinations are based on medical necessity and are never arbitrarily denied or reduced.

When making a determination of coverage based on medical necessity, the designated UM reviewer assesses the unique needs of the enrollee by obtaining relevant clinical information. Authorization and subsequent notification of coverage decision for proposed services, referrals, or hospitalizations involves utilizing information such as medical records, test results, specialists' consults, social determinants of health and if necessary, verbal communication with the requesting practitioner in the review process. We encourage our providers to use the Web portal for direct authorizations and educate them about our prior authorization process to ensure they provide all the necessary clinical information that facilitates a rapid authorization for the right services.

Our qualified and trained staff members are guided by established medical necessity criteria, but ultimately make determinations based on clinical judgement in the best interest of the enrollee, including consideration to specific and unique characteristics such as the local delivery system and the enrollees' age, comorbidity, complications, progress in treatment, psychosocial situation, and home environment.

Only a medical director can make an adverse coverage determination based on failure to meet criteria for care, as defined as medically necessary per nationally accepted guidelines. If a decision requires specialized judgment, the health plan maintains a list of specialist physicians available to participate in the utilization review process. Medical directors who participate in the utilization review process and conduct clinical reviews are available to discuss review determinations with attending physicians or other ordering providers. The medical director makes every effort to accommodate the prescribing practitioner's scheduling needs when a peer discussion is requested, including responding quickly to urgent requests and being available during non-traditional business hours if needed.

Utilization tracking and trending is reviewed by the CMO on a monthly basis and is reported at a minimum of quarterly to the QM/UM Committee. Our prior authorization monitoring includes, but is not limited to:

- Volume of requests received by telephone, facsimile, and website
- Service level
- Timeliness of decisions and notifications
- Process performance rates for the following and using established standards
  - Telephone abandonment rate: under 5%
  - Average telephone answer time: within 30 seconds
- Percentage of prior authorization requests approved
- Trend analysis of prior authorization requests approved
- Percentage of prior authorization requests denied
- Trend analysis of prior authorization requests denied
- Consistency in the use of criteria in the decision-making process among prior authorization staff measured by an annual inter-rater reliability audit
- Consistency in documentation measured by department file audits
- Grievance and appeals trends

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Beacon's clinical program activities are internally monitored monthly, tracking engagement, enrollment, and identification of outliers. Any trends are identified, analyzed quarterly, and brought to the appropriate clinical committee for review and discussion. Clinical program activities are evaluated at least annually as part of Beacon's Quality and UM Committee process. The evaluation measures clinical and functional improvement, appropriate benefit usage, reduction in costs and reduction in the need for crisis care. In addition, enrollee satisfaction is carefully monitored.

Peer-to-Peer Consultation

In the event of an adverse determination for a service request, we provide the opportunity for peer-to-peer discussions between the requesting provider and our medical directors to ensure coverage determinations are never arbitrarily denied or reduced. Aetna has the ability to provide specialty-matched peer review services if requested by the provider and we have the availability of specialists to consult with our medical director. Our peer-to-peer policy outlines our process and timeframes. Each request is tracked to help ensure response and completion in a timely manner.

Aetna's medical directors participate in the UM process, conduct clinical reviews, and are available to discuss review determinations with requesting physicians or other ordering providers. Practitioners/providers who are notified of adverse benefit determination may request a peer-to-peer consultation to discuss denied authorizations with the medical director reviewer. Prior to written notification, we may also elect to provide verbal notification, at which time the practitioner/provider is notified of the opportunity for the peer-to-peer consultation. We respond timely to a request by the attending physician or ordering practitioner for the opportunity to discuss the denial decision:

- With the medical director making the initial determination; or
- With a different medical director, if the original medical director cannot be available within one business day

If a peer-to-peer discussion 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, a denial letter informs the practitioner/provider and enrollee of the right to initiate an appeal or Medicaid Fair Hearing, and the procedure to do so.

\*\*\*\*\* [REDACTED] \*\*\*\*\*

[REDACTED]

[REDACTED]

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[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

\*\*\*\*\*

**UNDER-UTILIZATION, OVER-UTILIZATION AND INAPPROPRIATE UTILIZATION**

**CRITERION 5:** The adequacy of the review processes (data collection and analysis) deployed by the respondent to identify aberrant utilization patterns (under and over utilization)

Aetna's UM department is guided by written policies and procedures that establish thresholds for over- and under-utilization. These policies and procedures establish the methods by which to conduct further analysis when indicated. Our goal is to identify root causes of over- and under-utilization and to develop effective action plans to impact these trends. Actions plans may include staff based interventions, global network or individual provider level actions. Results of actions implemented are monitored to determine effectiveness. Action plans are not closed until it is determined that no further action is required.

Aetna measures the following data and analysis to identify potential areas of over- or underutilization of medical services:

- Provider performance profiles that compare provider
- UM reports and key indicators. Our reports can be sorted and analyzed by different parameters to allow for the flexibility of utilizing them to formulate UM strategies related to outliers. Examples would be identifying PCP, diagnosis, facility, and cost per service. These reports include:
  - ED utilization
  - Inpatient admissions
  - Observation vs. 1 to 2 day admissions
  - Re-admissions and avoidable re-admissions
  - Average length of stay (ALOS) for acute services and ALOS per thousand enrollees
  - Admissions and bed days per thousand enrollees

## **EXHIBIT A-4-a**

### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Laboratory and diagnostic utilization
- Outpatient utilization of services
- Ambulatory surgical center utilization
- Underutilization of services such as immunizations, EPSDT, prenatal and post-partum services and chronic condition (disease) management
- Medical management dashboards
- Complaints
- Grievances
- Pharmacy reports
- Practitioner audits (e.g., ambulatory medical record review)
- Prior authorization and claim reviews
- Notifications from the Agency for Health Care Administration
- Communication from special investigation units
- Claims review
- Retrospective utilization and claims review

For example, through our monitoring of one- to two-day inpatient admission UM reports, it was determined that many one- to two-day admissions did not require inpatient status and it was appropriate to divert these acute admissions into the observation setting. Enrollees with less severe conditions could and should be managed in this setting and usually require less than 48 hours to stabilize and start their treatment. Our Enhanced Observation Initiative resulted in the development of an avoidable admission list. Diagnoses on this list require a medical director review to determine whether the care could have been managed in a lower level of care. This initiative has resulted in a significant year over year savings of \$4,300 (or 88%) per hospital stay.

Our Quality and Care Management teams review, analyze and formulate strategies to address issues of underutilization of services such as immunizations, EPSDT, prenatal and post-partum services and chronic condition (disease) management. For example, we maximize the opportunity to enhance enrollee education about EPSDT requirements with every interaction. Our care coordinators are experts in EPSDT guidelines and closing gaps in care. Outreach to enrollees is individualized to the enrollee's unique needs and social determinants. The care managers educate enrollees on their gaps in care, identify barriers, and assist the enrollee to access the resources and benefits they need to overcome those barriers and complete needed care. Enrollees can work with care coordinators through every element of EPSDT service completion and other health needs.

Within 30 days of enrollment, we call new enrollees to offer assistance in accessing EPSDT services following 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. If an enrollee is identified for care management, our care managers place the outreach welcome call. We engage the parents and guardians of our enrollees to complete a health risk assessment on behalf of the child and ask what we can do to help them access their benefits. We also proactively reach out to existing enrollees to make sure they understand the importance of receiving timely and complete EPSDT services and following up on any referrals that may be made because of the well child visit. On calls to care management, Enrollee Services department, and other Aetna functional areas, our staff discusses EPSDT and other gaps in care with the enrollee based on the alerts built into our electronic system.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Aetna contacts enrollees with preventive screening reminders through interactive voice response calls, text messaging, and mailings. We mail postcard reminders and newsletters with age-appropriate recommendations as well as growth charts printed with the well-child visit schedule. Our enrollee welcome packets include information on EPSDT screenings and services. We also place notifications in our enrollee portal so that they are made aware of recommended services and potential gaps when they access our website to view the enrollee handbook or search for a provider. This type of outreach has proven to be very successful, with greater than 90% of our children accessing services on an annual basis.

### **Performance Monitoring**

Monthly, the CMO and vice president of clinical health services analyze utilization data, evaluate plan performance, and identify variances in the standard of care. Established methodologies are used to measure performance-comparing data against benchmarks or goals and historical information.

The CMO presents utilization reports to the QM/UM committee quarterly at a minimum. The QM/UM committee is responsible to provide feedback to the CMO and approves action plans including adjustments to the Quality Assessment and Performance Improvement (QAPI) program. Recommendations for action planning are provided by our CMO and QM/UM committees when variances are identified. Additionally, our CMO and vice president of clinical health services present utilization reports and findings to executive leadership during our monthly operations reporting meetings.

Aetna in partnership with Beacon proactively identifies instances of possible over- or under-utilization through case rounding with UM staff and medical directors as well as data analysis. Beacon's UM director reviews the care of identified individuals weekly with clinical supervisors for adherence to practice guidelines. Beacon has developed a utilization-based standard for identifying enrollees with a behavioral health presentation that suggests over- or under-utilization. This methodology is intended to identify those enrollees whose utilization patterns indicate the need for intervention. Beacon analyzes monthly UM and admissions reports to identify enrollees who are, or may become, high need and who have had multiple admissions to higher levels of care in the last six months. When this identification occurs, Beacon's clinicians follow-up on the enrollee's progress in community-based services, or the enrollee may be assigned to an intensive care management program for enhanced outreach and care coordination.

### **Provider Performance Profile**

We develop and provide a provider performance profile to practitioners and providers to distribute essential clinical and enrollee information that promotes quality efforts to maximize point-of-care delivery.

The provider performance profile is utilized to reflect panel enrollee receipt and costs of defined clinical services or healthcare status for the profile measurement and/or reporting period. Aetna utilizes profiles for various programs and initiatives.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

The provider performance profile is comprised of data such as:

- HEDIS measures
- Inpatient admissions
- Emergency department utilization trends
- Readmission rates
- Detailed utilization data
- Costs per enrollee
- Predictive modeling data
- Provider level detail on specific performance measures

### **Ambulatory Medical Record Review (AMRR)**

Aetna conducts reviews of our participating network primary care practitioner (PCP) groups, high-volume obstetrical/gynecological groups with a patient panel of 50 or more enrollees, and high-volume specialists who receive 50 or more referrals per contract year from Aetna's combined lines of business. High volume specialists include, but are not limited to, those practitioners or providers who provide care for enrollees with special needs and specialists acting as primary care practitioners.

Aetna has developed comprehensive AMRR review tools which incorporate the AHCA required medical records standards and takes into consideration professional and community standards and accepted and recognized practice guidelines.

Each medical record selected is reviewed against the appropriate AMRR criteria to verify the practitioner's compliance with Aetna, AHCA or medical record standards and requirements. Deficiencies are noted and a review score is determined.

If the review score does not meet the established Aetna standards for the practitioner/provider category, Aetna requires the practitioner/provider group to develop and implement a corrective action plan, which must be accepted by Aetna. The QM clinician is responsible for documenting the reviews in the QM confidential database and monitoring applicable follow-up activities.

An ambulatory medical record review or focused review of an individual physician or physician group practice may also be initiated by the CMO as a result of a clinical review conducted by QM or Medical Management. Actions that may be taken when trends are identified include:

- Personal visit by the CMO or designee
- Referral of practitioner to the Quality Management Oversight Committee for peer review as appropriate
- Limiting enrollee panel size
- Recommendation for continuing medical education
- Contract termination

### **Utilization/Performance Improvement Indicators**

Aetna monitors the use of clinical resources and services using utilization and performance improvement indicators. For example, our monthly Pharmacy Analysis Report provides insight into enrollee utilization of medications and includes pharmacy trends such as total cost, net cost

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

per-member-per-month (PMPM), prescription volume, average net cost per prescription, specialty total cost, specialty net cost PMPM, and specialty prescription volume. We also monitor formulary compliance, average generic dispensing rates, generic substitution rates, generic and brand ingredient costs, top 10 drugs by net cost, top drug class spend. This pharmacy analysis is utilized both in our provider education efforts and to identify under- and overutilization trends in the delivery of pharmaceutical services.

Performance improvement indicators may be developed internally or established to reflect State regulatory or business requirements and may include HEDIS or other comparable indicators. Utilization indicators are based on utilization data and information, such as trending reports and data sets showing over- or underutilization of resources or identifying specific diseases or large populations with a specific disease.

Quarterly summary of results of utilization/performance improvement monitoring are evaluated to identify utilization and performance trends and are reported to the QM/UM Committee and the QMOC.

Results of utilization and performance improvement monitoring are evaluated to identify utilization and performance trends and are reported to appropriate medical committees for recommendation. Utilization data and information may be reported to providers. Utilization results are included as components of physician profiles and reviewed during formal quality management processes, such as credentialing and re-credentialing.

### **APPROACH TO SERVICE AUTHORIZATION BASED ON LENGTH OF TIME**

**CRITERION 6:** The adequacy of the respondent's approach in differentiating between UM protocols for authorization of services that are needed short-term (e.g., one-time authorization) versus long-term (ongoing maintenance services/therapies)

We determine our enrollee's individual and unique service needs through our providers and our care plan development process, including identification of services that will be needed short-term versus long-term. Our holistic, enrollee-centric care management and UM approach is developed with consideration of the enrollees' medical, behavioral, psychosocial, cultural and spiritual health needs.

Duration of service need is developed in the assessment and care planning process for enrollees either at the provider level or through integrated care management and UM. The care planning development process is the first step; then the care manager works with UM to help ensure short- and long-term services are identified and authorized accordingly.

For both short- and long-term services, we apply a combination of clinical judgement, defined criteria sets, and the unique characteristics of the enrollee and his or her environment, in addition to the duration in the request itself. To address whether a treatment or service is needed short-term or long-term and in the best interest of the enrollee, the reviewers assess whether obtaining the treatment or service is clinically appropriate, the severity of the enrollee's situation, and whether not obtaining it will lead to adverse consequences for the enrollee. We review the codes (CPT, ICD-10, HCPCS, and NDC), the problem/diagnosis, reason for referral, and all supporting objective clinical information such as clinical notes, laboratory and imaging studies, and treatment dates, as applicable for the request.

**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

Our authorization and UM processes enable us determine whether the treatment for the enrollee's specific diagnosis and type of condition is required on a short-term or a long-term basis. For medical standard authorizations, Aetna makes the determination with a validity period of 60 days. Certain services are automatically approved long-term; if a longer period is requested, this can be approved by a medical director for up to one year.

In determining the length of authorization, we consider all contributing factors, including the chronicity of the illness and burden to the enrollee and the provider. We understand that many chronic illnesses will require long-term mitigating treatment and authorize longer service authorizations as a result with regular reassessments at three months, six months, nine months, or annually, since the enrollee's condition may have changed. We rely on the clinical expertise of our medical directors to determine when a long-term authorization should be reassessed to ensure that the services being provided are meeting our enrollees' needs and the treatment is appropriate for management of their medical condition.

The UM clinical staff members provide service authorizations for select services long-term to reduce the burden on providers. Those services include:

- Transplant related services
- Assisted Living Facility/Skilled Nursing Facility placement
- Select durable medical equipment (DME), like C-Pap or Bi-Pap
- Diabetic supplies
- Hemodialysis services
- Chemotherapy services
- Global authorization for maternity to cover entire course of treatment
- Physical therapy/speech therapy/occupational therapy

\*\*\*\*\* [REDACTED] \*\*\*\*\*

[REDACTED]

[REDACTED]

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**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**



**ENSURING CONTINUITY OF CARE**

**CRITERION 7:** The adequacy of the respondent's approach at ensuring continuity of care, particularly as it relates to special needs populations

Aetna recognizes the importance of maintaining continuity of care and service whenever an enrollee's medical needs, care setting, or provider changes to ensure there are no care interruptions due to lapses in prior authorizations. For medical standard authorizations, Aetna ensures that the continuity of care authorization has a validity period of 60 days. If a longer period is requested, it can be approved by a medical director for up to one year.

Processes to guard against interruptions in care are integrated into Aetna systems and departments. Integrated systems and interdepartmental processes are accessed by all departments involved in coordinating services for an enrollee, including UM and integrated care management staff members. The systems, including the UM business application system, allow departments to share enrollee and provider information, and to coordinate services that include ongoing clinical services, discharge planning, transitioning an enrollee from an institutional setting back in to the community, authorization of post-hospital services, and follow-up on complex cases or emergency department care.

Aetna maintains policies and procedures for monitoring the services received during transitions of individuals or groups between health plans and during transitions of enrollees within Aetna from one practitioner or ancillary provider to another. During such transitions, enrollees are identified and monitored to help ensure the previously authorized services and level of care are maintained, with special attention to those enrollees receiving chemotherapy, hemodialysis, transplant, maternity care, or behavioral health services.

We ensure continuity of care for special needs populations, including implementing, coordinating, monitoring and evaluating all options and services that meet an enrollee's needs. To help ensure all needs are met, we seek contracts with out-of-network providers and develop single case agreements as needed with providers to facilitate a comprehensive service delivery array for all of our enrollees. We encourage out-of-network providers to join our network for seamless continuity of care for our enrollees.

For oncology services, for example, Aetna ensures continuity of care by authorizing and paying for services for the duration of the current round of treatment, regardless of whether the provider participates in the health plan or not. In addition, Aetna will reimburse a non-participating provider at the rate they received for services rendered to the enrollee immediately prior to the enrollee transitioning to Aetna. The UM staff will coordinate a single case agreement to ensure

## **EXHIBIT A-4-a**

### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

that the non-participating provider will receive timely payment for services delivered to our enrollee.

We ensure prior authorizations do not impede continuity of care, including but not limited to the following coordination of care activities:

- Ensuring previously authorized covered services are provided for a minimum of 60 days after an enrollee transfers into the health plan or after termination of a provider's contract for the provision of services (not to exceed six months)
- Participating in outreach programs and other strategies for identifying every pregnant enrollee. This includes care coordination/care management, claims analysis, and use of health risk assessment, etc.
- Ensuring a pregnant enrollee, regardless of trimester, can continue the services until the completion of postpartum care, whether the provider is participating or non-participating
- Care coordination/care management follow-up services for children/adolescents Aetna identifies through blood screenings as having abnormal levels of lead
- Ensuring referrals for direct access to specialists for enrollees identified with special health care needs, as appropriate for their conditions and identified needs
- Scheduling and referral assistance for enrollees needing specialty health care or transportation services
- Determination of the need for non-covered services and referral of the enrollee for assessment and referral to the appropriate service setting (to include referral to Women, Infants and Children and Healthy Start) with assistance, as needed, by the Medicaid area office
- Documenting of referral services and emergency care encounters in enrollee medical/case records including appropriate follow up and reports
- Coordination of hospital/institutional or residential treatment setting (including residential SIPP and TGC services) discharge planning that addresses post-discharge care, including, but not limited to aftercare services, residential services, day treatment programs, outpatient appointments, skilled short-term rehabilitation, and skilled nursing facility care
- Sharing with other managed care plans serving the enrollee the results of identification and assessment of any enrollee with special health care needs so that those activities are not duplicated
- Ensuring that in the process of coordinating care/care management, each enrollee's privacy is protected consistent with HIPAA requirements
- Connecting enrollees to community services and resources that support their ability to reach their health care goals, e.g., transportation, housing/shelter, food banks, legal resources, including carved out services and those provided through waiver programs
- Securing urgent or emergent health care when the enrollee is in crisis or immediate danger
- Outreaching provider services for network providers who offer specialized services to enrollees or services in remote or rural locations
- Coordinating benefits by working collaboratively with contracted and non-contracted partners and providers to determine benefit eligibility and coordination of covered benefits
- Involving external/community care managers who are offering unique or specific services the enrollee may need

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Engaging the UM department to review and authorize services according to plan policies and external partner contract agreements within the plan's appropriate business application system
- Making referrals to services for which the enrollee may be eligible via Aetna partner programs or community resources and organizations
- Managing populations or State required programs that may or may not require enrollment in care management
- Coordinating care with the primary care practitioner and patient-centered medical home/federally qualified health centers/health home team and other interdisciplinary care team participants

### **EXAMPLES RESULTING IN SUCCESSFUL INTERVENTIONS TO ALTER UNFAVORABLE UTILIZATION PATTERNS**

**CRITERION 8:** The extent to which the respondent provides a specific example of how its review processes resulted in successful interventions to alter unfavorable utilization patterns in the system

Two examples of our successful interventions to alter unfavorable utilizations follow.

#### **Example 1: Emergency Department Utilization Management Program**

Aetna's Medical Management department implemented a strategy to reduce avoidable ED visits and increase enrollee involvement in self-management of acute and chronic conditions. In addition, we are committed to encouraging enrollees to follow age-appropriate screening and health-maintenance guidelines for preventive care.

##### **High ED Utilizers**

We initiated a process for high ED utilizers where we target enrollees who have been to the ED three or more times in a quarter. A report is pulled by our medical economics team that includes enrollee demographics, reason for ED visits, and contact information for enrollee and PCP. The care management team sends written notification to the PCP that the enrollee has been to the ED and how many visits were completed in the quarter. In addition, our care managers reach out to the enrollees to determine the root cause of the ED visits.

If the issue is that the enrollee simply does not like his or her PCP or the provider cannot accommodate the enrollee (extended hours, special needs, language), the care manager will assist with selecting another PCP and scheduling an appointment. If the issue is transportation-related, we will educate the enrollee about access and assist the enrollee with arranging for transportation. Care managers use these outreach opportunities to educate enrollees regarding:

- PCP offices with extended and weekend hours
- Availability of urgent care options
- What constitutes an emergency
- Aetna's Informed Health line (24-hour nurse line)

In addition, our care managers work with enrollees to mitigate social issues such as homelessness and complete referrals for behavioral health services including substance use

## **EXHIBIT A-4-a**

### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

concerns. The goal of PCP notification is so the physician can outreach enrollees and attempt to schedule visits in lieu of ED visits.

#### **Chronic Condition (Disease) Management**

Aetna has a chronic condition management program that targets enrollees with specific chronic conditions and includes education, care management interventions, coordination with PCPs and specialists, and regular follow-up with enrollees to ensure adherence to their treatment plans that can prevent the need for ED use and hospital admission. In addition to the diagnoses mandated by the state contract, we utilize our predictive modeling engine's Consolidated Outreach and Risk Evaluation™ (CORE) tool, which identifies enrollees at high risk for emergency department utilization and their diagnoses.

Aetna has designed our chronic condition program to address enrollees most likely to be high ED utilizers related to their diagnosis and severity of illness. The following diseases are currently on our chronic condition list: Alzheimer's disease/dementia, asthma, cancer, chronic obstructive pulmonary disease, coronary artery disease, depression, diabetes, end of life issues, and heart failure. Our care managers work with the enrollees in our disease management programs by coordinating services; scheduling appointments and transportation; reminding enrollees regarding necessary testing and services; reviewing medications and educating the enrollee about the medications that are being taken; coordinating care with the enrollee's physician as necessary; and providing educational materials.

#### **Urgent Care Centers**

Aetna has contracted with urgent care centers (UCCs) throughout the state of Florida. During our outreach calls to the enrollees on our high ED utilizers list, the care managers access the list of participating UCCs and minute clinics. Enrollees are educated about which facilities are within their ZIP code, and they are provided with the UCC address and contact information. Although urgent care is not to be utilized for primary care, it is a cost effective alternative to the ED whenever an enrollee truly has an urgent need that cannot be accommodated by his or her PCP.

#### **Extended Hours**

As part of our Provider Incentive Program, we encourage our provider offices to offer extended and weekend hours. This is particularly important in the pediatric offices when so many parents work during normal business or a child becomes ill in the evening or on the weekend. Providers who achieve key access and quality measures can earn enhanced payments equivalent to the appropriate Medicare fee-for-service rate.

#### **Informed Health Line (24-Hour Nurse Line)**

Aetna has an Informed Health Line, which is manned by clinicians who can provide health care information 24/7. This is a resource for enrollees to obtain information on a wide range of health and wellness topics, receive emails from a nurse with videos that are relevant to a question or topic, support the enrollee with making smarter health care decisions and help enrollees prepare for physician appointments or medical tests. Enrollees can access Informed Health Line information by calling the toll-free telephone number on our Website and in enrollee handbooks.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

In addition, they are provided with the Informed Health Line information during care management outreach calls.

### **Event Notification Services**

Aetna has enrolled in the Event Notification Service (ENS). This program provides real time notice of enrollee encounters from over 200 participating hospitals to subscribing organizations. This includes ED visits, inpatient admissions, and observations stays in the hospital setting. Some of the goals of ENS are: allowing for enhanced post-discharge care coordination; supporting health plan efforts to shift the setting of care for non-urgent conditions from the emergency department to primary care; and decreasing costs by reducing non-emergency ED utilization and hospital readmission rates.

Aetna is currently providing this real time information to our providers and care management staff. Our provider groups appreciate this information because it affords them the opportunity to contact the enrollees and schedule PCP and/or specialist follow-up, therefore enhancing the care coordination efforts and improving the PCP/enrollee relationship. For the health plan, ENS is utilized by the care managers when they are made aware that one of their enrollees has been to the hospital. They can contact the enrollee and provide proactive follow-up care. Enrollees who are identified through the high ED utilizers process are outreached after each ED encounter to help ensure they are scheduled to see their PCPs for follow-up.

### **Medical Director ED Utilization Review**

Aetna has an ED claims review process that includes review by clinicians of all ED claims. When ED claims are identified that do not meet criteria for an ED visit, our medical director reviews the claim and supportive documentation. Using his/her clinical judgment, the medical director can downgrade the claim and the hospital paid for a triage visit. The goals of this medical director review are to help ensure we are only paying for true emergencies and to encourage the hospital providers to redirect enrollees to alternative providers when they do not require ED services.

### **Summary and Findings ED Utilization Management Program**

EDs play a vital role in patient care by providing essential and sometimes life-saving services for patients with urgent medical conditions. However, many Medicaid enrollees utilize the ED for primary care in non-urgent situations. Since we implemented our ED UM strategies in early 2015, we have experienced a decrease in ED visits and costs PMPM for a savings of \$906,932.48 in 2016. ED visits per 1,000 enrollees decreased from 741.91 in quarter 4 of 2014 to 615.76 in 2016 with a corresponding decrease in ED expenses PMPM from 24.39 to 18.76, respectively.

We continue to explore additional strategies including telehealth monitoring. Telehealth will allow the PCP to monitor enrollees with chronic conditions, such as heart failure, and adjust treatments prior to the enrollees going into crisis and requiring emergency care.

## **EXHIBIT A-4-a**

### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

#### **Example 2: Aetna Medicaid Neonatal Intensive Care Units Initiative and Tools**

Our regular monitoring and review of Neonatal Intensive Care Unit (NICU) trends led to the identification that within pediatrics, NICU was the single largest category of expense and more rigorous and consistent application of MCG NICU guidelines and other recognized guidelines and criteria could reduce avoidable NICU admissions of term and near-term infants, reduce delays in care, and when and where appropriate improved NICU leveling.

First, we identify high-risk pregnancies and refer to high risk OBs to decrease premature deliveries as follows:

- Self/enrollee referral
- Health Risk Questionnaires (HRQ) and/or health appraisal
- Community agencies
- Enrollee Services referral
- Health practitioners caring for pregnant women and infants
- ACOGS submitted by OB providers
- Plan's Prior Authorization and Concurrent Review staff
- Reviews of emergency department reports
- Pharmacy claims for 17-hydroxyprogesterone (17-P or Makena)
- State enrollment file or state-generated health assessments
- Outreach activities
- Internal reporting on a monthly basis based on claims paid for diagnosis of pregnancy in prior month

We recognized that all infants in NICUs require increased monitoring and oversight. Knowing what transpired in the NICU before discharge is extremely helpful to the care manager who must follow the infant after discharge. We developed a model to care for enrollees in the NICU to promote the best possible outcomes for the baby and family.

All NICU cases are reviewed regularly. As such, we have found that forming a relationship with the hospital NICU, care management, and neonatology staff is very helpful in ensuring the child and family's needs are met. All our NICU cases are reviewed by concurrent review clinicians who are RNs with NICU experience.

We conduct daily rounds with the concurrent review team and medical director/CMO using a standardized NICU Review Template. Our team composition includes NICU concurrent review nurse, transition of care clinician, enhanced care coordination care manager, and our medical staff. Daily rounds offer the team the opportunity to discuss challenging cases and present innovative solutions to barriers.

We conduct concurrent review in the NICU for the following populations:

- Babies under 30 weeks corrected gestational age (CGA):
  - Concurrent review clinicians are allowed to authorize babies up to 30 weeks CGA.
  - The nurse can schedule a second review at 30 weeks CGA and can then approve up to 32 weeks if clinically indicated.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Babies at 32 weeks CGA:
  - All babies are reviewed by the CMO/medical director to help ensure they are making progress and to determine discharge needs.
  - We will authorize variable amount of days at this point depending on complexity of case and progress (or lack thereof).
  - For uncomplicated cases making good progress, the next review can be set at 34 weeks.
- Babies at 34 weeks CGA:
  - The concurrent review clinician will review feeding progress to determine if the baby can accept oral feeding and check that the baby is gaining weight.
  - All apnea/bradycardia episodes are documented.
  - The clinician will determine if the baby has moved out of the isolette and can transfer to a step-down unit (if available) or newborn nursery.
  - The concurrent review and enhanced care coordination care manager will work with the parents to ensure they are educated and engaged in discharge planning process.
- In addition, babies born with the following specific conditions are also considered for this intense review process:
  - Necrotizing enterocolitis
  - Short gut syndrome
  - Congenital anomaly of diaphragm
  - Congenital anomalies of abdominal wall (gastrochisis)
  - Hypoplastic left heart syndrome
  - Aortic atresia
  - Mitral valve atresia
  - Single ventricle
  - Tricuspid atresia
  - Pulmonary atresia
  - Trisomy 13 (Patau syndrome)
  - Trisomy 18 (Edward syndrome)
  - Cri du chat
  - PKU
  - Fetal alcohol syndrome
  - Caudal regression syndrome
  - Triple-X or fragile-x syndrome

We have found significant variance between facilities and practitioners, and we work collaboratively with them to get buy-in, as most physicians do not want to be outliers (unless hospital administration is pushing them to keep the beds filled). We utilize comparative data to find outliers. We are also working to involve community neonatologists (especially those at Level 4 nurseries) in guidelines on feeding and apnea.

- Most NICU graduates will need at least some care coordination after discharge.
- Newborn assessment should be done before discharge if possible.
- Parents should attend a cardiopulmonary resuscitation (CPR) class before baby goes home.
- Unless very stable, the baby should be followed for the first year, to coordinate care and assist with access to recommended well-child care and immunizations.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Our enhanced care coordinator will continue to provide care management for NICU babies who are discharged to home with private duty nursing or to a nursing facility. The care coordinator will meet with the enrollee and caregiver at least monthly, or more often as needed. In addition, the care coordinator will arrange a multidisciplinary team within 60 days of the child being enrolled into enhanced care coordination. There will be multidisciplinary team meetings every six months or more often if needed based on any changes in the enrollees medical condition or a significant life change. The care coordinator will be responsible to develop, update, and maintain a person centered, individualized plan of care that reflects the services and supports that the enrollee and their family need. The care coordinator will be responsible for arranging for services and monitoring that they are in place and meeting the enrollees needs.

### **Summary and Findings NICU Utilization Management Program**

NICU concurrent review is overseen by our CMO; and through this project, we have achieved an ALOS decrease of 23.97% and a cost per admission decrease of 13.39%.

### **Evaluation Criteria:**

1. The extent to which the respondent describes the process and data sources utilized to determine whether a service should be prior authorized, including reviewing complaints or feedback from providers regarding burdensome or unnecessary prior authorization criteria.
2. The adequacy of the processes used by the respondent to determine whether the utilization management criteria selected are appropriate and consistent with policy requirements for a Medicaid benefit.
3. The adequacy of the respondent's approach to ensure the consistent application of review criteria for authorization decisions (e.g., inter-rater reliability studies, and training for plan staff and network providers).
4. The adequacy of the review processes (data collection and analysis) deployed by the respondent to ensure services are not arbitrarily being denied or reduced.
5. The adequacy of the review processes (data collection and analysis) deployed by the respondent to identify aberrant utilization patterns (under and over utilization).
6. The adequacy of the respondent's approach in differentiating between UM protocols for authorization of services that are needed short-term (e.g., one-time authorization) vs. long-term (ongoing maintenance services/therapies).
7. The adequacy of the respondent's approach at ensuring continuity of care, particularly as it relates to special needs populations.
8. The extent to which the respondent provides a specific example of how its review processes resulted in successful interventions to alter unfavorable utilization patterns in the system.

**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**Score:** This section is worth a maximum of 40 raw points with each of the above components being worth a maximum of 5 points each.

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**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**SRC# 19 – Utilization Management – Ease of Use (Statewide):**

The respondent shall describe the following related to its utilization management systems:

- a. A description of how the respondent will ensure that the UM processes are designed so that service authorization requests are completed efficiently and with minimum administrative burden on network providers and enrollees;
- b. A description of software capabilities that facilitate ease in requesting service authorization and support data exchanges between providers, subcontractors and the respondent (to the extent any UM functions are delegated);
- c. A description of the respondent's experience meeting timeliness standards for service authorization requests;
- d. A description of the approach that the respondent will use to educate enrollees and providers about the process for seeking authorization; and
- e. A detailed workflow of how "special service" requests are processed for enrollees under the age of 21 years. Special services are requests that are made to the plan to exceed the limit on a Medicaid covered service or to cover a medically necessary service that is not listed in the Florida Medicaid handbooks/coverage policy or the associated fee schedule.

**Response:**

Aetna's approach to utilization management extends beyond the review of requested services—instead, we seek to identify ways to empower our enrollees to lead healthier, happier lives and ultimately improve their quality of life. With a firm commitment to meeting the Agency's objective for Medicaid enrollees to receive all medically necessary services in a timely and efficient manner and in the most appropriate setting, we employ comprehensive processes and systems that result in optimal quality outcomes while containing costs. Additionally, these processes and systems help the Agency to reduce potentially preventable inpatient and outpatient hospital events, as well as avoidable ancillary services.

Aetna's utilization management program is part of our continuous quality improvement strategy focused on improving health outcomes for all of our enrollees. Our proven results are evidenced by consistently high NCQA status ratings, as well as across our quality, medical management, and health-equity programs. Recently, Aetna was ranked the leading NCQA Florida Medicaid plan for the second consecutive year. Additionally, we are also ranked among the top 15 Medicaid plans in the nation. Our experience implementing, managing, and caring for Medicaid enrollees results in improved access to care, higher quality of care in appropriate settings, and a simplified enrollee experience in a culturally competent manner.

**UTILIZATION MANAGEMENT PROCESSES DESIGNED FOR EFFICIENCY AND MINIMUM ADMINISTRATIVE BURDEN**

**CRITERION 1:** The extent to which the respondent proposes the use of interoperable systems that will seamlessly integrate information from providers to the respondent and its

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

subcontractors (to the extent any UM functions are delegated) and the extent to which the respondent describes how that information will be used to enhance care coordination services and to ensure there are no delays in authorization or gaps in care

**CRITERION 2:** The extent to which the respondent uses strategies to reduce administrative burdens for the provider (e.g., software capabilities) in requesting authorization and its approach is streamlined with little to no redundancies between and across departments which could contribute to delayed service authorizations

Aetna's Utilization Management Steering Committee routinely reviews prior authorization requirements for thousands of medical procedures for the benefit of all of our health plans. This committee is staffed with clinicians and individual plan representation to analyze contract requirements by state, utilization of services, approval/denial statistics, financial impact, and administrative burden. Generally, exceptions to Aetna's service authorization standards are driven by the specific requirements in state contracts. Our parent, Aetna Inc., encourages health plans to align with Aetna's standards, which minimize authorization requirements for procedures where authorization has little or no impact.

### **Efficient Authorization Process**

The recommendations of the Utilization Management Steering Committee are built into Aetna's ProPat system, which enables providers to determine whether a service requires an authorization for a specific treatment or service. ProPat is designed to provide immediate authorization requirements and information to ensure there are no delays or gaps in care for the enrollee. Access to ProPat is available through both our provider Website and portal. Providers can input up to six Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes, select a line of business (Managed Medical Assistance [MMA] or Long Term Care [LTC]) and ProPat returns the authorization requirements.

The system also enables providers to determine whether Aetna has a delegated vendor or subcontractor to provide the service by referring to the variance detail, which includes benefit limits or extra information about the authorization requirements. If a delegated provider is identified, ProPat provides the name and contact information for the delegated vendor; thus reducing the administrative burden for the providers' office staff.

The availability of ProPat minimizes administrative burden on network providers and enrollees, eliminating the need to request authorization for services that do not require it. Claims pay accordingly and if no authorization is required, the claim pays without searching for one. Providers benefit directly by signing up for and using our provider portal because it enables them to access ProPat, submit authorization requests electronically, and reference the status of a request.

Electronic requests from the provider portal are delivered directly into our claims and authorization system for processing. Providers can check the real-time status of an authorization request in the portal throughout the process, which provides transparency into the process and saves our providers from making avoidable phone calls. In addition, Aetna's FaxComm system allows the UM staff to communicate with the provider offices through a call tracking function built into FaxComm. For example, if a provider faxes a request without clinical

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

information, the Utilization Management staff can simply return the request via fax, and track the request in keeping with timeliness requirements.

All applicable Aetna staff, such as those in the Care Management, Enrollee Services, Provider Services, and Pharmacy departments can view the same, real-time prior authorization progress information to eliminate redundancies between and across departments, which could contribute to delayed service authorizations.

Providers can also request expedited reviews for urgent situations. Approvals and denials are noted in the Utilization Management business application and are reflected on the portal in real time whenever the determination is received, pending, or completed in the claims and authorization system. In addition, Utilization Management staff calls the provider's office if an urgent request is not authorized or is downgraded, and they fax a copy of the enrollee's Notification of Adverse Benefit Determination (NABD) letter to the provider's office. The NABD letter includes an explanation of the denial rationale and the fax cover offers the provider the opportunity to request a peer-to-peer review with the medical director. Enrollees receive a copy of the NABD letter, and they are informed of their right to appeal or request a State Fair Hearing. Using our ProPat system, providers will find thousands of procedures and services that do not require prior authorization. Hospital admissions and observation stays require authorization; however, we empower our concurrent review clinicians to authorize services that clearly meet criteria, including obstetrical services and select observation requests, without medical director review.

Our Utilization Management department has clinician and medical director staff available 24/7, which is particularly important for hospitals. Utilization Management staff is available to accept authorization-related telephone calls on the weekend/holidays, and they process admission requests as they occur. This process supports the hospitals and relieves them of the burden of having to wait until business hours to submit authorization requests and admission notifications. We encourage hospitals to call in their admission notifications so that we can expedite them. We handle all inpatient and observation hospital requests as urgent.

Aetna's behavioral health subcontractor, Beacon, provides a timely and easy authorization process for behavioral health providers. Providers may contact Beacon 24/7 to conduct telephonic authorization for inpatient services and other higher levels of care, including residential, partial hospital, intensive outpatient, electro convulsive therapy, targeted care management, and SIPP services.

### **Utilization Management Processes**

Aetna's Utilization Management department uses written policies and procedures that promote the efficiency of the authorization process while adhering to federal, State, and regulatory requirements. Utilization management staff review policies and procedures annually and update them on an as-needed basis. Our utilization management functions manage and coordinate the use of physical and behavioral health resources and identify opportunities for improving utilization of care and services to promote quality health outcomes for enrollees.

Based on this process, Aetna Medicaid is removing the prior authorization requirement from more than 500 codes. An additional 300 codes have been identified for eventual movement from prior authorization to a less burdensome form of management. This staged process began

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

during the spring of 2017, and the timeline for its completion is flexible to accommodate provider notifications and the system changes that will be required. We conduct regular reviews of prior authorization requirements and remove those requirements for services that are consistently approved and for which no denials are being made.

Our utilization management process is designed to help enrollees get appropriate care and, whenever possible, avoid the risks associated with overuse, underuse, and misuse of health care interventions. Our processes and systems help us advise providers and enrollees of reimbursement and coverage determinations and to provide information on evidence-based care options. The following is the established hierarchy of referenced criteria:

- Medicaid Contract/Policy Guidelines: the Florida Medicaid Coverage and Limitations Handbook, coverage policies and associated Medicaid Fee Schedules, the AHCA contract, State Medicaid Director letters, Centers for Medicare & Medicaid Services (CMS) informational bulletins, and AHCA policy statements
- Milliman Care Guidelines: National evidence-based clinical guidelines, best practices, and care planning tools across the continuum of care to support clinical decision-making
- Aetna Clinical Policy Bulletins: Aetna's proprietary medical necessity guidelines are based on objective, credible sources such as scientific literature, guidelines, consensus statements, behavioral health criteria (LOCUS/CASII Guidelines and American Society of Addiction Medicine), and expert opinions.
- Aetna Clinical Policy Council: This team of clinical experts is responsible for the review of new and emerging technology; this council also provides consultation to Aetna's medical directors.

Our selected criteria are appropriate and consistent with specific contract requirements as well as federal and State regulations, including the policy requirements for a Medicaid benefit. We review and update our criteria as needed for any additions and changes no less than annually through the Aetna Medicaid organization's UM Steering Committee for evaluation, voting, and approval.

Qualified and trained staff members are guided by these criteria, but they ultimately make determinations based on clinical judgement in the best interest of the enrollee, including consideration to specific and unique characteristics such as the local delivery system and the enrollees' age, comorbidity, complications, progress in treatment, psychosocial situation, and home environment. Our medical directors and clinical staff use their clinical judgement and experience in addition to criteria because decisions to deny reduce, suspend, or terminate services are not based solely on criteria and other evidence-based guidelines. Service authorization criteria are available to providers to allow full transparency into the process.

Providers are advised that criteria are available upon request in the NABD, provider manual, and/or provider newsletters. Medical management criteria used for a specific utilization management decision are provided to all affected practitioners/providers and enrollees. Practice guidelines are available to enrollees and practitioners/providers on the Aetna website, and information on how to find these guidelines is provided in both the enrollee and the provider handbooks. Our Utilization Management staff is also available 24/7 to answer any questions from the providers.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **Peer-to-Peer Consultation**

Aetna's medical directors who participate in the utilization management process and conduct clinical reviews are available to discuss review determinations with practitioners/providers. The Utilization Management department notifies practitioners/providers when faxing the NABD that they may request a peer-to-peer consultation to discuss denied authorizations with the medical director by calling Aetna. Prior to issuing a written notification, we may also elect to notify the practitioner/provider verbally of the opportunity for peer-to-peer consultation. Aetna responds timely to requests by the practitioners/providers for the opportunity to discuss denial decisions:

- With the medical director making the initial determination
- With a different medical director, if the original medical director cannot be available within one business day

If a peer-to-peer conversation or review of additional information does not result in an authorization, or if the practitioner/provider elects not to request a peer-to-peer consultation, the adverse determination letter informs the practitioner/provider and enrollee of the right to initiate an appeal or a State Fair Hearing and of the procedure to do so.

### **SOFTWARE CAPABILITIES**

**CRITERION 1:** The extent to which the respondent proposes the use of interoperable systems that will seamlessly integrate information from providers to the respondent and its subcontractors (to the extent any UM functions are delegated) and the extent to which the respondent describes how that information will be used to enhance care coordination services and to ensure there are no delays in authorization or gaps in care

**CRITERION 2:** The extent to which the respondent uses strategies to reduce administrative burdens for the provider (e.g., software capabilities) in requesting authorization and its approach is streamlined with little to no redundancies between and across departments which could contribute to delayed service authorizations

Aetna's utilization management business application provides the infrastructure for utilization management and claims. Utilization Management staff uses this system for all physical and behavioral health care authorizations, to verify enrollee enrollment and eligibility, to verify provider status for participating and non-participating providers, and to view claims activity. The system facilitates care coordination by enabling our interdisciplinary care team and other care supports to view the authorizations and claims for enrollees through complete care episodes. The system streamlines care transitions and helps enrollees experience positive health outcomes.

### **Utilization Technology System**

The information entered by the provider into the portal is seamlessly integrated into the utilization management business application for processing. Aetna's interdepartmental staff, including Utilization Management, Care Management, community health workers, Enrollee Services, delegated vendors, and our 24/7 Nurse line has varying levels of access to information, ensuring no redundancies between and across departments, which could contribute to delayed service authorizations. Care managers can view enrollee progress in the utilization

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

management business application to identify and address gaps in care. The staff with access to the system and the level of access follows:

- Medical directors and chief medical officer: Enrollee Utilization Management files in the utilization management business application and care management files in the care management system to complete case rounds, document utilization management determinations, and monitor utilization trends
- Utilization Management clinical and non-clinical staff: Enrollment information to create authorizations, reference claims information, and reference prior authorization activities completed by delegated vendors; provider participation status and contact information; viewing care management information in the care management system; and storing census tool information
- Care managers: Enrollment information to create and conduct assessments, view authorizations, and contact information for enrollees and providers
- Care Management associates: Enrollment information; accessing information on enrollees we have been unable to reach; viewing authorizations; contact information for enrollees and providers
- Enrollee Services: Enrollee authorization and enrollment administrative data to handle information requests; claims information, call center notes
- After-Hours Help line: Enrollee authorization and enrollment administrative data to handle information requests; call center notes
- 24-Hour Nurse line: Enrollment information; authorizations; provider services notes; inpatient utilization; and emergency department utilization
- Provider Services: Enrollee information to determine gaps in care; conducting investigations to address enrollee concerns related to prior authorizations and claims

Using the utilization management business application technology system and its associated tools, any interdisciplinary care team member can view important enrollee information, including prior authorization activity and claims. In addition, interdisciplinary care team members can access our care management system, which allows them to view care plans, health-risk assessments, and other important information.

This technology enables care managers to develop an holistic enrollee picture; create an integrated care plan to meet the enrollee's needs, goals, and desires; follow up to evaluate integrated care plan effectiveness; and make changes when necessary. Remote access to our Utilization Management business application and our care management systems allow our care managers and community health workers to do the following:

- Make face-to-face visits with enrollees in the field
- Answer questions immediately
- Enter real-time enrollee information
- Verify information
- Develop comprehensive care plans
- Take action

### **How Utilization Management Business Application System Facilitates Care Coordination**

Our utilization management business application facilitates and promotes communication among the integrated care team to facilitate enhanced care coordination by doing the following:

## **EXHIBIT A-4-a**

### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- For Providers: Displays actionable data for our provider partners tied to specific, easy-to-follow workflows that support a team approach to care; providers use secure email to communicate with care managers. Through our provider portal, providers can check service authorizations, health reimbursement accounts, enrollee eligibility information, help line notes, and emergency department use. Providers also view their enrollee panels and a list of care gaps for follow up.
- For the Helpline Staff: Enables Enrollee Services staff (available 24/7) to answer enrollee benefit and authorization questions; enables the 24/7 Nurse line staff to verify enrollment, determine the enrollee's care manager, and assist enrollees based on access to their information
- For Enrollees: Links enrollees to the electronic care management system via the free Aetna mobile application for iOS and Android smartphones; enables enrollees to find a provider and view the enrollee handbook, profile, current medications, medication claims history, or ID card; and sends secure communications to the Enrollee Services department
- For the Utilization Management Clinical and Non-Clinical Staff: Enables entry of enrollee information in real time; verification of information; development of prior authorizations; entry of authorization requests from hospital providers and documentation of Utilization Management notes (clinical and non-clinical) and determinations; ability to view the claims, enrollee services, and care management systems, which includes care plans, assessments and care management notes.
- For Care Managers and Care Management Associates: Enables real-time entry of enrollee information, verification of information, development of comprehensive individualized care plans, and assistance to enrollees in completing advance medical directives. It also provides remote connectivity with the electronic care management system when performing assessments, but also provides an offline mode to complete assessments when the Internet is not available; when care managers or community health workers reach an area with connectivity, the information automatically synchronizes with the care management technology system so enrollee information is available to the interdisciplinary care team. Care management staff can view the utilization management business application systems so that they can track the status of prior authorization and claims.

Behavioral health providers may request telephonic authorization for inpatient and higher levels of care. They can also request online authorization for outpatient services using Beacon's eServices online portal. Beacon's innovative online portal, eServices, is a free service with the goal of making clinical, administrative, and claims transactions easy to do. Beacon's eServices provider website serves contracted provider organizations. Once registered, providers receive confidential login and password information to perform various business transactions via Beacon's secure website, improving efficiency, minimizing administrative burden, and increasing providers' time available to enrollees. The eServices tool is accessible 24/7 through Beacon's website.

Providers have indicated on provider satisfaction surveys that they prefer eServices over other competitor tools and find it easy to use. By utilizing eServices, providers can perform the following:

- Submit claims and outpatient services requests (when needed)
- Verify enrollee eligibility

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Confirm outpatient services status
- Check claim status
- View claims performance information
- Access to provider manuals, forms, bulletins, and mailings
- View or print frequently asked questions (FAQs)

### **Claims and Enrollee Services System**

Aetna's claims and customer service system handles all Aetna Medicaid transactions for 3 million enrollees nationally and processes approximately 49 million claims annually. This system includes leading-edge virtualization technology that enables us to scale our systems horizontally and vertically to meet nearly any claims capacity.

The configuration of our core application servers provides redundancy and scalability to meet future growth. We monitor these servers constantly. If we observe that server utilization is becoming excessive, we add servers to the cluster to increase CPU/RAM and disk capacity. This advanced virtualization technology enables the system to match quickly any escalation in demand while maintaining uptime and performance.

Our production systems exchange data to form a fully integrated and highly configurable information system. Interfaces provide and accept data feeds between our central claims, eligibility, enrollment, and data processing system, as well as surrounding production systems. We use automated batch transfers to update data elements across the production systems at regular intervals. In some instances, operators can run on-demand jobs to update system data. Timely, accurate, and complete data submission plays a critical role in the ability of the Agency to review continuously health care utilization, analyze expenditures, and monitor service delivery performance.

### **EXPERIENCE MEETING TIMELINESS STANDARDS**

**CRITERION 3:** The extent to which the respondent has demonstrated experience with meeting timeliness standards for service authorization requests

Aetna's UM department runs timeliness reports daily with monthly and quarterly summary reports. We are committed to making prior authorization decisions timely, using the strictest or shortest timeframes to assure compliance with all requirements. Timeliness reports are run throughout the day to determine which authorization requests are urgent and must be worked immediately and which standard requests have been in the work queue the longest. This allows us to monitor our Utilization Management program's compliance with the turnaround time requirements in our contract with the Agency (7 calendar days for standard prior authorizations and 48 hours for urgent prior authorizations), and to provide the appropriate services to enrollees when needed.

Compliance with the production and distribution of NABD letters whenever an adverse determination is completed by the medical director is also monitored. This enables us to prioritize UM staff members' workloads and to ensure the compliance of our UM processes, which has benefits for our enrollees' health outcomes. We report on our utilization management timeliness each month through the monthly operating report, which is distributed to health plan

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

leadership and on a quarterly basis to our Quality Management/Utilization Management Committee.

Aetna places great importance on responding to provider authorization requests in a timely and efficient manner. Each month, the chief medical officer and vice president of clinical health services analyze utilization data, evaluate plan performance, and identify variances in the standard of care. All UM staff and their supervisors can review the UM operational report dashboard to monitor workload timeliness.

The prior authorization monitoring includes, but is not limited to these items:

- Volume of requests received by telephone, fax, and portal, respectively
- Service level
- Timeliness of decisions and notifications
- Process performance rates for the following, using established standards:
  - Telephone abandonment rate: under 5%
  - Average telephone answer time: within 30 seconds
- Percentage of prior authorization requests approved
- Trend analysis of prior authorization requests approved
- Percentage of prior authorization requests denied
- Trend analysis of prior authorization requests denied
- Consistency in the use of criteria in the decision-making process among utilization management staff measured by an annual inter-rater reliability audit
- Consistency in documentation and clinical decision making measured by department file audits
- Established methodologies used to measure performance-comparing data against benchmarks or goals and historical information; recommendations for action planning when variances are identified

At a minimum, the chief medical officer presents utilization reports to the QM/UM committee. Our Utilization Management Authorization Dashboard provides turnaround time reporting compliance for all lines of business. It compares plan performance with contractual requirements for Florida:

- Average turnaround time for standard authorizations not to exceed 7 calendar days
- Average turnaround time for expedited authorizations not to exceed 2 business days
- 95% of all standard authorizations within 14 days
- 95% of all expedited authorizations within 3 business days

Our dashboard focuses on average turnaround times and timeliness of determinations. Review types include initial, subsequent, urgent, and non-urgent; concurrent (hospital); prior authorization; and retrospective review. This information is used by the Medical Management staff to monitor performance throughout the month. The staff can obtain enrollee-specific information through the dashboard, which allows us to monitor at a very granular level and includes the enrollee identifier, status (approved/denied), when the request was received, review type, when the request was completed, and number of days.

Results Achieved: For the period from August 1, 2017 through August 31, 2017, the turnaround time compliance rate for LTC was 97% for non-urgent prior authorizations and 100% for post-

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

service. There were no urgent requests. For MMA, concurrent (hospital) review turnaround time compliance was at 95%. Hospital requests are always categorized as urgent, and we use a 24-hour turnaround time for hospital requests. Post service hospital review rate was 100% compliant. Prior authorization non-urgent compliance rate was 99% and urgent was 96%. Post service authorization review compliance was 100%.

The average turnaround time for LTC was 2.28 calendar days (non-urgent). For MMA, the average turnaround time for non-urgent was 2.10 and 1.46 days for urgent. Our turnaround times for all lines of business comply with average turnaround requirements.

The authorization inventory monitoring detail report allows the chief medical officer and the UM supervisory staff to track the turnaround time of individual authorization requests. The Utilization Management staff is responsible to provide feedback to the chief medical officer on the timeliness of our utilization management functions and this is reported to the QM/UM Committee. The committee approves action plans including adjustments to the Quality Assurance and Performance Improvement program.

Beacon reported the following 2016 results related to timeliness of authorization decisions: 99.6% for urgent prior authorizations; 99.08% for non-urgent prior authorizations; 99.8% for urgent concurrent reviews; and 100% compliance for post service authorization reviews.

### **Utilization/Performance Improvement Indicators**

Aetna monitors the use of clinical resources and services using utilization and performance improvement indicators. These indicators are established internally to reflect regulatory or business requirements. The indicators we use may include HEDIS or other comparable indicators. We base utilization indicators on utilization data and information, such as trending reports and data sets showing over- or under-utilization of resources or identifying specific diseases or large populations with a specific disease.

Aetna regularly monitors the following performance improvement indicators to assess compliance with established performance standards:

- Timeliness of utilization decisions and notification to practitioners/providers and enrollees
- Accuracy with which utilization information is documented
- Timeliness of referrals to maintain continuity of enrollee care (e.g., for post-discharge services) to obtain assistance in coordinating services (e.g., to care management), or to follow up on potential quality-of-care concerns (e.g., quality/utilization/risk management referrals)
- Utilization of services
- Quarterly summary of results of utilization/performance improvement monitoring to identify utilization and performance trends and reported to the QM/UM Management Committee and the Quality Management Oversight Committee

We evaluate the results of utilization/performance improvement monitoring to identify utilization, and we report performance trends to appropriate medical committees for recommendation. Additionally, utilization data and information may be reported to practitioners/providers. We

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

include utilization results as components of physician profiles and review them during formal quality management processes such as credentialing/re-credentialing.

For example, based on a review of claims paid through July 2017, we found the following improvements in overall inpatient management utilization for all populations from May 2016 to April 2017:

- Inpatient per-member-per-month decreased spend by 15.97% despite an average increase in risk scores of 5.4%
- Cost per admission decreased by 7.08% across all lines of business
- Bed days per thousand decreased by 13.83%
- Admission per thousand decreased by 21.52%
- Observation conversions of one- to two-day inpatient stays have steadily increased, resulting in an average savings of \$1,500 (or 40%) per observation stay

### **APPROACH TO EDUCATING ENROLLEES AND PROVIDERS**

**CRITERION 4:** The adequacy of the respondent's education and training plan providers on the service authorization processes

Aetna provides education to both enrollees and providers about the service authorization process and we provide our education and training approach that follows.

#### **Educating Enrollees**

Aetna is committed to making the experience of our enrollees a positive one. We work to educate enrollees about our utilization management processes and authorization requirements through several methods. The enrollee handbook describes the authorization request process and how it benefits enrollees. Enrollee Services staff members are trained on how to answer enrollee questions about services and treatments for which authorizations are required. The enrollee website has instructions on what enrollees need to do to simplify the authorization process and on whom to call (the Enrollee Services department). If an enrollee receives an adverse determination, the letter includes instructions on how to file an appeal and request a State Fair Hearing.

Aetna excels at integrating medical health, behavioral health, and community-based services to support enrollees. We coordinate and integrate encounter data, risk assessment, wellness programs, care coordination, care management, disease management, provider support, and enrollee education into a comprehensive managed care program that delivers results. We understand the importance of coordinating services with essential stakeholders in serving the Medicaid population. Educating enrollees and providers is an important component of our approach, and we discuss challenges, changes, and issues with our enrollees at the quarterly Enrollee Advisory Council meetings.

#### **Educating Providers**

To ensure providers can navigate our utilization management processes easily, our Provider Services team, Prior Authorization staff, and Outreach team work in a closely aligned manner to help providers comply with authorization requirements as simply and efficiently as possible.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

These staff members and processes are overseen by our chief medical officer, vice president of clinical health services, provider services director, and pharmacy director.

Our Provider Services team works diligently to educate providers, including onsite visits as needed. Our outreach team regularly attends Joint Operating Committee meetings with large medical groups and hospitals and with any providers that request support for their efforts. Working collaboratively, these two teams communicate prior authorization requirements to practitioners and providers using a variety of tools.

Clinical and non-clinical utilization management staff members are available to assist providers who have questions regarding the authorization process. They are a reliable resource for the provider staff on the most current prior authorization requirements and processes. The UM staff will reach out to the Provider Services department if they identify a provider or office staff that is experiencing challenges with authorization requirements or systems. Provider Services staff will arrange for additional training and may complete a site visit. In fact, we have provider offices that call and ask for Utilization Management staff by name as we have developed solid and supportive working relationship with our providers.

Aetna communicates prior authorization requirements and procedures to practitioners and providers through the provider handbook, on the provider website and portal, in provider newsletter articles, and via practitioner and provider contracts. We make these resources available to network practitioners and providers upon request and through our quarterly Community Action Forum meetings. Changes to our prior authorization requirements are communicated to the provider offices by fax blast.

Beacon's Provider Services staff conducts ongoing provider education. The topics covered include:

- Clinical and utilization review procedures, including level of care criteria, coordination of care, and communication with primary care providers
- Covered CPT codes
- Access and availability standards
- Fraud, waste, and abuse
- Adverse incident reporting
- Billing procedures
- Electronic data interchange (EDI) capabilities
- Claim disputes
- PaySpan (Electronic Funds Transfer, printing of explanation of benefits)
- eServices, Beacon's web-based portal
- Contacts within Beacon for providers, for clinical services, claims, credentialing, provider services, and the Contracts department

### **TRANSPARENCY IN SERVICE AUTHORIZATION PROCESS**

**CRITERION 5:** The extent to which the respondent ensures transparency in service authorization processes (e.g., makes available all utilization management protocols and criteria in an accessible location for service providers)

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Our service authorization process is fully transparent to our providers, enrollees, and stakeholders. We are committed to providing education and coaching regarding the criteria and process to avoid denials that could lead to delays in care. Aetna communicates prior authorization requirements through the enrollee and provider manuals, on the Website and through the portals, in newsletter articles, via practitioner and provider contracts, and through our quarterly Community Action Forums. Changes to our prior authorization requirements are communicated promptly to our providers utilizing fax blasts.

To ensure providers can easily navigate our UM processes, our Provider Services team, Prior Authorization staff, and outreach team align closely to help providers comply with authorization requirements as simply and efficiently as possible. Providers can check the authorization criteria for and the real time status of an authorization request in our provider Web portal throughout the authorization process, which saves the provider making phone calls to Aetna. Medical directors are also available to discuss review determinations with requesting physicians or other ordering providers through peer-to-peer consultations.

We educate enrollees about our utilization management processes and authorization requirements through several methods. The authorization request process and how it benefits enrollee health is described in the enrollee handbook. Enrollee Services staff is trained on how to answer enrollee questions about services and treatments for which authorizations are required. The enrollee Website has instructions on what enrollees need to do to make the authorization process easy and on whom to call (the Enrollee Services department). If an enrollee receives an adverse determination, we send the enrollee an NABD letter that includes details about the decision, including criteria written in plain language and instructions on how to file an appeal and request a State Fair Hearing.

### **SPECIAL SERVICE REQUESTS CONSISTENT WITH EPSDT**

**CRITERION 6:** The extent to which the workflow describing the respondent's process for handling special service requests is consistent with Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements

The EPSDT program ensures that children and youth under age 21 receive a comprehensive array of preventive, diagnostic, and treatment services. Our EPSDT program promotes collaboration with enrollees, providers, state agencies, community organizations, and other stakeholders to achieve this goal for our enrollees. EPSDT is key to ensuring children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services.

An EPSDT screening may identify a need for health care services that are not covered by Florida Medicaid or that exceed Medicaid limitations. Federal law requires that these services be reimbursed if they are medically necessary. For a service to be covered by Aetna as a special service under EPSDT, the condition must meet the following criteria:

- The services shall be to correct or ameliorate defects and physical and mental illnesses and conditions
- The services to be provided shall be medical or remedial in nature
- The services shall be individualized and consistent with the child's medical needs

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- The services shall not be requested primarily for the convenience of the child, family, physician, or another provider of services
- The services shall not be unsafe or experimental
- If alternative medically accepted modes of treatment exist, the services shall be the most cost-effective and appropriate service for the child

Authorization is required for special services and includes services that are not covered benefits, exceed Medicaid covered allowable limits, or are to be provided by an out-of-network provider. To consider special services, our providers/practitioners are asked to provide the primary diagnosis and significant associated diagnoses; prognosis; date of onset of the illness or condition and etiology, if known; and clinical significance or functional impairment caused by the illness or condition. They also are asked to provide specific types of services to be rendered with a physician's prescription where applicable; therapeutic goals to be achieved and anticipated time for achievement of goals; the extent to which health care services have been previously provided to address the defect, illness, or condition; and any other documentation necessary to justify the medical necessity of the requested service.

Once the medical director has reviewed and authorized the EPSDT special services, the UM staff will complete the authorization and notify the provider. Authorizations will be processed in accordance with the turnaround time requirements in our contract with the Agency (7 calendar days for standard prior authorizations and 48 hours for urgent prior authorizations). The care manager will be notified so that he or she can assist the enrollee and responsible party with arranging for the services. The Utilization Management staff enters the information into the Utilization Management business application so that the provider can be paid promptly and, if a single case agreement is necessary, the Utilization Management staff will coordinate with the network team.

For example, most vision, hearing, and dental services are covered under the Medicaid MMA program. If a child exceeds the eyeglass limitation but needs an additional pair of glasses, the extra glasses may be billed for a replacement pair, then a third pair of eyeglasses may be billed to and reimbursed by the EPSDT special services, if medically necessary.

Beacon abides by the Medicaid contract and federal law that ensures that any mental health services for children under the age of 21 cannot be denied due to a non-covered benefit. Beacon has developed a process for authorization of any medically necessary service to enrollees under 21, in accordance with Section 1905(a) of the Social Security Act, when the service is not listed in the service-specific Medicaid Coverage and Limitations Handbook, Florida Medicaid Coverage Policy, or the associated Florida Medicaid fee schedule; or is not a covered service of the plan; or the amount, frequency, or duration of the service exceeds the limitations specified in the service-specific handbook or the corresponding fee schedule. Uncovered services require a prior authorization. To obtain prior authorization for any uncovered mental health services, the facility/provider calls Beacon's Utilization Management team to request prior authorization. Beacon's Utilization Management clinician uses its National Medical Necessity Criteria or ASAM criteria for substance use disorders to determine if the enrollee meets criteria for the requested uncovered service.

Working closely and collaboratively with our community partners and with providers of special services helps to ensure our enrollees have access to all needed services. We utilize our dynamic reference tool for a directory of all available community resource to assist enrollees

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

and providers in securing community based services. We first try to identify community-based providers to support our enrollees and support care coordination through our CareUnify<sup>SM</sup> technology.

### **CareUnify**

Our primary strategy to coordinate care with providers across the continuum relies on the underpinning technology of CareUnify. This innovative tool integrates data from multiple sources and is available to all participants in the enrollee's care to help support coordination with our provider and community agency partners. It is uniquely designed to share and aggregate actionable data across multiple systems and organizations digitally to create one enrollee profile or single source of truth that the interdisciplinary team can rely upon to make point-of-care decisions or engage in broader population health activities. Creating a single common platform and data-viewing experience for the interdisciplinary team promotes effective and efficient care coordination that includes a Web-based enrollee engagement experience.

By granting our provider network and community partners access to CareUnify, we promote care continuity, prevent duplication of services, and provide more efficient care coordination, which is particularly effective for individuals receiving services through the fee-for-service delivery system or prepaid dental plans.

Please refer Figure SRC 19-1: Detailed Workflow in Attachment SRC 19 for a detailed workflow of the process.

### **Evaluation Criteria:**

1. The extent to which the respondent proposes the use of interoperable systems that will seamlessly integrate information from providers to the respondent and its subcontractors (to the extent any UM functions are delegated) and the extent to which the respondent describes how that information will be used to enhance care coordination services and to ensure there are no delays in authorization or gaps in care.
2. The extent to which the respondent uses strategies to reduce administrative burdens for the provider (e.g., software capabilities) in requesting authorization and its approach is streamlined with little to no redundancies between and across departments which could contribute to delayed service authorizations.
3. The extent to which the respondent has demonstrated experience with meeting timeliness standards for service authorization requests.
4. The adequacy of the respondent's education and training plan providers on the service authorization processes.
5. The extent to which the respondent ensures transparency in service authorization processes (e.g., makes available all utilization management protocols and criteria in an accessible location for service providers).

**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

6. The extent to which the workflow describing the respondent's process for handling "special service" requests is consistent with Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements.

**Score:** This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

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AETNA BETTER HEALTH® OF FLORIDA

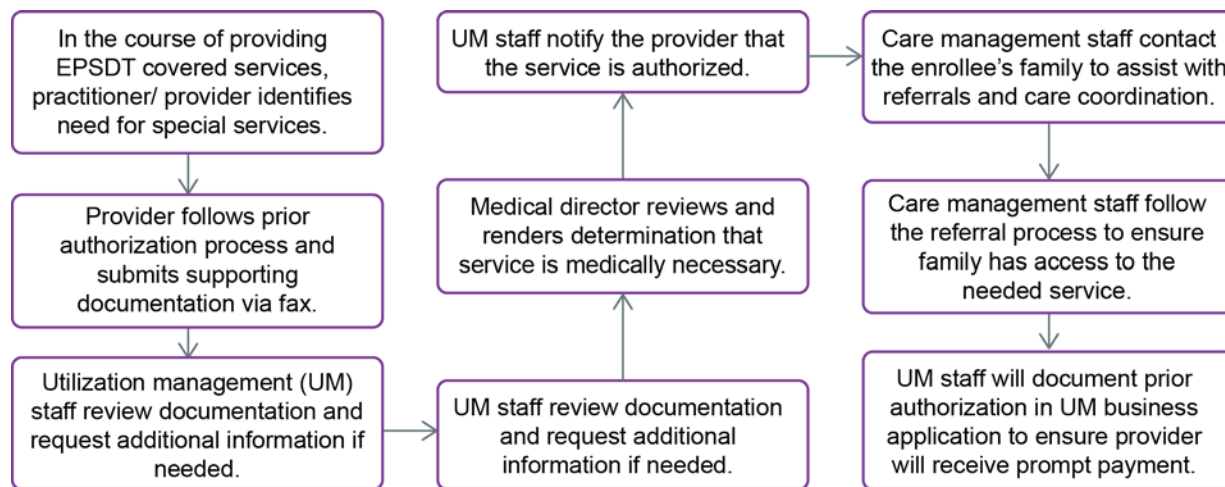
## **Attachment SRC# 19**



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**SRC# 19: Figure SRC 19-1: Special Service Request Workflow for EPSDT Enrollees**



69.117

**Figure SRC 19-1: Special Service Request Workflow**

*Special service requests are accepted, approved, and delivered to ensure EPSDT enrollees receive all necessary and appropriate services.*



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## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **SRC# 20 – Care Coordination (Statewide):**

The respondent shall describe its approach for identifying, assessing, and implementing interventions for enrollees that present with the following:

- Complex medical and/or behavioral health needs;
- High service utilization;
- Intensive health care needs; and
- Consistently accessing services at the highest level of care.

The respondent's approach shall include:

- a. A description of the algorithm used to identify and stratify eligible enrollees by severity and risk level;
- b. A description of minimum contact frequencies and contact type for each severity and/or risk level;
- c. A description of the maximum caseloads for each case manager (ratio requirements) and support staff;
- d. A description of evidence-based guidelines utilized in the care coordination approach, including interventions deployed to improve enrollee engagement and improve treatment adherence; and
- e. A description of performance metrics used to evaluate the efficacy of the care coordination, including cost-savings, reduction in the use of higher cost services, etc.

#### **Response:**

Our holistic, person-centered integrated care management approach is informed by evaluation and biopsychosocial assessments, and relies on collaborative care planning and coordination to meet an enrollee's comprehensive care needs. This multidisciplinary approach is consistent with our objective to promote high-quality, cost-effective outcomes.

Beginning with the individual enrollee, our goal is to understand his or her preferences and goals, physical and behavioral health care needs, family and community supports, strengths, and any barriers impacting his or her ability to access appropriate care—all with the overarching objective of optimizing the enrollee's level of functioning and enabling him or her to maintain or achieve an optimal level of independence.

#### **ALGORITHM, RISK STRATIFICATION, AND PREDICTIVE MODELING**

**CRITERION 1:** The extent to which the respondent's algorithm and risk stratification approach is well-defined and incorporates data elements other than diagnosis

**CRITERION 3:** The extent to which the respondent's approach includes the use of predictive modeling

## **EXHIBIT A-4-a**

### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Our fully integrated care management model provides the overarching strategy and framework for our care coordination process to ensure our holistic, person-centered approach is both achieved and maximized.

Two key aspects of this overarching framework are (1) integrated care team support and (2) Consolidated Outreach and Risk Evaluation™ (CORE) identification and stratification.

#### **Integrated Care Team**

Aetna's integrated care management approach identifies our most biopsychosocially complex and vulnerable enrollees with whom we have an opportunity to make a significant difference. These enrollees are engaged in care management programs to remove or lessen barriers that limit their ability to manage their own health and well-being. We educate them about disease management, enhance their engagement, and help them remain in the least restrictive and most integrated environment based on their preferences, needs, safety, burden of illness, and availability of family or other supports. This is conducted in a manner consistent with each individual's personal and cultural values, beliefs, and preferences, and with the goal of helping individuals exhibit resiliency, move toward recovery, and reach their self-defined level of optimal functioning.

#### **Identification and Stratification**

Aetna uses several methods other than diagnoses to identify and stratify enrollees, including our CORE predictive modeling tool, self-reporting through our health risk assessment (HRA), near real-time pharmacy data to identify members on certain drugs such as HIV, hepatitis-C, and prenatal vitamins, and surveillance or traditional case finding through referrals, concurrent review, real-time high utilization, etc. Enrollees with a high medical risk are identified first using our proprietary, evidence-based CORE application to analyze claims data. Predictive modeling uses analytic methods that identify individuals who are at risk for high cost or high utilization in the future. The scores are generated from Medicaid-specific, proprietary algorithms that we have developed internally based on data from our Medicaid populations, as well as our clinical and informatics expertise. Inputs to the algorithms include demographics, medical claims, and pharmacy claims data. The resulting inpatient and ED models provide enrollee-specific scores indicating the likelihood that the enrollee will visit the ED or experience an inpatient admission in the next 12 months. We run the model for our entire population monthly; the results are reviewed by the appropriate teams for enrollee contact and intervention opportunities.

CORE predictive modeling identifies enrollees who are candidates for intensive and supportive care management and enrollees who are candidates for high- and low-risk chronic condition management. For example, our predictive modeling shows that our highest-risk enrollees have multiple physical health conditions - between 70% to 90% had comorbid behavioral health conditions, making these enrollees appropriate for intensive case management. The CORE tool predicts the likelihood of integrated care management making an impact and ranks all plan enrollees from highest to lowest risk. Our CORE model places enrollees within risk groups based on anticipated use over the next 12 months: high-risk for an ED visit, medium or high-risk for an inpatient admission, or high-risk for high costs and poor outcomes. CORE risk stratification helps to guide our outreach to enrollees in the highest risk categories.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

CORE uses pharmacy claims to identify many risks related to non-adherence and other medication management issues that care coordination can influence. Approximately 40% of an enrollee's risk assessment is derived from pharmacy utilization and claims. The risks identified include:

- The complexity and number of medications in an enrollee's drug therapy, which is a major driver of inpatient admission risk
- An enrollee's adherence to critical maintenance medications to treat conditions like asthma, diabetes, heart failure, or a behavioral health conditions, which is a strong indicator for ED use risk
- Potential overlapping therapy or drug contraindications that may impact patient safety
- An enrollee who may be using multiple pharmacies or prescribers to obtain behavioral health-related or controlled substances
- Higher enrollee costs compared to the overall population (using the Medicaid Pharmacy risk adjustment methodology)

Enrollees are further stratified into levels for care management and disease management based on the information we gather from CORE and outreach activities that identify their biopsychosocial complexity and the intensity of their needs. Stratification is based on the enrollee's self-reported conditions and health care utilization, such as ED encounters, hospital utilization, or chronic conditions. The predictive modeling tool identifies enrollees likely to be future high-utilizers based on claims and diagnostic data. These tools determine the enrollee's potential risk level and predict that care management interventions can effectively improve the enrollee's outcome.

### **Stratification Levels**

Initial stratification through CORE enables us to focus HRA outreach to enrollees with the greatest health care need who may most benefit from our care coordination services. We run our CORE analysis monthly and perform daily reviews of prior authorization requests, census reports, and other information to determine changes in enrollee status.

Our CORE analysis stratifies enrollees into three levels; the level of care is finalized only after enrollee engagement and confirmation of needs:

- Level 1: Intensive
  - Contact Frequency: Contact frequency is initially driven by circumstances of each enrollee's life and can be as often as several times per week; as an enrollee moves forward in his or her recovery, the frequency slows but occurs at least monthly
  - Identified Risk: Enrollees with high risk and emerging high risk
  - Examples of Stratified Enrollees for Intensive Care Management:
    - o Individuals with multiple complex chronic conditions, co-morbidities or co-occurring conditions
    - o Individuals with three or more ED visits
    - o Pregnant women with a history of or currently using substances
    - o Pregnant women current or historical high-risk pregnancy
    - o Infants with neo-natal abstinence syndrome
    - o Children and adults with abuse and/or trauma histories

## EXHIBIT A-4-a

### GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

- o Adults and adolescents who are homeless or have a history of residential instability (four or more residences over the past year)
- o Adult with serious mental illness and children with serious emotional disturbances
- o Transplant candidates
- o Individuals with HIV/AIDS, cancer, chronic renal failure, and other chronic, complex conditions
- Examples of General Enrollee Conditions:
  - o Complex physical health and durable medical equipment (DME) needs
  - o Multiple treatment providers
  - o Physical and behavioral health co-morbidities
  - o Opioid use or other co-occurring substance use disorder treatment and follow-up for naloxone training
  - o Readmission and ambulatory sensitive admission and ED diversion
  - o Unstable chronic condition management
  - o Addressing social determinants of health
  - o Gaps in care resolution
  - o Treatment adherence
  - o Referrals to specialty
- Level 2: Supportive:
  - Contact Frequency: No less than quarterly; more often as needed
  - Identified Risk: At-risk enrollees with HRA score above a specific threshold (score of 55) are enrolled in a care management program
  - Examples of Stratified Enrollees
    - o Individuals with poorly treated chronic conditions
    - o Children and adolescents enrolled in the foster care system
    - o Individuals with mental health conditions requiring care management
    - o Children under age 21 requiring foster care management
  - Examples of General Enrollee Needs:
    - o Chronic condition management
    - o Naloxone training
    - o Collaboration with care management agencies and community service boards for single care plan development
    - o Collaboration with system stakeholders
    - o Information sharing between providers and system stakeholder agencies
    - o Referrals to internal integrated care management programs
- Level 3: Population Health
  - HRA indicating low risk of complex health issues and not identified as requiring intensive or supportive
  - Ongoing surveillance for status change takes place
  - Enrollee benefits from established wellness initiatives that target prevention, promote health literacy, and encourage healthy behaviors
  - Enrollees receive semi-annual health information and reminders

We use various outreach strategies to complete the initial HRA and obtain additional information when our initial CORE analysis indicates areas of high risk for health concerns or indicates a need for assistance with the HRA. Such occurrences include identification enrollees have needs related to behavioral health conditions; hearing, visual, or speech impediments; and multiple, complex physical and behavioral health conditions. For enrollees other than the cohorts

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

described, our care managers contact enrollees via phone and mail to complete a 13-item HRA. We use an interactive voice response system to complete the HRA. Enrollees can also ask for a callback by a care manager. We mail some HRAs and enclose a stamped, self-addressed envelope for return. After five outreach attempts for our intensive population and three attempts for supportive population, we move the enrollee to our hard-to-reach list and deploy specific strategies for such enrollees that are described in more detail later in this response.

As we conduct the initial assessment, we begin to develop the enrollee's individual care plan, including enrollee-identified and prioritized goals, activities, and information to foster the enrollee's ability to make informed decisions regarding his or her care, navigate the delivery system, and follow treatment plans. The final care plan will address identified barriers that may inhibit the enrollee from reaching his or her goals or adhering to the care plan. The care plan provides solutions to help reduce or eliminate those barriers.

We build and foster trusting relationships through an in-depth understanding of the enrollee and his or her needs. The care manager uses motivational interviewing techniques, in combination with the Patient Activation Measure tool (PAM), to establish trust and to engage the enrollee. Care managers use the PAM tool to assess an enrollee's level of activation, motivation, and likelihood of establishing and achieving goals (e.g., personal, health-related, etc.). This evidence-based tool generates a score based on the enrollee's responses. Based on his or her activation score, the PAM tool recommends specific approaches that align with the enrollee's activation level.

An understanding of an enrollee's personal story and background, individual needs, preferences, and values is essential to crafting a care plan with meaningful objectives meant to lead to healthy behavior change. The care manager provides information and education as the enrollee needs it, and does so in a culturally sensitive manner that considers the enrollee's health literacy. Our goal is to promote improved health literacy and encourage self-management of the enrollee's health conditions. Individual care plans also include the prioritization of goals that consider enrollee, family, and caregiver needs, along with goals, preferences, culture, abilities, and the desired level of involvement in the care plan. Providers and other support services are also encouraged to participate in care planning.

### **Interventions Across all Levels of Care**

For our most complex enrollees, intensive care management interventions may include disease management information and education, as appropriate, as well as assistance with accessing care across the continuum, remaining in active intensive care management for as long as necessary to stabilize or impact care outcomes. Enrollees who are less complex, but who are still experiencing difficulty understanding or stabilizing their conditions, also receive disease management and care plan interventions to stabilize them through the supportive level of care management. The care manager, in collaboration with the enrollee and his or her care team, addresses any conditions that are contributing to poor health, chronic or otherwise. These activities do not vary in type between the intensive and supportive levels, as they each receive assessment, education, targeted interventions, care coordination and care plans—all of which focus on their unique needs. The difference is in the intensity, complexity, and frequency of the interventions, enrollee contacts, and care team meetings.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

We complete reassessments of enrollees in Level 1 monthly. For enrollees receiving Level 2 care management reassessments, we perform reassessments quarterly in collaboration with the care management entity, or whenever the enrollee has a change in status. Routine, ongoing CORE analysis provides reports that flag status changes. Inpatient alerts in our care management technology system notify care management of hospitalizations; reassessments can be triggered by these changes and alerts.

### **Identifying Root Causes of Poor Health and Engagement**

The next step is the critical thinking required to identify the root cause(s) of poor health or poor engagement with health care for that enrollee. Any psychosocial issues and cognitive limitations that impact enrollees are incorporated into their individualized care plans, as are the cultural practices and beliefs that are most important to them. Barriers to improving health and root causes of poor health outcomes are specifically addressed to help both the care manager and the enrollee better understand what has prevented full engagement with a suggested clinical treatment or plan of care. Once these issues are identified, by the enrollee and informed by the care team, truly individualized and collaborative care planning begins.

### **DATA SOURCES INCORPORATED IN RISK STRATIFICATION PROCESS**

**CRITERION 2:** The extent to which the respondent describes data sources that are incorporated into the risk stratification process that is used for new enrollees

Our fully integrated care management model is designed specifically to manage all enrollee needs, particularly those enrollees with complex needs. Aetna uses analytic methods to identify our most biopsychosocially complex and vulnerable enrollees for whom we have an opportunity to make a significant difference. As previously noted, our CORE tool stratifies enrollees into three risk levels: intensive, supportive, and population health. We also identify complex enrollees using our HRA; comprehensive and specialty assessments; enrollment data indicators; as well as surveillance techniques that include utilization management processes, grievance and appeals activities, and claims reviews and through enrollee-direct and provider referrals, among others. In all instances, we make every effort to complete the HRA, which can independently identify enrollees at high risk based on their total score. It can also identify enrollees who require a more detailed screening. For example, if an enrollee endorses questions on the HRA related to mental health or substance use, he or she receives screens that are more detailed for both. This takes into account the large proportion of enrollees with co-occurring disorders and mitigates the risk that one or the other might be missed.

Aetna incorporates evidence-based practices and national chronic care guidelines to create clinical algorithms that assist our care managers in conducting the most appropriate assessments. CareUnify<sup>SM</sup>, our proprietary care management system is used to communicate with care team members - both in real time and virtually. The interdisciplinary care team for each enrollee uses the information obtained from our CORE analytics, surveillance techniques, the HRA, enrollment and other data, the comprehensive and specialty assessments, evidence-based practices and guidelines, and provider data (laboratory results and prescribed medications) to design the enrollee's individual plan of care, which is tailored to meet his or her specific needs. Because changes in social status, housing, employment, and access to nutritional food are dynamic and may place an enrollee at increasing risk, we continuously monitor our enrollee populations and contact any new enrollees with emerging risks.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

CORE uses data from multiple sources to identify and monitor enrollees with high utilization or emerging high-risk factors, including:

- Care coordination claims data
- 834 enrollment file—encounter data
- Health risk screenings and assessments
- Enrollee, caregiver, physician, pharmacy, and provider referrals
- Concurrent review and prior authorization referrals
- Medical, behavioral health, and pharmaceutical claims utilization reports
- Inpatient admission, readmissions, and avoidable admission reports
- Enrollee utilization management reports
- ED high utilization and avoidable visit reports
- Enrollees with utilization totaling over \$25,000 annually

Information from enrollees, providers, family members, hospital discharge planners, caregivers, pharmacy, and others is incorporated into our predictive modeling processes to address any identified care management needs.

Our care management technology system (CMTS) is a Web-based tool that supports our care management monitoring and surveillance efforts proactively, addressing gaps in care and supporting enrollee health, which results in improved outcomes for our enrollees. It provides the infrastructure for all care coordination efforts and the flexibility to integrate data needs into the solution. Furthermore, CMTS serves as a fully integrated information system for physical and behavioral health coordination and enables our care managers and other care supports to follow enrollees through episodes of care and streamline care transitions. Our CMTS also provides access for providers, care managers, community health workers, enrollee services staff, and nurse line staff, and enables any integrated care team member to access relevant information, including utilization reports, care plans, HRAs, and other assessments to meet enrollee needs.

Our CMTS is a complete suite of functional, physical, and behavioral health assessments, care planning tools, and monitoring functions, including those specific to housing, employment, wellness needs. Our care managers collaborate with the enrollee to create an individualized care plan that meets his or her specific needs, goals, and preferences; follow-up to evaluate the plan's effectiveness; and make changes when necessary. Through remote access to CMTS, our care managers and community health workers can make face-to-face visits with enrollees in the field, immediately answer questions, enter real-time enrollee information, verify information, develop comprehensive care plans, and take actions.

CMTS includes CORE to identify enrollees who will benefit most from our integrated care management program. We also use a variety of surveillance strategies and tools to identify whether an enrollee not currently stratified as high-risk requires reassessment for a higher level of care. For example, whenever an Aetna enrollee visits an ED or experiences a health emergency, the system flags his or her as high risk through our built-in monitoring triggers, and CORE generates an alert sent directly to the care manager.

Aetna also assesses social determinants of health by capturing data through multiple mechanisms, including the HRA, condition-specific assessments, existing care plans, gaps-in-care reports, reports through our health care equity (HCE) dashboard, predictive modeling, care coordination claims data, provider feedback, community health workers, community and

## **EXHIBIT A-4-a**

### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

advocate outreach, enrollee surveys, enrollee advocacy committees, and focus groups. Our HCE dashboard tracks utilization and identifies enrollees who may benefit from additional interventions and education. It also provides inpatient and ED usage by gender, age, race, ethnicity, and county. Similarly, providers access real-time admission, discharge, and transfer information for ED, inpatient, and outpatient utilization at the individual enrollee level through our population health platform, CareUnify.

Gathering cross-departmental data on our enrollees can help us determine which populations and communities fall into higher-risk categories. We use the HCE dashboard to identify and monitor populations experiencing or at risk for health disparities. The dashboard pinpoints health plan-specific areas of concern (or hotspots) based on characteristics such as geographic area, race, ethnicity, and health conditions. We gain a better understanding of enrollees' health care needs and can develop specific interventions to address gaps in care or service. As a result, we can implement highly effective targeted care management approaches to address health care disparities. We maximize the strengths of the community and its resources (protective factors) to assist in building a culturally responsive community and individual capacity.

#### **ALIGNMENT OF FREQUENCY AND INTENSITY OF CARE MANAGEMENT SERVICES WITH RISK STRATIFICATION PROCESS**

**CRITERION 4:** The extent to which the frequency and intensity of the care coordination services (i.e., maximum caseload and minimum contact requirements) are aligned with the respondent's risk stratification process and proportional to the clinical and psychosocial needs of the target population – 5 points

Cases are assigned by matching the enrollee's unique needs to the skills and expertise of the care manager (e.g., those experienced in obstetrics or lead-exposed children). Flexible, scalable staffing models enable us to adjust to the State's changing needs. Our corporate medical management division may adjust staffing ratios to accommodate specific local market needs and the needs of specific integrated care management programs. As previously noted, enrollees are stratified by levels based on the intensity of the services offered to the enrollee by our care management staff. Caseloads for each level are dependent upon the activities required to perform at each level, such as the type and number of assessments, the frequency of care plan reviews, and whether or not the enrollee requires face-to-face interaction with his or her care manager. Our medical management team adjusts workloads based on case weights and the level of intensity of the enrollee. This system fosters both employee satisfaction and adequate workloads.

Our caseload ration for each of the levels follows:

- Intensive: 1:41
- Supportive: 1:125
- Population Health: 1:400 (dual enrollees only)

Mixed caseload protocol or case weights are considered for those care managers who have a mixed caseload inclusive of Levels 1, 2, and 3. In cases where care managers carry a combination of Level-1, -2, and -3 cases, we utilize the total case weight as a measure to ensure they maintain a manageable caseload. We always consider specialized enrollee needs

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

when setting enrollee care levels in addition to enrollee geographic location and accessibility of services. Enrollees may move from one care level to another based on the care needs/stratification level so membership acuity is fluid.

Stratification is based on the results of the physical, behavioral, and social assessments, as well as the personal goals of each enrollee. When making assignments, the overall acuity of the caseload for each care manager is considered, the licensure of the care manager is matched to the highest priority issues of the enrollee. For example, an enrollee with behavioral issues will be assigned to a licensed social worker, while enrollees with more complex physical issues will be assigned to a registered nurse—some enrollees will require a team of interdisciplinary care managers. The culture and diversity of both our enrollees and our care manager is also considered, to help assure the best fit between the two.

When appropriate, care managers are assigned to enrollees in specific placement settings (e.g., skilled nursing facilities, home- and community-based services, or specific populations such as children with intellectual or developmental disabilities). This enables providers to interface with fewer care managers and assists care managers in developing a collaborative and responsive working relationship with specific providers. Through the continuum of care, efforts are made to maintain care manager continuity of care. Care managers also develop expertise in managing care in the specific assigned setting or specific populations. Language is also a consideration when assigning care managers. If a new enrollee has a relationship with an external care manager, we will collaborate to maintain the relationship by offering a contract with the provider or developing a single case agreement to formalize this relationship. If the provider chooses not to contract, we will still collaborate with them by inviting the provider to the enrollee's interdisciplinary team, as the enrollee chooses.

The care management population is divided into three enrollee-intensity levels. We base caseloads for each level on the associated activities: for example, assessment types (screenings, comprehensive, and disease management tools), care plan review frequency, and whether the enrollee requires face-to-face interaction with his or her care manager. We also consider geography to make sure adequate time for travel to and from an enrollee visit is included. By deploying a mixed caseload model, care managers are better positioned to be flexible to meet the needs of each enrollee in each geographic area. This model supports a mentoring approach to the education and development of care managers to maximize enrollee satisfaction and outcomes. To help ensure a balanced caseload mix, we apply a case weight to make sure care managers have adequate capacity to meet enrollee needs. This approach fosters both employee satisfaction and appropriate workloads. Every case in levels one or two will have an associated case weight; this weighting enables a mixed caseload approach that facilitates staff satisfaction so no one individual has the most complex cases and it enhances the engagement of enrollees as the care manager has more time to spend with them.

Our electronic care-management dashboard enables the supervisor to make sure case weights are calculated and recorded accurately and assignments are based on the established criteria of enrollee stratification, ZIP code, specialty, and placement setting. This report is helpful to address who has capacity to add new enrollees.

**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**INNOVATIVE STRATEGIES TO ADDRESS HIGHLY RESISTANT OR DIFFICULT TO SERVE POPULATIONS**

**CRITERION 5:** The extent to which the respondent's approach includes innovative strategies for addressing the unique needs of highly resistant or difficult to serve populations

To achieve positive behavior change in all of our enrollees, including those with unique needs that may pose barriers to their ongoing engagement, Aetna employs a number of innovative strategies, including (but not limited to) telemedicine, remote patient monitoring, CareUnify, and innovative regional partnerships across the State.

**Telemedicine**

Telemedicine improves access to specialty providers for enrollees in underserved and rural areas, and those who have mobility or behavioral health issues that make it difficult for them to attend a specialty consultation visit. The availability of telemedicine eliminates access barriers to enable enrollees to obtain the care they require within their local communities. This leads to improved outcomes for enrollees at the highest risk for ED visits, hospitalizations, and more, as identified through our predictive modeling.

We are working with our provider network to identify those who are interested in expanding their capabilities through telemedicine. For example, in rural areas not currently served by specialists such as cardiologists, pulmonologists, endocrinologists, and behavioral health specialists, telemedicine can 'transport' these specialists virtually to enrollees' local communities. An enrollee and his or her local PCP office can easily consult with a specialist using our telemedicine platform. In addition to saving the enrollee a long trip to see the specialist, this also expands the PCP's knowledge in treating his or her patients with the same conditions. In our experience with telemedicine in Florida and other markets, the concept is somewhat new, and many providers are challenged by the initial requirements for infrastructure and financing. However, that our network providers are eager to participate in the new modes of delivery that telemedicine offers.

Recently, Aetna initiated a telemedicine program in collaboration with Jessie Trice Community Health Center, Inc. (Trice Center). Working with [REDACTED] at the Trice Centers in Region 11, Aetna is implementing telemedicine capabilities. The program will deliver a cost-effective solution to Trice Center providers, which is both secure and easy to use. As the providers and centers adopt the telemedicine platform, Aetna will coordinate all training and support with our telehealth vendor to facilitate effective implementation. Additionally, through [REDACTED], Aetna will also contact specialists at the University of Miami. We intend to expand availability to specialty care for Trice Center providers in the areas of dermatology, child psychiatry, and clinical telehealth. We have reached out the telehealth director, [REDACTED], and her colleagues, [REDACTED].

In our Louisiana Medicaid market, telemedicine is growing as an accepted care model, with the number of enrollees seeking telemedicine services doubling this year in. Positive outcomes associated with telemedicine include cost savings of \$260,000 in 2016 and savings already reaching \$280,000 in 2017, respectively. Such savings are largely driven by diverted ED visits. In our follow-up surveys, 95% of individuals noted their virtual care experience was favorable, with 79% reported they would have visited the ED if telemedicine had not been available.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

This approach to using telemedicine and remote patient monitoring is well aligned with AHCA's goals and addresses several areas addressed in the AHCA telemedicine report, particularly scaling the telemedicine infrastructure to improve cost savings and access. In Florida, we are offering a diverse approach that encompasses financial and infrastructure support that has been embraced by our network providers in Florida and other markets.

### **Remote Patient Monitoring**

Aetna offers our remote patient monitoring program for enrollees with specific chronic diseases such as congestive heart failure, diabetes, hypertension, respiratory disorders, and high-risk pregnancy. We use remote monitoring in several states where the technology is helping members monitor their symptoms, therefore reducing avoidable hospitalizations and readmissions by focusing on early detection and intervention. Early outcomes from our pilot program in Michigan include:

- Enrollee appointments to their PCP reduced by 54%
- Enrollee appointments to a physician who is not their PCP reduced by 40%
- The number of emergency department visits reduced by 65%
- The number of inpatient admissions reduced by 37%
- Almost all of the participating enrollees (96%) found the equipment easy to use
- Enrollee confidence in managing their condition after 30 days was 93% and 96% of participating enrollees said the program made them more comfortable caring for themselves at home

For our first phase of implementation, we will provide identified high-risk enrollees with diabetes, hypertension, chronic heart failure (CHF), and high-risk pregnancies with our in-home remote monitoring technology package. We contract with national remote monitoring expert, Care Innovations, a joint venture between GE and Intel. Enrollees in the program receive a remote monitoring bundle and kit iPad mini™ and up to four peripheral devices including a weight scale, pulse oximeter (measures blood oxygen), blood pressure cuff, and glucometer (measures blood sugar). These devices are automatically 4G-enabled with call center and delivery support both to and from an enrollee's home. The unit is designed for a simple set-up, with the iPad personalized for each enrollee, listing their name on the landing page with easy-to-follow instructions and videos on how to use the devices, how and when to contact their provider and care manager, and how to seek emergency help.

The tablet provides educational content on disease management, warning signs of worsening conditions, and enables our care managers to video conference and facetime with enrollees to check in and provide assistance when needed. Assessments, such as our new social determinants assessment can be completed in real time via the tablet. This would allow in near-real time notification if an enrollee has immediate social needs pertaining to food, security or transportation needs or behavioral or medical concern, such as depression. Care managers and the care team can then take action to address these issues as part of the dynamic plan of care to address issues as they occur.

The devices are plug-and-play and easy for enrollees to use with a wireless network built in-enrollees do not need any technology or Web access, but do need standard cell tower reception. The enrollee simply attaches the devices or stands on the scale and biometric readings will automatically transmit to a secure HIPAA-compliant database monitored by the

## **EXHIBIT A-4-a**

### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

24/7 Informed Health Line (i.e., nurse line). Based on the PCP or other provider's recommendations, devices are programmed to trigger and alert the enrollee if his or her reading is abnormal. The same information is monitored by the Informed Health Line, where an immediate follow-up outreach is made for any high or abnormal readings to ensure the enrollee can access care and help if needed. In addition, our care managers and the enrollee's PCP, care team, or other designated provider can access the device readings, along with alert notifications, to identify an abnormal or critical reading that requires action. Because PCP engagement is critical to the success of this initiative, we will emphasize the value providers gain with remote monitoring and will identify ways to incentivize providers that adopt this technology.

Remote patient monitoring hold much promise to promote an entirely new approach to using technology for disease and condition management. Remote patient monitoring engages enrollees by empowering them to manage their health proactively by learning how to manage their condition to avoid preventable admissions and ED visits. Additionally, members of our care management team and larger interdisciplinary team benefit by receiving notifications that allow them to address issues directly in real-time that can lead to higher quality care and early intervention.

#### **CareUnify<sup>SM</sup>**

CareUnify includes a mobile application that is now live for providers, with an enrollee application that will be launched in the fourth quarter of 2017. CareUnify pushes out secure email or text notifications to remind enrollees of the integrated care team or that a particular action or intervention is needed. Care paths are built into the system that can be tailored to drive care coordination for all enrollees of the care team around specific key events. For example, after an enrollee is discharged, a care path can be implemented that is aligned to best practices for medication reconciliation to ensure the enrollee receives medications and all follow-up care. The system will send reminders on key actions that need to be taken to prevent breakdowns and to promote clean hand-offs between organizations, such as between a PCP and a behavioral health provider. The system also ensures the enrollee and his or her family can access his or her care team 24/7, with real-time notifications sent to the care team. Furthermore, each enrollee can direct and access the entire care team with access to his or her personal health records, education tools, appointments, transportation requests, as well as initiate a telehealth visit on the system, and access healthy lifestyle campaigns.

#### **Managing Difficult-to-Reach Enrollees**

For enrollees who are difficult to reach, we use a multi-pronged approach to identify, engage, and manage the care of these enrollees. We flag them in our care management and utilization management systems so that whenever an enrollee has an ED visit, hospital visit, or any other form of utilization, our care managers are alerted and, in some cases, can connect with the enrollee immediately. The enrollee's providers are notified that we are trying to reach the enrollee. Aetna engages community health workers who live in the communities to connect directly with difficult-to-reach enrollees and begin the engagement process. Additionally, we visit homeless shelters, churches, and other local community gathering places to connect with our enrollees and to establish relationships with the goal of appropriately enrolling and engaging them in care management and reconnecting them with their providers. We also establish connections with the criminal justice system, education system, and supportive housing system.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

When enrollees who decline care management, we listen carefully to understand their reasons and continue to offer support and guidance. Maintaining relationships with enrollees to ensure care management remains accessible is of tantamount importance, and effort are made to ensure enrollees have direct phone number and point person to contact to initiate care management. Aetna provides all enrollees who have targeted chronic medical and behavioral conditions with appropriate bi-annual, condition-specific newsletters even if they decline care management. Newsletters, written at an accessible, understandable level and submitted to the Agency for review and approval, are meant to promote health literacy. Enrollees who receive disease management mailings are tracked and reported within the population health level of care management.

Because Medicaid enrollees are often transitional, moving without notification, changing telephone numbers or losing service, or struggling with homelessness or housing issues, contacting them can be challenging. In many instances, locating Medicaid enrollees cannot be accomplished through methods that are more traditional. Therefore, we seek solutions to locate and engage them, such as speaking with health care providers and vendors (over-the-counter pharmacy benefits, DME vendors, phone numbers obtained through the AHCA Lifeline program and more) that may have more current contact information.

As an adjunct to our outreach efforts and care management, we have initiated a vendor relationship to assist our staff with reaching more enrollees. The goal of this relationship is to close the information gap and obtain updated/verified enrollee contact information necessary for Aetna's care management and outreach efforts. This vendor provides the following:

- Extensive location services using proprietary and proven methods to locate difficult to reach Medicaid enrollees
- Updates to contact information for our health plan staff
- A call center program designed to reach and engage enrollees by phone. While engaged with the enrollee, the vendor representative educates the enrollee on significant plan benefits, with a focus on the value of utilizing a PCP in his or her health care benefits
- Call center representatives who conduct a complexity screen with the enrollee to gather important information that Aetna can utilize to determine if the enrollee will benefit from an individual plan of care; the representative then completes a warm call transfer to an Aetna care manager who assists the enrollee in scheduling an appointment with his or her PCP

This vendor's creative search methods have yielded positive results; for example, one study with a major Medicaid health plan showed that for enrollees without phone and home address information, this vendor successfully obtained valid contact information for 70% of those enrollees using its proprietary tools and processes.

### **EVIDENCE-BASED INTERVENTIONS TO ACHIEVE IMPROVED OUTCOMES AND ENHANCED ENROLLEE ENGAGEMENT**

**CRITERION 6:** The adequacy of the respondent's description of evidence-based interventions in achieving improved outcomes and enhancing enrollee engagement

Aetna's 30 years of experience working with states and Medicaid enrollees, coupled with our knowledgeable clinical and administrative staff and innovative technology solutions, affords our

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

enrollees the benefit of evidence-based managed care interventions that have been tested in practice. The following examples represent just several of the many evidence-based interventions and best practices Aetna employs that result in improved coordination and enrollee engagement, reduced costs, improved treatment adherence, an improved care experience, and ultimately more timely and comprehensive support necessary to meet our enrollees' care needs.

### **Example 1: Mercy Maricopa Integrated Care (MMIC)**

Mercy Maricopa Integrated Care (MMIC), a health plan Aetna manages in Arizona, demonstrates our ongoing efforts across the nation to collaborate closely with community programs and to incorporate best practices.

MMIC collaborated with justice system leaders to examine the causes related to incarceration and identified populations where we sought to focus our interventions. The findings reflected an increased rate of recidivism and longer length of incarceration for the people with Serious Mental Illness (SMI) compared to the overall jail population. SMI enrollees assessed by adult probation who indicated a high risk to recidivate experienced increased interaction with the criminal justice system even when they were enrolled in services through one of our providers. Addressing mental health and substance use issues alone did not have an impact on the length of stay in jail or recidivism.

Risk assessments completed by the criminal justice system differentiate individuals at risk of recidivism and identify criminogenic factors that can lead to continued acts of criminal behavior. Based on these assessments, individuals designated with SMI and at the highest risk for re-incarceration are referred to one of three Forensic Assertive Community Treatment (FACT) teams at Community Bridges, Inc. These teams include probation officers, a psychiatrist, nurse, PCP, and specialists in substance use, housing, peer support, and employment—all of whom collaborate to develop treatment plans that address the clinical and social needs of each individual, as well as criminogenic factors identified through justice system assessments.

For example, individuals with criminogenic factors often continue to associate with others involved in the justice system (anti-social peers); therefore, treatment plans may include forensic peer support services focused on helping those individuals identify and participate in opportunities to interact in pro-social activities. This initiative enables MMIC, in partnership with area county and justice system leaders, to meet with individuals prior to release to provide intensive, wraparound services in a holistic, person-centered approach in coordination with probation/parole, thus reducing re-arrests, hospitalizations, ED utilization, homelessness, and more.

Based on Aetna's experience and success in Maricopa County, Arizona, Aetna initiated a partnership with Treatment Alternatives for Safe Communities (TASC) to assist in accessing health care for the population exiting the Illinois prison/jail system. This partnership will involve an Aetna care manager and a TASC care manager to work in tandem to ensure this population is located, engaged in care management, and linked with a PCP to ensure medical and psychiatric needs are met while the enrollee reintegrates into the community.

From August 1, 2014, through September 30, 2016, FACT teams achieved the following:

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- 19% reduction in the number of homeless enrollees in the past 25 months
- 84% increase in the percentage of enrollees who have seen a medical provider at least once per year
- 76% reduction in the number of jail bookings for this population
- 31% reduction in psychiatric hospital admissions
- 18% reduction in the number of enrollees who utilize the ED

### **Example 2: Aetna Better Health of Illinois**

Formed in 2010 to support the State's expansion to Medicaid managed care, Aetna Better Health of Illinois supports Illinois' Integrated Care Program; Medicare-Medicaid alignment initiative; Family Health Plan; Managed Long Term Services and Supports (MLTSS) and the Colbert Decree. Through this partnership, we serve over 229,000 Illinoisans (as of March of 2017) utilizing Medicaid benefits.

With more than 500 employees from local and surrounding communities, Aetna continues to invest time in support of our enrollees' efforts to change their behaviors, follow their physicians' treatment recommendations, and adopt healthier lifestyles by caring, empathizing, listening, planning, thinking, and educating enrollees to reach a common understanding and shared goals. We place every enrollee at the forefront of all we do, and we remain committed to improving their lives and well-being by offering the services and supports necessary to maintain and enhance their health and overall quality of life.

The following outcomes illustrate our success in serving Illinois Medicaid:

- Utilization management:
  - LTSS interventions (three-year results between 2013 and 2015):
    - o Inpatient per-member-per-month (PMPM) decreased by 44.8%
    - o Bed days per thousand decreased by 35.5%
    - o Cost per bed day decreased by 14.0%
    - o 17.4% of enrollees transitioned from nursing facility care to HCBS
  - Overall inpatient utilization management (results year-over-year)
    - o 12.7% reduction in PMPM inpatient spend despite an increase in risk scores of 12%
    - o Cost per admission decreased by 7.2%
    - o Admission rate per thousand enrollees decreased by 18.0%
    - o Observation conversion of 1- to 2-day inpatient stays increased with an average savings of \$4,300 (or 88%) per stay
- Care management: Aetna has completed five times more post-discharge assessments since deploying a care transitions team in September 2015:
  - From October 2015 to present: 10,450
  - From October 2014 to September 2015: 1,840
  - Face-to-face enrollee visits in 2016: 22,000
- Diversion of non-traumatic dental care from ED to dental offices: Targeted enrollees who visited the ED for dental care were educated about their benefits, referred to a dental home, and provided oral health preventative care information.

The initiative resulted in:

- Decrease in ED utilization by 17% since the initiative went live in July 2016

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Decrease in spend by 50.5% for the same time period
- Colbert initiative: Transitioning from institutional care to community based services, in response to the Colbert consent decree for a specific project in Illinois that requires moving individuals out of nursing home settings and back into the community:
  - Successfully transitioned 702 Colbert enrollees back to the home setting since launch of the program in March 2013
  - Of the 702 Colbert enrollees transitioned to-date, 201 are Aetna enrollees
- Pharmacy formulary management:
  - 35 new formulary enhancements implemented in 2017 with estimated savings of approximately \$13 million
  - Hepatitis C:
    - o Monthly care management and pharmacy director clinical rounds
    - o Estimated savings of \$1.9 million from revision to prior authorization criteria with Zepatier steerage in September 2016
- Behavioral Health: A long-acting antipsychotics prior authorization guideline revision in 2016 realized more than \$190,000 in savings:
  - Pharmacy restriction rounds: Identify controlled substance overutilization, use prescriber abuse outlier report to identify fraud, waste, and abuse and refer to the Special Investigations unit. In 2016, 224 enrollees were restricted and 57 enrollees graduated.
  - Psychotropic Workgroup: Commenced December, 2016; review overutilization of psychotropics, provide enrollee referral, prescriber notifications/education and provider engagement

In response to over-utilization of opioids among enrollees, Aetna Better Health of Illinois also implemented new prior authorization guidelines for opioid analgesics in August of 2015, along with a protocol to steer prescribers to the most cost effective generics. Opioids have a hard block at pharmacy point-of-sale and reject for prior authorization needed. Prior authorization requirements include documentation of a treatment plan that includes a diagnosis and therapy goals, assessment of addiction risk with the therapy, attestation from the prescriber that the State's prescription monitoring program database has been recently reviewed, and a pain contract between the prescriber and enrollee. We continue to examine ways to enhance this program to reduce opioid utilization among Illinoisans, and remain focused on reducing indiscriminate prescribing and the opportunity for controlled substances to be diverted into illegal channels of distribution. This program resulted in savings of \$58,105, surpassing the projected savings of \$45,892.

### **Example 3: Aetna Better Health of Ohio**

Aetna's experience integrating physical and behavioral health and transitioning from institutional settings to community-based care demonstrates marked improvement of HEDIS measures and performance indicators such as ED visit reduction. Aetna Better Health of Ohio's integrated health home (IHH) strategy, which was implemented in early 2014, resulted in enhanced quality and improved outcomes for five HEDIS measures by aligning incentives with IHH providers and moving the majority of enrollees into an integrated value based arrangement.

Aetna Better Health of Ohio contracts with the State of Ohio and CMS to provide benefits to individuals who are dually eligible for Medicaid and Medicare. Aetna Better Health of Ohio provides both Medicaid and Medicare health benefits by coordinating physical, behavioral, and

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

long-term care services for individuals age 18 and older. This includes individuals with disabilities, older adults, and individuals who receive behavioral health services.

Aetna Better Health of Ohio began serving Ohio duals in 2014 in the Columbus, Toledo, and Cincinnati regions. As of January 2017, this plan has enrolled 22,000 enrollees, which represents 52% market share. Dual-eligible enrollees are required to participate in the MyCare Ohio program for their Medicaid benefits; however, they may opt out of the Medicare portion of a MyCare plan and choose to receive their Medicare coverage either through traditional fee for service or by selecting a Medicare Advantage plan. Of Aetna Better Health of Ohio's 22,000 enrollees, 15,000 receive both their Medicare and Medicaid benefits from Aetna Better Health of Ohio.

Aetna Better Health of Ohio boasts the following overall performance indicators:

- More than 50% of Aetna Better Health of Ohio enrollees use providers on value-based contracts that incentivize high-quality care with improved health outcomes.
- Measuring visits on a quarterly basis per 1,000 enrollees, Aetna Better Health of Ohio has seen a reduction of approximately 10% of behavioral health ED visits from 2015 to 2016 for enrollees in our duals plan.
- From January 2016 to March 2017, Aetna Better Health of Ohio transitioned 27% of their enrollees residing in nursing facilities into the community.

Additionally, Aetna Better Health of Ohio conducted an analysis of 394 PCMH health home enrollees with SMI, comparing the health-home population quality-improvement rates with quality improvements in a matched cohort of primary care practices.

Our 2016 HEDIS results note the positive impact of the health home approach:

- Seven-day follow-up after a mental illness hospitalization: 19% improvement
- Breast cancer screening: 13.4% improvement
- Cervical cancer screening: 6.3% improvement

In a three-year care coordination initiative for enrollees with SMI, Aetna Better Health of Ohio chose five health home providers to deliver care coordination services to improve outcome measures for their enrollees. More than 500 unique enrollees with SMI have received care coordination for integrated behavioral and physical health services to date. Aetna Better Health of Ohio provided health homes with access to the plan's care management system, which offered real-time notification for all inpatient behavioral health and medical/surgical hospital admissions and enabled health home providers to identify gaps in care. Through this collaborative partnership, the health home providers gave input into the development of a formal agreement for coordination of care, information exchange, and performance deliverables, which ultimately led to the launch of the project in June 2014.

Aetna's improvements in HEDIS scores and other outcomes for the health home population follow.

2015: A total of 580 unique health home enrollees were identified based on claims data; 323 of 580 met the criteria for continuous enrollment with Aetna Better Health of Ohio for June 2014

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

through May 2015 with at least 9 claims billed with code S0281 (health home services). Results and findings were as follows:

- Health homes' seven-day follow-up after hospitalization for mental illness was 21.3 percentage points higher than the non-health-home average
- Health homes' breast cancer screenings were 7.1 percentage points higher than non-health-home screenings
- Health homes' HgA1c rate of testing was one percentage point higher than the non-health-home average

2016: Analysis included 394 health home enrollees with SMI enrolled with the health plan for at least 12 months and receiving Medicaid health home services. Results and findings were as follows:

- Seven-day follow-up after a mental illness hospitalization had a 19 percentage-point improvement over the overall Aetna Better Health of Ohio population. This resulted in the health home population achieving the 95th percentile while the Aetna Better Health of Ohio population ranked in the 75th percentile
- Breast cancer screenings had a 13.4 percentage-point improvement over the overall Aetna Better Health of Ohio population
- Colorectal cancer screenings had a 6.3 percentage-point improvement over the overall Aetna Better Health of Ohio population
- Cervical cancer screenings had a 6.1 percentage-point improvement over the overall

Aetna Better Health of Ohio population

### **Example 4: Aetna Better Health of Virginia**

Aetna's experience with care coordination for complex populations such as foster kids, adoption assistance youth, and long-term care waiver programs demonstrates seamless transitions that reduce gaps in care driving higher overall HEDIS scores. Aetna Better Health of Virginia proactively executed internal PIPs resulting in increased Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores and overall enrollee satisfaction.

Aetna Better Health of Virginia's partnership with the Commonwealth began in 1996 at the outset of Medicaid managed care in Virginia. Having served the Commonwealth's 41,000 Medicaid enrollees for the last 21 years, Aetna Better Health of Virginia has a long-established local presence that will expand to support the Managed Long Term Services and Supports (MLTSS) program. Aetna Better Health of Virginia is NCQA-accredited and, while operating as Coventry Health Care of Virginia, earned the highest ranking for a Medicaid health plan in Virginia for 2014 to 2015, according to NCQA's Health Insurance Plan Rankings.

Between 2013 and 2014, as part of Virginia's progressive transition of all populations from fee-for-service to managed care, the Commonwealth moved its foster care, adoption assistance youth, and enrollees eligible for the Elderly or Disabled with Consumer Direction (EDCD) Waiver into managed care. Additionally, Aetna Better Health of Virginia is one of seven health plans awarded the Commonwealth's recent MLTSS contract, which is scheduled to go live in August 2017.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

The success of Aetna Better Health of Virginia's approach to managing its enrollees is evidenced by improved HEDIS results. In 2016, the following programs and activities were incorporated into Aetna Better Health of Virginia's quality improvement program to improve HEDIS scores:

- Attended various community meetings/events to understand barriers to care and prevalent social determinants of health better in each area of the State
- Developed and distributed various educational documents for providers pertaining to HEDIS and EPSDT
- Provided training on HEDIS measures and Quality CORE reporting to Care Management and Enrollee Services departments

These programs and activities served to drive significant improvements for Aetna Better Health of Virginia's 2016 HEDIS measures. Aetna improved in 63 HEDIS measures or sub-measures overall and achieved the 90th percentile or above in 5 measures/sub-measures

### **ACHIEVING COST SAVINGS, COST AVOIDANCE, ED DIVERSION, AND INCREASED UTILIZATION OF AMBULATORY CARE SETTINGS**

CRITERION 7: The efficacy of the respondent's approach in achieving cost savings, cost avoidance, emergency department diversion, increased utilization of ambulatory care settings, etc.

Aetna serves more than 100,000 enrollees in Florida where we manage integrated health care services to Temporary Assistance for Needy Families (TANF), Aged, Blind and Disabled (ABD), LTC, and Florida Healthy Kids populations. The following demonstrates the value and impact of our work in Florida to achieve cost savings, cost avoidance, and more:

#### **Overall Inpatient Utilization Management (Year-Over-Year Results)**

- 15.97% decrease in inpatient PMPM spend, despite an average increase in risk scores of 5.4%
- 7.08% decrease in cost per admission across all lines of business
- 13.83% decrease in bed days per thousand
- 21.52% decrease in admissions per thousand
- Observation conversions of 1- to 2-day inpatient stays have steadily increased, resulting in an average savings of \$1,500 (or 40%) per observation stay

#### **Neonatal Intensive Care Unit (NICU)**

Aetna's dedicated NICU clinician reviews NICU admissions at admission and throughout an enrollee's stay. If an enrollee has been admitted to NICU for a problem (e.g., rule out sepsis) that does not require the highest level of NICU, we will advise the hospital that we approve a specific level in the NICU. When an enrollee no longer requires NICU, we notify the hospital that we will pay a normal nursery rate. These decisions are made in conjunction with the medical director and the neonatologist at the hospital.

Weekly NICU rounds are conducted with Aetna's chief medical officer, NICU clinician, concurrent review clinician supervisor, and a care manager. The focus of these rounds is to

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

ensure the enrollee is placed properly, to monitor the enrollee's progress, and to work on discharge planning to ensure that these high-risk enrollees are discharged appropriately with needed services in place.

The program began in 2016 and helped achieve the following results: allowed PMPM (excluding outliers) decreased from \$3.33 in 2015 to \$2.58, and NICU claims per 1000 decreased from 1.28 to 0.79.

### **Prior Authorization**

The Aetna Medicaid organization remains committed to decreasing the administrative burden of the prior authorization process on our providers and enrollees. In the spring of 2017, we implemented a process designed to define the principles upon which prior authorization decisions are made, and re-evaluate our existing prior authorization requirements based on those principles. As a result of this process:

- Prior authorization requirements from more than 500 codes will be removed
- An additional 300-plus codes have been identified for eventual movement from prior authorization to a less burdensome form of management

### **Emergency Department (ED) Diversion**

In 2015, Aetna implemented a strategy to reduce avoidable ED visits and increase enrollee involvement in self-management of acute and chronic conditions. Our multifaceted approach focuses on enrollees with high utilization (i.e., three visits in a quarter). A care manager is assigned to ED over-utilizers who are supported with our disease management program, access to urgent care centers, provider incentive program for extended office hours, utilization of Aetna's toll-free, 24-hour nurse line, integration with the event notification service (ENS), and utilization review by our medical director.

We achieved an 8.5% improvement overall for reduction in ED visits per 1000 enrollees from 2014 to 2016, and a 19.1% improvement in reduction of ED cost per enrollee month in the same time period. In 2016, we achieved savings of more than \$906,900.

### **Increased Utilization of Ambulatory Settings**

Aetna employs a multi-pronged approach to increasing utilization of ambulatory settings and diverting services from the acute care and higher cost outpatient hospital setting.

In 2015, we introduced our prior authorization review initiative, the purpose of which was to identify procedures with the potential to be performed in an outpatient setting. We reviewed and compared contracted rates for surgical procedures in both the inpatient and outpatient settings, with the understanding this may vary by hospital and by contract. We found that many outpatient procedures with an associated 23-hour observation/recovery were less costly to the plan than a full inpatient procedure/case rate.

Aetna's medical management clinical team identified a list of procedures that could be completed in a less costly ambulatory or outpatient setting. One hundred percent (100%) of these procedures undergo prior authorization review by our medical director to determine

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whether the procedure can be safely provided in an ambulatory setting. Very often, we also recommend the outpatient surgeries be completed in less costly freestanding ambulatory surgical centers when available and appropriate.

Aetna has a strong inpatient-to-observation program designed to appropriately divert acute diagnosis-related group admissions to the observation setting upon review by Aetna's medical director. Patients with less severe conditions are managed in the observation setting, and they usually require less than 48 hours to stabilize and begin their treatment. Enrollees are then transitioned to a home or alternate setting for completion of their care. The program has resulted in an average savings of \$1,500 (or 40%) per observation stay.

The UM team regularly redirects provider requests for services to participating ambulatory providers and has network relationships that are favorable in terms of cost and availability to our enrollees. For example, we often receive requests for therapy services (PT/ST/OT) to be delivered in the hospital outpatient setting; however, there can be long wait times for these services. We have ambulatory therapy network relationships that will accommodate our requests promptly, providing lower-cost ambulatory services in freestanding centers close to the enrollees' residence. Providers and enrollees are often very pleased to discover these therapy centers are in our network and they can quickly accommodate our enrollees' needs. This same strategy applies to redirecting providers to lower-cost, freestanding radiology centers in lieu of higher cost hospitals, when available.

### **Evaluation Criteria:**

1. The extent to which the respondent's algorithm and risk stratification approach is well-defined and incorporates data elements other than diagnosis.
2. The extent to which the respondent describes data sources that are incorporated into the risk stratification process that is used for new enrollees.
3. The extent to which the respondent's approach includes the use of predictive modeling.
4. The extent to which the frequency and intensity of the care coordination services (i.e., maximum caseload and minimum contact requirements) are aligned with the respondent's risk stratification process and proportional to the clinical and psychosocial needs of the target population.
5. The extent to which the respondent's approach includes innovative strategies for addressing the unique needs of highly resistant or difficult to serve populations.
6. The adequacy of the respondent's description of evidence-based interventions in achieving improved outcomes and enhancing enrollee engagement.
7. The efficacy of the respondent's approach in achieving cost savings, cost avoidance, emergency department diversion, increased utilization of ambulatory care settings, etc.

**Score:** This section is worth a maximum of 35 raw points with each of the above components being worth a maximum of 5 points each.

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**SRC# 21 – Coordination of Benefits (Statewide):**

The respondent shall describe the strategies utilized in care coordination with other plans and insurers (e.g., Medicare) to provide necessary services for its enrollees when the third party payer is the primary insurer. The respondent shall include information on its approach in the following circumstances:

- a. Florida Medicaid does not cover the service, but it is available through the third party payer;
- b. Florida Medicaid and the third party payer cover the service, but Medicaid is only liable for the coinsurance/copayment expenses. In this scenario, the respondent shall identify any differences in its approach if the enrollee is dually eligible for Medicare and Medicaid;
- c. The third party carrier benefit limit is exhausted and the service is now a Medicaid expense. In this scenario, the respondent shall identify any differences in its approach if the enrollee is dually eligible for Medicare and Medicaid; and
- d. The service is not covered by the third party but is available through Florida Medicaid.

**Response:**

In order to maintain continuity of care for our enrollees, our approach to coordination of benefits is focused on ensuring access to all necessary services, regardless of the service or benefit provider. As primary care coordinators for enrollees, it is our responsibility to facilitate services from third party carriers, when available. Care managers are trained on benefit coordination and State and community resources. This coordination helps to reduce potentially preventable events, and containing costs.

Effective coordination of care, services, and payments across Medicare and Medicaid programs improves our enrollees' access to necessary care, increases their satisfaction and engagement, helps them achieve better health outcomes, and maximizes efficient use of resources. Our approach to coordinating care, services, and payments focuses on preventing cost shifting, closing gaps in care, providing seamless transitions to our enrollees and ensuring all services are provided regardless of payer source.

Aetna ensures appropriate continuity of services by honoring (at a minimum) a 60-day transition of care period. This period is extended whenever the enrollee requires the conclusion of a course of a treatment, as is the case with pregnancy, transplant services, or oncology. We involve applicable Aetna staff members, practitioners and providers, advocates and other health plans as necessary so that services will continue without disruption.

**STRATEGIES UTILIZED IN CARE COORDINATION WITH OTHER PLANS AND INSURERS**

Early identification and reporting of third-party liability (TPL) resources is a key component of our strategy that ensures the State is the payer of last resort. Third-party information is directed to our TPL and Coordination of Benefits (COB) departments under shared services with Aetna,

## **EXHIBIT A-4-a**

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Inc. Our TPL/COB analysts are guided by written policies and procedures that maximize the use of other available sources of payment and recovery.

Aetna's education strategy surrounding care coordination with other plans and insurers includes enrollee education regarding benefits through staff interaction and the enrollee handbook. Enrollee services and care management staff provide enrollees with information about covered and non-covered services, coordination of benefits, continuity of care, and ways to access non-covered benefits. (This information is also included in the enrollee handbook.) Online information, including the enrollee handbook and provider information, is also provided. Aetna is responsible for the cost of continuation of the treatment course without additional authorization and without regard to whether the covered services are provided by participating or non-participating providers. During the continuity of care period, non-participating providers are reimbursed at the rate previously received for services prior to the transition of costs.

Aetna promptly begins TPL/COB efforts and educates providers on their responsibility to identify other existing coverage to maximize TPL/COB identification and recovery opportunities. Early identification of possible TPL resources significantly increases our ability to effectively research those resources, process claims as payer of last resort, and pursue recovery of medical expenses paid.

Continuation of services is provided until the enrollee's PCP or behavioral health provider (as applicable to medical or behavioral health services, respectively) review the enrollee's treatment plan, which occurs no more than 60 days following the effective date of enrollment. We spend time with our providers in person and through online resources explaining the contractual requirements of continuity of care, including instances where services may extend beyond the 60-day continuity of care period. The following services may extend beyond the 60-day continuity of care period, and Aetna continues the entire course of treatment with the enrollee's current provider as follows:

- Prenatal and Postpartum Care: Aetna continues to pay for services provided by a pregnant woman's current provider for the entire course of her pregnancy, including the completion of her postpartum care (six weeks after birth), regardless of whether the provider is in the managed care plan's network.
- Transplant Services (through the first year post-transplant): Aetna continues to pay for services provided by the current provider for one year post-transplant, regardless of whether the provider is in the managed care plan's network.
- Oncology (radiation and/or chemotherapy services for the current round of treatment): Aetna continues to pay for services provided by the current provider for the duration of the current round of treatment, regardless of whether the provider is in the managed care plan's network.

#### **Aetna Staff Training**

Targeted strategies are used to educate different audiences, including Enrollee Services, Provider Services, Medical Management, Care Management, Quality, Claims, Grievances and Appeals, and IT departments to communicate appropriate information about services available through other payers. We maintain and disseminate internal policy and procedure documents, as well as provide role-specific training to make sure that our staff is well educated.

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Our staff are thoroughly trained to identify potential gaps in care, and provide the coordination necessary to get the enrollee the services they need. Notification of an enrollee's change in benefit triggers care manager outreach to offer support during benefit transition and education on new benefits and limitations.

Training for our staff does not end at the completion of the training sessions. We also conduct audits of staff performance, including observation and listening to calls to ensure the correct information is being disseminated. Files are audited to review whether referrals should have been made on behalf of an enrollee, whether the referral was made, and the disposition of the referral. Staffing and clinical case rounds are conducted with our medical directors, care managers and other applicable staff to brainstorm solutions and community services for our enrollees.

All of this information is used as ongoing training opportunities for staff to ensure that each staff member has internalized the information and trainings and to provide additional individualized re-training, coaching, and mentoring as needed.

### **Care Coordination When Services are Covered by Other Plans and Insurers**

Aetna determines and supports our enrollees' unique service needs through our care plan development process, including identification of services that will be needed from Aetna and those funded through other plans and insurers. Our care planning process considers prioritization of goals, the timeframe for re-evaluation, resources to be utilized, including appropriate level of care, planning for continuity of care, transition of care and transfers. Care managers facilitate a multidisciplinary approach to care planning by partnering with the enrollee, primary care provider, specialty care and behavioral health providers, community social workers, community health workers, ancillary providers, caregivers, pharmacy providers, hospital discharge planners and family members or the interdisciplinary care team when requested by the enrollee. They will also collaborate with Utilization Management staff, medical directors, pharmacy, Enrollee Services department, and other internal resources to ensure that we consider all appropriate information for incorporation in the enrollee's plan of care.

We ensure services provided and funded by all agencies are aligned and consistent. The enrollee is educated about the ability of these services and on how treatment will contribute to his or her identified goals. Care managers are trained to understand the coordination of benefits process and educate enrollees to ensure they understand the responsibilities of other payers. Enrollees are informed about payer rules and that Medicaid is the payer of last resort. The care management team takes responsibility for arranging, coordinating, and referring enrollees to all the identified programs that meet enrollees' needs, regardless of payer. The team tracks the completion of the referral and receipt of the service using established policies and processes.

Once an enrollee is identified through care management, we reach out to ensure they are receiving the needed services irrespective of the payer. Aetna works with other health plan care managers to coordinate services and our care managers expedite prior authorization for services not covered by a third party insurer. For services covered by Medicaid and not a third party, we work with the requesting provider to coordinate any authorization requests or delivery of equipment and services. For enrollees enrolled in Medicare and Medicaid, we are notified through a monthly report generated by the Informatics team to conduct outreach to both the enrollees and case managers from other insurers. Our long-standing relationships with

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providers (particularly with hospitals) are such that they notify us when enrollees are admitted (no matter who is listed as the primary payer). This allows us to follow the enrollee, support discharge planning needs, and provide prior authorization for Medicaid-covered services. Each contact with a provider offers us the opportunity to provide education on the benefits coordination and payer responsibility processes.

#### **Pharmacy Benefit Management Outpatient Drug Claim Quality Assurance**

Aetna's pharmacy benefit management (PBM) employs a quality assurance team that performs rejected claims review using targeting logic built to validate accurate clinical adjudication based upon the benefit structure. The PBM monitors each network pharmacy on all claims submitted via our online claims processing system. These edits, applied at the point of service, are designed to 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. Whenever errors are detected, an outreach is completed to the submitting network pharmacy to have it reverse the claim and submit a corrected claim with the appropriate data.

In addition, the PBM's network pharmacies are subject to audit desk reviews based on utilization and cost data pulled from reports of high-dollar claims. An automated statistical review called the Pharmacy Exceptional Activity Report (PEAR) is used to identify pharmacies for audit. 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 3% of on-site audits of the total number of network pharmacies.

Monitoring and oversight of the processing of outpatient drug claims adjudicated by the PBM include the following activities:

- Annual third-party audit (SAS-70) to evaluate controls relevant to the processing of claim and drug rebate transactions
- Encounter submission edits and checkpoints to validate for accuracy, completeness, and eligibility
- Quarterly meetings of the Delegation Oversight Committee to review claims statistics, reject metrics, claims summary of paid reversed and reject claims, and claims prompt pay

If non-compliance issues are identified, immediate action is taken to correct them. Each item is tracked to resolution and we will monitor each item through the weekly PBM operations review calls.

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### **Medical Outpatient Drug Claim Adjudication Quality Assurance and Oversight**

Managed separately from claims processing, an independent team assesses the effectiveness of the claims system configuration and claims procedures against the resulting adjudication process. This team does not have claims adjudication access and cannot alter claims data. A claims audit will follow these steps:

- Planning: Conducts routine and ad hoc audits based on timelines and business needs
- Data gathering: Extracts claim data from the adjudication system using sampling methodology for the outpatient drug claim audit (a valid random sample of all processed or paid outpatient drug claims upon initial submission in each month)
- Verification: Accesses and verifies data against the required attributes of the Department of Human Services
- Completion: Evaluates test results and identifies issues
- Reporting: Documents results and issues reports to operational departments

Audits are completed monthly to confirm claims processing met or exceeded outcomes in comparison to benefit set up and payment structures in line with provider contract terms. Our Claims Quality department's audit teams finalize, publish, and distribute monthly and quarterly audit results to the Department of Human Services. This includes reports that identify trends by error type, claim ID, and analyst ID to the business units. This data enables the Claim Operations department to conduct continuous quality improvement discussions.

### **SERVICES AVAILABLE THROUGH THIRD-PARTY PAYERS NOT COVERED BY FLORIDA MEDICAID**

**CRITERION 1.a:** The adequacy of the respondent's approach when: (a) Florida Medicaid does not cover the service, but it is available through the third party payer

On occasion, enrollees require a medically necessary service that is available through a third-party payer, but is not covered by Florida Medicaid. In such situations, Aetna serves as educator and facilitator for the provider to enhance the coordination of care for the enrollee. Whenever a service is available through a third-party payer but is not covered by Florida Medicaid, our care management staff contact the enrollee and the practitioner/provider and inform them that the plan does not cover the service but the service is covered by a third party payer.

Following this contact, Aetna educates the provider regarding what is covered by the plan and how the provider can help enrollees find medically necessary services not covered by the plan. The care management staff also provides the enrollee with education regarding Medicaid plan-covered versus non-covered services. If authorized by the enrollee or the enrollee's representative, we facilitate care coordination with the third party payer's provider by providing clinician-to-clinician consults or nurse-to-nurse consults. Medical management and pharmacy staff provide all necessary information to the third-party payer prescribing practitioner/provider or dispensing pharmacy to ensure continuity of care in a comprehensive and streamlined manner to help the enrollee meet his or her health goals. If the enrollee is receiving inpatient services, we provide ongoing monitoring of clinical progress through daily concurrent review rounds and communication with hospitalists and hospital staff to ensure that Aetna is aware of the enrollees discharge planning needs. We also use interdisciplinary care teams to engage all

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providers in addition to care managers from other plans (e.g. Medicare) to ensure care is coordinated and the appropriate insurer is paying for necessary claims

### **SERVICES IN WHICH FLORIDA MEDICAID AND THIRD PARTY PAYER COVER THE SERVICE, BUT MEDICAID IS ONLY LIABLE FOR THE COINSURANCE/COPAYMENT EXPENSES**

CRITERION 1.b: The adequacy of the respondent's approach when: (b) Florida Medicaid and the third party payer cover the service, but Medicaid is only liable for the coinsurance/copayment expenses

In some circumstances, enrollees may require a medically necessary service that is covered by Florida Medicaid and a third party, but Florida Medicaid is only liable for the coinsurance/copayment. In such instances, Aetna serves as educator and facilitator for the provider to enhance the coordination of care for the enrollee. Our claim system automatically pays the coinsurance/copayment claim to facilitate payment. We honor the authorization of the third-party plan without involving utilization management in obtaining another prior authorization for covered benefits.

If the provider is not in our network, we perform a single case agreement to ensure that the provider will receive timely payment. If the enrollee is dual-eligible (an enrollee who is eligible for both Medicaid and Medicare programs), we submit the claim directly to Medicare. (The claim is sent to Medicare automatically as a crossover claim.) All information is seamlessly coordinated between the TPL/COB and Care Management departments to make sure the claim is being charged to the primary payer and the enrollee receives the care they require.

We are guided by established and standardized policies and procedures to facilitate quick and appropriate payment for covered services. Claims submissions and payments are monitored through our quality management processes, including feedback and complaint information received from our enrollees and providers.

Aetna closely monitors the case even when we are only liable for the coinsurance/copayment expenses to ensure the enrollees' needs are being met. We follow our established policies and procedures to remain in close communication with hospitals and providers to ensure that necessary payments are being made by the primary insurer. We ensure make sure the enrollee is empowered to seek care whenever he or she needs it and that we pay his or her provider timely for any covered services provided.

### **THIRD-PARTY CARRIER BENEFIT LIMIT HAS BEEN EXHAUSTED AND SERVICE IS NOW A MEDICAID EXPENSE**

CRITERION 1.c: The adequacy of the respondent's approach when: (c) The third party carrier benefit limit is exhausted and the service is now a Medicaid expense

Through an integrated, team-based, and holistic approach to coordinating care and services for our enrollees, including dual eligibles, we provide unified coordination of services, care, and payment. When Medicare stops paying, hospitals and providers notify us that benefits are exhausted - they start sending the claims to us and we begin paying.

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These types of claims are for individuals who may already be monitored through our care management program. Care management staff members contact the Medicare care managers and the enrollee to conduct a reassessment to determine if the care plan is appropriate or requires modification. We facilitate a consultation between PCPs and specialists, if needed.

\*\*\*\*\*[REDACTED]\*\*\*\*\*

[REDACTED]

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**SERVICES NOT COVERED BY THIRD-PARTY BUT AVAILABLE THROUGH FLORIDA MEDICAID**

**CRITERION 1.d:** The adequacy of the respondent's approach when: (d) The service is not covered by the third party but is available through Florida Medicaid

In instances where a service is not covered by a third party but is available through Florida Medicaid and when the service requires it, Aetna conducts our regular established utilization management review process. We complete a referral to the participating provider and complete the authorization process, if applicable. If the service does not require an authorization, it will be paid through our normal claims adjudication process.

**DOCUMENTATION OF EFFECTIVE COMMUNICATION STRATEGIES TO REDUCE CONFUSION FOR THE ENROLLEES**

**CRITERION 2.a:** The extent to which the respondent's approach includes: (a) Documentation of effective communication strategies to reduce confusion for the enrollee (e.g., strategies used in enrollee materials)

An individual attempting to take care of his or her health is frequently confronted with a complicated health care system wherein components do not always work well together. Enrollees must have the information necessary to make informed health decisions. Ensuring the enrollee is informed and educated regarding the services covered by Aetna is an essential part of the informed decision-making process. We are committed to reducing confusion by making it as simple to understand as possible and by providing navigator services to assure each person arrives at his or her destination in the health care system for the best possible health outcome.

Our enrollee services team is often the enrollee's first line of contact. We train these staff members to communicate effectively with enrollees and support them with navigating through the health care continuum. We thoroughly train all our staff to identify where enrollees can receive coverage for necessary services, as well as potentially referring or looping in care management to the call to support overall enrollee outcomes.

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Whenever an enrollee calls, we track his or her questions and our responses in a frequently asked question (FAQ) format, which we also make available on the website. These FAQs include questions such as how to change your PCPs, what to do to visit a dentist and what is the over-the-counter (OTC) medication benefit. Offering these responses in an FAQ format ensures consistency in responses from our staff as well as making the information available 24/7 on the Web without the added burden of making a call.

Information is provided to each new enrollee in an information packet. This information packet includes a practitioner/provider directory, enrollee handbook, information about available services, such as EPSDT services, care management, special population information, and other preventive guidelines. We provide bilingual materials when at least five percent of the population in a region speaks a particular language. (Information is always available to the enrollee in his/her primary language.) Additional educational materials, such as our enrollee newsletter, provide enrollees with more in-depth coverage information.

Our website provides timely, accurate, and accessible information to offer enrollees immediate answers to their questions. The website is also available in Spanish, and uses a WCAG 2.0 AA screen reader to read pages aloud. Our website provides secure access to enrollees. This gives enrollees the ability to review their benefits, review and download a copy of the enrollee handbook, and send secure communication requests/questions to the enrollee services team and receive a response within 24 hours.

Additionally, we communicate directly with our enrollees through our quality improvement (QI) program processes to help enrollees obtain and understand their well care benefits. Our QI staff members call and send materials to enrollees to help guide care needs along with services offered.

### **PROCESSES USED TO IDENTIFY NON-COVERED SERVICES BY THE PRIMARY INSURER FOR THE INDIVIDUAL ENROLLEES**

**CRITERION 2.b:** The extent to which the respondent's approach includes: (b) Processes used to identify non-covered services by the primary insurer for individual enrollees

Our care managers know and understand what other plans cover and how to reach out to enrollees to help them understand their benefits. We train our care managers about community resources available and work directly with the enrollees to connect them to services and supports enrollees need. The care managers are the primary resource for identifying non-covered and coordinating services that might benefit an enrollee.

Comprehensive staff-training curriculum includes a variety of topics: service availability, contract requirements, program requirements, claims, billing and prior authorizations. We maintain and disseminate internal policy and procedure documents and provide role-specific training to make sure our staff receives education on availability and accessing covered and non-covered services. We thoroughly train all our staff to identify potential gaps in care and provide the coordination necessary to make sure enrollees receive the services they need, including:

- Specific in-service trainings to understand the services that might include representatives of the services
- Internal directories of all services and community resources available, including 2-1-1

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- Enhanced staff skills training related to person-centered referral process for all health plan staff
- Enrollee services and medical management scripts for each carved-out service

Training for our staff does not end at the completion of the training sessions. We also conduct audits of staff performance, including observation and listening to calls to ensure the correct information is being disseminated. We audit files to review whether referrals should have been made on behalf of an enrollee, if the referral was made, and the disposition of the referral. We conduct staffing and clinical case rounds with our medical directors, care managers and other applicable staff to brainstorm solutions and community services that would better serve our enrollees.

Aetna uses all of this information as ongoing training opportunities for staff to ensure through all these communications and supervision every staff has internalized the information and trainings, and we provide additional individualized re-training, coaching and mentoring as needed.

### **CareUnify**

CareUnify facilitates a fully integrated system of care across the continuum. This innovative tool integrates data from multiple sources and is available to all participants in the enrollee's care to bring together and support our provider and community agency partners. This platform is uniquely designed to share and aggregate actionable data across multiple systems and organizations—digitally creating one comprehensive enrollee profile or single source of truth that an interdisciplinary team can rely upon to make point-of-care decisions or engage in broader population health activities. Creating a single, common platform and data-viewing experience for the interdisciplinary team promotes effective and efficient care coordination and supports Web-based enrollee engagement experiences. By granting our provider network and community partners' access to CareUnify, we promote care continuity, prevent duplication of services, and provide more efficient care coordination.

### **PROCESSES USED TO STREAMLINE AUTHORIZATION AND PAYMENT OF SERVICES**

**CRITERION 2.c:** The extent to which the respondent's approach includes: (c) Processes used to streamline ongoing authorization and payment of services once the initial determination has been made that a service is not covered by the primary insurer or the benefit from the third party insurer has been exhausted

The focus of our utilization management program is to provide enrollees access to quality care and to monitor the appropriate utilization of services. To promote delivery of cost-effective quality care to our enrollees, our program goals and objectives consider membership characteristics, demographics and health care needs so that services best suited to meet medical and biopsychosocial needs are available to enrollees.

Aetna ensures appropriate continuity of services by honoring, at a minimum, a 60-day transition of care period. This period is extended when the enrollee requires the conclusion of a course of a treatment, as is the case with pregnancy, transplant services, or oncology. We involve applicable Aetna staff members, practitioners and providers, advocates, and other health plans as necessary so that authorizations, services, and payment to providers will continue without

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disruption. We do not require any additional authorizations or that the provider is participating in our network for this transition of care period.

If the third-party payer does not cover the service, or if the benefit is exhausted, the utilization management team evaluates the service using our established prior authorization process in compliance with required turnaround timeframes to ensure no delays or gaps in care. While our qualified and trained staff members are guided by established best practice criteria, they ultimately make determinations based on clinical judgement in the best interest of the enrollee with consideration for specific and unique characteristics. These characteristics include the local delivery system and the enrollees' age, comorbidities, complications, progress in treatment, psychosocial situation, and home environment.

We forward any service requests that do not meet applicable medical necessity criteria to the chief medical officer or designated medical director for review. The chief medical officer or a designated medical director must review any request that does not clearly meet criteria for coverage. Only a medical director may decide to deny, suspend, or reduce service authorization based on medical necessity and appropriateness. If requested services are not approved, we provide written notification to the requesting practitioner/provider and enrollee of the decision to deny, suspend, or reduce services within the applicable time. We document denial decisions in the prior authorization module of our utilization management/claims business application system.

If the service is a covered benefit through Aetna, we determine if the third-party payer's provider is participating in our network. If the provider is not participating, we ensure continuity of care by entering into a single case agreement with that provider. We also encourage the provider to join our network as a way to make certain enrollees continue to receive care from their chosen providers.

### **PROCESSES IN PLACE TO IMPROVE CARE COORDINATION, INCLUDING PROVIDER COMMUNICATIONS, AND SERVICE PROVISION FOR DUAL ELIGIBLES WHEN MEDICARE IS THE PRIMARY INSURER**

**CRITERION 3:** The extent to which respondent's description specifically addresses special processes in place to improve care coordination, including provider communications, and service provision for dual eligibles when Medicare is the primary insurer

If the enrollment file indicates that the Medicare plan is primary and we identify that the enrollee is eligible for the care management program, the care manager contacts the enrollee and advises him or her that a care manager is available and that the plan is prepared to work with the Medicare care manager. Because we fully understand challenges related to coordinating care for dually-eligible enrollees, Aetna has created and implemented strategic solutions based upon lessons learned in overcoming barriers that confront our enrollees when Medicare and Medicaid benefits are not delivered through the same program.

**Provider Communication:** We use a deliberate and thoughtful approach to communicating with providers using technology and a hands-on, collaborative strategy. We structure this strategy to make certain all types of providers fully understand their responsibilities in a managed care environment, including contract requirements and their responsibility to collaborate with other providers to meet the needs of our enrollees.

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Initial training is conducted within 30 days for newly contracted providers regarding the system of care, coordination of care, and contract compliance. We conduct ongoing monthly training for the specified provider types identified through monitoring, QI processes, and claim submission and payment processes. Training includes information on how we can assist the provider with any questions, issues, or problems with this process and how to access our provider portal for access to immediate information.

All of our Florida subcontractors are well versed in the service delivery system and availability of services through other Medicaid delivery systems. Provider services liaisons are located throughout the State to provide ready access to subcontractors. Our outreach team regularly attends joint operating committee meetings with large medical groups and hospitals and any providers that request support for their efforts. This approach includes a general overview of the available service delivery system, Agency's goals, information on where to seek assistance, access to the provider portal, how to bill for services or how to seek answers on claims, how to request prior authorizations, criteria for Medicaid eligibility, and our integrated care management model.

Provider Services staff members provide information to our providers via letter, telephone, and email and fax. Communication focuses on limiting disruption in services to enrollees and includes instructions for making information available to enrollees and downstream providers. Our network staff members also communicate with providers regarding continuity of care for enrollees and the implementation of agreements when necessary that allow us to work directly with them to provide services.

Additionally, we also communicate with requesting practitioners through the Pharmacy Prior Authorization call center. If a request is received and an enrollee is identified as having other primary insurance, we will provide direction to the practitioner on submission of the request to the primary insurer.

**Service Coordination:** Through our experience, we have found that information regarding existing social services and supports used by the enrollee may not be readily available. Therefore, we provide our enrollees service coordination, nutrition counseling, level of care assessments, home modifications, social determinants counseling, and explanation of benefits. We work with the Area Agencies on Aging (AAA) and Centers for Independent Living (CIL) to leverage their network of providers to address enrollee needs and all potential gaps, while honoring existing provider relationships and maintaining continuity of care. We streamline prior authorization processes for better service coordination and to take the burden off the provider from having to seek dual authorizations from both Medicare and Aetna. For example, we cover the room and board expenses for our dual enrollees in hospice without prior authorization.

**Care Coordination:** Enrollees often do not, or cannot, understand which payer covers which aspect of their insurance. As a result, we provide extensive training to our care managers on the Medicaid enrollee benefit package as well as on Medicare benefits and coordination of care for dually eligible enrollees. We help enrollees develop an interdisciplinary plan of care that encompass all benefits and services to allow transparency to the enrollee and his or her providers. The plan of care is shared with enrollees and all their providers to address any gaps in care. Care managers are trained and supported to manage all aspects of an enrollee's care, regardless of service or payer. Additionally, we collaborate with community health centers to exchange information in a HIPAA-compliant manner, and engage non-traditional community

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

providers of care and services to ensure a holistic, integrated approach to health and well-being. Our enrollee services team receives extensive training to help facilitate appointments and conduct provider outreach with the enrollee on the line to assist with any needed coordination of appointments and services.

### **Evaluation Criteria:**

1. The adequacy of the respondent's approach when:
  - (a) Florida Medicaid does not cover the service, but it is available through the third party payer.
  - (b) Florida Medicaid and the third party payer cover the service, but Medicaid is only liable for the coinsurance/copayment expenses.
  - (c) The third party carrier benefit limit is exhausted and the service is now a Medicaid expense.
  - (d) The service is not covered by the third party but is available through Florida Medicaid.
2. The extent to which the respondent's approach includes:
  - (a) Documentation of effective communication strategies to reduce confusion for the enrollee (e.g., strategies used in enrollee materials).
  - (b) Processes used to identify non-covered services by the primary insurer for individual enrollees.
  - (c) Processes used to streamline ongoing authorization and payment of services once the initial determination has been made that a service is not covered by the primary insurer or the benefit from the third party insurer has been exhausted.
3. The extent to which respondent's description specifically addresses special processes in place to improve care coordination, including provider communications, and service provision for dual eligibles when Medicare is the primary insurer.

**Score:** This section is worth a maximum of 40 raw points with each of the above components being worth a maximum of 5 points each.

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**GENERAL SUBMISSION REQUIREMENTS**  
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**SRC# 22 – Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Statewide):**

The respondent shall describe its approach to education and monitoring of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements, including:

- a. A description of outreach and communication strategies that will be used to enhance enrollee education on EPSDT requirements and to improve compliance with the periodicity schedule and treatment recommendations that are identified as a result of a screening.
- b. A training plan that includes descriptions of strategies that will be used to facilitate a firm understanding of federal and State EPSDT requirements throughout all operations of the plan (case management, utilization management, provider relations, etc.) as well as subcontractors.
- c. A description of the monitoring approach that will be used to ensure compliance with EPSDT requirements throughout all relevant departments within the plan and with subcontractors.
- d. A plan for ensuring greater transparency among external stakeholders (e.g., advocacy groups) in the respondent's approach towards coverage of the EPSDT benefit.

**Response:**

Children are our future—and all children deserve the essential screenings and services necessary to ensure they grow into healthy, fully functioning adults. The timely uptake of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services is key to making sure children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty care. In direct alignment with the Agency's goals, Aetna has met or exceeded EPSDT goals under the Statewide Medicaid Managed Care Program (SMMC) contract since implementation, including the 80% federal and state screening goals and the 80% federal participation goal.

Our approach to EPSDT services requires constant testing to assure we meet requirements and improve our rates. Interim rates are reviewed for improvements, and we strive to exceed the State's goal of the 90th percentile or higher—elevating our year-over-year performance. While they are not EPSDT measures, we monitor dental and lead well-child visits as the litmus tests for EPSDT compliance. Whenever we have EPSDT information from the State, we act to improve performance immediately, regardless of how positive the result. We also close the loop on follow-up, which can be an indicator of our progress against EPSDT goals. In January 2015, Aetna examined our adolescent population to determine whether they had completed a follow-up visit for any abnormal child checkup EPSDT code; 96% of enrollees had visits within 60 days.

Education plays a vital role in ensuring enrollees' access to important preventative services. We remove barriers to receiving benefits by first educating enrollees on their Medicaid coverage through care managers and physicians, newsletters, community events, and through Healthy

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Start, WIC, schools, and other community groups that serve Medicaid enrollees. When our enrollees, their parents, and caregivers are educated to understand and follow the periodicity schedule, we are able to assist them in identifying potential medical and developmental concerns right away and take steps to minimize risk and improve the overall health of the child. Under the leadership of Dr. Jorge Cabrera, our chief medical officer, our pediatric care managers reach out to enrollees to help them receive coordinated, timely services for EPSDT. We then automatically approve all referrals for services extending from the well-child visit. Aetna's relationships with community organizations expand our reach to the larger Medicaid population with education and initiatives for all Floridians.

Our enrollees are unique, and our approach to education and monitoring requirements of EPSDT must be customized to meet their individual needs. We engage them in our process so that they can educate us on their preferences and challenges. We seek enrollee and provider input through advisory committees, asking them to help us identify and solve problems proactively and soliciting feedback on the materials we use.

Aetna collaborates closely with the Florida Department of Health to close gaps in care, including encouraging and requiring our providers to participate in the Florida State Health Online Tracking System immunization registry. All providers in our network are encouraged to use the registry and are educated about its benefits and features, such as the option to retrieve their own health records. To this end, providers are encouraged to utilize Health Insurance Portability and Accountability Act-compliant meaningful use of electronic health record systems with standardized questionnaires and health risk assessments. Additionally, providers receive one-on-one education through training and toolkits, provider forums, conferences, and webinars, as well as through our easy-to-read provider bulletin that keeps them abreast of the measure requirements, changes, proper billing, and other issues pertinent to ensuring EPSDT services are rendered completely and in a timely fashion.

### **Outreach and Communication Strategies to Enhance Enrollee Education**

**CRITERION 1:** The adequacy of the respondent's approach related to outreach and communication strategies that will be used to enhance enrollee education on EPSDT requirements

Aetna maximizes the opportunity to enhance enrollee education about EPSDT requirements with every interaction. Our care coordinators are experts in EPSDT guidelines and closing gaps in care. Outreach to enrollees is individualized based on their unique needs and social determinants. Care coordinators educate enrollees on their gaps in care, identify barriers, and assist them with accessing the resources and benefits they need to overcome those barriers and complete needed care. Enrollees can work with care coordinators through every element of EPSDT service completion and other health needs.

Within 30 days of enrollment, we call new enrollees to offer assistance in accessing EPSDT services following 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. If an enrollee is identified for care management, our care managers place the outreach welcome call. We engage the parents and guardians of our enrollees to complete a health risk assessment on behalf of the child and ask what we can do to help them access their benefits. We also proactively reach out to existing

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### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

enrollees to make sure they understand the importance of receiving timely and complete EPSDT services and following up on any referrals made as a result of the well-child visit. On calls to care management, our Enrollee Services department, and other Aetna functional areas, our staff discusses EPSDT and other gaps in care with the enrollee based on the alerts built into our electronic system.

The gaps-in-care alerts in both our enrollee services and care management systems help ensure that all enrollee-facing areas, such as Quality Management and Care Management, have access to the same information at every point of contact. In this way, we extend our no-wrong-door approach to Aetna and AHCA's shared priority on EPSDT. The alerts are prompts for Aetna personnel to inform the parent or caregiver they are due for an appointment and to reduce any barriers to scheduling or transportation. We empower and encourage all enrollee-facing staff to handle these requests without having to transfer the enrollee to another department. Aetna performs outreach in Spanish and English, with additional languages supported by Enrollee Services or our translation service.

Aetna contacts enrollees with preventive screening reminders through interactive voice response calls, text messaging, and mailings. Postcard reminders and newsletters with age-appropriate recommendations are mailed to enrollees. Growth charts tracking progress are provided at each well-child visit. Enrollee welcome packets include information on EPSDT screenings and services. We also place notifications at our enrollee portal so that they are made aware of recommended services and potential gaps when they access our website to view the enrollee handbook or search for a provider. This type of outreach has proven to be very successful, with more than 90% of enrolled children accessing services on an annual basis.

As previously noted, our telephonic interactions with enrollees and their parents/caregivers are not limited to simply alerting them to gaps in care. We help them understand the importance and potential health impacts of timely and complete screenings. Descriptions of communication methods used to educate our enrollees follow:

- Live outreach: In addition to the live outreach implemented by our Quality Management and Care Management teams, Aetna hosts community events centered increasing health literacy in children. Our mascot, Ted E. Bear, MD, creates a positive experience for children while educating them on the importance of regular checkups. When we teach children that physicians are their partners, whether or not they are our enrollees, we improve the health outcomes for them and their peers into adulthood. We help to create a community garden to promote healthy eating, offering opportunities for enrollees of all ages to be active participants in their health.
- Telephonic outreach: Aetna uses interactive voice response technology to automate reminders for dental and other well visits. We also use Text4baby to send reminders about upcoming appointments, lead screening, and more.
- Digital communication: We communicate digitally with enrollees and providers through our website, enrollee and provider portals, digital handbooks, and provider gaps-in-care reports. Our enrollees also have access to MyActiveHealth online health education. We have the capability to do educational email campaigns for our enrollees and are ready to implement those upon approval from AHCA.
- Print media: We use handbooks, postcards/mailers, growth charts with the EPSDT periodicity schedule, and newsletters to educate our enrollees about EPSDT requirements. We also use newsletters to communicate to the primary care physicians in

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

our network why dental care and fluoride treatments are important. Printed reminders to our physical health providers include a phone number for MCNA.

Enrollee Engagement Approach and Strategies to Improve Compliance with Periodicity Schedule and Resulting Treatment Recommendations

**CRITERION 2:** The adequacy of the enrollee engagement approach and strategies that will be deployed to improve compliance with the periodicity schedule and treatment recommendations, including identification of the data sources that will be used to monitor compliance

Aetna follows the Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care. We empower and train all staff to help enrollees overcome barriers to care and improve compliance with EPSDT requirements. Our engagement approach includes a first-call resolution process through which the individual helping the enrollee at that time will complete all requests. We do not transfer enrollees to other departments when we have them on the line presenting with a barrier. All enrollee-facing staff makes certain enrollees receive immediate assistance by offering end-to-end resolution for barriers such as scheduling difficulties or transportation needs. Enrollees are connected with every available resource necessary to meet their needs and close any gaps in care, regardless of whether or not it is one of our covered services.

We will assist an enrollee with more than one child in finding a physician who can see all of the children for well visits at the same time. PCPs who can see adults and children so that caregivers do not have to sacrifice necessary care for themselves. Enrollee barriers as problems to solve; instead, they are opportunities to innovate for an individual enrollee's needs. We model inspiration, a key component of our organizational values, thereby encouraging enrollees to replicate the strategic thinking that goes into their health care in their daily lives.

Our strategies for increasing EPSDT have proven highly successful in the State of Florida. Our CMS screening ratio has increased from 79% before implementation of the current SMMC contract (2013 to 2014 federal fiscal year [FFY]) to 89% on the last reported rate (2015 to 2016 FFY). Our CMS participation ratio increased from 75% before the SMMC contract to 82% for the most recent FFY reported. Our Florida screening ratio increased from 42% for the 2013–2014 FFY to 86% for the last reported. We have also made improvements in preventive dental, treatment dental, and sealants; our dental benefits opened at the beginning of fiscal year 2014, and our rates for preventive dental increased from 31.30% to 36.2% year over year, for treatment dental from 18.83% to 19.80%, and for sealants from 11.96% to 13.40%. Despite rate improvement and goal achievement, we continue working to improve all areas of EPSDT. The most important finding from the analysis of the EPSDT non-compliant data is that enrollees did receive appropriately timed screenings or dental services. However, they received them outside of our health plan, so they could not be counted in our reporting. This is generally an issue with the short continuous enrollment period in the EPSDT methodology. One way to overcome the methodology issue is to have longer enrollment periods. We credit having the highest enrollee Consumer Assessment of Healthcare Providers and Systems score of a Medicaid health plan in Florida to the way we build enrollee partnerships and create engagement opportunities.

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A summary of our strategies follows:

- Our quality outreach team encourages immunization catch-up for all enrollees who have missed scheduled vaccinations.
- The quality outreach team assists parents/guardians with scheduling and transportation to appointments, and works to find providers who are the right fit for the enrollee in terms of hours, physician types, locations, and other characteristics preferred by the enrollee's parents/guardians.
- We arrange for all the children in a family to go to the same physician and help address any related barriers to care.
- Our system notifies Enrollee Services, care managers, and the quality management team whenever an enrollee is in need of EPSDT services such as well-child visits, immunizations, or annual dental visits. Enrollee Services may schedule or transfer calls to our Prevention and Wellness staff to schedule an appointment with the enrollee's physician, if needed.
- Provider Services representatives educate providers on the EPSDT requirements as part of the clinical practice guidelines and benefits for enrollees. Providers are also trained to access a list of panel members with gaps in care through the provider portal and our proprietary care management system. We use the HEDIS gaps-in-care report to monitor compliance while enabling providers to identify enrollees who have not received required care. These reports are available on our provider Web portal and can be delivered by hand, email, or fax. They are also available to our care management team.
- Electronic toolkits support our providers in the management of our enrollees. These kits include a HEDIS gaps-in-care report, tips for successfully leveraging that report, a billing guide and billing codes, HEDIS measure definitions, and patient chart tips, such as how to avoid common mistakes. Provider Services staff and the quality management team are available to discuss the toolkit and gaps-in-care report with providers and office staff for measures such as Pap smears, mammograms, immunizations, physicals, and diabetic screenings.
- We encourage providers to perform well visits in tandem with acute visits to record preventative services through coding. Providers can take care of EPSDT requirements while the patient is in the office for a well or acute visit.
- We analyze our EPSDT rates monthly and quarterly. 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 enrollees' barriers to care.

In addition to educating our enrollees to make and keep scheduled well-child visits, Aetna improves compliance with EPSDT requirements by ensuring enrollees receive services related to any abnormal findings on the EPSDT exam. We automatically approve any service related to or requested for EPSDT. All services related to findings in an EPSDT exam are covered and provided as expeditiously as possible, including with intervention from the plan case management team as needed to treat the enrollee.

Training Plan to Facilitate Firm Understanding of all Federal and State EPSDT Requirements

CRITERION 3: The adequacy of the respondent's training and education approach to facilitate a firm understanding of federal and State EPSDT requirements throughout all operations of the plan/subcontractors. The respondent must illustrate a commitment to ongoing training and

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retraining of staff/subcontractors utilizing an array of mediums to earn all points for this component

For Aetna, quality assurance and improvement is a health plan-wide endeavor. Our Florida plan employs a dedicated quality team supported by shared resources and knowledge at the corporate level. Leaders in Quality Management as well as in our Corporate Learning and Performance department confirm that all relevant associates across the health plan have a firm understanding of EPSDT requirements. Across the Aetna organization, staff in each functional area, including Medical Management, Quality Management, Provider Services, Informatics, Enrollee Services, and Claims as well as key Aetna national Medicaid staff are trained upon hire and retrained annually. Retraining also occurs when deficiencies are found. Aetna uses a face-to-face, mandatory, comprehensive, weeklong, role-based training program that is supplemented by technology-based trainings to refresh or update information. Evidence of these trainings becomes part of our associates' files, which are monitored by our internal compliance department. Additionally, we train physicians, other medical providers, subcontractors, and vendors providing EPSDT-related services at least annually, and more often as needed.

Aetna's training and education approach for staff and stakeholders is key to driving quality outcomes for EPSDT. We offer training on HEDIS measures to providers via face-to-face sessions and in our provider newsletter and webinars, as applicable. Additional materials reinforce our commitment to ensuring a firm understanding of EPSDT guidelines. Training topics for all stakeholders include EPSDT requirements and benefits, well visits and periodicity schedules, Vaccine for Children program, billing/coding/payment, referrals for related services, closure of gaps in care, Screening, Brief Intervention, and Referral to Treatment, enrollee education and coordination of care efforts, provider responsibilities, service authorizations, plan responsibilities, and reporting.

#### **Approach to Monitoring Compliance with EPSDT Requirements**

**CRITERION 4:** The adequacy of the respondent's monitoring approach, including all data sources that will be used to ensure compliance with EPSDT requirements throughout all relevant departments within the respondent and with subcontractors

Aetna monitors the quality and effectiveness of preventive care and treatment by participating in compliance reviews. These reviews focus on our participating network provider groups, including those whose services involve EPSDT.

As part of our ongoing efforts to ensure compliance with EPSDT requirements, we remain diligent about monitoring performance. EPSDT requirements and HEDIS are some of the measures that serve as indicators of EPSDT performance and provide insight into deviations, trends, and potential issues early in a measurement year, so that we can intervene as needed.

Using the Plan-Do-Study-Act methodology and employ rapid-cycle processes as guidelines, we adapt those processes as needed, resulting in a constant review of all the elements that affect our performance and taking steps to mitigate problems. We also use information on where we do well to replicate success in other areas. When conducting such a deep dive review, we analyze the entire measure looking for gaps in our performance as well as measures with

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positive outcomes. For example, enrollee, provider, geographic differences, or even data quality are some of the types of issues that may be affecting performance.

EPSDT oversight and compliance reviews include the following elements:

- Data Analysis: Timely EPSDT screenings completed; timely completion of services enrollees are referred to as part of EPSDT; authorizations for EPSDT services in utilization management; turnaround time reporting for key services related to EPSDT exams; claims audits to test claim edits and rules; Identification of enrollees who may need EPSDT screening or who have no record of completed services
- Data Sources: Medical records for providers with low compliance (if the provider has a low compliance rate, the quality management team will pull records for additional investigation.); use of Florida state immunization registry; claims data

#### **Opportunities to Improve Transparency for External Stakeholders**

**CRITERION 5:** The extent to which the respondent's overall outreach approach identifies opportunities to improve upon the level of transparency for external stakeholders

Transparency is a key component of sustaining quality improvement and we infuse that priority into our interactions with external stakeholders—enrollees, providers, community organizations—each of whom have a stake in the enrollee's well-being. These external stakeholders have access to our current performance, as well as our plans and processes for improvement.

Our collaborative approach welcomes and solicits bi-directional feedback to identify opportunities to improve transparency. We have developed and we encourage active participation in quarterly provider forums wherein we discuss the EPSDT benefit and providers' successes and challenges. Similarly, quarterly Enrollee Advisory Committee meetings and Community Action Forums with representatives from faith based organizations, community groups, and advocacy agencies are held quarterly to increase transparency proactively by sharing performance results. These forums also provide an opportunity to obtain and to garner immediately firsthand feedback with which to act on requests for greater transparency.

Our stakeholders understand that EPSDT services are fully covered, do not require separate authorization, and are considered medically necessary. These points are reiterated during quarterly community action forum meetings, on our provider and enrollee websites, in newsletters, at provider trainings, and in the provider toolkit. Aetna also publishes HEDIS scores and EPSDT rates in our provider bulletins and websites and includes EPSDT benefit information in the provider toolkit to improve our enrollees' uptake of EPSDT services. To increase the level of transparency in provider performance related to EPSDT, we report provider performance to the provider and Enrollee Advisory Committee.

#### **Aetna's Awesome Provider Program in Florida**

Aetna developed the Awesome Provider program to celebrate Medicaid Managed Medical Assistance PCPs with high clinical quality performance and to improve performance-related transparency. The program is designed to acknowledge providers offering exceptional service to our enrollees, motivate providers to increase clinical quality performance, and empower

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enrollees and other external stakeholders to select and refer providers who consistently meet quality goals. Primary care providers with at least 100 assigned enrollees are eligible whenever they have at least five enrollees in each quality measure denominator. If a measure has more than one sub-measure, five or more enrollees need to be in at least one denominator to be scored for that measure. Providers are grouped and scored by their tax identification number (TIN).

Providers who score at the 50th percentile rate in 75% of applicable program measures are eligible for an award. Applicable measures are based on provider type. If the TIN includes both pediatricians and either internal or family medicine providers, the provider group is included under the Internal/Family/Multi-Specialty measure category (for example, internal medicine and pediatrics are under one TIN). The 50th percentile rate used is the rate of the National Committee for Quality Assurance (NCQA) Quality Compass for the year prior to the measurement year. HEDIS 2018, reported in 2018 for the 2017 measurement year, will use the 2017 NCQA Quality Compass representing the HEDIS 2017 measurement for consistency with AHCA's goals for Medicaid managed care plan performance.

EPSDT-related HEDIS measures included by provider type are listed as follows:

- Internal/Family Medicine/Multi-Specialty: Child and adolescent access to care (all rates); Well-child visits for children ages three to six years; lead screening; annual dental visits
- Pediatrics: Child and adolescent access to care (four rates); well-child visits for children ages three to six years; lead screening; annual dental visits

Award: The award includes an announcement of winners in newspapers throughout areas where our enrollees are served, and a press release will be issued to the Florida Association of Health Plans. An Awesome Provider will also be rewarded with a provider office pizza party to include special mementos for the staff, announcement of the awardee(s) on our enrollee website, and presentation of a plaque to commemorate the accomplishment. Awesome Provider program awardees receive priority auto-assignment of enrollees.

### **Evaluation Criteria:**

1. The adequacy of the respondent's approach related to outreach and communication strategies that will be used to enhance enrollee education on EPSDT requirements.
2. The adequacy of the enrollee engagement approach and strategies that will be deployed to improve compliance with the periodicity schedule and treatment recommendations, including identification of the data sources that will be used to monitor compliance.
3. The adequacy of the respondent's training and education approach to facilitate a firm understanding of federal and State EPSDT requirements throughout all operations of the plan/subcontractors. The respondent must illustrate a commitment to ongoing training and retraining of staff/subcontractors utilizing an array of mediums to earn all points for this component.
4. The adequacy of the respondent's monitoring approach, including all data sources that will be used to ensure compliance with EPSDT requirements throughout all relevant departments within the respondent and with subcontractors.

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5. The extent to which the respondent's overall outreach approach identifies opportunities to improve upon the level of transparency for external stakeholders.

**Score:** This section is worth a maximum of 25 raw points with each of the above components being worth a maximum of 5 points each.

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**SRC# 23 – Behavioral Health/Primary Care Integration (Statewide):**

The respondent shall describe its proposed approach in promoting integrated behavioral health and primary care models, including:

- a. Identification of integrated models in various practice settings that have documented improved patient outcomes, patient satisfaction, and cost-effectiveness.
- b. Identification of opportunities for improvement across the respondent's system of care (e.g., care management, provider network, utilization management, enrollee services) with the goal of advancing to more integrated care models.
- c. Description of strategies the respondent will deploy to overcome the barriers/gaps identified to increase its capacity for providing integrated care models, including use of alternative payment models/financing strategies.

**Response:**

Each enrollee's unique health care needs are intricately bound together by his or her personal life story. We have learned that the best way to serve each individual's needs within a diverse population is to integrate behavioral health care and primary care within an integrated system of care. As a market leader in promoting innovative, outcome-driven, cost-effective, integrated physical and behavioral health care to Medicaid enrollees across the United States, we bring our expertise as system change agents to Florida to promote, incentivize, and remove barriers to integrating behavioral health and primary care throughout the systems of care that serve enrollees in each region of the State.

Aetna is committed to the biopsychosocial integration of physical, behavioral, and oral health, along with the social determinants of health, illness, and disability on behalf of enrollees whose health is compromised by the biopsychosocial complexity of their lives. Successfully promoting growth of integrated behavioral health and primary care across Florida begins with the example we set. By integrating behavioral health and primary care throughout our own internal system of care (Care Management, Provider Network, Utilization Management, Enrollee Services), we coordinate enrollees' physical, behavioral, and social needs in an individualized, person-centered, holistic manner.

Aetna Better Health of Florida has successfully subcontracted with Beacon Health Options (Beacon) for the past 12 years, delegating management of the behavioral health benefits and the specialty behavioral health network. Beacon strongly supports the Aetna integrated care management model and has a strong record of accomplishment promoting integrated behavioral health and primary care models in many locations across the State. Combining our mutual strengths and resources, Aetna and Beacon have formed an integrated partner model that is fully capable of meeting and exceeding the State's goals for this procurement.

This model extends well beyond simply co-locating clinical staff. Beacon and Aetna have an aligned clinical vision that enables Beacon and Aetna clinical staff working side-by-side to integrate utilization management and care management for all enrollees seamlessly. The experience of our enrollees and our providers will be that we speak with a single voice, doing what is best for our enrollees.

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In addition, Beacon brings the strongest network of Medicaid behavioral health providers in the State of Florida, many of whom are already progressing toward full integration of physical and behavioral health. Tighter integration of physical and behavioral health resources within the plan will enable us to accelerate the growth of integrated behavioral health and primary care models throughout all regions of the State of Florida.

### **APPROACH TO PROMOTING INTEGRATED BEHAVIORAL HEALTH AND PRIMARY CARE MODELS**

**CRITERION 1:** The extent to which the respondent thoroughly describes its current approach to and readiness for promoting/incentivizing, and removing barriers to, integrating behavioral health and primary care throughout its system of care

Aetna and Beacon are closely aligned in their shared approach to promoting integrated behavioral health and primary care models. Aetna's experience demonstrates the importance of managing behavioral health conditions when caring for enrollees with physical health conditions:

- Compared to individuals with no known behavioral health condition, individuals with one behavioral health condition have double the physical health costs; those with two behavioral health conditions have triple the physical health costs; and individuals with three or more behavioral health conditions have quadruple the physical health costs.
- Patients with serious mental illness (SMI) have a higher prevalence of chronic illness, such as diabetes or heart disease, and have many significant challenges managing these comorbidities.
- Our highest prospective-risk individuals have multiple physical health conditions and multiple/severe behavioral health conditions. Complexity and multi-morbidity are more accurate predictors of high utilization and cost than any specific diagnosis or group of diagnoses.

This analysis highlights our commitment to holistic care through the integration of behavioral health and primary care, as well as our ability to drive provider practice transformation by aligning provider incentives with preferred practices to integrate care across all conditions for our enrollees.

Beacon manages clinical complexity using the Four-Quadrant Model to match enrollees' needs with optimal clinical settings:

- Quadrant 1: Enrollees with low-severity mental health and/or substance use disorders are best served in a primary care setting with behavioral health resources integrated into it.
- Quadrant 2: Enrollees with serious mental health conditions without clinically significant substance use disorders or physical health conditions are best served in the specialized mental health continuum of care
- Quadrant 3: Enrollees with severe substance use disorders without clinically significant mental or physical health conditions are best served in the specialized addictions medicine continuum of care, as described by the American Society of Addictions Medicine.

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- Quadrant 4: Enrollees with severe co-occurring mental health and substance use disorders, often complicated by multiple physical health conditions, require the highest level of integration and coordination of services

Aetna and Beacon have reached the same conclusion—to serve the diverse and wide-ranging needs of our enrollees across the State of Florida, we must promote a range of integrated behavioral health and primary care models. We promote these models because they are evidence-based and they have been shown to improve patient outcomes, patient satisfaction, and cost-effectiveness in various practice settings.

Our preferred models include:

**Collaborative Care:** This model was originally developed to enhance behavioral health care in the primary care setting. The American Psychiatric Association has identified collaborative care as a critical strategic response to the growing shortage of behavioral health clinicians across the nation. The standard model requires the primary care practice to include a licensed behavioral health clinician as a member of the primary care treatment team. This behavioral health clinician becomes a member of the primary care treatment team; it is not an embedded psychotherapist role. Brief visits in examination rooms, hallway consultations, and networking within the larger system of care are all expectations of the role. The second requirement is easy access to an external consulting psychiatrist who supports the behavioral health clinician directly, consults with the primary care providers as needed, and may work with selected patients using telepsychiatry technology.

Using telepsychiatry, a PCP can effectively extend behavioral health treatment into the primary care setting, which is especially useful in rural areas where the PCP is the only provider available for depression, anxiety, insomnia, etc. Through such an arrangement, enrollees can access care more quickly and conveniently from a provider whom they already know and trust, avoiding stigmatization by receiving treatment in the privacy of the PCP's office.

Beacon has already deployed this model in Florida and will collaborate with Aetna's network of primary care practitioners to make it more broadly available. We have found that larger primary care practices and FQHCs seem to accommodate this model more easily because they have the capacity to add full-time behavioral health clinicians to the primary care treatment team.

**Project ECHO™** is another evidence-based model for enhancing behavioral health treatment in the primary care setting. PCPs require expertise in diagnosing and treating behavioral health conditions without referring enrollees to behavioral health specialists. Using Project ECHO, an interdisciplinary team of behavioral health clinicians meets in a central location and videoconferences with primary care practitioners who are usually in remote areas. These are clinical case conferences in which the PCP describes challenges and concerns of caring for a particular patient and the team works with the clinician to develop a treatment plan to address each person's biopsychosocial situation and achieve an optimal outcome. As a result of these case conferences, PCPs become more proficient in specialty care practices. This is the force-multiplier benefit in that, after a while, the PCP acquires specialized expertise and begins receiving referrals from other practitioners within that region. High-quality care becomes more accessible, more timely, and more effective.

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Project ECHO has several behavioral health modules. Aetna and Beacon will implement an ECHO program for treating enrollees with opioid use disorders, including medication-assisted treatment. Educating PCPs and other practitioners such as obstetricians will expand resources available to enrollees with opioid use disorders. The goals are to improve early recognition of enrollees with a substance use disorder, to engage them in treatment, to increase the use of office-based medication-assisted treatment, and to integrate primary care practices with specialized substance use treatment providers to enhance communication and coordination of care.

Consultation: Long before collaborative care and Project ECHO became available, PCPs provided most of the behavioral health treatment in the United States, and they continue to do so. PCPs who are not participating in Project ECHO or changing their practice into a collaborative care model but who are providing behavioral health treatment appreciate having access to a colleague for consultation on an as-needed basis. For example, in response to the scarcity of child and adolescent psychiatrists, Beacon helped establish the Massachusetts Children's Psychiatry Access Project (MCPAP) to improve access to treatment for children with behavioral health needs in the primary care setting. The program provides telephonic psychiatric consultation and coordination support to pediatric primary care providers. This highly successful primary care support model that has since been replicated in at least 20 states provides psychiatric consults to pediatricians across the Commonwealth. Statewide, 57% of pediatric network providers use this real-time consultation service, which offers a response within 30 minutes. Over 80% return to their PCPs for management of their behavioral health/medication needs after consult. Approximately 70% of consult request are addressed by a behavioral health clinician, with 30% resulting in a psychiatric consultation.

Beacon has also introduced the MCPAP for Moms program, is modeled after the original MCPAP but geared toward providers serving pregnant and women through one year postpartum. The purpose of MCPAP for Moms is to help front-line providers identify and address the mental health and substance use concerns of their pregnant and postpartum patients. MCPAP for Moms has three core components:

- Trainings and toolkits for providers and their staff on evidence-based guidelines for depression screening, triage and referral, risks and benefits of medications, and discussion of screening results and treatment options
- Real-time psychiatric consultation and care coordination for providers serving pregnant and postpartum women in obstetric, pediatric, primary care, and psychiatric settings
- Linkages with community-based resources to support wellness and mental health of pregnant and postpartum women

Telepsychiatry: A concern raised by many PCPs is what to do when the behavioral health treatment they are providing is not working well. This can be a significant barrier to assuming responsibility for treating a person with a behavioral health condition. Aetna and Beacon both support telepsychiatry to promote integrated behavioral health and primary care in a variety of settings:

- Primary care practices: Psychiatrists in Beacon's network offer telepsychiatry consults to primary care practitioners to answer specific questions about diagnosis and treatment.

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- Emergency departments: In Broward County, Beacon offers psychiatry consultation to multiple emergency departments, which makes it possible for a person to be treated and stabilized without admission to a hospital.

### **AETNA'S SYSTEM OF CARE: OPPORTUNITIES FOR IMPROVEMENT**

#### **Care Management**

Aetna's Medicaid organization first implemented its fully integrated care model in 2010, and it quickly became our standard model of care for every health plan. This holistic, person-centered approach begins with developing a biopsychosocial understanding of every enrollee with whom we are privileged to work. The enrollee must be the foremost authority on his or her preferences and life goals. Our role is to serve as an advocate and to partner with the enrollee to determine how health care services and supports can assist in reaching those goals. The integrated care model incorporates input from family and other individuals in the enrollee's circle of support, with enrollee consent, as well as health care providers, representatives from related services and support organizations, and information from service utilization and pharmacy records.

Once an enrollee is identified as needing care management, we schedule a visit to the enrollee's home. We make every effort to meet with enrollees within one week of their identification. The visit provides an opportunity for the care manager to meet the enrollee (and his or her family or circle of support) to begin a relationship based on trust and compassion and focused on the enrollee achieving his or her health goals. The care manager engages enrollees in conversation about goals that are most important to them, about their strengths and available resources, and about the areas in their lives with which they need our help. Listening carefully to each enrollee helps us individualize our approach to meeting his or her physical, mental, emotional, and social needs. We are able to provide enrollees with the physical and behavioral health help they need, as well as referrals to services that augment that help.

Care management staff prioritizes enrollee understanding of roles and rights to choose self-management options. Care managers work with enrollees to help identify challenges, and provide education about their care plans, medication, and the potential consequences of not following their plans. We promote each enrollee's increasing ownership and responsibility for managing his or her health and well-being.

After a shared understanding of the enrollee's needs, goals, and preferences is confirmed, we identify the barriers to achieving those goals. We then help to shape a care plan that incorporates each enrollee's strengths and resources and is tailored to the enrollee's needs and objectives. Often, an enrollee's health is affected by non-clinical factors such as housing instability or social isolation and complicated by inequitable access to basic services and supports. Addressing both physical and behavioral health needs and social determinants in an integrated, comprehensive way produces optimal results. As a person progresses, their needs and circumstances might change. Care managers consult with team medical directors and clinical supervisors on a regular basis to maintain a high quality of care without transferring the enrollee from one care manager to another.

To optimize care management, transition of care, and early interventions to enhance outcomes and close gaps in care, our enrollees, providers (traditional and non-traditional), and community resources all join together in a virtual environment to share and coordinate care management

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activities related to physical and behavior health and social determinants. This includes a comprehensive review of all medications prescribed for an enrollee. CareUnify is Aetna's comprehensive, Medicaid-centric population health platform that captures information in real time to create a cohesive picture of an enrollee's data for providers at the point of care. This makes it possible for the enrollee's interdisciplinary care team to manage care in all settings, preventing unnecessary duplication of tests, facilitating timely closure of care gaps, mitigating risks of adverse drug-drug and drug-condition interactions, and maintaining care continuity.

Utilization Management

Aetna's integrated care model incorporates utilization management decision-making guidelines using appropriate evidenced-based clinical settings and services to treat behavioral and physical disorders. We choose and train our utilization management clinicians to manage acute episodes of care from all causes, as individuals admitted to an acute setting are often complex and require attention and care continuity for multiple conditions, not just the condition that led to admission.

For example, our utilization management clinician would manage an individual admitted for an episode of pancreatitis who also has a diagnosis of alcohol abuse and depression. While addressing the pancreatitis, the clinician would also address the risk that antidepressant levels may decrease under conditions in which an enrollee cannot take any food or liquid by mouth, worsening depression. The utilization management clinician would also recognize that alcoholism is a treatable condition requiring follow-up after discharge and would collaborate with the facility discharge planner to include that in the discharge plan. Finally, enrollee social situations may contribute significantly to the risk of relapse and readmission, so mitigating those factors in the treatment and discharge plan is critical to recovery. Using a biopsychosocial approach, we have found that many hospitalizations, including readmissions for both physical and behavioral health treatment, are preventable.

Upon admission, a plan begins to develop to prepare for discharge and coordinate continuity of care following release. As part of this planning, utilization management staff works to understand the reason for the current admission. This understanding will help an enrollee's team work with the enrollee to identify circumstances that produced the current hospital admission, and prepare for potential reoccurrence of those conditions. For example, staff are trained to consider different timeframes: an hour, a day, a week, and a month before the enrollee was admitted. We examine what should have occurred as well as what should not have occurred in the course of illness leading up to the point of admission. We also identify social determinants that need to be addressed prior to discharge, such as housing instability or homelessness or a toxic home environment (e.g., domestic partner violence). We address these issues and mitigate these risks as part of our plan for continuity of care after discharge. This might include helping the enrollee apply for Section 8 housing, temporary housing, legal protections, and more. We do whatever is necessary to ensure a safe discharge for the enrollee.

We then collaborate with the hospital to mitigate the risk of readmission. Concurrent Review clinicians work in tandem with hospital case management staff, as well as our care management staff, to identify enrollee discharge needs, make appropriate follow-up referrals, and assist in obtaining prior authorization if needed for post-hospitalization services. This may include coordination of physical health services after a behavioral health admission as well as behavioral health services after a physical health admission.

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Under our integrated partner model, Beacon will manage the specialty behavioral health services benefits. With mirror-image approaches, Aetna and Beacon have utilization management programs, which are committed to and embrace the integration of physical, social, and behavioral health care. Beacon's utilization management strategy begins with service authorization for all care and combines review criteria with data-driven management of facilities and providers to improve quality and control costs. Our shared focus is on increasing access to the most clinically appropriate levels of care for individuals while minimizing the administrative burden on providers. Beacon is also attentive to identifying and addressing clinical practices that are not supported by published guidelines or evidence-based practices. Like Aetna, Beacon's approach is focused on promoting the best, most cost-effective interventions, treatments, setting, and approaches. It is about being aware of and attentive to the individual's total life situation, including illness, social needs, strengths, and resources available for promoting recovery.

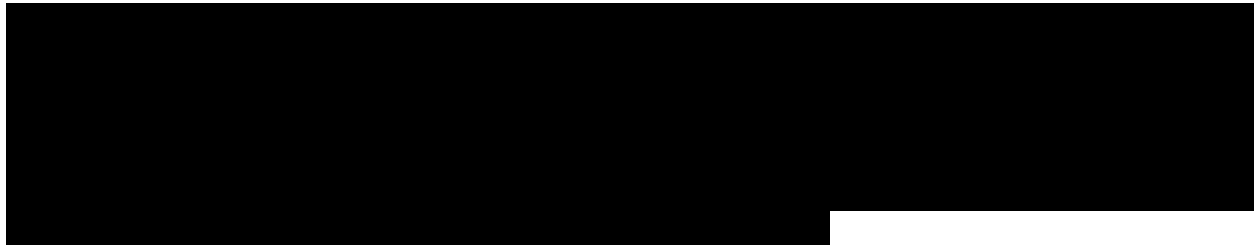
Beacon's clinical program enables a recalibration of resources and activities to drive system value. With an integrated approach to utilization management, the focus is on connecting enrollees with the most effective care available, helping them return to full functioning in their life as quickly as possible. Aligned in our approaches, Beacon also uses an approach that is based on ensuring the right treatment in the most appropriate treatment setting. This strategy enhances coordination with specialty behavioral health providers and with Aetna and our primary care and other specialty providers. This includes a particular emphasis on care coordination for enrollees who are most at risk and seeking emergency services or inpatient/institutional care and those with co-morbid physical health conditions. Moreover, Beacon delivers on its mission to promote recovery and resiliency in the community by providing services and supports that are preventive, accessible, and comprehensive.

\*\*\*\*\*[REDACTED]\*\*\*\*\*

[REDACTED]

[REDACTED]

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Collaboration between Care Management and Utilization Management

Enrollees with multiple physical and behavioral health conditions complicated by adverse social determinants are at high risk for readmission. They are best served when care management and utilization management clinicians work together as a team. As previously described, our utilization management clinicians work with hospital discharge planning staff to understand what led to the current admission to shape the discharge plan to minimize the risk of readmission. If the enrollee is already engaged in care management, the utilization management and care management clinicians will collaborate on the root cause analysis and discharge planning. If the enrollee is not already engaged in care management, the utilization management clinicians will refer to care management prior to discharge and review the issues with the care manager. The care manager may then have an opportunity to speak with the enrollee prior to discharge, increasing the likelihood the enrollee will engage with him/her after leaving.

All services and supports—including follow-up appointments with the enrollee's PCP or appropriate specialist, behavioral health provider, prescriptions and medication reconciliation, home health care, durable medical equipment, community resources and supports—are scheduled prior to the enrollee's discharge and in place on the enrollee's first day at home. If an enrollee requires transition to a secondary setting for continued follow-up, our utilization management team works closely with our care management team to identify any barriers or need for a meeting with the enrollee.

The biopsychosocial complexity of an enrollee's life is one way we identify those at high risk of readmission. There are other groups of enrollees for whom we coordinate utilization management and care management prior to discharge. The first includes enrollees identified (through our predictive modeling tool) at elevated risk of a future admission or ED visit. Another group includes enrollees identified prior to admission as likely to benefit from care management, but whom we have been unable to locate or engage. To identify these enrollees while they are in the hospital, our care management platform is designed to provide real-time in-patient alerts to both our utilization management and care management clinicians so they can work in tandem to begin the discharge planning upon admission.

Enrollee Services

Enrollee support services at Aetna are a function shared by our Enrollee Services and Care Management departments. At every point of enrollee contact, our caring, discerning, and supportive staff joins enrollees where they are by focusing on matters most important at the time of contact. For example, if on a call scheduled by an Enrollee Services support staff an enrollee shares that he or she has just received an eviction notice, our staff member will focus on helping the enrollee find safe housing as quickly as possible. After that, the Enrollee Services

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representative will make a warm transfer to a care manager if the enrollee wants a referral to manage a health condition such as diabetes.

Our Enrollee Services support staff is also embedded in our Care Management department and teams, where each staff member has direct access to a real-time electronic record of enrollee information and individual care plans. An Enrollee Services support staff member can assist enrollees with accessing community-based resources, provide information about services both covered and not covered by the health plan, help file complaints and appeals, and address coordination-of-care issues and social determinants of health. Our conscientious and thorough Enrollee Services support staff provide services that include (but are not limited to):

- Promoting enrollee preferences with respect to receiving person- and family-centered care
- Assisting enrollees with accessing community-based resources to address non-medical needs such transportation, respite care, and daycare; assistance with daily activities like dressing or bathing, housing, and food insecurity
- Conducting three-way calls to promote behavioral health with primary care providers and coordinate care when multiple providers are treating the same patient
- Identifying primary care providers that treat behavioral health conditions and group practices that offer both physical and behavioral health care
- Identifying a need to speak to a care manager and promptly connecting the enrollee to a care manager
- Supporting the enrollee's care plan objectives and independence

### **Provider Network Strategies/Value-based Solutions**

Aetna's provider network strategies offer the greatest opportunities for improving the care enrollees receive by actively promoting and incentivizing integrated care models throughout the network of providers. Our commitment to working with enrollees holistically has made us acutely aware of the need for improved integration of primary care and behavioral health throughout our provider network. Because Beacon has been managing specialty behavioral health benefits, our focus has been on the integration of behavioral health treatment within primary care settings (such as PCMHs, FQHCs and RHCs), as well as accountable care organizations/clinically integrated networks of providers. As described in detail, Aetna and Beacon share a similar vision and are able to enhance each other's efforts within our integrated partner model.

Aetna's experience with complex and high-risk populations has shown that physical health providers assuming financial risk in value-based contracts need to take into account the impact of behavioral health conditions on the enrollees for whom they are accepting risk. Aetna and Beacon both use the Integrated Practice Assessment Tool (IPAT), a simple self-assessment instrument to assess a practice's level of integration based on the standard integration framework described on the SAMHSA-HRSA Center for Integrated Health Solutions website. This framework has six levels of integration, ranging from the least (Level 1) to full integration (Level 6). Our intent is to transform the system of care in Florida through incentive agreements, training and technical assistance, and the continued development and use of information-sharing tools such as CareUnify.

As described in the next section, some physical health providers are innovators and early adopters of integrated practices. We value these premier providers and offer them enhanced

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value-based incentives according to their level of integration. Many PCPs are ready to integrate behavioral health into their practices, but need administrative support and technical assistance to manage the change. Aetna is prepared to meet providers where they are as they transform their practices to meet this need. We will offer them targeted administrative support and technical assistance, and incentives based on progressing in their level of integration and expanding the range and capacity of evidence-based practices in their region. Aetna's provider network strategies include:

- A patient-centered medical home (PCMH) is a primary care practice with enhanced capabilities to serve a general population. These include care coordination, expanded evening and weekend hours, 24/7 accessibility, an electronic health record, and more. Enrollees affiliated with a PCMH will range from completely healthy to having one or more chronic and potentially progressive/disabling physical and/or behavioral conditions. Consistent with standard health care practice, many enrollees affiliated with a PCMH will have one or more behavioral health conditions, with the PCMH as their only source of behavioral health treatment. PCMHs vary widely in the progress they have made toward higher levels of integration. Aetna's incentives for a PCMH include progression toward higher levels of integration as measured by the IPAT.
- An accountable care organization (ACO) is commonly a hospital/health care delivery system that is large enough to accept population risk. Many hospital systems have eliminated behavioral health inpatient capacity and may have few, if any, behavioral health practitioners on staff. At the same time, it is likely that approximately 25% of the individuals in medical-surgical inpatient beds have at least one behavioral health condition, and that percentage may be higher among individuals visiting emergency departments. Aetna recommends that an ACO has a robust behavioral health treatment capacity, either as a part of its own organization or in close alliance with a nearby behavioral health delivery system.

Aetna's telehealth capabilities and population health platform, CareUnify, are supporting technologies for these provider network strategies. CareUnify improves access to providers, helps prevent avoidable emergency department and urgent care use, and improves specialty access, especially for behavioral health. We can share meaningful data to support broader population health and point-of-care interactions, with a focus on quality and total cost of care. CareUnify encourages providers to access and share information within the enrollee's interdisciplinary care team. This gives providers ready access to a more complete enrollee profile and a connected interdisciplinary team of physicians, pharmacists, behavioral health clinicians, extended community care teams, care managers, the enrollee, and the enrollee's circle of support.

Aetna and Beacon both recognize that providers need technical assistance to become integrated practices. Together, we will coordinate our consultative efforts based on the needs of each practice. Aetna employs population health specialists who are a team of experts working directly with our provider partners to support and coordinate all population health activities for providers. A population health specialist works directly on site with our provider partner care teams to support them in their overall population management, including serving as the relationship manager and single point of contact; providing a minimum of monthly reviews on all performance trends, including, total cost, quality, and utilization with guidance on actions to achieve targets; supporting advanced care coordination with the health plan and other providers such as behavioral health; identifying high-risk and emerging-risk enrollees who need care;

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supporting practice transformation and workflow re-design; and providing direct training and ongoing education with the CareUnify system. Aetna is committed to providing these resources to create a shared approach in collaboration with our provider partners. This will help them achieve success on their value-based arrangements, while also ensuring our enrollees receive the highest quality care.

Similarly, Beacon employs managers of provider partnerships (MPPs) who work closely with providers to provide technical assistance, build highly collaborative relationships, and drive performance improvement through education and data review. MPPs serve as a hybrid position encompassing clinical, quality, and provider supports. They serve as a single point of contact and concierge for high-volume providers by providing timely resolution of provider concerns, presentation of data identifying provider performance over time, highlighting key areas of focus, and identifying strategic plans to address performance improvement. Today, Beacon employs four MPPs in Florida (positioned regionally) that are focused on ensuring full engagement with 80 of its major network providers throughout the State.

Beacon shares practice-level performance data with high-volume practices quarterly. Beacon's MPPs hold meetings in person. These meetings focus on the interpretation of quality reports and collaborative technical assistance intended to assist practices to reduce variation in practice patterns and improve the quality of care.

Beacon's MPPs share more than 20 metrics with providers, which are benchmarked against similar providers in the State. Utilization management metrics for inpatient and higher levels of care include readmission rates, the length of stay by the hospital, the length of stay by the attending provider, quality of care and service issues, admissions to each facility, and admissions to lower levels of care, such as step-downs. Many of these same metrics are reviewed with Aetna's primary care providers.

Beacon also evaluates outpatient providers with high no-show rates and providers with enrollees who only attend one post-discharge visit with no follow-up. This information is reviewed facility by facility. For high-volume facilities, this information is shared with the facility by using a blind comparison to other facilities, with instances of unusual patterns of utilization discussed. Information on enrollees is also tracked, such as high-dollar claims, readmissions, and diagnoses. This is another example of how Beacon and Aetna collaborate: joint review of these items allows Aetna to offer intensive care management services when they are needed. For outpatient care, metrics include the length of stay; enrollees seeing multiple providers; providers seeing multiple family members; providers and their rate of admission to higher levels of care; and quality of care and quality of service.

There are a variety of measures available in the alternative payment model framework that allow us to incentivize providers away from volume and toward value, and these same measures are employable when it comes to encouraging and formalizing integration of behavioral and physical health. Such measures may include models from upside adjustments to fee schedules based on quality performance to risk sharing and population-based payments, depending upon provider readiness and practice maturity.

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Examples of Integrated Models within Our Current Network

Aetna will collaborate with the Florida Association of Community Health Centers to promote its model of collaborative care. We are confident this will increase our reach and improve the level and effectiveness of its adoption by FQHCs and large provider practices. We will focus on the ways in which compensation can foster practice and care integration in the primary care practices that accept risk. Provider contracting, including value-based contracting, provider education, technical assistance and data monitoring, and reporting will be addressed. Aetna will take a grassroots approach with smaller provider practices and community mental health centers. Our Provider Services liaisons will employ assessment tools and assist in the development of resource pods in each region, enabling us to link behavioral health providers and physical health providers that are geographically close to established collaborative efforts to achieve integration targets.

Recently, Aetna initiated a telemedicine program collaboration with Jessie Trice Community Health Center, Inc. Working with [REDACTED] at the Trice Centers in Region 11, Aetna is implementing telemedicine to deliver a cost-effective solution to Trice Center providers, which is both secure and easy to use. As the providers and centers adopt the telehealth platform, Aetna will coordinate all training and support with our telehealth vendor to facilitate effective implementation. Additionally, through [REDACTED]

[REDACTED]

Beacon believes strongly in the importance of value-based payment arrangements with behavioral health providers to influence both the quality and the cost of care for Medicaid enrollees. In Florida, Beacon designed and implemented a full-risk downstream sub-capitation program for community mental health centers and other providers serving Medicaid, TANF, SSI, SMI, Child Welfare, and HIV/AIDS enrollees. To ensure that funds are properly extended and appropriate/innovative services occur, sub-capitation providers must provide encounters for 85% to 90% of capitation (maintenance of effort), with escalating annual quality withholds/incentives associated with readmissions, follow-up, engagement, and other key metrics. Rates are based on total population and include the following payment parameters:

- Maintenance of effort
- Quality measure withholds
- External claims pool threshold
- Medical outcomes payments (future state)

Sub-capitation rates are developed using historical behavioral health spending, including additional adjustments for added benefits (e.g., substance use treatment added to the 2014 MMA contract), anticipated trend, and any unique service a provider offers that may not be encapsulated within the historical behavioral health data. Beacon takes these amounts by Medicaid region and disburses funds according to the historic allocation of behavioral health funding providers received, keeping in mind the pricing factors previously mentioned. To ensure appropriate risk mitigation, different rate cells are created for SSI, TANF, SMI, and specialty populations (e.g., HIV/AIDS, Child Welfare). Those rates are then applied to a monthly enrollment roster to determine the total sub-capitation payment for each provider.

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Beacon has established nearly statewide sub-capitation agreements with Florida behavioral health providers. This results in increased accountability, improved flexibility, and ultimately better clinical outcomes for enrollees. Beacon currently has 9, and by the end of 2017, Beacon will have 11 behavioral health provider sub-capitated arrangements in 7 of the AHCA regions. Beacon has a long history establishing sub-capitated arrangements for Florida Medicaid. For example, before the MMA program was established, Beacon legacy companies served as part of the MediPass behavioral health program since 1995 and had established more than 10 sub-capitated arrangements throughout Florida.

By continuing to expand the number of CMHCs and other behavioral health providers under sub-capitation, this will elicit better enrollee outcomes, increased satisfaction with care provision, and ensure appropriate and innovative services are in place and available for the enrollees who need them the most.

Integrated Health Home: Mercy Maricopa Integrated Care

**CRITERION 2:** The extent to which the respondent provides examples of more effective integrated models within its provider network that have documented improved patient outcomes, patient satisfaction, and cost-effectiveness. The respondent must also describe the data sources

The integrated health home (IHH) model is based on an enrollee-centered, whole-health care approach. An IHH provides full medical, behavioral health, health promotion/prevention, and wellness services using available best practices for integrated care delivery. The goal of an IHH is to provide team-based, integrated health services that deliver an individualized, recovery-oriented, coordinated, and accessible approach to care that focuses on providing enrollees with the right services at the right time at the right level to optimize their health and wellness.

IHHs function like one-stop shopping, whereby an enrollee can see both their assigned PCP and receive behavioral health, health promotion, and prevention services in one facility. In this model, the PCP is fully incorporated into the team, working with the behavioral health provider and supporting other team enrollees to deliver comprehensive person-centered care. Enrollees desiring to join the IHH are required to see the PCP on the team. This requirement is made very clear during enrollment so that the enrollee has the autonomy to agree to this requirement or choose an alternative model of care. The integrated care plan incorporates the enrollee's whole health goals.

One example of our success is the work we have done in Arizona through the Aetna Medicaid organization's management of Mercy Maricopa Integrated Care (MMIC), an Arizona health plan. Since 2014, MMIC has coordinated physical and behavioral health services as well as housing, employment, and court services to Medicaid enrollees around the Phoenix, Arizona metropolitan area. MMIC was the first regional behavioral authority in Arizona to integrate physical health, behavioral health, and substance abuse services for Medicaid-eligible individuals with a SMI. The integrated model serves approximately 20,000 individuals in Maricopa County.

MMIC worked directly with large behavioral health clinics serving individuals with SMI to help them evolve into IHHs. These clinics are now positioned across Maricopa County and include PCPs who work in full collaboration with behavioral health practitioners, clinicians, and paraprofessionals to form the enrollee's interdisciplinary care team. Each enrollee diagnosed

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with a serious behavioral health condition is assigned to a care manager who supports coordination of care across disciplines. Using a shared electronic medical record, an annual or based-on-change-in-condition, fully integrated comprehensive assessment is conducted. This assessment enables the enrollee's clinical team to understand how social determinants affect his or her medical and behavioral health care needs, which, in turn, facilitates the interdisciplinary team's ability to work with the enrollee and his or her circle of support to develop a holistic, culturally appropriate individual plan of care that encompasses the medical, behavioral health, co-occurring substance use, functional, and socioeconomic needs. The individual plan of care and assessment are provided to referral sources to support housing, employment, respite, and other service needs.

MMIC implemented virtual health homes (VHHs) as an innovative approach to delivery IHH services for enrollees who choose to stay with their primary care practice or behavioral health homes that are not integrated. The plan uses an adapted version of the team model developed by Dr. Thomas Bodenheimer at the University of California at San Francisco for its VHH. The model places health coaches in designated primary care practices. The health coaches take a person-centered approach and work collaboratively with the enrollee and the PCP as part of a mini team to provide comprehensive health care and health education services. The VHH unites two specialty teams: one at the enrollee's primary care practice, including a clinician, support staff members, and one to two health coaches, and another team at the enrollee's behavioral health provider. This model is thought to strengthen communication and coordination practices across the medical and behavioral health domains to foster true enrollee-centered, whole-health care.

A model of integrated care unique to individuals with SMI is a medical assertive community treatment (MACT). The team is comprised of the traditional ACT staff required per SAMHSA as part of the transdisciplinary model but with the addition of a PCP. By having a psychiatrist and PCP on one team, MACT can provide integrated care for enrollees who experience the most acute psychiatric symptoms and co-morbid chronic medical conditions. As of September 2016, the MACT team served 89 enrollees.

The goal of the team is to help enrollees manage and mitigate the effects of chronic illness by receiving coordinated care and interventions that support healthy lifestyle changes, such as smoking cessation, improved diet, and physical activity. Some of the chronic medical conditions that meet the medical criteria to qualify for the team are diabetes, pulmonary and cardiovascular disease, obesity, asthma, tobacco dependence, and hypertension. The goal is to reduce exacerbation of the chronic health condition and improve health outcomes. The MACT team is a truly individualized medical and behavioral health treatment program integrated into a community setting.

The largest proportion of enrollees served in these programs is in a pre-chronic disease state. Half are addicted to nicotine; more than half are obese, pre-hypertensive or hypertensive, and half have pre-diabetic or diabetic conditions. The individuals served in these integrated models will have treatment designed to slow or even reverse their progress toward a chronic condition.

Most of the integrated practices rate themselves three or more out of six on the path toward full integration. There are many ways to achieve integrated care for a diverse population. These models were supported in their development by the health plan, which provided training, support, data, and incentives largely focused on decreasing acute episodes of care, decreasing

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inappropriate use of emergency departments, and some standard HEDIS measure improvements. The MACT service achieved an 81% fidelity score using the SAMHSA EBP tool, and it was incentivized for decreased homelessness, increased employment, ensuring at least one primary care visit, and improvement in health risk assessment scores.

Opportunities for Improvement: Overcoming Barriers to Integrated Care

CRITERION 1: The extent to which the respondent thoroughly describes its current approach to and readiness for promoting/incentivizing, and removing barriers to, integrating behavioral health and primary care throughout its system of care

CRITERION 3: The extent to which the respondent identified opportunities for improvement in delivering an improved integrated care model and subsequent steps the respondent will implement across its systems to increase capacity for providing integrated care

A major barrier to implementing integrated care is how difficult it can be for an enrollee to get the treatments, services, and supports he/she needs. Health care is often fragmented; physical providers operate apart from behavioral health providers, and behavioral health providers often operate apart from providers who treat substance use disorders. Adding to this fragmentation is the number of separate agencies and organizations to serve enrollees with adverse social determinants. There are often gaps in the mix of services and limited capacity of services, creating barriers to serving an enrollee's needs.

Aetna has implemented standard operating protocols throughout our internal system of care (care management, provider network, utilization management, and enrollee services) to mitigate the risks to individual enrollees. We described the integration of utilization management and care management to address the root causes of preventable admissions earlier in this response. Going beyond just coordination of care, enrollees are matched with complex co-occurring conditions with integrated clinical practices in either of our networks (Aetna or Beacon) that would be a best fit with their needs, and educated about the benefits of getting their health care from an integrated provider.

In an effort to remove barriers for enrollees, our Enrollee Services representatives facilitate referral of enrollees to appropriate care settings by routing enrollees to a care manager when representatives become aware of complex situations.

Traditional barriers individuals with mental illness face:

- They may be too disorganized to access health care or community services
- Medical and behavioral providers tend not to communicate with one another
- Some health care providers are unsure or fearful of treating individuals with mental illness
- Interactions between behavioral health and physical health conditions and medications
- Community organizations and advocates are unaware what organized systems are available to help them

How our integrated model aids enrollees and removes barriers:

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- Aetna's Enrollee Services personnel are community-based navigators who make appointments arrange transportation and community support
- Aetna engages providers and shares information through Web-based tools such as CareUnify
- Aetna and Beacon provide education and support for providers and community groups
- Aetna and Beacon have developed unique tools to educate providers on evidence-based considerations for clinical practice

Aetna goes beyond care coordination to become a true collaborator with the State in driving the transformation of care. We have created an innovative approach to meet the needs of enrollees whose health is compromised by biopsychosocial complexity. We have learned that these enrollees are at risk for poor health and will not respond to standard care, adding to the complexity of their lives. They drive a disproportionate share of total cost of care through their utilization of intensive and expensive health care resources—and they have increased risk of poor health and high costs in the future.

The paradox is that many of these individuals are eligible for a range of available resources. These may be covered by Medicaid, often as a Medicaid waiver, or may be available outside of Medicaid. Just as standard health care is fragmented and complex, the array of available resources is fragmented into different funding streams with different eligibility requirements managed by different state, county, and local agencies and programs. The model is not user-friendly.

Aetna has implemented our integrated system of care approach to address these barriers. We recognize that utilization management and care management will be more effective with a robust network of providers practicing integrated care capable of serving enrollees with special needs, including complex, high-risk populations. Plan staff include system of care administrators who assess the resources in each region of the State and engage stakeholders in the region to work toward a mature integrated system of care with the following features:

- Person-centered and inclusive of each enrollee's family/circle of support, and respectful of each enrollee's cultural community
- Health care and related services and supports necessary for enrollees
- Includes resources that address physical health, behavioral health, oral health, and all social determinants of health, illness, and disability
- Resources capable of providing:
  - Medicaid-covered services managed by the health plan
  - Medicaid-covered services not managed by the health plan
  - Services not covered by Medicaid but available through other State agencies and other funding streams
  - Services available locally from community-based organizations
- Structure through which blended/braided funding supports services from all agencies of State government in the most cost-effective and efficient way:
  - Aligns and coordinates multiple care managers from multiple agencies, simplifying each enrollee's experience because multiple care managers are not inflicted upon them
  - Creates a single integrated care and services plan for each enrollee that satisfies the requirements of each State agency and funding stream

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- Matches each enrollee with the services that best meet his or her needs, regardless of the source or origin of those services, eliminating duplication and service gaps
- Region specific resources, complimented by broader service area providers that are outside the region
- Includes effective working relationships between and among all stakeholders within each integrated system of care, demonstrated through seamless coordination and reciprocal referrals embodied in Memoranda of Understanding
- Capable of fully serving enrollees of special needs populations, each of which has its own dedicated system of care and network-within-a-network; where service capability goes beyond contractual requirements for network adequacy, and adequacy requirements are applied to each well-defined population of individuals, including enrollees with:
  - Serious mental illness/severe and persisting mental illness
  - Severe emotional disturbance
  - Disabling substance use disorder
  - Intellectual and/or developmental disability
  - Foster care
  - Traumatic brain injury
- Capable of fully serving:
  - Enrollees in different age groups: children, adolescents, and adults
  - Enrollees who are members of different cultural communities
- Delivers care and services through integrated interdisciplinary care teams either within an organization or as virtual teams integrating across multiple organizations, to create a person-centered care team
- Simplifies the task of each health plan concurrent review clinician, discharge planner, and care manager by addressing the root causes driving preventable utilization
- Provides trauma-informed care based on a universal precautions model that serves each enrollee as if he or she has been traumatized, and evidence-based trauma treatment and recovery services

Transforming the delivery system into an integrated system of care will integrate behavioral health and primary care by organizing the services in each region of the State to meet the needs of enrollees living in each region of the State.

### **Evaluation Criteria:**

1. The extent with which the respondent thoroughly describes its current approach to and readiness for promoting/incentivizing, and removing barriers to, integrating behavioral health and primary care throughout its system of care.
2. The extent to which the respondent provides examples of more effective integrated models within its provider network that have documented improved patient outcomes, patient satisfaction, and cost-effectiveness. The respondent must also describe the data sources.
3. The extent to which the respondent identified opportunities for improvement in delivering an improved integrated care model and subsequent steps the respondent will implement across its systems to increase capacity for providing integrated care.

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**Score:** This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

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**SRC# 24 – Transportation (Statewide):**

The respondent shall describe its experience and approach for coverage of non-emergency transportation services by providing the following:

- a. A description of the software capabilities utilized to facilitate ease in scheduling and tracking of enrollee pickup adherence;
- b. Strategies for determining the most appropriate mode of transportation; and
- c. Providing data on the following performance metrics for calendar year 2016:
  - (1) Percentage of trips where the enrollee arrived to their scheduled appointment on-time;
  - (2) Percentage of missed trip requests (failed to pick up the enrollee);
  - (3) Percentage of hospital discharge requests fulfilled within three (3) hours of the request;
  - (4) Percentage of urgent care requests fulfilled within three (3) hours of the request; and
  - (5) Number of transportation related complaints and grievances per 1,000 enrollees.
- d. A description of how the respondent uses the performance metric data above to identify areas in need of improvement and implements successful strategies that improve the provision of service.

**Response:**

Transportation is a vital lifeline for many of our enrollees—and can sometimes mean the difference between health and serious illness. Aetna understands that transportation is among the critical factors necessary to help ensure access to timely, medically necessary care. Lack of transportation options place enrollees at increased risk for poor health outcomes due to missed appointments or delayed medical care, which can ultimately lead to higher usage of emergency care and preventable hospitalizations.

In early 2017, Aetna conducted a series of stakeholder and enrollee focus groups to gain a comprehensive, region-specific understanding of the issues our enrollees face. Additionally, we visited 420 community and stakeholder organizations across the State to learn about opportunities to better serve enrollees. Through this research, transportation emerged as a reoccurring theme in these focus groups and in discussions with community organizations in the State as one of the key barriers to care. Enrollees and stakeholders alike expressed the need for consistent, reliable, and effective transportation.

The focus group results pertaining to transportation were shared with our vendor and we analyzed the information and agreed to work collaboratively to ensure significantly more reliable and efficient non-emergency transportation system to offer enrollees access to care resulting in improved health outcomes and lower health care costs.

Aetna's person-centered care management model considers the critical importance of transportation, ensuring it meets the needs of our enrollees for accessibility, timeliness,

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

appropriateness, and safety. We utilize vendor contracts to provide, manage, and coordinate non-emergent transportation and to collaborate with our transportation vendors by:

- Serving as a liaison between the enrollee and the vendor to assist with non-emergent transportation services as necessary
- Collaborating to help ensure appropriate utilization, both under- and over-utilization of services
- Coordinating the complex needs of enrollees
- Coordinating with our Enrollee Services department and that of the vendor's to resolve issues in real time whenever an enrollee calls with any issues, concerns or delays
- Collaborating to address enrollee eligibility of services
- Joint review of any quality of service issues to determine root cause and implement any necessary corrective actions
- Documenting all enrollee, provider, or vendor interactions

We are confident that working in concert with our transportation vendor will further the Agency's goal to help ensure safe and efficient access to medically necessary services in a timely and cost-effective manner.

### **EXPERIENCE AND APPROACH TO COVERAGE OF NON-EMERGENCY TRANSPORTATION SERVICES**

Aetna covers on-demand transportation, utilizing our transportation vendor to provide the most appropriate, most accessible transportation for our enrollees, including an innovative Lyft-like solution to improve service, quality, and accessibility. Enrollees, care managers, and discharge planners can arrange transportation using the method most convenient to them, including via phone, fax, email, web portal or mobile application.

Our full array of covered transportation options includes mileage reimbursement, public transit, ambulatory (sedan, van, and taxi), wheelchair- or stretcher-enabled transport, including door-to-door service when necessary. Our vendor also uses an on-demand Lyft-like service and technology as a part of its full-service transportation network throughout the State for eligible enrollees when it is appropriate.

We selected our transportation vendor based on its experience and ability to meet contractual requirements and enrollee needs effectively. Our transportation vendor has over 18 years of experience successfully managing 8.6 million trip requests annually nationwide for over 5.5 million covered individuals across urban, suburban, rural, and remote rural regions. Our transportation vendor maintains a broad view of the health care landscape to leverage its experience to create leading-edge improvements in the delivery of services. Nationwide, 99.8% of our vendor's trips are complaint-free, based on the number of complaints to completed trips. Even more impressive is that its rural trips have the highest percentage of complaint-free transports.

In Florida alone, our vendor has more than 300 providers and nearly 4,000 vehicles. More than 250 of their employees are based in Florida, serve the State's enrollees, and apply their local knowledge and years of experience in their customer interactions. The vendor transports enrollees in every county in Florida. It has serviced over 1.4 million enrollees in Florida, providing 1.9 million trips annually.

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As part of the enrollee benefit, we ensure the enrollee has no other means of transportation, the mode of transportation offered is medically appropriate to the individual's condition(s), and the transportation is to/from a Florida Medicaid covered service, including out of state travel with prior authorization. We support innovative solutions with our vendor, including supplementing the on demand transportation needs of our enrollees with Lyft, to increase satisfaction, reduce wait times and no shows and improve on-time performance. We have also selected our vendor based on their innovative technology solutions, including mobile platforms, GPS, and analytical software for precise tracking and reporting.

Our current non-emergent transportation (NEMT) program covers transportation to:

- AHCA program-covered services provided by Aetna, including home- and community-based waiver services and expanded benefit services
- Covered community mental health and rehabilitation services
- Dental appointments
- Physical, rehabilitation, and mental health appointments
- Enrollee's pharmacy directly following a covered service or physical and mental health appointments

As required by the Agency, our NEMT program also covers inter-facility transfers, EPSDT visits as well as escorts for eligible enrollees, including those receiving services at a Prescribed Pediatric Extended Care Center (PPEC). We do not require reservations to be made for unscheduled or urgent care trips, or for reservations to be made more than three business days in advance. We do not limit the number of trips or restrict the distance required for an enrollee to receive a medically necessary covered service.

We also follow the Agency's exclusion criteria, including:

- Enrollees in the Qualified Medicare Beneficiary (QMB), Qualified Medicare Beneficiary Renal (QMBR), Special Low Income Beneficiaries (SLMB), Qualifying Individuals (QI1), Working Disabled (WD), Legal aliens (ALIEN), Family Planning Waiver (FP) or the Program of All-inclusive Care for the Elderly (PACE) programs
- Transportation services to an out-of-state facility when the Agency has closed or decertified a nursing facility
- NEMT when it is included in another Florida Medicaid compensable service
- Salaries, fees, or other compensation for professional health care attendants or escorts
- Time spent waiting for an enrollee to receive a service
- Telephone communications with enrollees, their representatives, caregivers, and other providers, except for services rendered in accordance with the Florida telemedicine policy
- Transportation that can otherwise be provided, or arranged, through a home and community-based waiver in which the enrollee is enrolled
- Transporting an enrollee from a hospital or facility to a behavioral health care facility, if the enrollee is receiving services pursuant to the Baker Act (Chapter 394, F.S.)
- Visits to hospitalized or institutionalized family members

We require close, ongoing communication, information and regular reporting from our vendor for our oversight and monitoring of the quality of services provided. Depending on the circumstances, we communicate with our transportation vendor daily at times, but formally no

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less than monthly in our Joint Oversight Committee (JOC) meetings where we review performance metrics, complaints, trends, encounter timeliness, and denials. We have open access to our enrollee NEMT information through our dedicated Aetna portal with our transportation vendor, where we can access all important trip and program information online, including scheduled trips, reports, and complaints.

### **Vendor and Driver Training**

We recognize our enrollees may have an array of conditions and needs. Through audits that include requests for training tools and training attestations, we ensure our vendor and its drivers are trained in sensitivity, safety, and accessibility needs. We ensure our transportation vendor and drivers receive a thorough orientation regarding this covered service benefit, all program requirements, transportation provider manuals and the importance of enrollees getting to their appointments timely to receive the health care they need. We encourage the use of local resources for training, as well as resources for online training and audit documentation to verify that drivers have received the required training. Through our yearly audit process, we also validate requirements of the vehicles, drivers, customer service, and system capabilities. Through its years of experience, our vendor has built a staff that is professional and compassionate with a deep understanding of the needs of passengers seeking health care emphasizing the importance of dignity and respect in every interaction.

Aetna and our transportation vendor have embraced the value of meeting our enrollees where they are throughout the course of Hurricane Irma. We worked closely with our vendor to ensure, even with the challenges traveling throughout the State, our enrollees had their needs met, including attending their dialysis and chemotherapy appointments. We remained in daily contact with our vendor from the moment the hurricane watch began to prioritize and meet these needs throughout the constantly changing weather conditions and other weather-related circumstances impacting our vendor and its drivers' ability to safely travel and transport.

### **SOFTWARE CAPABILITIES**

**CRITERION 1:** The adequacy of the respondent's software capabilities to facilitate ease in scheduling transportation and tracking of enrollee pickup adherence

With the expectation and demand for accountability in all services provided to Florida Medicaid enrollees, Aetna holds our transportation vendor to high accountability standards for accessibility, timeliness, and other criteria. To provide data for their accountability measures, we require our transportation vendor to maintain state-of-the-art software and technologies to enhance and improve the enrollee experience. Its applications are unique to the industry, streamline the gatekeeping process, and incorporate carefully designed safeguards to help prevent errors. These systems manage the entire process including eligibility, scheduling, provider assignment, and reporting.

Through our Aetna dedicated portal with our transportation vendor, we can access all important trip and NEMT program information online. This allows Aetna staff to view scheduled trips, access reports, and respond to complaints filed by enrollees. We utilize this portal to perform administration functions on behalf of our enrollees and to access information on providers, enrollees, trip statistics, and the complaint process.

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### **Ease in Scheduling**

To this end, our vendor provides enrollees and providers with seamless access to transportation by calling a toll-free number, reserving online, through a mobile application, by email or fax for ease in scheduling. The expectation when calling the toll-free number is that all requests can be handled in a single call for simple and straightforward scheduling facilitated by the software capabilities whether to schedule single trips, multiple rides, or standing orders.

Enrollees have easy 24/7 access to online ordering and trip management functions through the online portal capabilities. There, enrollees are able to schedule, modify, or cancel their trips, enter mileage reimbursement claims, as well as retrieve contact information and obtain online user guides. Enrollees are also able to authorize additional users (for example, a child or legal guardian) to act on their behalf to perform trip management functions.

The software is designed to facilitate on-time and efficient transportation by supporting better communication, easier scheduling, better handling of on-demand trip requests, and improved operational processes. The enrollee application is user friendly and available on both the iOS and Android platforms. The interface was tested to confirm ease of use before implementation and Aetna validated all written materials for ease of reading using the Flesch-Kincaid readability tests.

### **Tracking of Enrollee Pickup Adherence**

All pick-ups and drop-offs are tracked using state-of-the-art software to facilitate ease in scheduling, tracking of enrollee pickup, and monitoring adherence to requirements. This innovative mobile technology is coupled with GPS-enabled tools to capture advanced data analytics to better manage and track services in real time. Online trip scheduling offers integrated technology reminders for drivers and enrollees with text message reminder capabilities. No matter how a request for transport is made, our vendor completes an eligibility check to ensure the enrollee qualifies for NEMT services through Medicaid, has no other means of transportation available, and the trip is for a covered appointment.

The mobile application allows for GPS routing and tracking of pick-ups, providing total transparency during the trip and allows the transportation vendor to see when and where all trips were performed. This information is sent to Aetna for oversight and monitoring on a monthly basis, or more frequently if needed.

The vehicle locator function of the system allows staff to view all vehicles in an area or by the transportation provider in an area. In addition, the system alerts staff to determine or verify the vehicle's estimated time of arrival at its destination, enabling the vendor to facilitate changes required for any service deficiencies that may occur.

### **DETERMINING THE MOST APPROPRIATE MODE OF TRANSPORTATION**

Ensuring the appropriate mode of transportation to meet the unique needs of our enrollee is an integral part of the transportation service. Care managers work with the enrollees and their families to identify the extent to which the enrollee has any means of transportation and the need and necessary level of support.

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Level of Service Determination

CRITERION 2: The extent to which the respondent describes strategies for determining the appropriate mode of transportation equipped to meet the enrollee's individual needs

Once the initial assessment of need is completed, Aetna transmits that information to the transportation vendor. We work closely with our transportation vendor to develop protocols specific to our values, needs, and contractual requirements to deliver the highest quality NEMT benefit to our enrollees. These business rules produce a level-of-service (LOS) determination in an objective manner.

We provide our transportation vendor details about the capabilities and challenges of the population it will be serving, including specifics about needs of individuals with chronic conditions. We then coordinate with the vendor to help ensure it is providing appropriate service based on enrollees' needs.



We work regularly with our vendor to ensure that the most effective and efficient protocols, specific to our needs and those of our enrollees, are developed and implemented. For example, after determining that trip reservations being initiated by facilities on behalf of enrollees were resulting in inappropriate, non-covered trips, we changed the process to only accept reservations from the enrollee's care managers to ensure that only necessary, covered transportation is being provided.

These protocols ensure assignment of the least expensive, appropriate mode of transport based on the medical necessity and level of assistance needed by the enrollee from the driver, including curb-to-curb, door-to-door, hand-to-hand, etc., as well as the use of escorts, attendants, or child car seats.

To learn more about enrollees and their needs and determine the proper level of service, our vendors rely on exploratory questioning generated by on-screen prompts that address details about access to transportation, mobility, vehicle access, and special needs. These questions are designed to discover more details about other available means of transportation and limitations on mobility, the proximity of public transit, and any other special care needs that require coordination (especially for minors, elderly, disabled, or frail enrollees).

Our vendor inputs this information into their scheduling system using data-driven technology. The vendor determines appropriate modes of transportation available to the enrollee using Aetna-specific protocols described above. The vendor's system guides its employees, using our specified criteria and protocols, in determining the most appropriate transportation for each enrollee. Transportation is available to eligible enrollees with no other means of transportation available to them 24/7.

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Using these pre-programmed business rules to determine the authorized LOS, we are assured that the mode of transportation is chosen to fit our enrollee's needs, and not just arbitrarily decided upon by the vendor's employee. This assignment process maintains consistency, minimizes human error, controls cost, and decreases fraud, waste, and abuse.

For unique circumstances, all our transportation vendor associates are trained to override the system's LOS assignment, if required, to best accommodate the enrollee's medical needs. Management reviews and audits all overrides to ensure the appropriate level of service is being provided based on the enrollee's needs. When the level of service being requested and recommended is clearly outside of the contract limitations, the health plan is consulted for approval and authorization.

Some of the system logic to select the correct LOS for the enrollee includes:

- If equipment code is "in stretcher" then schedule stretcher van
- If bus (public transit) is equal to "yes" and urgent is equal to "no" and additional stops is equal to "0" and pick up bus miles is in 0.75 miles and destination bus miles is in 0.75 miles and equipment code is "not in stretcher" and special needs code is not in "door to door", "pregnant over eight months", "wheel chair" and trip reason code is not in "chemotherapy", "dialysis", "radiation treatment" and pick up county is equal to destination county then bus "public transit" is scheduled.
- If gas option is equal to "yes" and age is less than 18, then do not schedule mileage reimbursement and flag account "payee cannot be a minor"
- If gas option is equal to "yes" and age is greater than 17, then schedule mileage reimbursement
- If gas option is equal to "no" and equipment code is "in wheel chair lift," then schedule wheelchair
- If gas option is equal to "no" and equipment code is "in wheel chair storage," then schedule sedan

This ability to override the system is not just left to the vendor; however, in some instances, our care manager intercedes at the beginning of the transportation process to help ensure the appropriate mode of transportation is chosen for our enrollee:

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\*\*\*\*\*[REDACTED]\*\*\*\*\*

[REDACTED]

[REDACTED]

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**Assessing Other Means of Transportation**

CRITERION 3: The extent to which the respondent's approach includes an assessment of whether the enrollee has any other means of transportation, including a description of the process that will be utilized to make this assessment

We strategize exploring all means of supporting the enrollee's transportation needs to determine definitively whether the enrollee has any other means of transportation support. If he or she does not, we assist in coordinating NEMT transportation for our enrollees to Medicaid covered services, including out-of-state travel with prior authorization. For those enrollees with a relative, friend, or neighbor who can provide the transportation, we offer mileage reimbursement as an appropriate mode of transportation.

Our vendor authorizes the most appropriate form of transportation based on the physical and cognitive abilities of the enrollee. Care managers, as well as our transportation vendor inquire with the enrollee regarding any other means of transportation available to them. NEMT is offered only if all other options are exhausted. Transportation is available to eligible enrollees for covered services 24/7, including holidays.

**Data on Performance Metrics**

CRITERION 4: The adequacy of the respondent's performance related to: (a) Percentage of trips where the enrollee arrived to their scheduled appointment on-time; (b) Percentage of missed trip requests; (c) Percentage of hospital discharge requests fulfilled within three (3) hours of the request; (d) Percentage of urgent care requests fulfilled within three (3) hours of the request; and (e) Number of transportation related complaints and grievances per 1,000 enrollees

Aetna continuously reviews the performance metrics of our transportation vendor. We ensure our vendor is committed to continuous quality improvement of its performance, and in turn, engages in ongoing monitoring and oversight of their contracted transportation providers and drivers. We closely review all qualitative and quantitative information, including utilization, complaints, driver scorecards, and satisfaction survey results. We have open, transparent

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access to this information through regular and ad hoc reports available to us through our dedicated Web-portal access with the vendor.

We set our performance expectations with our transportation vendor during the contracting and credentialing process. In 2016, we monitored its performance on the following metrics:

- Percentage of trips where the enrollee arrived to their scheduled appointment on-time: 91.23%
- Percentage of missed trip requests (failed to pick up the enrollee): 0.09%
- Percentage of hospital discharge requests fulfilled within three (3) hours of the request: 45.8%
- Percentage of urgent care requests fulfilled within three (3) hours of the request: 80.2%
- Number of transportation related complaints and grievances per 1,000 enrollees: <1 transportation related complaint and grievance per 1,000 enrollees

We evaluate these metrics on a monthly basis through our JOC, and more frequently through reporting if any issue is identified. If performance expectations are not met, we increase oversight of the identified issue, including additional meetings and more frequent reporting until resolved.

### **Reports**

To evaluate our performance on transportation metrics, we provide continuous monitoring and oversight to our NEMT vendor to gauge provider quality and ensure performance meets or exceeds the established standards. We have real time access to the complete data set of our transportation vendor, regularly review over 30 reports, and we can create our own ad hoc reports at any time, including:

Performance dashboards: Shows call volume, completed trips, no-shows

Transportation provider report: Includes the percentage of trips where the provider received more than a 24-hour notice and the percentage of trips where the provider received less than 24-hour notice

Driver monthly scorecards: Includes benchmarks of their performance compared to other providers

Complaint reporting: Allows real-time reporting on complaints by specific type, date range, complaint status, category (transportation provider, Enrollee Services center, enrollee-generated complaints), and time to resolution; the report helps monitor network efficiency and performance results and helps proactively manage and avoid compliance issues.

Daily and monthly enrollee service center reports: Gives access to all data regarding call volume, talk time, hold times, and the number of dropped calls

Utilization reports: Show detailed utilization metrics with customizable parameters

NEMT High-utilizer report: Provides near real-time data on highest users of medical transportation, as compared to the mean number of transports of the entire population; care

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managers and others have the ability to create reports quickly that identify specific enrollees with high utilization and their corresponding trip data, including destination and reason for transport. This report tracks services used by high-risk enrollees and helps care managers identify enrollees with frequent physician visits for possible targeted care management. This report immediately shows those enrollees who generate a large number of health care transportation claims and this information can be used to reduce waste, fraud, and abuse.

### **Identifying Areas for Improvement and Implementing Strategies for Improvement**

**CRITERION 5:** The extent to which the respondent uses performance metric data to identify areas in need of improvement and implements successful strategies to improve the provision of services

The provision of optimal transportation services for our enrollees requires close monitoring. We have instituted a series of checks and balances to help ensure our transportation vendor maintains accountability to us and to our enrollees. By using performance metrics and timely reviews and audits, we monitor compliance, assess areas of need for improvement, and implement corrective action strategies on a timely basis. The key for us is to continuously work toward improving the transportation services for our enrollees and ensure those services are timely, cost-effective, and provide quality service.

Performance metrics are monitored no less than monthly in our JOC to identify issues and ensure satisfactory resolution and system improvements. If we identify an issue, we increase monitoring, including more frequent meetings, enhanced reporting requirements to ensure issues are tracked, and establishing and reviewing action plans to remediate.

Our national Delegation Management team conducts annual audits of subcontractor performance to evaluate subcontractors' compliance with standards and criteria. These audits include review of associated policies and procedures and file audits, where applicable. Our local quality and compliance teams review 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 of our subcontractors, and we understand that no subcontract relieves us from any obligation or liability arising from our contract with the Agency.

Aetna determines the type and level of monitoring of work performed by subcontractors on a case-by-case basis depending on the subcontractor, the services being provided under a subcontract, and the subcontractor's performance history with us. As part of our monitoring process, we require the subcontractor to submit reports in a manner and frequency that meets our contractual obligations with the Agency and our internal quality improvement processes. These reports include information about performance against the metrics, standards, and service-level agreements defined in the subcontract. This information is cross-referenced with enrollee feedback and peer-to-peer reviews to establish accuracy in reporting.

### **Audits**

In addition to adhering to the credentialing and re-credentialing requirements of the Agency, on a yearly basis, we audit the following specifically for transportation vendors:

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Vehicle review, including general liability coverage, auto liability coverage, workers' compensation, vehicle registration and inspection, availability of child safety/booster seats and that Aetna and State-specific requirements are met
- Driver review, including general liability coverage, auto liability coverage, workers' compensation, current driver's license, Office of Inspector General (OIG) checks, GSA checks, drug screen, national criminal background check with national sex offender check, motor vehicle report, training in PASS, wheelchair, defensive driving, first aid/cardiopulmonary resuscitation (CPR)/ automated external defibrillator (AED) and that Aetna and State-specific requirements are met
- Customer service, including service center staffing, structure, locations, workflows, policies, and procedures
- System capabilities, including system security, reporting capabilities, record retention and business contingency/emergency procedures

### **System Improvements**

Data elements are reviewed in the monthly JOC meetings we hold with our transportation vendor. Specific call metrics, complaints, trip reports, trends, overall performance, and future innovations are reviewed in monthly JOC meetings, in addition to being reviewed in our yearly oversight audits. There are times where Aetna requests additional information and ad hoc reports. These reports are reviewed with the vendor either during the JOC or in additional work meetings. At times, these reports are in response to noticing high appointment no-shows, complaints, or high-risk enrollees not following through on discharge plans even after the care managers have schedule and coordinated transportation.

Our strong oversight process allows us to review metrics through reports, identify usage patterns, review complaints, and better understand how the vendor is managing the day-to-day demands of our business. The oversight provides us with information to improve service, develop improvement processes, and identify trends and innovations to improve service to our enrollees.

At the monthly JOC, the transportation vendor must present to the committee all performance metrics. We discuss each performance metric, and if the vendor is not meeting expectations, we require submission of additional data, as well as formal action plans. If we have an enrollee who is stranded, our Enrollee Services department intervenes immediately and calls the vendor to facilitate a pick up or determine an alternative. These incidents are reviewed with the transportation vendor in our monthly JOC meeting. If necessary, we may request a full root cause analysis and additional details to best understand what improvements will need to be made to avoid driver no-shows and we will require additional detailed information that we will monitor regarding any driver no-shows to better understand the issue and develop corrective actions.

Aetna requested from the vendor a root cause analysis to examine the main contributing factors that led to missed pick-ups or delays. This analysis completed in early 2017 found these to be some of the contributing factors:

- Transportation provider fails to route correctly
- Accidents or weather causing traffic delays

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Router assigns the incorrect transportation provider or assigns beyond a provider's capacity
- Transportation provider vehicle breakdown
- Construction causing traffic delays
- Shifting of traffic patterns

Aetna monitors and works closely with the vendor to ensure our enrollees are always picked up timely for every trip; punctuality is a key performance expectation. When there are problems identified with punctuality, resolutions are developed including providing additional training and re-training of drivers, monthly scorecard performance reviews and corrective actions, better utilization of technology, such as routing, GPS systems, enrollee notifications, and an increased use of Lyft to recover trips.

Part of the corrective action plan was to instill a more rigorous training program for the transportation vendor's drivers:

- Receiving training and education where needed to increase performance
- Assessing the staff to determine if patterns exist of repeat instances and, where appropriate, implementing alternative arrangements for upcoming trips. In some cases this may include arranging for scheduled upcoming trips to be rescheduled with other drivers or driver companies.
- Placing staff on a process improvement plan (PIP) where results are monitored; upon completion of PIP period, determine if further plans are needed or if driver should be removed from the network

### **Evaluation Criteria:**

1. The adequacy of the respondent's software capabilities to facilitate ease in scheduling transportation and tracking of enrollee pickup adherence;
2. The extent to which the respondent describes strategies for determining the appropriate mode of transportation equipped to meet the enrollee's individual needs.
3. The extent to which the respondent's approach includes an assessment of whether the enrollee has any other means of transportation, including a description of the process that will be utilized to make this assessment.
4. The adequacy of the respondent's performance related to:
  - (a) Percentage of trips where the enrollee arrived to their scheduled appointment on-time;
  - (b) Percentage of missed trip requests;
  - (c) Percentage of hospital discharge requests fulfilled within three (3) hours of the request;
  - (d) Percentage of urgent care requests fulfilled within three (3) hours of the request; and
  - (e) Number of transportation related complaints and grievances per 1,000 enrollees.

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5. The extent to which the respondent uses performance metric data to identify areas in need of improvement and implements successful strategies to improve the provision of services.

**Score:** This section is worth a maximum of 45 raw points with each of the above components being worth a maximum of 5 points each.

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## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **SRC# 25 – Vignette (Statewide):**

The respondent shall review the below case vignette, which describes potential Florida Medicaid recipients. Note: The vignette included below is fictional.

*Deshea is 25 years old. She was auto-assigned to your plan and enrolled effective January 1, 2019. Deshea's enrollment information did not include a telephone number and listed a local area homeless shelter as her last place of residence. She left the shelter on December 27, 2018, and the shelter does not know her current whereabouts.*

The respondent shall describe the process it will use to attempt to contact Deshea by March 29, 2019.

#### **Response:**

Deshea is representative of approximately 36,000 individuals experiencing homelessness in Florida—the third-largest homeless population in the United States—according to the Florida Coalition for the Homeless. “Whether a primary or contributing factor to losing housing, or a condition acquired or made worse afterwards, individuals who are homeless have disproportionately high rates of health problems,” reports the National Health Care for the Homeless Council.

#### **APPROACH**

Aetna is committed to helping enrollees like Deshea. Deshea's situation is not uncommon in our support of new Medicaid enrollees. Our immediate priority is to locate Deshea and help support her immediate needs, educate her on the benefits available to her, and help coordinate and provide the services and support she desires. We do this through integrated care management services and coordination of care within the framework of a biopsychosocial approach and a system of care. Our objective is to help ensure Deshea's physical and behavioral health needs are being met as well as social components such as housing, food, and employment. We will follow proven processes and utilize all our resources to try to locate Deshea.

We understand individuals with special needs, and those who are difficult to identify, may have barriers that make it hard for them to engage in outpatient care. They might be homeless or move frequently, which is often associated with social isolation. These circumstances often correlate with having serious mental illness and/or substance use disorder. As a result, they rely on emergency departments for acute problems and have multiple inpatient admissions, further disrupting their lives. The solution goes beyond simply locating people, but engaging them wherever they are and continuing to support them until they engage with treatment providers.

Aetna's comprehensive and coordinated approach to identifying difficult to reach enrollees involves field-based outreach specialists who communicate and collaborate with community-based organizations and providers, as well as actively search for enrollees in the community and visit enrollees if they present to an emergency room or inpatient setting. Similarly, system alerts notify us of an enrollee's utilization activities as do intensive data mining processes. These data-mining processes include surveillance of available data, including monitoring changes to enrollment file information, post-service pharmacy claims, online searches, and past

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provider information. We are committed to this approach to help ensure enrollees have access to optimal treatment and care management to mitigate the root causes of the barriers confronting them.

We want to help Deshea receive medically necessary services in a timely manner and in the most appropriate setting, thereby achieving optimal quality outcomes while containing costs. Our integrated model of support will enhance continuity of care for Deshea.

### **STRATEGIES TO IDENTIFY, CONTACT, AND ENGAGE NEW ENROLLEES**

**CRITERION 1.a:**. Identification of strategies for identifying new enrollees

**CRITERION 1.b:**. Description of the sources of data/information that will be utilized to identify enrollees with special health care needs or circumstances

**CRITERION 2:** The extent to which the respondent describes its process for contacting enrollees, including the data sources

Deshea's name will appear on a new enrollee file in Aetna's system with an effective date of January 1, 2019. The enrollment file we receive will include indicators of an enrollee's special health care needs or circumstances. The high-risk indicators include asthma, birth defects, cancer, developmental delay, diabetes, drug/alcohol use, hearing impaired, heart disease, high blood pressure, HIV/AIDS, kidney problems, mental health condition, physical disability, recent surgery, sickle cell disease, speech impaired, substitute care, visually impaired, wheelchair access required, and other chronic illnesses.

We give enrollees with high-risk indicators the highest priority in our search for difficult-to-reach enrollees to help ensure their health and safety.

Because Deshea's enrollment record does not include a telephone number, our automated outbound call system will send the Enrollee Services department notification that we need to locate a phone number and/or contact her in a face-to-face meeting to complete an assessment using the health risk questionnaire. The Enrollee Services department notes in the tracking module in our claims processing and enrollee services system that we do not have a valid number for Deshea. The outbound call system provides the Enrollee Services department with weekly reports on enrollees we are unable to reach. This data is cross-referenced with enrollment reports indicating special needs for enrollees. The outbound call center and the field outreach team receive this report within a week of the data comparison.

All new enrollees are sent a welcome packet with an enrollee handbook, welcome letter, and identification card to the address listed as the primary address in the enrollment file. This occurs within five days of an enrollee's auto-assigned enrollment. In Deshea's case, the U.S. Postal Service's protocol is to return Deshea's welcome packet to Aetna marked undeliverable at the address of the homeless shelter. An Enrollee Services representative logs the returned mail in our system, noting that Deshea no longer resides at the address in her enrollment file and that we have no forwarding address.

Aetna attempts to contact all new enrollees with a telephone number through a welcome call within 30 days to confirm receipt of the program benefits mailing and identification card. During

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the call, we conduct a brief health screening with questions about specific physical conditions, history of behavioral health treatment, smoking, emergency department utilization, and scheduled appointments with a primary care provider (PCP). We are in compliance with the current Statewide Medicaid Manage Care program contract and conduct outreach to new enrollees at least once every 30 days for the first 90 days of their enrollment. It is our practice to continue outreach after the 90-day period to improve enrollee engagement and health outcomes. Enrollee outreach may involve mailing, telephone calls and through past providers who may have more up to date information.

Since we do not have a phone number for Deshea, the Enrollee Services department will coordinate with our community-based field outreach team in our enrollee identification efforts. We strategically place representatives within the community to identify enrollees by coordinating with shelters and other community-based organizations for support. Our field representatives follow up all leads that could result in the identification of Deshea. Aetna has an active community outreach program that focuses on developing relationships with organizations that provide ancillary services, such as housing, food, occupational training and assistance, mental health prevention, emergency shelter, childcare, homeless assistance, and food. We recognize that our enrollees may experience significant social challenges that affect their health and their ability to remain adherent to treatment recommendations.

### **Utilizing Data Resources**

The Enrollee Services department queries our system for data that might help us locate Deshea. We review the enrollment file to see if Deshea selected a PCP when she enrolled. If she chose a PCP, an Enrollee Services representative outreaches the office of her assigned PCP to determine if they have additional addresses, phone numbers, or emergency contacts that can be used for outreach. Additionally, we ask if Deshea has a scheduled appointment and if we can speak with her at that time or meet with her at the PCP's office.

The Enrollee Services department monitors our system for pharmacy data and utilization data to determine if Deshea has used her benefits. We use pharmacy data to determine if Deshea has filled any prescriptions and provided an updated phone number or address information. Aetna collaborates with CVS Health to obtain contact information based on enrollee fill history (if available) by contacting the dispensing pharmacy to obtain a valid phone number. Pharmacy claim data is available in real time and is a valuable tool in identifying valid contact information for enrollees.

Additionally, Aetna uses LexisNexis to search public records and other Web-search tools to find current information on Deshea. We use information found through public records requests to conduct outreach, which we add to our notes on Deshea in our claims processing and enrollee services system. In addition, enrollee services will add alerts in the system just in case Deshea calls for assistance. Often, new enrollees contact our Enrollee Services hotline for help in obtaining a supply of prescription drugs. We run a daily report mining new data on difficult-to-reach enrollees.

The State's Event Notification Service (ENS) also aids with locating enrollees. This system provides us with daily notifications of enrollees that have been admitted to the hospital or have had an emergency department visit. The information provides an opportunity to establish contact with the enrollee. Our automated system shares this data with an enrollee's PCP. If an

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enrollee has participated in our integrated care management program (which is not the case for Deshea who is a new enrollee), our system also notifies care management staff of an enrollee's hospital admission or emergency department visit.

In many instances, locating Medicaid enrollees cannot be accomplished through traditional methods. Therefore, we seek innovative solutions to locate and engage them, such as speaking with health care providers and vendors and obtaining phone numbers through the AHCA Lifeline program and others who may have more current contact information.

As an adjunct to our outreach efforts and care management, we have initiated a vendor relationship to assist our staff with reaching more enrollees. The goal of this relationship is to close the information gap and obtain updated/verified enrollee contact information necessary for Aetna's care management and outreach efforts. This vendor provides the following:

- Extensive location services using proprietary and proven methods to locate difficult to reach Medicaid enrollees
- Updates to contact information for our health plan staff
- A call center program designed to reach and engage enrollees by phone. While engaged with the enrollee, the vendor representative educates the enrollee on significant plan benefits, with a focus on the value of utilizing a primary care physician (PCP) in his or her health care benefits
- Call center representatives who conduct a complexity screen with the enrollee to gather important information that Aetna can utilize to determine if the enrollee will benefit from an individual plan of care; the representative then completes a warm call transfer to an Aetna care manager who assists the enrollee in scheduling an appointment with his or her PCP

This vendor's creative search methods have yielded positive results; for example, one study with a major Medicaid health plan showed that for enrollees without phone and home address information, this vendor successfully obtained valid contact information for 70% of those enrollees using its proprietary tools and processes.

If Deshea were to have an inpatient admission, a field representative would coordinate with the hospital to meet with Deshea (with her consent). During the hospital visit, the field representative would educate Deshea on the benefits available to her, complete our health risk questionnaire with Deshea, help facilitate her discharge plan—supporting Deshea's biopsychosocial needs—and make a referral for care management services with Deshea's consent.

Self-reported data, such as that captured in the health risk questionnaire, is a critical component of our integrated care model. Our model addresses physical, behavioral, and social health, which is necessary for managing our most vulnerable, highest-risk enrollees like Deshea. Our health risk questionnaire includes several questions to identify the possibility of a mental health or a substance use disorder. A positive response to any question about mental health or substance use prompts the use of more focused screening tools. We understand Deshea may be among approximately one-third of the homeless population that includes individuals with serious, untreated mental illnesses according to the Treatment Advocacy Center. She is also at high risk for substance use. The Substance Abuse and Mental Health Services Administration

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estimates 38% of individuals experiencing homelessness are dependent on alcohol and 26% abuse other drugs.

After Deshea completes the health risk questionnaire and initial assessment process, she is contacted by the outbound call center to schedule a face-to-face visit between Deshea and her care manager. If Deshea had an ED visit but not a hospital admission, a care management associate will outreach her using the contact information she provided to the hospital. With Deshea's consent, a care management associate or care manager will complete the health risk questionnaire, ask about and address any immediate needs for Deshea, and schedule a face-to-face visit with a care manager.

Whenever we receive new contact information for an enrollee like Deshea, we educate, assist, and guide enrollees to update their addresses with Medicaid enrollment services and the Department of Children and Family. We stress to enrollees the importance of maintaining accurate contact information in the State system so that they do not experience a disruption in benefits.

### **Providing Care Management Support to Shape a Life Plan**

Through the assessment process, we meet Deshea where she is physically, mentally, emotionally, and socially. We listen to what she is saying and use all of our resources and training to ensure our approach to her care is individualized and focused on her health goals and ambitions.

Our care manager will complete a comprehensive, evidence-based assessment with Deshea using motivational interviewing and active listening to identify root causes of Deshea's health issues. The comprehensive assessment gives us a deep understanding of who Deshea is and what her needs are from a medical, behavioral, social, functional, and cognitive standpoint. Aetna's comprehensive assessment instrument is based on best practices and clinical guidelines and it contains a biopsychosocial scope with elements of root-cause analysis and social determinants. The comprehensive assessment includes questions about Deshea's daily activities, including home stability, employment status, and the occurrence of domestic violence in her life.

The care manager engages Deshea in conversation about the goals that are most important to her, about her strengths and available resources, and about the things in her life that make it harder to take better care of herself. We put it all together into a case formulation that tells a story in terms that make sense to Deshea and is verified by her. This becomes the basis for identifying the root causes of Deshea's current and recent challenges. The care manager and Deshea will finalize her plan of care within five days of their initial visit in accordance with Attachment B of the Invitation to Negotiate. In supporting Deshea through our integrated care management program, we help her to address her risk factors and shape a life plan, as opposed to simply a care plan.

To maintain communication with Deshea, the care manager will verify Deshea's eligibility to participate in the federally funded Lifeline Assistance program, which provides smartphones to Medicaid enrollees. With this device, Deshea can remain in contact with Aetna so that we can contact her as needed and link her care and services. The program will provide Deshea with free voicemail, unlimited calling to the health plan, unlimited inbound and outbound text

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messaging, 9-1-1 and 4-1-1 calling, and 250 free minutes of personal talk time. We also inform Deshea that we will add her new phone number to our database.

Deshea's preliminary plan of care addresses Deshea's immediate needs and describes how we will work with Deshea to mitigate the impact of the most important root causes. This work is not complete until Deshea agrees that it makes sense and commits to the activities in the plan of care.

The care manager works with Deshea to define and prioritize both short- and long-term goals, translate these goals into achievable steps, and implement the plan of care in phases according to their activation level. This phased approach helps Deshea meet short-term goals quickly, gain trust with the care manager, and increase her confidence level early on. Based on the results of the assessment, the care manager also discusses with Deshea resource options for services and support for which we can make referrals with Deshea's consent.

Aetna is aligned with the Agency's system of care approach as described in the report, "Behavioral Health Services Revenue Maximization Plan." Aetna's integrated system of care is a coordinated model of health care and related services that work in concert for each enrollee and his or her circle of support. By building upon enrollees' strengths and removing barriers to care, each individual is afforded the opportunity to pursue those goals that are most important to him or her. An integrated system of care includes physical, behavioral, and oral health services, as well as services that address the social determinants of health and well-being. While each enrollee population with special needs benefits from this system of care, the mix of services may differ to reflect his or her specific needs. A system of care for enrollees with special needs coordinates the mix of resources capable of serving them within a region.

### **INTERVENTIONS USING NETWORK PROVIDERS AND COMMUNITY PARTNERS**

**CRITERION 3:** A description of how network providers and community partners will be engaged in the identification process

An essential part of our strategy to identify new enrollees and enrollees who do not have a permanent known address and phone number is providing our network partners and community organizations with the tools to identify these enrollees when they present for care or services. Our field outreach team conducts an orientation for our community partners on our integrated care management approach and provides contact information and education on linking individuals to their health plans for continuity of care. We conduct regular outreach to these organizations to retain their attention and engagement to the process of helping us locate hard-to-reach enrollees. Our outreach team contacts our community partners on a regular basis to inquire whether any of our enrollees are being cared for or are receiving services. We follow up with identified enrollees to help ensure they are aware of their benefits and the resources available to them, and that their needs are being met.

Currently, we have strong collaborative relationships with the following community organizations in South Florida:

- Camillus House (Miami)
- Chapman Partnership (Miami)
- Susan B Anthony Recovery Center (Pembroke Pines)

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- The Lotus House (Miami)

As Aetna plans for our service expansion statewide in 2019, we will continue to develop both collaborative and formal agreements with organizations that can help us in cases like Deshea's. We will leverage existing relationships with organizations like the Florida Coalition for the Homeless to expand our deep base of community-based resources. For example, in Region 1, we have had discussions on collaborations with Waterfront Rescue Mission and EscaRosa Coalition on the Homeless, which provide support and services for individuals experiencing homelessness. Additionally, we have had discussions with the Christian Sharing Center in Seminole County, as well as many other organizations from region to region.

Aetna's Illinois health plan provides a strong model for leveraging relationships with providers and community-based organizations to identify enrollees through interventions. In Florida, we can adopt best practices from the Illinois model. For example, the Illinois health plan's partnership with the AIDS Foundation of Chicago (AFC) helps identify enrollees and offers an immediate connection to care, housing, specialized providers, and resources unique to the communities they serve. They administer our health risk questionnaire, establish a connection to a PCP, and (with the enrollee's permission) complete HIV/AIDS and hepatitis-C testing. In 2016, AFC helped Aetna reach and engage more than 50% of enrollees referred to them who were initially difficult to contact.

Deshea could be at serious risk because of her possible physical health, behavioral health, and social needs. Our goal is to locate and engage Deshea as soon as possible through data mining, field outreach and collaboration with providers in our network and community-based organizations. Once we engage Deshea, we develop her individualized plan of care and serve as an advocate for the goals most important to her.

### **Evaluation Criteria:**

1. The adequacy of the respondent's approach in addressing the following:
  - (a) Identification of strategies for identifying new enrollees; and
  - (b) Description of the sources of data/information that will be utilized to identify enrollees with special health care needs or circumstances.
2. The extent to which the respondent describes its process for contacting enrollees, including the data sources.
3. A description of how network providers and community partners will be engaged in the identification process.

**Score:** This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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**F. OVERSIGHT AND ACCOUNTABILITY**

**SRC# 26 – Subcontractor Oversight (Statewide):**

The respondent shall list any proposed subcontractors to which it will delegate the management of: provision of covered services, utilization management, provider networks or paying providers. The respondent shall describe how it will oversee and monitor the performance of subcontractors in general, as well as any specific oversight planned for certain subcontractors, including any corresponding service level agreements. The respondent shall include in its response the schedule and type of monitoring and how findings are reported, remediated, and used for process improvements.

**Response:**

Aetna engages in subcontracting only when it adds value for our enrollees. We use well-qualified, experienced subcontractors to provide services in support of our Medicaid programs—subcontractors with unique expertise and proven records of accomplishment relative to improving outcomes for our enrollees by providing appropriate, coordinated care and services in a financially responsible manner. Whenever possible, we contract with entities that fall under the Aetna Inc. organizational umbrella. Doing so enables us to use entities that have established processes adherent with internal controls that meet Aetna standards to promote quality and compliance in our commitment to achieving the Agency's goals.

Through a series of intercompany agreements, certain management functions are delegated to Aetna affiliates to leverage operational efficiencies. Our affiliates share our passion and long-term vision for transforming health care and for improving the lives of the enrollees we serve. To improve overall access to services and complement our model of care, we also use subcontractors that are not owned by Aetna and that contribute additional capacity, specific experience, or expertise to our mission of achieving State goals and improving the health of our enrollees.

**PROPOSED SUBCONTRACTORS**

**CRITERION 1:** The extent to which the respondent provides a list of subcontractors it proposes to use under the SMMC Program for the delegation of work as described above

Aetna has a proven record of accomplishment and understanding relative to improving outcomes for our enrollees by providing appropriate, coordinated care and services in a financially responsible manner. Through a series of intercompany agreements, reviewed and approved by AHCA, certain management functions are delegated to Aetna-owned companies. These Aetna affiliates provide delegated management functions related to the provision of covered services, utilization management, provider networks, or paying providers. The following describes the work each affiliate performs in these areas:

- Aetna Medicaid Administrators LLC: Management services for physical and behavioral health, including care and disease management, quality management, utilization management, enrollment processing, claims payment, program integrity monitoring

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- Aetna Health Management, LLC: After-hours call center, provider credentialing, pharmacy benefit management (PBM) administrative services (when not performed by Caremark PCS Health) and Aetna's nurse Informed Health Line

We select qualified subcontractors with experience in and knowledge of the Florida Medicaid program and a shared vision for improving the quality of care for enrollees. For example, Beacon Health Options offers the strongest behavioral health provider network in Florida, understands the Aetna integrated care management model, and has the flexibility to support value-based payment arrangements along the continuum of clinical and financial complexity and sophistication in risk sharing. Each subcontractor must also meet Aetna and NCQA standards, as applicable, and comply with all applicable federal and State laws and regulations.

The following list summarizes the proposed unaffiliated subcontractors to which we delegate the management of provision of covered services, utilization management, provider networks, or paying providers:

- Access2Care (formerly known as TMS Management Group, Inc.): Access2Care provides non-emergency transportation management to Medicaid and Medicare enrollees through government and managed care organization contracts, with customized programs for each unique region and diverse population. Annually, Access2Care manages 8.6 million trip requests for over 5.5 million covered lives across urban, suburban, rural, and remote rural regions in 29 states and the District of Columbia. Its parent company, Envision Healthcare Holdings, Inc., was founded in 2005 to provide a broad range of coordinated, clinically based solutions across the continuum of care, from medical transportation to hospital encounters to comprehensive care alternatives in various settings. Its Florida office is located in Clearwater. Access2Care has a large statewide transportation network, strives to meet Aetna's and the State's quality standards, and is able to leverage their national experience in transportation to develop innovative processes and technologies, improving the transportation experience for Florida Medicaid enrollees.
- Beacon Health Options (Beacon): Our behavioral health manager, Beacon, combines two of the country's most prominent behavioral health companies—Beacon Health Strategies and ValueOptions. Together, they serve more than 50 million people across all 50 states. Beacon has programs serving Medicaid recipients and other public sector populations in 26 states and the District of Columbia. It has contracted directly with State and county agencies since 1995 to manage Medicaid behavioral health carve-out programs, including Florida's MediPass program. It is accredited by both the Utilization Review Accreditation Commission (URAC) and the NCQA, and it offers superior clinical mental health and substance use disorder management, a strong employee assistance program, work/life support, specialty programs for autism and depression, and insightful analytics to improve the delivery of care.

Aetna has collaborated with Beacon to serve the complex health care needs of Florida Medicaid enrollees since April 2005, when it was known as Psychcare. The expertise of the two organizations allows Aetna and Beacon to offer integrated medical and mental health and substance use disorder management and insightful analytics to improve the delivery of care for the Agency's Medicaid enrollees. The Aetna and Beacon partnership brings together two companies with wide-ranging experience in working with state agencies to develop customized specialty care programs that meet the specific needs

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across the spectrum of Medicaid populations, including Temporary Assistance for Needy Families (TANF); aged, blind, and disabled (ABD); intellectual and developmental disabled (IDD); seriously and persistently mentally ill (SPMI); children with severe emotional disturbance (SED), C HIV/AIDS Special Needs Plans (SNPs); Programs for All Inclusive Care for the Elderly (PACE), and dual eligibles. Under this contract, Beacon will manage the behavioral health provider network, claims payment, credentialing and utilization management, while Aetna will manage all aspects of care management and enrollee services, including those related to behavioral health.

- CVS Health: As Aetna's pharmacy benefit manager (PBM) since 2011, CVS Health provides prior authorization services, utilization review, and pharmacy network management. Pharmaceutical Card System (PCS), a predecessor of Caremark, was founded in 1969 in Scottsdale, Arizona, effectively launching the pharmacy benefit management industry. Today CVS Health serves more than 2,000 clients and more than 88 million members across all 50 states, Puerto Rico, and the Virgin Islands. CVS has supported managed Medicaid clients since 1988, and presently serves approximately 1.7 million Medicaid enrollees in Florida. CVS Health currently has 862 retail pharmacies, 1 specialty mail pharmacy, and 3 Coram CVS/Specialty infusion pharmacies in Florida. CVS Health has received URAC accreditation in PBM, drug therapy management, specialty pharmacy, and mail service pharmacy.
- Firstsource Solutions/Firstsource Transaction Service, LLC: Firstsource Solutions performs overflow claims processing for us, and has offices located in Tampa, Florida. Firstsource is a global provider of business process outsourcing services with more than 26,000 employees in total. Firstsource entered the health care space with its 2005 acquisition of an existing health care company originally started in 1993. Since then, it has increased its portfolio of clients in both the payer and provider space through acquisitions and organic growth. Today, Firstsource services 22 health care payers (including 5 of the top 10 insurers in the United States) and more than 1,000 hospitals and service providers.
- iCare Health Solutions: Our ophthalmology, optometry, and vision services vendor is iCare Health Solutions, which was founded in 1982. With offices in Miami and Tampa, iCare provides vision services to over 3 million individuals annually. Its program uses a powerful technology-driven infrastructure combined with simple and effective benefit management services to support integrated eye care delivery. Our relationship with iCare extends back to August 2013, when the company's predecessor began serving enrollees through the long-term care (LTC) program, and December 2013, when it began serving Florida Healthy Kids and managed medical assistance (MMA) enrollees. Our experience with iCare has been consistently positive. They are very responsive to our needs as well as those of our enrollees, are easy to work with, and have a strong network throughout the State.
- Managed Care of North America, Inc.: Our dental benefits administrator for dental expanded benefits is Managed Care of North America, Inc. (MCNA), which provides exceptional service to state agencies and managed care organizations for Medicaid, Children's Health Insurance Program (CHIP), and Medicare enrollees. Founded in Florida in 1992, MCNA is headquartered in Fort Lauderdale and serves approximately 4 million children and adults nationwide. It was the first dental plan in the country to be awarded full URAC Dental Plan Accreditation. MCNA underwrites Medicaid and CHIP dental programs in Florida, Texas, Louisiana, Iowa, Idaho, Nebraska, and Arkansas. Its corporate leadership team has over 200 years of combined experience in patient care, financial administration, and corporate compliance. We have had a relationship with

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MCNA to serve our LTC enrollees since August 2013, and to serve our MMA enrollees since July 2014. MCNA has a large statewide provider network, has developed innovative processes to better engage enrollees, is responsive to the needs of Aetna and its enrollees, and is highly proficient in administration of dental benefits including timely and accurate claims payment and encounter submissions.

- MedSolutions, Inc. dba eviCore Healthcare: We collaborate with eviCore Healthcare for radiology and musculoskeletal pain management services. A national leader in integrated, innovative care management solutions for managed care organizations, eviCore began providing services in the managed care setting in the 1990s as MedSolutions, Inc., and CareCore National. These two companies merged and became eviCore healthcare in 2015. With 25 years of experience in its background, eviCore currently covers over 100 million members. Its Florida offices are located in Melbourne.
- Public Partnerships, LLC: Our consumer directive services vendor and fiscal employer agent is Public Partnerships, LLC, which formed in the late 1990s to serve the Robert Wood Johnson Foundation's National Self Determination Grant initiative. Public Partnerships, LLC, provides fiscal management services and related supports for participant direction in 24 states, across 51 Medicaid waiver and state-funded programs, serving over 65,100 participants and over 76,000 support workers each year. Sharing Aetna's commitment to keeping enrollees at the center of all we do, Public Partnerships, LLC, empowers enrollees to make decisions over some of the most important activities of their lives—what kind of care they need to stay at home, who should provide that care, and how it should be managed.

Aetna has contracted with Public Partnerships, LLC since 2013 to provide fiscal management services for participant direction in Florida. Aetna has benefited from its experience in participant direction and commitment to promoting and ensuring participant direction is successful for Aetna's Florida LTC enrollees. Since the inception of the LTC program, Public Partnerships, LLC, has worked with Aetna care managers to ensure they are trained and have the information and understanding of the PDO program necessary to bring PDO services to as many interested and qualified enrollees as possible. They are also effective in providing all necessary fiscal agent services to ensure that payroll is timely processed, background checks are timely submitted, and encounters are submitted accurately and on a timely basis.

#### **OVERSIGHT AND MONITORING**

**CRITERION 2:** The adequacy of the respondent's oversight structure, including the extent of executive level staff participation

Aetna uses defined company-wide subcontractor monitoring processes to maintain accountability and oversight for all functions and responsibilities that we delegate to any subcontractor, in accordance with 42 CFR 438.230, including the updates that have recently become effective, and NCQA standards, as well as all other State and federal requirements. Aetna assumes full responsibility for active, ongoing monitoring and continuous evaluation of subcontractor performance and compliance. We develop, implement, and maintain comprehensive policies and procedures regarding subcontractor performance to meet stakeholder needs and expectations. Aetna's quality management program includes formal, multi-layered processes and comprehensive policies and procedures to monitor contract compliance, quality of care, services, and reporting provided under any subcontract.

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### **Oversight Structure**

Aetna oversees all subcontracted activities, which includes monitoring performance metrics and identifying opportunities for improvement for all subcontractors. Once contracted, all new and existing subcontractors are subject to our multi-layered delegation oversight process on an ongoing basis. This process embraces a multilevel approach for continuous accountability, with oversight activities occurring at both the national and local levels. A flowchart illustrating our multi-layered subcontractor oversight processes appears in Figure SRC 26-1: Aetna Subcontractor Oversight Process Flowchart in Attachment SRC 26.

#### **National Oversight**

At the national level, we have a centralized team of delegation oversight experts that manages the oversight process across Aetna lines of business to ensure that they all 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, Appeals and Grievances, 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.

#### **Local, Executive-Level Oversight**

The chief executive officer, chief medical officer, compliance officer, chief operating officer, vice president of clinical health services, director of quality management, and selected leadership staff from our Enrollee Services, Provider Services, Network Management, and Grievance and Appeals departments comprise the local-level DOC. These local, executive-level plan leaders and key leaders from functional areas meet with all subcontractors on a monthly or quarterly basis, depending upon the type of subcontractor, to monitor service delivery, troubleshoot problems, review and resolve enrollee complaints, and most importantly, identify opportunities to collaborate on new or enhanced services for our enrollees. The DOC approves all delegates and delegation reports, and it monitors subcontractor performance at the plan level. Executive-level leaders monitor the success of corrective action plans and handle escalated issues when the corrective actions are not producing satisfactory results.

Critical issues are escalated through the director of quality management who ensures that the entire leadership team, Medical Management, Provider Services, Network, and Enrollee Services department managers are aware of critical issues and can formulate immediate risk mitigation strategies. An escalation framework is critical to resolve issues and ensure continuity of services to our enrollees and health plan.

A component of our quality program structure, the DOC monitors operational and clinical performance measures and identifies areas in need of improvement and intervention. The DOC analyzes and disperses monthly, quarterly, and annual reports to key plan departments. Multi-departmental representation on the committee enables analysis and assessment of all subcontractor deliverables to assess the quality of services provided and to ensure that the

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services meet the objectives of the subcontract. The result of this inter-departmental effort is that our monitoring process is a fluid, iterative, and collaborative process.

The DOC meets quarterly and reviews subcontractors' operational and clinical performance measures, compliance with service-level agreement and contract requirements, and overall effectiveness. Any operational items are discussed and evaluated during oversight meetings with actions agreed upon and reviewed by the committee. The following are some of the committee's responsibilities:

- Evaluation of each subcontractor's or prospective subcontractor's quality assurance plan and ongoing reporting (such as prior authorization time standards and customer service performance measures and monitoring)
- Review of results of oversight assessments conducted by Aetna to monitor the performance of subcontracted or prospective subcontracted entities and make recommendations to the Quality Management Operational Committee (QMOC) regarding delegation status and corrective action plans
- When deemed necessary, requesting and monitoring corrective action plans from subcontractors
- Monitoring and evaluating delegated functions via monthly, quarterly, and annual reports, as defined in the subcontractor agreement

In addition, our local plan compliance officer meets with certain key delegates on a monthly or quarterly basis to discuss performance. These key delegates are those who provide sensitive services that have a significant impact on our enrollees, such as behavioral health and transportation. In these regular Joint Operations Review Committee (JORC) meetings, we review operations and compliance reports, and address enrollee complaints. The purpose of these meetings is to provide effective oversight of those to whom we entrust with serving the needs of our enrollees. By doing so, we help to ensure that subcontractors and delegates are providing the level and quality of service that we expect and require.

In addition to planned JORC meetings with subcontractors, we are in contact with certain vendors on a daily or weekly basis to coordinate needed equipment and services for our enrollees as part of Aetna's integrated care management model. Our care managers are the front line in identifying potential problems or issues related to vendors and subcontractors. If an interaction with an enrollee related to a subcontractor raises a red flag or suggests there is a problem, the care manager will escalate the issue to management. Issues can often be resolved without further escalation once they are referred to the appropriate department for remediation. The following are a few examples of the types of subcontractor-related concerns that are addressed by different Aetna departments:

- Network Management: Contract-related issues, such as questions about whether a subcontract covers the type of service needed by the enrollee
- Provider Services and Operations: Issues with claims (e.g., overpayment, underpayment, or nonpayment); service related questions or concerns including eligibility, credentialing, or compliance, etc.
- Quality: Vendor relations, trending issues such as enrollee or provider complaints, failure to meet metrics, quality of care or service concerns
- Fraud, Waste, and Abuse: Referrals from any staff member or provider regarding suspected cases of enrollee, subcontractor, or provider fraud, waste, or abuse

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- Compliance: Any issues related to compliance with legal, contract, ethics rules, policies and/or procedures
- Contract Management: Any questions, issues or concerns related to the administration and compliance with agency contracts rules or policies

For example, our Utilization Management, Operations, Appeals and Grievances, and Enrollee Services departments recently worked together to resolve an enrollee's complaint about our dental vendor, MCNA. The enrollee complained to the State that she had visited an MCNA provider and requested a set of dentures. The provider's office explained to her that, because she had already received dentures, a new set was not covered. The enrollee maintained that she had not received dentures, and appealed to the State. We participated in the State Fair Hearing and supported the opportunity for MCNA to arrange for a second opinion. Upon investigation, it was revealed that the enrollee had received dentures previously, but they did not fit, and so she was unable to use them. Enrollee Services, along with the Grievance and Appeal team, worked with Utilization Management to help to ensure the enrollee received new dentures that fit.

#### **USING AND MONITORING SERVICE LEVEL AGREEMENTS CONSISTENT WITH THE SMMC PROGRAM SCOPE OF SERVICES**

**CRITERION 3:** The extent to which the respondent uses and monitors for service level agreements consistent with the SMMC Program Scope of Services

Prior to contracting, we conduct a pre-delegation audit to evaluate the subcontractor's ability to perform the functions under a delegated agreement to ensure they have the capacity to meet Florida contract requirements, and that the service level agreement is consistent with the Statewide Medicaid Managed Care (SMMC) program scope of services and NCQA requirements. For all subcontracting arrangements, we require a written and signed Aetna subcontractor agreement that:

- Describes the activities and responsibilities of Aetna and the subcontractor
- Includes required State contract provisions and terms, NCQA requirements, and service-level requirements
- Describes reporting requirements from the subcontractor to Aetna
- Describes the process by which Aetna evaluates the subcontractor's performance
- Specifies that Aetna retains the right to approve, suspend, or terminate individual practitioners, providers, and sites even if Aetna delegates decision-making
- Describes the remedies available to Aetna should the subcontractor not fulfill its obligations, including revocation of the subcontractor agreement

All subcontractors must demonstrate compliance with the SMMC program scope of services, as well as with Aetna's program requirements for delegated activities. Providers delegated for administrative functions must follow the criteria and standards designed by Aetna, consistent with the standards of the NCQA and, where applicable, the Joint Commission on Accreditation for Healthcare Organizations, the American Accreditation Healthcare Commission/URAC, the Centers for Medicare and Medicaid Services, applicable State regulatory authorities, and other governing agencies. If there is variation in all of the various State, federal, and other regulatory requirements that we must follow, we meet the most strenuous requirement that is most favorable to our enrollees and providers.

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As described above, our service-level agreements with each subcontractor are consistent with the SMMC program scope of services upon initiation of the subcontract. Subcontractor performance and continued compliance with scope of services requirements is monitored by performing specific audits. The type of audits we perform depends upon the work performed by the vendor, and can include, for example, call, claim, credentialing, customer service, financial, or utilization management audits. We have specific tools for each type of audit that we will use to assess compliance with each component of the service-level agreement. For example, a claim audit will assess the vendor's compliance with the following program elements:

- Claim department staffing and structure, including:
  - Staffing ratios
  - Claim volume
  - Production and quality standards training program
  - Confidentiality statements and compliance with the Health Insurance Portability and Accountability Act
  - FWA training
  - Audit program
- Claim processing procedures such as:
  - Claim inventory and controls (e.g., tracking, sorting, logging, and batching controls)
  - Workflow charts
  - Misdirected claim handling process
  - Claim payment policies, procedures, and processes
  - Payment methodology
  - Coordination of benefits, subrogation, third-party liability, overpayment, and offset processes
  - Medical review process
  - Claim denial policies, procedures, and processes
  - Explanation of benefits and explanation of payment compliance
  - Regulatory compliance
  - Provider dispute resolution processes
- Systems/reporting capabilities and business contingency information, including:
  - System capabilities
  - System security
  - Reporting capabilities
  - Claim history retention
  - Disaster recovery policy and procedure
- Actual claim audit results:
  - Paid claim accuracy measures
  - Denial appropriateness score
  - Turnaround time compliance

The audit report will provide details regarding these elements and will include an operational and performance compliance summary, along with the auditor's recommendations regarding next steps including corrective action plans (CAPs), re-audit requirements, and general comments. The auditor will share the resulting audit report with the vendor, initiate a CAP if needed, and conduct re-audits as part of the CAP oversight process.

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Audit results may also indicate potential quality concerns that suggest there might be an FWA issue. If this is the case, our Compliance and Quality Management departments will be involved in remediation, and FWA issues will be referred to the Special Investigation unit (SIU) for investigation. We will meet with the vendor at regular intervals (e.g., every 30, 60, or 90 days as indicated by the type of issue being remediated) to review the vendor's progress and verify they have successfully completed the CAP or other quality improvement program. The audit team will report the audit results and any CAP or quality improvement results to Aetna's National Vendor DOC, the National Medicaid DOC, and the local DOC. Results will be used to determine if further actions including assessment of penalties, additional monitoring/audits, or even termination is warranted. They will also be used in the decision-making process when the time comes for contract renewal.

### **APPROACH TO MONITORING QUALITY OF WORK**

**CRITERION 4:** The adequacy of the respondent's approach to monitoring the quality of work performed by subcontractors, including the frequency and type of monitoring

Oversight of subcontractors begins before Aetna signs a contract with them, and it includes the pre-delegation assessment by the appropriate audit teams (e.g., claims, customer service, finance, utilization management, general controls, and compliance), followed by reviews by multiple committees and approval at both local and national levels. We use standardized audit tools for evaluation and documentation during the assessment of the prospective subcontractor's program. The completed assessment report documents the strengths and opportunities for improvement of the prospective subcontractor's program. Aetna's national DOC then forwards the report to the local plan DOC for review and approval. The local plan DOC then forwards it to the QMOC for final review and approval. At minimum, we perform another assessment of each subcontracted provider entity annually and report the results to the QMOC.

After the delegation agreement is approved, the process moves to contract negotiations and execution, system capability assessments, implementation of file/feed exchange, testing, and training. Post-implementation efforts consist of, but are not limited to, health plan monthly operations team meetings, annual delegation team audits, and maintenance of documentation such as audit reports, action plans, licensure, and insurance. While our administrative services personnel may manage the contract with a multistate subcontractor, we manage at the local level issues directly related to our enrollees. Feedback in the form of enrollee and provider satisfaction surveys, complaints and appeals trends, and communication from AHCA also can indicate quality concerns. For example, our transportation vendors conduct enrollee satisfaction surveys after trips. The survey results are used to identify opportunities for improvement and are shared with the health plan as part of the JORC meetings.

Our vendor oversight staff will meet with subcontractors on an ad hoc basis to address questions and remediate issues related to claims, encounters, and other trending concerns. For example, recently we learned that one of our subcontractor's claims was repeatedly rejected by the State. We learned that the vendor was submitting duplicate encounters and therefore the improper claims were being rejected. Immediately upon receiving the report from AHCA, we brought the issue to the vendor's attention by first calling and then performing an onsite visit. There was an issue with the vendor's system that was generating the erroneous claims, and we

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worked with the vendor to research the problem and implement corrections to remediate the issue.

### **Monitoring Frequency**

Our national Delegation Management team conducts annual audits of subcontractor performance to evaluate subcontractors' compliance with standards and criteria. These audits include review of associated policies and procedures and file audits, where applicable. The local DOC 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 of our subcontractors, and we understand that no subcontract relieves us from any obligation or liability arising from our contract with the Agency. 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.

The next scheduled audit dates for the subcontractors to which we delegate the management of provision of covered services, utilization management, provider networks, or paying providers are as follows. All of our subcontractors were in compliance as of our most recent audit, and they are being audited on an annual basis.

- Access2Care
  - Call Audit Date: September 13, 2018
  - Claim Audit Date: September 13, 2018
  - Credentialing Audit Date: December 1, 2017
- Beacon Health Options (Beacon)
  - Call Audit Date: March 10, 2018
  - Claim Audit Date: March 10, 2018
  - Credentialing Audit Date: May 4, 2018
  - Utilization Management Audit Date: May 4, 2018
  - Financial Audit Date: July 20, 2018
- CVS Health
  - Customer Service Audit Date: October 10, 2017
  - Claims Audit Date: October 11, 2017
  - Financial Audit Date: February 15, 2018
- Firstsource Solutions/Firstsource Transaction Service, LLC
  - Call Audit Date: October 31, 2017
  - Claim Audit Date: October 31, 2017
  - Financial Audit Date: April 30, 2018
- iCare Health Solutions
  - Claims Audit Date: May 30, 2018
  - Credentialing Audit Date: June 29, 2018
  - Financial Audit Date: July 19, 2018
- Managed Care of North America, Inc.
  - Financial Audit Date: April 14, 2018
  - Call Audit Date: August 31, 2018
  - Claim Audit Date: August 31, 2018
- MedSolutions, Inc. dba eviCore Healthcare
  - Utilization Management Audit Date: June 1, 2018
- Public Partnerships, LLC

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- Credentialing Audit Date: December 15, 2017

### **Type of Monitoring**

We determine the type and level of monitoring the quality of work performed by subcontractors on a case-by-case basis depending on the subcontractor, the services being provided under a subcontract, and the subcontractor's performance history with us. As part of our monitoring process, we require the subcontractor to submit reports in a manner and frequency that meets our contractual obligations with AHCA and are in accordance with the SMMC Report Guide. These reports include information about performance against the metrics, standards, and service-level agreements defined in the subcontract. This information is cross-referenced with enrollee feedback and peer-to-peer reviews to establish accuracy in reporting.

In addition to annual and more frequent audits and monitoring of subcontractor reports, we have interdepartmental meetings and meetings with our subcontractors to monitor subcontractor work quality. Our Compliance department confers with our Operations department daily on concerns, issues, and needs regarding subcontractors. Local operations personnel, along with our Compliance, Provider Services, Medical Management, and Quality departments participate in JORC meetings no less frequently than monthly with subcontractors to review the following:

- Subcontractor performance as it relates to service-level agreement and contract compliance
- Relevant State and federal legislation and regulations
- Contractual obligations to the Agency
- Performance expectations or concerns
- Reporting requirements

We increase the frequency of these meetings, as needed, to address pressing issues, new legislation, or regulatory changes. Meetings can occur as frequently as daily, depending upon the type of issue being addressed, the impact of the issue on operations, and the timeframe required to resolve it. Close collaboration occurs with our subcontractors to assess compliance with performance objectives and to maintain proper oversight and accountability. We provide subcontractors with initial training and, when necessary, retrain in aspects of contract requirements that are included in their scope of work. Our goal is to help ensure our subcontractors successfully perform their duties.

### **PROCESSES FOR ADDRESSING PERFORMANCE ISSUES**

**CRITERION 5:** The adequacy of the respondent's processes for addressing performance issues, including the triggers for increased monitoring activities, interventions and Contract compliance action

To provide a seamless experience for enrollees and providers, we establish close working relationships with our subcontractors to assess compliance with performance objectives while maintaining proper oversight and accountability. We monitor all of our subcontractor partners for performance using compliance monitoring tools, audits, and performance reports. At a minimum, vendors are audited annually; we perform additional audits where appropriate if there are deficits. Re-audits are performed semi-annually and CAPs are followed at appropriate intervals based on the issue. If a subcontractor assessment reveals an issue related to patient

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safety, we do not wait to complete a re-audit, but take action immediately to address the issue with the vendor. In addition to the work completed by the audit teams, we discuss audit results and remediation plans during the monthly local JORC meetings with subcontractors.

#### Triggers for Increased Subcontractor Monitoring

The following performance indicators will trigger increased monitoring activities, interventions, and contract compliance actions:

- Complaint and appeal trends, including results from real-time complaint resolution processes
- Enrollee satisfaction data, e.g., wait times
- Issues identified during audits, including regular and ad hoc claim and encounter audits, monitoring activities, or other reports that require heightened focus and attention, such as poor financial results
- Findings on quarterly monitoring reports
- Peer review process results indicating quality-of-care or service issues
- Utilization management reporting results indicating under- or over-utilization
- Referrals from customer service, provider networks, enrollees, providers, or sub-delegates
- Referrals or indicators of potential FWA issues
- Changes in laws, regulations, contract requirements, or Agency policies that impact subcontractor responsibilities
- Natural disasters
- Medical record reviews
- Delegated vendor site visits
- Agency-identified issues
- Florida Association of Health Plans or Florida Healthy Kids-identified issues

Trends in data such as customer complaints, Healthcare Effectiveness Data and Information Set (HEDIS) results, and other quality measures that can indicate potential quality of care concerns are identified and reviewed regularly. When any of these performance measures suggest a subcontractor is not meeting requirements, monitoring activities are intensified, including performing additional auditing of more detailed, micro-performance indicators and enrollee-level data, as appropriate.

Interventions are developed in partnership with the subcontractor and are specific to the identified issue. We employ several levels of oversight to help ensure that issues are found and identified in a timely manner. The delegation oversight lead completes audits and assessments, the DOC reviews those audits and assessments, and the QMOC oversees the DOC's work. If a corrective action plan is necessary, the compliance officer and compliance committees help to ensure that the CAP is effective and resolves the issue.

For example, we perform claim and call audits. If a delegated vendor's results are below 95%, we will re-audit within six months. If there are issues with the policies, procedures, and workflows as part of the operational review, we will develop a CAP. We monitor the CAP until it is completed, typically within 30, 60, or 90 days, and we report the audit and CAP results to the local and national oversight committees. The committees are advised of any deficits, and the

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health plan works directly with the vendor to provide additional support as needed or to address escalated issues if the audit team's CAPs are not successful.

### **Interventions and Contract Compliance Action**

We require and provide oversight to help to ensure all subcontractors follow all State and federal laws and regulations. If a subcontractor fails to meet any performance or regulatory standard, we work with the subcontractor as their partner in building the processes and elements that will help them meet contractual requirements. We provide advice and guidance about evidence-based interventions that can help bring the subcontractor into compliance. If these efforts are unsuccessful, we may pursue various sanctions, remedial actions, or other remedies because of such failure, per the terms of the applicable subcontract. The following are some of our remedies:

- Requiring the subcontractor to cure any deficiency and provide a written CAP demonstrating appropriate controls are in place to prevent future breaches
- Assessing performance penalties against subcontractors if they fail to meet designated standards for areas such as claims processing and encounters
- Termination of contract for continued non-compliance

We use any or all of these remedies to address a subcontractor's non-compliance. An Aetna auditor, along with the Network and Compliance departments—including the compliance officer and Compliance Committee, the applicable DOC, and the affected subcontractor—will monitor the CAP from beginning to end. If the non-compliance issue is not resolved, or if the subcontractor repeatedly fails to meet service levels or align performance with applicable standards, we may terminate the subcontract for material breach of contract. In all vendor contracts, we will include performance metrics tied to a portion of payment or a quality bonus, and we will take action(s), including withholding payment, as allowed under the vendor contract if any performance metric is not met.

For example, our delegation agreement with behavioral health vendor Beacon includes specific performance metrics that will be used to monitor the quality of every function they perform for us and for our enrollees. The following are a few examples of the metrics we will use to monitor and measure Beacon's performance, by function.

- Call Center:
  - Average speed of answer for telephone calls placed by enrollees or providers
  - Rate of inbound calls abandoned by the customer before speaking to a customer service representative
  - Percentage of calls answered within 30 seconds or less
  - Internal random call monitoring quality scoring criteria
- Credentialing:
  - Maintenance and review of credentialing and re-credentialing files
  - Reports containing information such as the names and numbers of providers approved, terminated, suspended, or denied; statistical data; and the results of any studies or quality improvement projects
  - Compliance with confidentiality and other information security measures
  - Access to files and data in accordance with our contract with AHCA

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- Claims Management:
  - Financial and statistical accuracy of claims
  - Percentage of clean and non-clean claims processed and paid within required timeframes
  - Use of approved written communications to enrollees and providers
  - Performance guarantees
  - Financial protections such as letter of credit or performance bond
- Utilization Management and Network Adequacy:
  - Utilization management reporting, including provision of utilization management program details, updates, and revisions; annual written evaluation; and Utilization Management Committee meeting minutes
  - Annual, semi-annual, quarterly, weekly, and ad hoc reporting and audit requirements
  - Identification of individuals who will receive and address enrollee communications regarding utilization management and authorizations
  - Surveys to assess enrollee and provider satisfaction and notification regarding receipt of complaints
  - Cooperation with and participation in appeal, grievance, and external review procedures
  - Network adequacy standards including availability of practitioners, accessibility of services, and assessment of network adequacy

### **Process Improvement**

The local DOC uses data integration and predictive analytics to promote quality outcomes by identifying and acting upon opportunities for improvement. We take a cross-functional approach to monitoring the quality of our subcontractors' services. Sources of our data include HEDIS, Consumer Assessment of Healthcare Providers and Systems, enrollee utilization data, grievances and appeals, and telephone customer service results, among others. We continuously monitor the data to proactively identify areas in need of improvement and address such issues by implementing quality improvement programs, such as CAPs or performance improvement projects.

Quality improvement programs often reflect the unique needs and barriers that affect our enrollees, such as limited access to and limited availability of services, demographic challenges, racial disparities, and health risks that affect their ability to meet recommended HEDIS measures. Our Quality team uses our access to comprehensive claims information to identify gaps in care or other quality-related issues. In cooperation with the DOC team, Aetna's Quality Management department measures and quantifies gaps to establish benchmarks, and then we analyze the data to identify the root causes. Our cross-functional teams develop and implement solutions to improve the identified gaps in care. The team determines how the solution will be monitored and successfully sustained by our Care Management, Utilization Management, and Provider Services teams, as well as by providers, subcontractors, and other key stakeholders. Our quality improvement processes are non-linear and take into consideration real-time data to course correct when appropriate. By bringing in the expertise of multiple departments, we are able to be proactive and flexible in addressing subcontractor quality issues.

Through our oversight efforts—including regular delegation management, DOC, and JORC meetings and ongoing audits and reporting—we make sure our subcontractor partnerships are

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

helping us close gaps in care, reduce complexities for enrollees and providers, and create innovative solutions to reduce barriers to access in care in Florida. We use the findings from our oversight activities to identify opportunities to implement process improvements. For example, routine oversight of our behavioral health vendor revealed an unusually high number of codes that indicated locations of “Other” for services related to follow-up after hospitalization for mental health, a quality measure. The use of “Other” as a location for services resulted in inaccurate claims, in addition to lowering our quality measure for services related to follow-up after hospitalization for mental health. We worked with the provider to correct the coding issue, resolving the problem and eliminating it as a barrier in achieving improved quality measures. This incident prompted a change in our process for examining vendor codes, and taught us to look at measures more critically and more quickly act upon issues we find.

### **ENSURING FINANCIAL STABILITY**

**CRITERION 6:** The extent to which the respondent provides monitoring activities it will use to ensure the financial stability of the subcontractor, including the required financial reporting frequency for subcontractors

Aetna also maintains financial oversight by assessing each subcontractor’s financial condition to determine its ability to maintain financial solvency. The Aetna provider liability/delegation financial review department performs a financial review of delegated entities that perform financial functions, such as claims payment, on our behalf. These reviews occur at least annually as part of our financial due diligence to provide oversight of the contractor’s continuing compliance with and ability to meet Aetna standards. A financial auditor reviews audited and unaudited financial statements such as the subcontractor’s balance sheet, income statement, statements of cash flow, and interim reports. The auditor will provide an assessment of the results of the operations analysis, 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 financial auditor will make recommendations regarding increasing the frequency of re-audits. Finally, the auditor’s financial report is distributed to all of the various oversight committees.

Anything from poor audit results, increases in enrollee complaints or grievances, indications that downstream providers are not being paid to news reports about a subcontractor’s financial instability, or alerts from the Agency can trigger heightened financial monitoring and oversight activities. We will implement a CAP to ensure the subcontractor becomes compliant as quickly as possible, and we will require improvement and resolution on a short timeline—typically 30 or 60 days. The DOC, Compliance department, and JORC will review audit and re-audit 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. In the unlikely event that we are unable to resolve the issue with our subcontractor, the health plan JORC would review the performance data and make the decision to move forward with terminating the delegation agreement/contract. We will report this decision to the Agency and develop an action plan to communicate with providers and enrollees, ensure network adequacy, and address payment of claims, etc. Multiple Aetna departments, including Operations, Network, Provider Services, Legal, and Finance departments, will review the contract to determine the contractual basis for and assess the financial and enrollee impact of terminating the contract, and implement the action plan.

**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**Evaluation Criteria:**

1. The extent to which the respondent provides a list of subcontractors it proposes to use under the SMMC Program for the delegation of work as described above.
2. The adequacy of the respondent's oversight structure, including the extent of executive level staff participation.
3. The extent to which the respondent uses and monitors for service level agreements consistent with the SMMC Program Scope of Services.
4. The adequacy of the respondent's approach to monitoring the quality of work performed by subcontractors, including the frequency and type of monitoring.
5. The adequacy of the respondent's processes for addressing performance issues, including the triggers for increased monitoring activities, interventions and Contract compliance action.
6. The extent to which the respondent provides monitoring activities it will use to ensure the financial stability of the subcontractor, including the required financial reporting frequency for subcontractors.

**Score:** This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.



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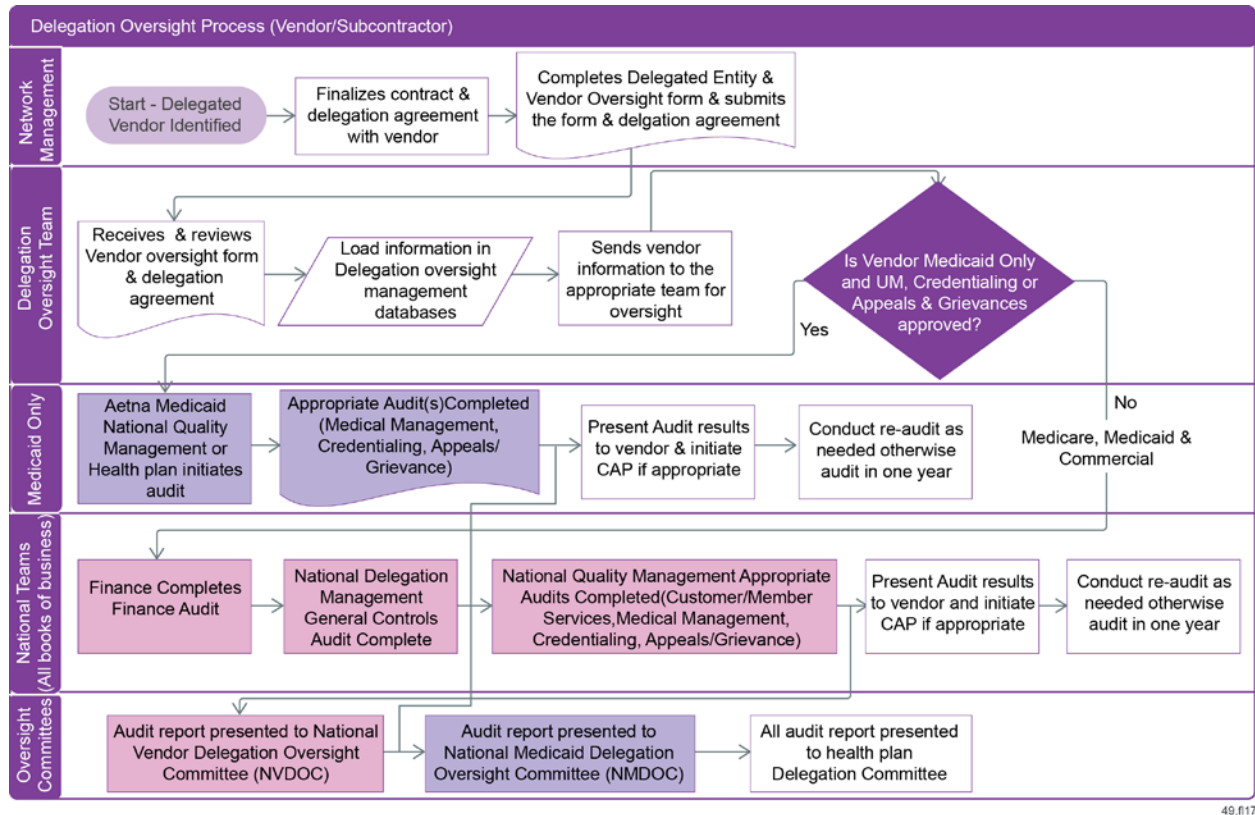
## **Attachment SRC# 26**



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**SRC# 26: Figure SRC 26-1: Aetna Subcontractor Oversight Process Flowchart**



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**Figure SRC 26-1: Aetna Subcontractor Oversight Process Flowchart**

*Our multi-layered delegation oversight process promotes accountability and compliance at the local and national levels.*



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**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**SRC# 27 – Subcontractor Oversight (Statewide):**

The respondent shall submit a sample contingency plan it would enact in the event a subcontractor to which the plan has delegated authority to manage utilization and pay providers on behalf of the plan, files for bankruptcy or otherwise becomes unable to continue operations due to lack of financial resources.

**Response:**

As part of the subcontracting process, subcontracted vendors that manage utilization review and claims functions are required to post a bond or have a letter of credit in order to help ensure continuity of performance in the event of a crisis. In the event a subcontractor to which we have delegated authority to manage utilization and pay claims on our behalf files for bankruptcy or otherwise becomes unable to continue operations due to lack of financial resources, Aetna will implement a contingency plan.

In 2015, we experienced a situation wherein one of our durable medical equipment (DME) vendors ceased operations unexpectedly. We swiftly enacted an emergency transition work plan to minimize disruption to our enrollees and to help to ensure valid claims were paid appropriately. The Agency was a part of the solution, providing guidance and serving as a resource for us while our Operations, Network, Provider Services, Health Services, and Claims departments navigated the challenges presented by the vendor ceasing operations. In the event that we experience a similar situation in the future, we will again collaborate with the Agency as a partner in implementing the contingency plan, including presenting our enrollee communication materials for Agency pre-approval in a timely manner.

We learned from our experience dealing with the unexpected shutdown of our DME vendor that it is essential to require our subcontractors to have a bond or letter of credit as a condition of our subcontract with them. Now, any new subcontract with a vendor providing utilization management or claims processing will contain language to protect Aetna in the event of a breach, including requiring a letter of credit or bond that can be drawn upon in the event the vendor fails to pay claims as required under their Aetna contract. In addition, we conduct financial audits to identify areas of concern before they become critical. We increase our financial auditing and oversight when results are poor, and we implement corrective action plans to address issues directly as they arise. In addition, this experience taught us to look for patterns in enrollee complaints, provider complaints, or other indications that a subcontractor might be experiencing financial difficulty. All of our departments, from Quality to Enrollee Services to Provider Services, are prepared and empowered to identify and report suspected issues to our compliance officer.

The primary objectives of the contingency plan are to prevent disruption of care and services for enrollees and to ensure the availability of services to new enrollees requiring access to care. To achieve these goals, we have a thorough subcontractor oversight strategy that includes robust processes to identify potential problems before such an event occurs (e.g., continuous performance monitoring and audits), contingency planning, and a communications strategy to ensure timely coordination with our enrollees and providers.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **CONTINGENCY PLAN**

#### **Purpose**

The contingency plan addresses our strategy for responding in the event a subcontractor to which we have delegated authority to manage utilization and pay providers on our behalf files for bankruptcy or otherwise becomes unable to continue operations due to lack of financial resources. Our primary objectives in this event are to prevent disruption of care and services for enrollees and to ensure the availability of services to new enrollees requiring access to care.

#### **Revision Schedule**

At a minimum, the contingency plan is reviewed and revised annually, and every time a new subcontractor is given authority to manage utilization or pay providers on behalf of the plan.

#### **Date of Last Revision**

The contingency plan was last revised on October 3, 2017.

#### **Affected Subcontractors**

The following unaffiliated subcontractors perform utilization management and claims functions:

- Beacon Health Options
- Firstsource Solutions/Firstsource Transaction Service
- iCare Health Solutions
- Managed Care of North America, Inc.
- MedSolutions, Inc., d/b/a eviCore Healthcare

### **DATA SOURCES**

**CRITERION 1:** The extent to which the respondent has outlined the data sources it would use to trigger the respondent to put the contingency plan into play in advance of the subcontractor filing for bankruptcy or otherwise becoming unable to continue operations due to lack of financial resources

We continuously monitor and track subcontractor performance metrics such as financial reports, volume of encounter submissions, timeliness of claims payment, and utilization management statistics. We look for patterns and trends in complaints to our Provider Services and Grievances and Appeals departments and to the Agency to identify potential problems. When enrollees complain about interruption in services or having not been provided needed services, or providers report to us that enrollees are not being provided certain services by a vendor, this information triggers further investigation and potential implementation of the contingency plan.

If a delegated vendor performs poorly on a standard financial audit, for example, the Provider Liability/Delegation Financial Review team will increase financial oversight by implementing a corrective action plan (CAP), monitoring progress, and re-auditing. This team will report results to the national Delegation Oversight Committee (DOC) and local health plan DOC, which is comprised of multiple departments including executive leadership, Operations, Network,

**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
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Provider Services, Legal, and Finance departments. If there appears to be a potential quality of care issue, our Quality Management team will work with the subcontractor to resolve the issue through a quality improvement program. If there is a suspected fraud, waste, or abuse (FWA) issue, the individual or department who uncovered the suspicious activity will refer the findings to the compliance officer and Special Investigations unit (SIU) for investigation. If the CAP or other quality improvement program is unsuccessful or we continue to receive complaints about the vendor, the DOC will terminate the subcontract in accordance with contract provisions before the vendor's financial instability becomes critical.

In addition, we review with subcontractors any complaints or concerns during our monthly Joint Operations Review Committee (JORC) meetings. Concerns may come from various Aetna departments, such as Grievances and Appeals, Quality, or Provider Services, or we may receive notification of potential issues through AHCA's quarterly FWA meetings, Agency alerts and notices, our Agency contract manager or other health care organizations. Again, we will attempt to remediate the issue through normal measures such as implementing a CAP and re-auditing. If we are unable to resolve the issue in a reasonable amount of time, we will terminate the relationship with the vendor and implement the contingency plan.

In the unlikely event that, in spite of our multilayered delegation oversight processes (e.g., subcontractor monitoring, reporting, and meetings; and remediation and quality improvement programs), it appears that one of our subcontractors responsible for utilization management or claims functions might be preparing to file for bankruptcy or otherwise is unable to continue operations due to lack of financial resources, the following are some of the data source triggers that will enable us to implement the contingency plan in advance of such action:

- Enrollee and provider satisfaction data that suggests unsatisfactory progress in remediating previously identified issues
- Re-audit results showing unsatisfactory progress in remediating issues identified in previous audits
- Results from investigations of referrals from customer service, provider networks, enrollees, providers, or sub-delegates that confirm fraud, waste, and/or abuse issues
- Notices, alerts, or guidance from AHCA



## **EXHIBIT A-4-a**

### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

#### **COMMUNICATIONS STRATEGY**

**CRITERION 2:** The extent to which the respondent outlines a communications strategy in the contingency plan

Plan leadership and/or our Medicaid contract manager will inform AHCA that we have decided to implement the contingency plan within 24 hours or the next business day, and provide the Agency with a task list outlining the contingency plan tasks. A sample Contingency Plan Task List is listed Figure SRC 27-1: Sample Contingency Plan Task List in Attachment SRC 27. Depending upon the severity and impact of the situation, and with AHCA's guidance, we will communicate status updates on a daily or weekly basis in a manner of the Agency's choosing.

Within 24 hours from beginning contingency plan implementation, plan leadership will communicate the implementation of the contingency plan to managers via a telephone call and email. Within 24 hours of receipt, managers will cascade the information to their teams as appropriate. Within two days, our Operations department will develop customer service talking points to help to ensure that staff members are empowered to share information and work to prevent disruption to enrollees. We will submit the talking points to AHCA for approval, and then roll out the approved talking points for use by our customer service representatives.

Within three business days from beginning contingency plan implementation, our Operations department will update our enrollee notice, submit proposed enrollee communications to the Agency, and request expedited approval. Within 24 hours of receiving Agency approval, our Enrollee Services department will direct Agency pre-approved communications to enrollees via letter, telephone, email, and text messaging, and we will update our website to prominently display pertinent information for enrollees.

Within three days from beginning contingency plan implementation, Operations team members will develop a network notification and work with our Network department to develop Frequently Asked Questions (FAQs) for distribution to our providers. Within three business days from beginning contingency plan implementation, our Provider Services staff will contact all providers via letter, telephone, email, and facsimile blasts. This communication will focus on limiting disruption in services to enrollees, and will include instructions for making information available to enrollees and downstream providers. It will assure providers that claims will be covered, provide instructions for submitting unpaid claims, and explain our policy for waiving authorization requirements and identifying and honoring past authorizations.

The Provider Services team will call every provider serving Aetna enrollees who had contracts with the defunct subcontractor within three days, and provide FAQs with information about how to submit claims and obtain prior authorizations. Our Health Services department will ensure prescription alignment. Our network staff members will communicate with downstream providers within two business days regarding continuity of care to enrollees and the implementation of letters of agreement (LOAs) designed to enable us to work directly with them to provide services. As LOAs are returned, Network department staff will enter them into our claims processing system, and our Claims and Operations departments will help to ensure claims acceptance for timely payment.

Within five business days from beginning contingency plan implementation,, if there is no alternative vendor under contract in our network, our Network team will secure a short-term LOA

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

with a new vendor to provide coverage until full contract execution is achieved with a permanent replacement vendor. Within 24 hours of securing the LOA, we will notify AHCA of our decision to use a vendor on a temporary basis until a contract is finalized with the permanent replacement vendor. Network department staff will also notify all impacted internal departments, including Health Services, Provider Services, Enrollee Services, and Quality, of the decision within two business days, and will notify impacted downstream and other impacted providers within three business days of the temporary replacement vendor. We will update our Website to reflect the change.

To ensure continuity of care for our enrollees, within five business days from beginning contingency plan implementation, our Health Services department will compare data from the defunct subcontractor with existing claims and authorization data in our system. Along with our care management team, the Health Services department will review each case for care coordination needs and develop an escalation process for complex cases. Care managers will retrieve and review claims and utilization management reports in order to identify needed services, develop a continuity of care plan, and prevent disruption to affected enrollees. Care managers will transfer enrollees' medical/case records to the replacement service provider and assist with scheduling appointments as needed. Health Services department staff will work with the replacement vendors to formulate a plan for submitting new referrals.

### **STRATEGIES TO ENSURE PROVIDERS RECEIVE PAYMENT**

**CRITERION 3:** The extent to which the contingency plan includes strategies for ensuring providers get paid for situations where there were open authorizations

To help to ensure providers receive payment and that enrollees have the continuity of care they need, we will waive authorization requirements for covered services and honor past authorizations for 30 days. Our approach is to work collaboratively with providers and to provide them with information, guidance, and assistance in submitting claims. Whenever possible, at the time a downstream subcontractor contracts with one of our vendors, we execute a letter of agreement or other type of agreement to secure the downstream subcontracted providers to Aetna. This enables us to easily pay the downstream providers and ensure that we have providers in place to provide services should the vendor disappear.

As described in the communications strategy above, within three days upon implementation of the contingency plan, our Provider Services team will inform potentially affected providers of the situation and provide detailed instructions for documenting and submitting claims. If a provider is out-of-network, our Network Management team will execute single case agreements as required. This initial information will advise providers that we will honor past authorizations for covered services and waive timely filing requirements for the period of time in which the provider was not being paid to assure them we would pay all valid and appropriate claims. We will work with providers in a collaborative manner to assist them in submitting their documentation and claims. For example, we will offer technical assistance, Webinars, and forums for providers who are unfamiliar with our system.

Our Operations team members will assume claims payment functions. We will pay the claims and seek reimbursement from the defunct vendor, for example, by drawing upon their letter of credit or bond.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **STRATEGIES TO PREVENT PROVIDER FRAUD AND ABUSE**

**CRITERION 4:** The extent to which the contingency plan includes strategies to prevent provider fraud and abuse in situations where a subcontractor files for bankruptcy or otherwise becomes unable to continue operations due to lack of financial resources

Our strategies to prevent provider fraud and abuse include requiring affected providers seeking payment to submit detailed, well-documented claims information; employing our SIU's FWA and overpayment prevention and detection systems and technologies; and training and equipping our team members with the knowledge to identify and report suspected FWA.

To ensure the safety of enrollee information and prevent fraud, we will assume custody of records in the defunct vendor's possession, or otherwise assure that records are secured or destroyed. We will lock the defunct subcontractor out of systems to make certain they do not have access to past, present, or future enrollee records; e.g., we will discontinue all data feeds of enrollee demographic and eligibility information, in addition to claims. Furthermore, we would review the subcontractor's records for other issues, including potential quality of care or quality of service concerns, as well as verify that all associated providers and staff are screened and properly credentialed.

As part of our communications to affected providers described above, we include a letter to downstream and out-of-network providers explaining how to submit a claim for services rendered during the time in which the defunct subcontractor failed to pay claims. Providers will be given 6 months to submit claims for consideration, or later if within the 180-day prompt payment submission requirement. The claim submission must be accompanied by a sworn affidavit attesting that the provider has not yet been paid for the services and a release form. In addition, the following documentation will need to be submitted by the provider:

- Copy of the contract between the downstream provider and the defunct subcontractor, including specifically the contractual payment amounts and methodology
- Copies of any prior authorizations or other documentation that may have been required approving the services rendered or equipment delivered
- Copies of any and all communications between the affected provider and the defunct subcontractor regarding the claim, including any requests by the subcontractor for additional documentation or information
- Contact information for the person who will be responsible for addressing questions Aetna may have regarding any unpaid claims
- Evidence that the services or equipment were delivered to Aetna enrollees
- Other information that is directly related to the claims reconciliation and payment process that will facilitate proper documentation and validation

Aetna will work closely with AHCA to prevent provider fraud and abuse, using all available data mining and information management systems to identify instances of suspected fraud or abuse. Our SIU employs data integration, predictive analytics, and management information systems to combat fraud, waste, abuse, and overpayment. We monitor all of our subcontractor partners for performance using compliance monitoring tools, audits, and performance reports. We perform reconciliation to confirm that services billed were actually rendered to the enrollee and to identify vendors that require heightened oversight or investigation. In addition, we monitor encounter

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

data, promptly investigate significant discrepancies from one month to another, and take actions including CAPs and contract termination if the investigation reveals evidence of FWA.

When necessary, we are able to tailor our monitoring and reporting methods to help ensure that we are not double-paying. Our front-end automation systems for correct coding and medical policy decisions helps to detect coding irregularities, conflicts, or errors while making recommendations for correction. Our claim system and editing vendors perform edits for enrollee data (e.g., age, gender), provider data, current coding protocol, assistant surgeon, place of service, type of bill, medical visit logic, medical unlikeliness, durable medical equipment, new-visit frequency, and professional, technical, and global services.

Monitoring and analysis of utilization patterns for suspicious increases in services provided also yields opportunities to protect against FWA. If there are questions about whether services were actually rendered, we will conduct targeted chart reviews and report to the Agency whenever suspicious patterns are identified. If a higher level of review is triggered through our monitoring process, we will examine actual referrals to verify that the service took place within the correct timeframe.

In addition, our staff members are trained to identify and report instances of suspected FWA. Our annual, mandated FWA training module provides specific case examples of issues, and highlights frequently used schemes. Through our training, we provide employees the opportunity to understand fully the impact of FWA in terms of financial cost as well as how it can detrimentally affect enrollee care.

### **Evaluation Criteria:**

1. The extent to which the respondent has outlined the data sources it would use to trigger the respondent to put the contingency plan into play in advance of the subcontractor filing for bankruptcy or otherwise becoming unable to continue operations due to lack of financial resources.
2. The extent to which the respondent outlines a communications strategy in the contingency plan.
3. The extent to which the contingency plan includes strategies for ensuring providers get paid for situations where there were open authorizations.
4. The extent to which the contingency plan includes strategies to prevent provider fraud and abuse in situations where a subcontractor files for bankruptcy or otherwise becomes unable to continue operations due to lack of financial resources.

**Score:** This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

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## **Attachment SRC# 27**



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**SRC# 27: Figure SRC 27-1: Sample Contingency Plan Task List**

Contingency Plan Task List		
Task	Department	Deadline (+ number of days from implementation)
<b>Communication Strategy</b>		
Inform AHCA that contingency plan is being implemented; submit task list for review	Medicaid contract manager	+1
Inform staff that contingency plan is being implemented	All	+2
Develop customer service talking points and submit to AHCA for approval	Operations	+2
Update enrollee notice and submit to AHCA for approval	Operations	+3
Notify enrollees via letter, telephone, email, text messaging, and update Website	Enrollee Services	+1 from date of Agency approval
Develop network notification materials and Frequently Asked Questions (FAQ)	<ul style="list-style-type: none"><li>• Operations</li><li>• Network</li></ul>	+3
Notify providers via letter, telephone, email, and fax blasts	Provider Services	+3
Identify and contact via telephone every provider with contracts with defunct vendor	Provider Services	+3
Ensure prescription alignment	Health Services	+3
<b>Continuity of Care</b>		
Compare data from defunct vendor with existing claims and authorization data	Health Services	+5
Perform case reviews to identify enrollees with complex needs; develop continuity of care plan	<ul style="list-style-type: none"><li>• Care Management</li><li>• Health Services</li></ul>	+5
Transfer enrollee records to replacement provider; schedule appointments as needed	Care Management	Upon identification
<b>Contracting, Claims Payment, and System Readiness</b>		
Communicate with affected providers regarding continuity of care; execute letters of agreement (LOA)	Network	+2



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Contingency Plan Task List		
Task	Department	Deadline (+ number of days from implementation)
Enter LOAs into claims processing system; ensure claims acceptance	<ul style="list-style-type: none"><li>• Network</li><li>• Claims</li><li>• Operations</li></ul>	Upon receipt
Secure short-term LOA with replacement vendor	Network	+5
Notify AHCA and affected providers, and update website regarding replacement vendor	Network	Upon execution of LOA

**Figure SRC 27-1: Sample Contingency Plan Task List**

*If we must implement the Contingency Plan, we will submit a task list to AHCA for review.*

**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**SRC# 28 – System Modification Protocol (Statewide):**

The respondent shall describe, in detail the following change control IT processes:

- a.** How the respondent will initiate and coordinate internal modifications for any of its core systems (including, but not limited to, encounter submission, EDI/Clearinghouse, and financial reporting) or any potential subcontractor's core systems,
- b.** How the respondent will accommodate Agency-directed IT modifications; and
- c.** How the respondent will identify, track, communicate, and resolve IT production issues that affect internal or external stakeholders.

For each of the descriptions, the respondent shall also include the expected timeframes for making modifications, the prioritization process employed, the communication processes used for planned or unplanned changes, as well as status updates provided to employees, Agency staff, and providers. The descriptions shall also address testing procedures, production control procedures, and any applicable claims/encounter reprocessing for historical or retroactive system changes.

**Response:**

Aetna employs a comprehensive information technology change management protocol that helps guide all system modifications to help ensure the least impact to operations and to our customers. Our protocols align with the Agency's objects to strive for minimal disruption, implement a proactive communication strategy to all stakeholders, and conduct thorough testing with feedback mechanisms to measure implementation barriers and successes. Aetna recognizes that stakeholders are dependent upon our systems functioning optimally and on our ability to effectively manage all system changes. Our approach is transparent and collaborative. When implanting significant system changes or upgrades, we inform the Agency prior to these changes, involve the Agency in the planning process and provide updates on the implementation and outcome of the changes.

Aetna uses contractual requirements and service performance agreements to monitor provider and subcontractor compliance with all contractual responsibilities. We hold subcontractors to the same requirements to which we hold our internal Medicaid Information System departments.

Aetna uses the same criteria, including expected timeframes, prioritization process, communication process, status updates, testing procedures, production control procedures, and applicable claims/encounters reprocessing for each element of our change control IT processes:

- Internal modifications
- Agency-directed IT modifications
- IT production issues

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **INITIATING AND COORDINATING INTERNAL MODIFICATIONS**

**CRITERION 1:** The adequacy of the respondent's IT processes addressing internal modifications for its core systems and subcontractor's systems

Effective and efficient change management is a critical process. Our change management process provides a structured, fully recoverable framework in which to implement system changes in accordance and on schedule with federal, State, and contract-specific requirements. Our process protects our core business applications and the systems from changes that may be disruptive or have an unacceptable level of risk. This is achieved through a robust design, development, and testing process that are outlined in the sections that follow. We employ an industry standard workflow tool to manage system change requests.

Our implementation schedule for the Agency will provide full conformity with future federal and/or AHCA-specific standards for the following:

- Claims processing
- Eligibility and enrollment processing
- Encounter submission
- EDI/clearinghouse
- Service authorization management
- Provider enrollment and data management
- Conversions of core transaction management systems
- Financial reporting

Integrating Core System Changes across Departments: Aetna brings vast experience managing information and the technology associated with gathering, maintaining, storing, transmitting, and reporting on that information. This enables us to provide partner states with the information necessary to manage and improve their Medicaid programs through informed decisions and support their enrollees' well-being.

All enhancements and maintenance activities require approval through Aetna's Demand Management office before the project begins. The demand management process makes certain that all projects within IT have the proper level of governance and visibility. The Demand Management office evaluates projects based on priority, size, and support of goals and objectives. The office works with IT leadership to assign project managers to each change project.

We have change processes at the IT cross-functional and functional team level, with multiple subject matter experts representing the business and IT domains to identify and track everything affected by any system change.

Please refer to Figure SRC 28-1: Change Management Process in Attachment SRC 28 for a high-level view of our change management process.

### **ACCOMMODATING AGENCY-DIRECTED IT MODIFICATIONS**

**CRITERION 2:** The extent to which the respondent's IT processes documented for implementing Agency-directed modifications is less than ninety (90) days

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Aetna is confident in our professional IT resources and robust software delivery lifecycle process that is crucial for implementing Agency-directed IT modifications in 90 days or less. Any change required (Agency-directed or internal) can be achieved quickly and accurately to meet the requirements of the agreement depending on the size and complexity of the modification. As an example of our proficiency, over 1,100 enhancements were successfully completed in 2016, including migrations and market expansion across the Aetna Medicaid enterprise. The majority of these modifications/enhancements were completed in fewer than 90 days.

Once Agency-directed IT changes are communicated and approved, large -scale core system changes run through the software development lifecycle workflows as follows:

- **Planning and Requirements:** This step includes, but is not limited to, user interviews and/or management documentation of need (i.e., projected user or operating outcome along with identification of any downstream systems or datasets that could be affected by the change). If a change is found to impact more than one system, additional change requests may be created for each system affected. These additional change requests are all linked back to the main change request. Each affected application is evaluated by each team's operating area business owners, IT business analysts, IT architects and developers, and IT quality assurance to assess the impact to all applications as early as possible. Each individual team enrollee also has historical documentation (e.g., applicable claims/encounter reprocessing for historical/retroactive system changes) to assist him/her in evaluating system impacts. In addition, each of these stakeholders is accountable for signing off on each change request, main and linked, at various points throughout the lifecycle of any system change.
- **Design:** Involves determination of the scope of targeted change and item-by-item detailed design; these design steps may include, but are not limited to, specific calculations, coding requirements, interface considerations, use case scenarios, and any workflows or supporting documentation developers may need to build.
- **Development:** Involves the specific construction of system components, including reports and interfaces, the correct configuration of the various information systems, and the production of documentation, including training materials
- **Testing:** Involves systematic testing of selected sample datasets and populations to assess accuracy of delivered changes against known longitudinal data outcomes and/or test case scenarios; it also involves the training of all who are connected to the systems and workflows to validate understanding of the incorporated change. User acceptance testing and subsequent training is also incorporated into this stage to identify any possible issues that may be identified by those who are most familiar with the results the system should be producing.
- **Deployment:** Involves activating the configured system (with any changes) for use by its user population. Notification of changes is typically conducted using multiple communication vehicles to maximize the user community reach, including e-mail, fax, WebEx, and Web alerts. In these cases, the deployment stage only commences after our community of users (including AHCA) are satisfied with the results of both testing and training. During this phase, the production environment is updated to include the change. Updates implemented during deployment are released to production so it will not affect the availability of critical system functions. This typically means release during scheduled downtime windows.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- **Post-Deployment Review:** Involves providing post-implementation support (i.e., warranty) to the applications that were deployed to the production environment during the deployment phase.

### **Expected Timeframes**

Our change management process provides a structured, fully recoverable framework in which to implement and manage system change releases on schedule and per federal, AHCA, and contract-specific requirements. The expected timeframe for internal changes depends on the size and complexity of the change. For Agency-directed modifications, Aetna will coordinate with AHCA to make sure that development and implementation of the modification is performed within 90 days as directed by the Agency.

### **Prioritization Process**

We prioritize and monitor internal and Agency-directed system modifications based on the impact to enrollees, providers, and regulatory compliance. Priorities are monitored daily to make sure our performance is in compliance and meets the AHCA's enrollees and providers' needs.

### **IDENTIFYING, TRACKING, COMMUNICATING, AND RESOLVING IT PRODUCTION ISSUES**

**CRITERION 3:** The adequacy of the respondent's processes documented for handling production IT system issues

In the event of a production issue affecting one or more systems, Medicaid Production Support analyzes the issue and assigns it for resolution. The support staff creates an incident ticket, which follows the change order process to resolution. The issue is based on the service level agreement (SLA) requirements of the ticket, which in turn depends on the urgency of the ticket. When we identify a critical issue, we mobilize an Immediate Response team to resolve the issue on an accelerated timeline.

Severity 1 is the most critical level, and therefore requires immediate attention and resolution. It can be a system outage or complete service interruption. In this scenario, critical functionality is inaccessible (i.e., application is not working for any customer), and there is no alternative/workaround. For severity 1, issues are resolved within 24 hours, incident closure is 32 hours, and user response time is 4 hours.

Severity 2 means operations continue, but there is a high service interruption; therefore, immediate attention is required. For severity level 2, critical functionality is degraded (i.e., application is not working for a large plan or all customers in a product line), and there is no feasible alternative/workaround. For severity 2, issues are resolved within three business days, incident closure is five business days, and user response time is two business days.

Severity 3 is a moderate service interruption where non-critical functionality is degraded. Critical functionality is not impacted significantly (i.e., application is not working for some enrollees), and there is a workaround available. For severity 3, issues are resolved within six business days, incident closure is nine business days, and user response time is three business days.

## **EXHIBIT A-4-a**

### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Severity 4 level is a minimal service interruption where critical functionality is normal. Non-critical functionality is not impacted significantly (i.e., application is not working for one enrollee), and there is a workaround available. For severity 4, issues are resolved within 10 business days, incident closure is 14 business days, and user response time is 4 business days.

The team consistently meets SLA requirements for critical severity level incidents using the Immediate Response team. If a production issue requires an emergency fix, it is worked on immediately to minimize the impact to users (internal and external). Production issues are tracked by severity and priority is driven by the business impact of the issue defined.

For Internal Stakeholders: Any production issue requiring system change is communicated using Medicaid production support team. Communication of issues is based on the severity of the issue. Severity 1 and 2 issues are communicated immediately upon discovery. Our Production Support team manages various distribution lists based on function and these distribution lists are used for mass communication to provide regular updates on progress on issues at hand.

For External Stakeholders: Aetna understands that for change management to be successful, a comprehensive work plan needs to include active and continuous input from a consortium of stakeholders that are potentially affected. With this in mind, once a change has been approved by the Demand Management Office (which is responsible for outbound project delivery), and the level of change has been defined, a communication/notification plan is put into place focusing on the following areas:

- **Provider IT Workgroup:** Depending upon the level of change, Aetna may involve a Provider IT workgroup. This workgroup comprises members of IT, the Provider Services team, and providers and Agency staff where applicable. The group collaborates to understand the change, impact on process, and GAP analysis to assist in providing a seamless major change, upgrade, modification, or update. Depending upon the scale of the project, the group will be involved at different stages from planning to testing and potential first-level training so that Aetna has taken the necessary steps to address any weaknesses in its development, training, or rollout.
- **External Notification:** When external stakeholder notification is necessary, Health Plan leadership coordinates with Medicaid Compliance to communicate with the requisite Agency partners of production issues and resolutions. Communication methods include mail notifications, e-mail, fax, WebEx, and Web alerts. In addition, system changes with impact to providers, enrollees, or AHCA are documented on the Aetna website. The use of this notice and centralized location helps to ensure all stakeholders can access the information in addition to the traditional notifications methods mentioned above. For any unplanned change originated from a production issue, Enrollee Services is informed to communicate the same to our enrollees who are affected. Alerts in our enrollee and provider Web portals are also used to communicate the impact to users.

Additionally, we prioritize and monitor IT production issues based on the impact to enrollees, providers, and regulatory compliance. Priorities are likewise monitored daily to make sure our performance is in compliance and meets the AHCA's enrollees and providers' needs. For production issues, the severity level is defined during the prioritization process. Severity 1 (critical) issues are worked immediately by our production support team. We use an Immediate Response team, a model under which pager notifications are sent to on-call staff from all

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

support functions, to join a working session and start collaborating immediately until the issue is resolved.

### **COMMUNICATION PROCESS**

**CRITERION 4:** The adequacy of the respondent's communication process used when system issues/updates are identified and resolved by the respondent and/or its subcontractors throughout the change control process criteria

Aetna has systems, technology, processes, and analytical staff in place to comply with AHCA's current and future communication requirements. We follow our project management methodology to be sure we deliver to AHCA the structure, transparency, and timely communications required to share information, collaborate on program details, and provide the tools necessary to give the Agency the information it requires. We are committed to transparent communication throughout the contract term as essential to a collaborative and successful working relationship. We strive to automate required reports wherever possible to optimize timeliness and accuracy of report generation and transmission. We transmit reports to AHCA through a variety of means, depending on the report, including but not limited to email, the Web portal, and secure file transfer protocol. Aetna coordinates with our dedicated AHCA Government Operations consultant to rapidly inform the Agency of any system issues or outages. Our first step following identification of an issue is to contact our assigned consultant. We strive to maintain a transparent and open dialogue with the Agency to best manage any and all issues that may potentially impact our operations, providers, and enrollees.

Monitoring and evaluation of the effectiveness of our communications begins with our Communications Review team composed of representatives from our Finance, Marketing, Operations, Enrollee Services, Compliance, Legal, Health Services, Health and Medical Management, and Outreach divisions. The Communications Review team meets on a bi-monthly basis to confirm system issues/updates are identified, resolved, and documented to standards and guidelines. The Communications Review team also establishes internal policies, procedures, and uniform communication standards. Document owners make all additional revisions and provide final documents to the compliance officer to present to the Agency to review, approve, and track approval status. The department representative makes sure all necessary parties are educated regarding the newly approved document.

Our change management process takes into account the impact each change has on all stakeholders, both internally and externally, and integrates appropriate notification, levels of feedback, communication, and testing. Some of these methods include mail notifications, e-mail, fax, WebEx and Web alerts, our newsletter, the provider handbook, and provider calls.

Aetna will provide the Agency with the following information 90 days or more prior to any system conversion, enhancement, or upgrade:

- Description of the system (hardware/software) to be upgraded and the nature of the upgrade
- Timeframe for the upgrade
- Summary of how protected health information will be secured and protected during the upgrade
- Description of how the upgrade will be tested prior to final promotion

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Plan to revert to the original system if there is a problem

Subcontractors: Aetna meets on a routine basis with all subcontractors to monitor service delivery, identify opportunities to improve collaboration and to conduct a review of operational metrics. Potential system changes and upgrades are discussed as part of these meetings. Vendors are required to notify us immediately upon any system outages and issues that potentially can impact providers, enrollees or our system interfaces. Compliance, Provider Services, Medical Management, and Quality departments participate in these meetings no less frequently than monthly with subcontractors to review the following:

- Subcontractor's performance metrics
- Relevant State and federal legislation and regulation changes that may require system updates or changes
- Contractual reporting requirements
- Any applicable corrective actions or performance improvement activities
- Results of self and external audits

We increase the frequency of these meetings as necessary. We have frequently done so to implement new regulatory or contractual changes that required system changes or upgrades. Close collaboration occurs with our subcontractors to assess compliance with performance objectives and to maintain proper oversight and accountability of all operational areas including IT. Subcontractors are provided with initial and on-going training on contract requirements, state mandates, quality improvement topics and their scope of work. Our goal is to make sure all subcontractors successfully perform their duties in accordance with Agency standards.

### **Status Updates**

Our system development lifecycle includes providing the employees, AHCA staff, and providers with monthly status updates on change orders and the status of active and planned changes. Because of our commitment to transparency, we also conduct frequent dialogue to address current and future business needs and requirements. Providers can track the status of changes online and can contact Aetna representatives for resolution of system modification questions. When critical production issues are identified that affect day-to-day operations, we provide the Agency, providers, and enrollees with daily status updates.

### **TESTING PROCEDURES**

**CRITERION 5:** The adequacy of the respondent's approach to system internal testing to ensure the respondent's and/or subcontractors' system changes/updates are accurate

**CRITERION 6:** The adequacy of the respondent's approach to integration testing to ensure the respondent's and/or subcontractors' system changes/updates do not adversely affect other systems, including systems operated by Florida Medicaid and subcontractors' systems criteria

### **Internal Testing to Verify Aetna/Subcontractor Changes/Updates are Accurate**

Testing provides an objective, independent view of the software to allow the business to appreciate and understand the risks of its implementation. It is a critical component for any implementation project and is performed throughout all the phases of the project lifecycle

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

workflows. Our implementation project plans test setting and output as performed in all functional areas to see whether the software functions as expected for successful operation. Functional areas involved in the process include Claims, Eligibility, Enrollee Services, Medical Management, Encounters, and Compliance.

Aetna uses well-qualified, experienced subcontractors to provide services in support of our Medicaid programs. Whenever possible, we contract with entities that fall under the Aetna Inc. organizational umbrella for services in support of the contract. This enables us to use entities that have established processes adherent with internal controls for testing that meet our standards to promote quality and compliance in our commitment to achieving AHCA's goals.

We build on our company-wide subcontractor monitoring processes to hold ourselves accountable for the performance of all of our subcontractors, and we understand that no subcontract relieves us from any obligation or liability arising from our contract with the Agency. Aetna assumes full responsibility for active monitoring and continuous evaluation of subcontractor testing, performance, and compliance in the same manner as we monitor and evaluate internal resources. Our quality management program includes formal processes and comprehensive policies and procedures to monitor contract compliance, quality of care, services, and reporting provided under any subcontract. Aetna makes sure that changes/updates do not adversely affect systems operated by Florida Medicaid and subcontractors' systems.

### **Testing Types**

The following types of testing in different phases of the software development lifecycle workflows allow for all components of implementation to be tested thoroughly and exhaustively, including subcontractors' changes, too. Each type of testing is accompanied by robust deliverables, including, but not limited to, test strategy, test scripts, and test result summary:

- Unit Testing: Executed by the developer who builds the code or code module; involves testing functionality
- System Testing: Performed to assess proper behavior of an application based on business requirements and application design
- AHCA Testing: We exchange file data with the Agency to validate that system changes are compatible with updated AHCA requirements.
- Specialty Testing: Performed to assess the proper behavior of an application based on documented non-functional requirements, this testing validates how the application behaves under various conditions (e.g., 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 to see whether it is operating in business-as-usual mode and has not been affected negatively by change; automated test scripts are executed to validate that there are no additional impacts on upstream and downstream applications.
- End-to-End Testing: Performed to see whether data flow from one application to the other and work as expected (e.g., claim end-to-end testing includes file load, file import, adjudication, payment check run and encounter process)
- User Acceptance Testing: Validates the business case using established user acceptance criteria and verifies that the application meets all the end-user requirements.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Production Checkout Testing: Confirms that all application changes have been migrated successfully to the production environment and all functionality is working properly
- Integration Testing to Verify Aetna/Subcontractor Changes/Updates Are Accurate and Do Not Adversely Affect Other Systems: Our testing methodology validates the integration of technology, processes, and organizational changes not previously validated or tested for both Aetna and subcontractors. Testing of subcontractor systems is performed in the same manner as internal systems. An important part of our change control process includes the determination of any effects a projected change may have on other operating systems within our operating environment. Our IT implementation project teams rely on references and feedback from two sources to determine whether there are any system-oriented interdependencies associated with a projected systems change:
  - Test strategy documentation represents an operational process blueprint that indicates interdependencies and connections between various IT systems and applications and enforces systems strategy compliance and design considerations. This documentation is the guide for building impact assessments and mitigating dependency conflicts. We reference up-to-date architectural blueprints for each application, which allows us to assess quickly system changes and the impact of proposed design changes to individual processes.
  - Functional area input and review is solicited at change control meetings where the different functional areas (i.e., claims, eligibility, medical management, encounters, etc.) review the changes for impact to their own applications or systems. This forum also contains IT cross-functional team representatives. This approach effectively brings together subject matter experts representing multiple business units and IT domain representatives that support them to discuss the impacts and any necessary adjustments related to system changes.

Our testing team leverages industry-standard tools and best practices for sub-functions of testing such as defect management, test scripts management, and execution.

### **Production Control Procedures**

Aetna employs robust Sarbanes-Oxley controls and testing procedures to address the identification and analysis of potential risks within our IT. In addition, an annual Statement of Controls report is executed by external auditors to assess the IT control environment. Aetna personnel monitor and support security controls within our environment. These employees complete identity access management, security reviews, and network monitoring. All Aetna employees are subject to applicable required training necessary to maintain regulatory compliance and management of protected health information. Our commitment to Health Insurance Portability and Accountability Act is bolstered by our dedicated Privacy office, which is responsible for developing and overseeing the implementation and enforcement of our privacy program. Our privacy program assists business areas in resolving privacy- and security-related issues.

### **APPLICABLE CLAIMS/ENCOUNTER REPROCESSING**

**CRITERION 7:** The adequacy of the respondent's approach to applicable claims reprocessing for retroactive system changes, including processing performed by its subcontractor(s)

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Retroactive system changes, including processing performed by subcontractors that require claim re-adjudication, are reprocessed in the appropriate claim system. Our Encounter Management unit uses two processes to manage encounter correction activities—encounters requiring re-adjudication and those where re-adjudication is unnecessary:

- If re-adjudication is unnecessary, the Encounter Management unit will execute corrections to allow resubmission of encounter errors per the Agency's encounter correction protocol.
- Encounter errors that require claim re-adjudication are reprocessed in the appropriate claim system.

The adjusted claim (including subcontracted vendor claims) is imported to the encounter management system (EMS) for resubmission to the Agency per the encounter correction protocol.

As an example, if CMS or the Agency terminates a code retroactively, we update our system with the termination date and adjust claims within the claims processing system. The EMS then generates the void, replacement and/or original encounter record using the appropriate frequency code (1, 7 or 8), in accordance to State void and adjustment rules. All retroactive changes in the system are reviewed and full testing is completed to ensure the changes and reconfiguration is resulting in the expected outputs. There are systematic checks in place to make sure the retrospective changes are implemented in accordance to the processes outline previously for all system changes. Aetna uses the same change and project management protocols.

### **Evaluation Criteria:**

1. The adequacy of the respondent's IT processes addressing internal modifications for its core systems and subcontractor's systems.
2. The extent to which the respondent's IT processes documented for implementing Agency-directed modifications is less than ninety (90) days.
3. The adequacy of the respondent's processes documented for handling production IT system issues.
4. The adequacy of the respondent's communication process used when system issues/updates are identified and resolved by the respondent and/or its subcontractors throughout the change control process.
5. The adequacy of the respondent's approach to system internal testing to ensure the respondent's and/or subcontractors' system changes/updates are accurate.
6. The adequacy of the respondent's approach to integration testing to ensure the respondent's and/or subcontractors' system changes/updates do not adversely affect other systems, including systems operated by Florida Medicaid and subcontractors' systems.

**EXHIBIT A-4-a**  
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7. The adequacy of the respondent's approach to applicable claims reprocessing for retroactive system changes, including processing performed by its subcontractor(s).

**Score:** This section is worth a maximum of 35 raw points with each of the above components being worth a maximum of 5 points each.

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COVENTRY HEALTH CARE OF FLORIDA, INC. DBA  
AETNA BETTER HEALTH® OF FLORIDA

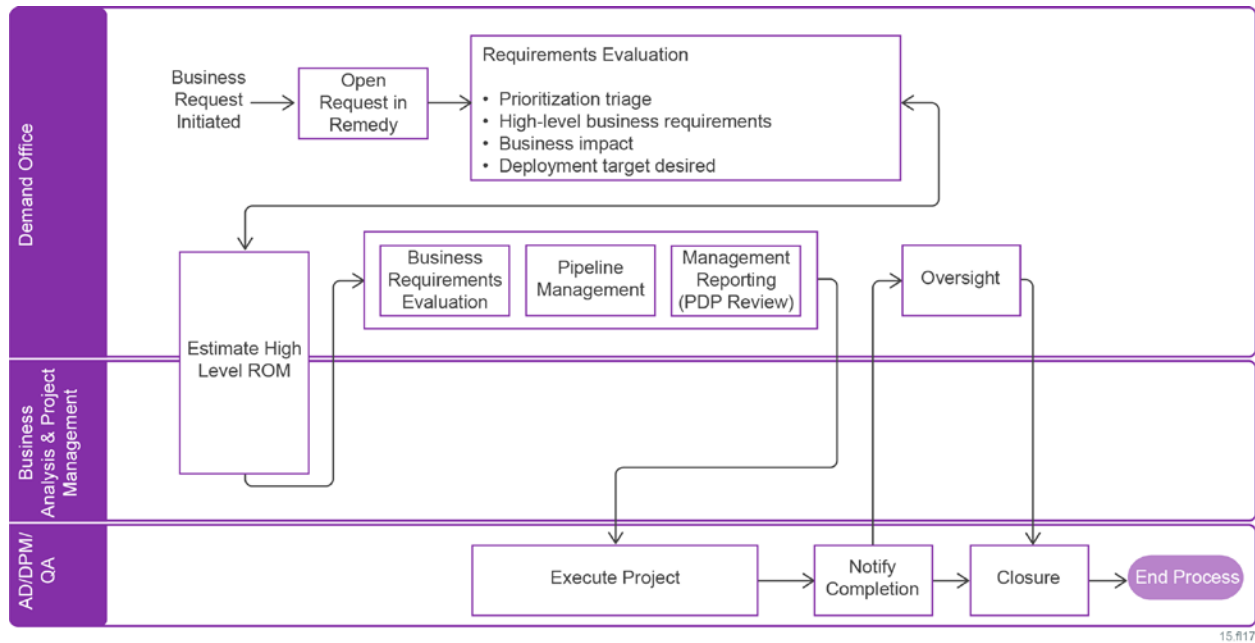
## **Attachment SRC# 28**



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**SRC# 28: Figure SRC 28-1: Change Management Process**



**Figure SRC 28-1: Change Management Process**

*Our change management process provides a structured framework to implement system changes to meet contract-specific requirements*



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**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**SRC# 29 – Encounter Data Submission (Statewide):**

- a. The respondent shall submit a flow chart and narrative description of its encounter data submission process including, but not limited to, how accuracy, timeliness and completeness are ensured.
- b. Completeness of encounter submissions requires that key fields are populated accurately for every encounter submission. The respondent must describe quality control processes that will ensure key fields including, but not limited to, recipient Medicaid ID, provider Medicaid ID, claim type, place of service, revenue code, diagnosis codes, amount paid, and procedure code are accurately populated when encounters are submitted.
- c. The respondent shall demonstrate quality control procedures to ensure documentation and coding of encounters are consistent throughout all records and data sources (ASR, FMMIS, special submissions) and across providers and provider types. The description should include tracking, trending, reporting, process improvement, and monitoring of encounter submissions, encounter revisions, and methodology to eliminate duplicate data.
- d. The respondent shall include any feedback mechanisms to improve encounter accuracy, timeliness and completeness.
- e. The respondent shall include documentation of the most recent three (3) years of encounter data submission compliance ratings, corrective actions, if indicated, and timeframe for completing corrective actions for Florida Medicaid.
- f. The respondent shall submit documentation describing the tools and methodologies used to determine compliance with encounter data submission requirements.

**Response:**

Aetna understands the critical role that timely, accurate, and complete encounter data plays in the Agency's ability to continuously review the health care utilization of its Medicaid enrollees, to analyze expenditures associated with that utilization, and to monitor service delivery performance with its partners. Over the past three years, Aetna has maintained a consistent accuracy rating of 97% and completeness and timeliness ratings over the required 95%. We participate in all encounter workshops hosted by the Agency, and we meet with the Agency and DXC Technology (the State's fiscal agent) on a regular basis to receive updates, receive and provide feedback to AHCA, and resolve any outstanding questions or issues related to encounters.

Aetna focuses on encounter accuracy, completeness, timeliness, and compliance with HIPAA, as well as all other Federal and State regulatory requirements. Aetna has 30 years of experience in transmitting encounter data to Medicaid agencies, including the State of Florida.

We use various levels of support to assist with the encounter submission process, including resources at the corporate level that are dedicated to Aetna, as well as team members that

**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
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support the process at the plan level. Plan-level support includes the provider services manager, reporting and analysis director, and finance associates, all of whom work directly with the corporate team on different aspects of the process of encounter data submission. Direct oversight of this process is the responsibility of the health plan's chief operating officer (COO) and chief financial officer, who work to confirm accuracy of all submissions.

Florida currently has a dedicated corporate operational Encounter Management Unit responsible for encounter data submission and correction processing for the Agency. This dedicated team has more than 25 years of health care and encounters related experience. They are subject matter experts on Aetna claims/encounter processing systems and have detailed knowledge of X-12; HIPAA Files (837, 835, 277U, 999, NCPDP D.0); Medicaid compliance requirements; business intelligence tools; knowledge of analytic programming tools and methods (SAS, SQL, Business Objects, Crystal, Visual Studio, Microsoft Office, etc.).

██████████, Director of Reporting and Analysis, has more than 22 years of managed care experience and has worked with Florida encounters for over seven years. In that time, ██████████ has been instrumental in improving the initial encounter acceptance rate of the health plan from 65% (in 2012) to 97% (in 2013) and to 98% (2014 to 2017).

CRITERION 1: The adequacy of the respondent's process to ensure accurate, timely, and complete encounter data

CRITERION 6: The completeness of the respondent's flowcharts describing its encounter data submission process

CRITERION 11: The adequacy of the respondent's process for converting paper claims to electronic encounter data

To achieve accurate and timely submission, Aetna transmits all encounter data utilizing HIPAA-compliant 837 (I, P, and D) and National Council for Prescription Drug Programs (NCPDP) electronic formats. Our provider contracts require providers to submit claims within six months from the date of service on the approved electronic or paper claim form, and each claim must contain the necessary data requirements. Paper claims are received by the imaging vendor, scanned, and converted to electronic claims, then loaded into our claims processing system. Following adjudication and payment, we export claims data into the Encounter Management System (EMS) system twice a week after each check run.

Aetna utilizes the EMS application that imports claims data from the health plan claim processing system. This data is formatted to Florida-specific encounter data requirements. The EMS also imports encounter data from subcontracted vendors and formats it for submission to AHCA. We use our EMS to monitor that the data is accurate, timely and complete in our encounter submissions to the Agency (refer to Figure SRC 29-1: Life of an Encounter in Attachment SRC 29 for our encounter data submission process). Our EMS processes CMS 1500, UB-04, dental, pharmacy, long-term care, and expanded benefit claims utilizing the most current coding protocols (e.g., standard Centers for Medicare and Medicaid Services (CMS) procedure or service codes, such as ICD-10, CPT-4, HCPCS-I, II). Specific to pharmacy submission, part of our encounter protocol is the requirement for providers to utilize National Drug Code coding in accordance with the Agency's requirements.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Secondary to our claims processing system, EMS offers further encounter validation, accurate and consistent tracking throughout the submission continuum. This includes collection, validation, reporting, and correction. Additionally, the EMS application processes encounter data received from any third-party contractors such as dental, vision, and pharmacy vendors. Through EMS, we conduct a coordinated set of edits and data checks, allowing us to identify proactively potential data issues and correct them at the earliest possible stage of the reporting process, course correcting as necessary to ensure the integrity of the encounter:

- After data from our claims processing system and vendor sources are loaded into the EMS, the data passes through a series of automated customized (based on Agency's requirements) scrub edits (i.e., primary diagnosis code is missing, National Drug Code information is missing or invalid, or Medicaid ID is invalid). We maintain encounters in these hold queues within the scrub analyzer until the Encounter Management Unit validates each encounter. The Encounter Management Unit reviews reports and verifies that claims within the core claims processing system and ancillary applications contain all required data and is populated with appropriate values in order to meet encounter completeness and accuracy rates. Transfer Validation Reports are also used upon extraction to validate completeness by assuring that all claims from the core processing system were transferred into EMS. The Encounter Management Unit works internally and with the appropriate department area to resolve errors based on our encounter error and weekly inventory reports. Once we resolve the errors, we submit the encounter record to the Agency. Our proactive approach to identifying and correcting errors prior to the submission of data to the Agency reduces cost, ensures completeness of data, and improves acceptance.
- Upon submission, attestation forms are signed off on by the approved Health Plan delegate who reports directly to the chief executive officer and chief financial officer and emailed to AHCA for each file submitted in accordance with in 42 CFR 438.606.
- State 999 response files are reviewed, loaded, and tracked to help ensure that the files submitted to AHCA have been accepted and all records loaded successfully. Any errors received on the 999 are worked by the Encounter Management Unit within 24 to 48 hours and resubmitted to the Agency for timeliness.
- State 835 response files are loaded into EMS to track acceptance rates and to correct errors on a first in, first out basis. The EMS system allows management and tracking of errors across denial reasons, claim type, recipients, providers, claim adjudication date, and 835 received date.
- Responsibility for correcting the encounters denied by the Agency depends on the type of denial. The Encounter Management Unit prepares weekly reports of the denied inventory and assigns the work to the responsible department. For example, denials related to an enrollee's enrollment are assigned to the Enrollment Services team for research and resolution (i.e., check enrollee data elements) and are then returned to the Encounter Management unit for encounter resubmission. Denials related to a provider's registration (i.e., not enrolled with AHCA) are assigned to the provider services team to assist with guiding providers to enroll with the Agency. The Encounter Management Unit then coordinates with these teams on a weekly basis to track and resubmit the corrected claim/encounters within the contractual timeframes. The Encounter Management Unit also meets with the subcontracted vendors to review denial trends, accuracy results, and provide feedback and assistance in resolution of errors.
- Errors identified on a subcontracted vendor's file or denied by AHCA are returned to the vendor for correction. We contact the subcontractor to review the errors and establish a

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

plan for correction of the errors. The subcontractor then fixes the errors and resubmits the encounters. During this iterative process, we meet with vendors daily if needed, until all errors are resolved and the file processes successfully.

- The Encounter Management Unit has specially trained correction analysts with experience, knowledge, and training in encounter management, claim adjudication, and claim research. This substantial skill base allows us to research and adjust encounter errors accurately and efficiently. Additionally, the unit includes technical analysts who perform the data extract and import functions, perform data analysis, and oversee and monitor the encounter files submitted to the Agency.

The Encounter Management Unit monitors the accuracy, timeliness, and completeness of the encounter data submissions to make sure that we are meeting AHCA's requirements via a series of reports (discussed later in the response) that track:

- Accuracy based on the 835-response file received from the Agency twice a week.
- Timeliness based on the turnaround time between adjudication and initial submission to AHCA for original claims, or from the 835-response date to resubmission date for denied or resubmitted encounters.
- Completeness based on end-to-end reports comparing paid dollars to accepted dollars and audit reports that verify completeness of data received on the claims against medical records and against claims data entered into the system.

### **DESCRIPTION OF KEY FIELDS/QUALITY CONTROL PROCESSES**

**CRITERION 2:** Demonstrated knowledge of the combination of key fields needed to identify services

**CRITERION 3:** Adequacy of procedures, including quality control procedures, to identify key fields and ensure they are accurately populated during encounter data submission

**CRITERION 12:** The adequacy of the respondent's approach to identifying and correcting specific processing/systems issues that could result in invalid data being submitted to the State

To achieve accurate, complete, and timely submission, Aetna transmits all encounter data utilizing HIPAA-compliant 837 (I, P, and D) and NCPDP electronic formats. Our validation begins with the delivery of services. Our quality control processes in place today in Florida require participating providers to submit all encounter services with the required information. Our claims adjudication system requires that key data fields are provided at the claim level in order to proceed to adjudication. These key fields are the following:

- Recipient Medicaid identification number
- Provider Medicaid ID
- Provider national provider identifier
- Claim type
- Place of service/bill type
- Revenue codes
- Procedure codes – Current Procedural Terminology (CPT 4)
- Diagnosis codes – International Classification of Diseases (ICD-9 and ICD-10)
- Healthcare Common Procedure Coding System (HCPCS, Levels I and II)
- Modifiers

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Date of service
- Charges
- Units of service

The Encounter Management Unit is accountable for the accurate, timely, and complete submission of encounter data through the EMS. Their roles include managing the data correction process. Inherent to EMS is its ability to allow the Encounter Management Unit to apply Florida-specific encounter editing profiles to records that may be unacceptable to AHCA. This enables the team to evaluate all data files from the claims processing system and from subcontractors for accuracy and completeness before submission. The team can customize EMS edits to AHCA's requirements. Encounters that do not meet requirements are maintained in hold queues within the scrub analyzer until the Encounter Management Unit validates the encounters are complete with required data.

Internal system review of encounter submissions has been established to identify known errors or potential data defects strategically during encounter processing to prevent denials by the Agency on encounter submissions. All encounters that are held because of system edits are reviewed on a weekly basis and appropriate action is taken to correct or deny the claim. Once the claim passes all internal system edits and reviews, it will be submitted as an encounter to the Agency.

Additionally, the encounter unit meets to review encounter scrubs, rejections, file tracking, and trend reports. During the review process, the Encounter Management Unit, with the help of IT and business teams, identify issues that may be system related. This joint team analysis determines if adjustments need to be made to the claim adjudication system, encounter editing, or encounter processing. Feedback from the State of Florida may also prompt review of system rules. The analysis process is also used to identify opportunities for provider education and potential corrective action. Weekly meetings are also held with the health plan's management team. These meetings are both tactical and oversight in nature and are used to discuss ongoing analysis and trends.

The Encounter Management Unit employs correction analysts who undergo 13 weeks of training specific to encounter processes, claim adjudication, and claim research. This substantial, specialized expertise allows us to research and adjust encounter errors accurately and efficiently. The team also includes validation and technical analysts who perform data extract and import functions, perform data analysis, and oversee and monitor encounter files submitted to the Agency.

The Encounter Management Unit uses two processes to manage correction activities, depending upon whether re-adjudication is necessary. If re-adjudication is unnecessary, the Encounter Management Unit executes corrections to allow resubmission of encounter errors per Agency encounter correction protocol. If re-adjudication is necessary, the Encounter Management Unit reprocesses the encounters in the appropriate claim system and then imports them into EMS for resubmission per the encounter correction protocol. EMS generates, as required, the appropriate void, replacement, and/or adjustment records. Aetna submits accurate encounters with the first submission. More specifically, we have maintained one of the highest encounter accuracy rates among all managed care organizations in Florida with an average accuracy rate of over 97% for the last three years.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

As a safeguard to help ensure accuracy, our data correction procedures enable the team to identify and correct encounters that failed the acceptance process. We apply lessons learned through the data correction procedures to improve EMS edits. By doing so, we expand our system edits to improve the accuracy of encounter submissions and to minimize rejections as part of our continuous process improvement protocol. Aetna attests that these correction activities are performed in compliance with Attachment B, Section X.E.2.h of the ITN, which states that we submit encounter data, without alteration or omission of provider submitted data, no later than seven days following the date on which we adjudicated the claims.

### **PROCEDURES TO ENSURE CONSISTENCY**

**CRITERION 4:** Adequacy of procedures to ensure encounters are coded consistently across providers and provider types

**CRITERION 5:** Adequacy of procedures to ensure encounters (volume, categorization, dollar amounts, dates) are consistent across data sources, including applicable subcontractors

Along with the system claim intake and adjudication edits described above, our strict quality control procedures help ensure that coding of encounters is consistent throughout all records, data sources, across providers and provider types. Our EMS is designed to extract and store data from our internal claim system and all subcontracted vendors. This data is aggregated for all service categories, provider types, and treatment facilities. With this data accumulated in one central repository, we efficiently identify duplicated services and prevent them from being submitted on our encounter files. This also helps ensure consistency between our Achieved Savings Rebate (ASR) report, special feed encounter submissions, and FMMIS (Florida Medicaid Management Information System) encounter submissions to AHCA since all of the data comes from one source. In fact, on our latest report card from our special encounter data feed submission in January 2017, the health plan received straight As from the Agency on plan-submitted encounter data (Statewide Medicaid Managed Care Managed Medical Assistance services payments from May 1, 2014 to December 31, 2016).

We work continuously with providers and subcontractors to promote compliance. To correct provider behaviors, encounters, and claims denials are discussed regularly as part of the Joint Operations Committee meetings we hold with large provider stakeholders. If providers or subcontractors fail to submit complete, timely, and accurate encounter data, we use training, oversight, and corrective action, as well as contractually appropriate sanctions to address the deficiency. Subcontractors and network providers must attest to the completeness, truthfulness, and accuracy of all claims and encounter data submitted to Aetna, including required medical records data, and must ensure that they submit the information on the applicable claim form or electronic format type.

We train providers through the orientation process and are there to support them during claims submission. Additionally, our subcontractors are trained on proper encounter data submission, including submission frequency, acceptable data formats, and completeness. We also provide support on proper coding and present an overview of how EDM enforces accuracy. If providers or subcontractors fail to meet these standards, we work with them to correct the problems. Aetna uses contractual requirements and service performance agreements to monitor provider and subcontractor compliance with all contractual responsibilities. We hold subcontractors to the

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

same requirements as our internal Medicaid Information System department, which includes meeting the AHCA's encounter data submissions requirements.

In 2010, Aetna created a delegation oversight policy that outlines how we actively monitor subcontractor performance, including non-submission of encounter data. Specifically, Aetna monitors subcontractors and providers by performing the following:

- Approving subcontractors' or providers' program operations as outlined in our quality and utilization management programs and plans
- Monitoring that reports from subcontractors or providers (delegated-use organizations) are submitted according to the delegation agreement (or contract) to the medical management director or manager, who reviews the report with the chief medical officer

We proactively report subcontractor or provider non-submission of encounter data to our quality management director, who promptly reviews the report with the vendor relations and provider services manager. Additionally, our quality management director prepares and delivers quarterly summaries to our COO. The vendor relations and service operations director assess the situation. This includes meeting with the subcontractor or provider to determine whether the performance issue can be resolved or if escalation to the COO is necessary. If issues persist, the COO refers the matter to the appropriate committees to create a corrective action plan that includes all actions necessary to correct deficiencies.

If the provider or subcontractor does not correct the problem, Aetna may impose a financial penalty or even terminate the relationship in accordance with the contract. The quality management director submits audit reports of delegated activities and corrective action plans to the appropriate Aetna oversight committee (e.g., the Quality Assurance Plan Committee [Quality Management/Utilization Management Committee] or Subcontractor Oversight Committee [Delegation Subcommittee]). The committee reviews and gives approval.

From this point, the Quality Management/Utilization Management Committee reviews the item and may recommend one of the following actions:

- Assessment of performance credits against subcontractors if they fail to meet designated standards for claims processing and encounters
- Pursuit of indemnification from any subcontractor for any financial penalty, fine, or interest assessed against Aetna as a result of the subcontractor's failure to meet required standards, or offsetting the amount of any such penalty, fine, or interest against payments Aetna owes to the subcontractor
- Termination if other remedies fail to help the provider or subcontractor meet encounter data and submission requirements

### **FEEDBACK MECHANISMS**

**CRITERION 7:** The adequacy of the respondent's mechanisms for tracking, trending, monitoring encounter submissions and revisions, including the type and frequency of activities, and methodology to eliminate duplicate data

Based on our experience working with the State of Florida, we use a series of data reports and analysis tools to identify, monitor, and track each phase of the encounter process, thus

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

providing valuable feedback mechanisms when meeting with our providers and subcontracted vendors regarding their encounter submissions. Using these reports, our Encounter Management Unit can identify the status of each encounter in EMS and monitor the accuracy, timeliness, and completeness of encounter transactions from entry into the EMS, to submission, to acceptance by the Agency. Our Encounter Management unit utilizes a suite of scheduled and ad hoc reports to monitor claim receipts, reconcile encounter receipts, oversee error processing, and quality on a daily, weekly, and monthly basis. Encounter processing and associated performance results are actively tracked by these operating reports.

Through these reports, we identify potential encounter submission issues and implement corrective actions to resolve them. These reports, analysis tools, and chart reviews help us eliminate duplicate data, allow for identification of trends or data problems, including providers or vendors that consistently provide inaccurate or incomplete claims or encounter data.

In addition to our front end duplicate logic within the claims processing system which identifies duplicates during adjudication, we are able to efficiently identify duplicated services and prevent them from being submitted on our encounter files through our EMS's ability to extract and store aggregated data from our internal claim system and subcontracted vendors for all service categories, provider types, and treatment facilities. Our Encounter Management unit and Provider Services personnel have the skills, training, and experience to use this valuable data to identify providers that need additional training or technical assistance.

Additionally, the EMS meets bi-weekly to review encounter edits, rejections, file tracking, and trend reports. During the review process, the Encounter Management unit along with the help of IT and Business teams identify issues that may be system related. This joint team analysis determines if adjustments need to be made to the claim adjudication system, encounter editing, or encounter processing. Feedback from the Agency may also prompt review of system rules. The analysis process can also be used to identify opportunities for provider education and potential corrective action. We hold periodic meetings that are tactical and provide oversight with the health plan's management team and with each subcontracted vendor to discuss ongoing analysis, review trends, and to resolve errors.

We apply lessons learned through the data correction procedures to improve our EMS and claims processing edits described earlier. In this way, we expand our system edits to improve accuracy of our encounter submissions and to minimize encounter rejections. This is part of our continuous process improvement protocol.

### **COMPLIANCE RATINGS, CORRECTIVE ACTIONS, AND TIMEFRAMES FOR COMPLETION**

**CRITERION 8:** The adequacy of the respondent's encounter data submission historical compliance ratings

**CRITERION 9:** The adequacy of the respondent's ability to implement timely corrective actions to compliance ratings, if indicated

We submit accurate encounters with the first submission; specifically, the health plan has consistently maintained accuracy rating of 95% and greater, and completeness and timeliness ratings over the required 95%. As a safeguard to help ensure accuracy, our data correction procedures enable the team to identify and correct encounters that failed the acceptance

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

process. We apply lessons learned through the data correction procedures to improve EMS edits. By doing so, we expand our system edits to improve the accuracy of encounter submissions and to minimize rejections as part of our continuous process improvement protocol.

We had no corrective action plans from December 2014 through August 2017.

In August 2017, we received a report card of straight-As from AHCA on plan submitted encounter data statewide Medicaid Managed Care Managed Medical Assistance services from May 1, 2014, to December 31, 2016. One of only two plans to receive straight-A's on the following: timeliness, use and reporting on valid codes, reasonable sub-capitation reporting, consistency with sub-capitation reporting, consistency with annual statistical reports (ASR), valid hospital Medicaid IDs, diagnosis, procedure and revenue codes, service dates, adjustments and duplicates. AHCA began sending timeliness reports beginning in July 2016, and on average between July 2016 and September 2017, we have sustained a 98.1% timeliness rating.

Our encounter accuracy acceptance rates for the past three years (2014 through 2017) are reflected as follows. Aetna consistently ranks higher than the average showing exceptional accuracy ratings.

For 2014, the accuracy rate percentages were as follows: 97.0% in July, 98.1 in August, 97.6% in September, 97.9% in October, 97.6% in November, and 97.5% in December.

For 2015, the accuracy rate percentages were as follows: 98.0% in January, 97.6% in February, 96.7% in March, 96.6% in April, 97.4% in May, 96.9% in June, 96.8% in July, 97.0% in August, 95.8% in September, 97.1% in October, 97.2% in November, and 96.5% in December.

For 2016, the accuracy rate percentages were as follows: 96.8% in January and February, 97.4% in March, 98.0% in April, 98.4% in May, 98.1% in June and July, 98.3% in August, 98.7% in September, 98.6% in October, 98.9% in November, and 99.0 in December.

For 2017, the accuracy rate percentages were as follows: 98.3% in January, 97.5% in February, 98.8% in March, 98.5% in April, 96.6% in May, and 97.3% in June.

### **TOOLS AND METHODOLOGIES USED**

CRITERION 10: The adequacy of the tools and methodologies used to determine compliance

CRITERION 13: The adequacy of the tool to ensure that all encounters are submitted

Our EMS is designed to extract and store data from our internal claim system and sub contracted vendor. This data is aggregated for all service categories, provider types, and treatment facilities. With this data accumulated in one central repository, we are able to efficiently identify duplicated services and prevent them from being submitted on our encounter files.

Our Encounter Management Unit uses a series of weekly management reports to monitor, identify, track, and resolve problems in the EMS or issues with an encounter file. Using these reports, our Encounter Management Unit can identify the status of each encounter in EMS by

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

claim adjudication date and date of service. Using these functional reports, our Encounter Management Unit can monitor the accuracy, timeliness, and completeness of encounter transactions from entry into the EMS to submission to and acceptance by the Agency.

Responsibility for correcting the encounters denied by AHCA depends on the type of denial. The Encounter Management Unit prepares weekly reports of the denied inventory and assigns the work to the responsible department. For example, denials related to provider information are assigned to the Provider Services team; those related to enrollee enrollment are assigned to Enrollee Services team. The encounters unit then coordinates with these teams to track and resubmit the corrected claim/encounters.

Report examples are as follows:

- Transfer validation: Confirms all current paid encounters are extracted from our claims system into EMS
- File tracker and remit load tracking: Monitors submissions and response file receipts and compares file record count to the record count in EMS
- Encounter inventory tracking: Tracks encounter status by date of service through EMS until accepted or finalized
- Encounter error: Provides detail by error code and aging; used by plan, vendor and encounter staff to correct internal or external errors for claim, enrollees, and provider
- Monthly compliance: Monitors timeliness and accuracy results by month of submission including subcontractors
- End-to-end financial reconciliation report: This reports compares finalized claim volume and dollars against accepted encounters

These reports are available upon request of the Agency from Aetna systems by authorized Agency staff in a static, secure, updated, and compartmentalized environment.

To assist with maintaining compliance with Encounter data reporting, we use AHCA's Weekly Encounter Combined Timeliness Report to confirm we are aligned. We also follow State-managed care alerts and monitor AHCA's Web portal to help ensure we have the most updated information keeping us in compliance.

### **Evaluation Criteria:**

1. The adequacy of the respondent's process to ensure accurate, timely, and complete encounter data.
2. Demonstrated knowledge of the combination of key fields needed to identify services.
3. Adequacy of procedures, including quality control procedures, to identify key fields and ensure they are accurately populated during encounter data submission.
4. Adequacy of procedures to ensure encounters are coded consistently across providers and provider types.

**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

5. Adequacy of procedures to ensure encounters (volume, categorization, dollar amounts, dates) are consistent across data sources, including applicable subcontractors.
6. The completeness of the respondent's flowcharts describing its encounter data submission process.
7. The adequacy of the respondent's mechanisms for tracking, trending, monitoring encounter submissions and revisions, including the type and frequency of activities, and methodology to eliminate duplicate data.
8. The adequacy of the respondent's encounter data submission historical compliance ratings.
9. The adequacy of the respondent's ability to implement timely corrective actions to compliance ratings, if indicated.
10. The adequacy of the tools and methodologies used to determine compliance.
11. The adequacy of the respondent's process for converting paper claims to electronic encounter data.
12. The adequacy of the respondent's approach to identifying and correcting specific processing/systems issues that could result in invalid data being submitted to the State.
13. The adequacy of the tool to ensure that all encounters are submitted.

**Score:** This section is worth a maximum of 65 raw points with each of the above components being worth a maximum of 5 points each.

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COVENTRY HEALTH CARE OF FLORIDA, INC. DBA  
AETNA BETTER HEALTH® OF FLORIDA

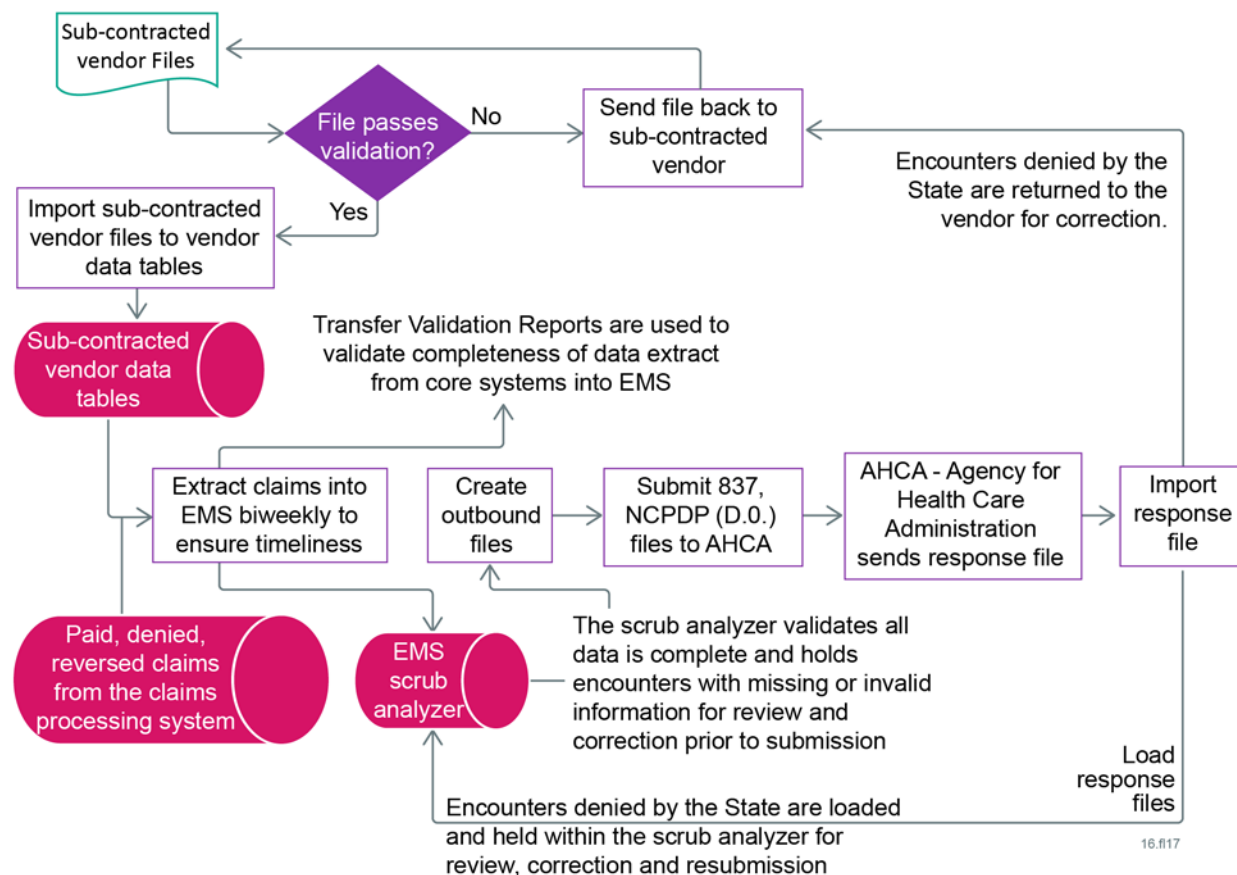
## **Attachment SRC# 29**



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**SRC# 29: Figure SRC 29-1: Life of an Encounter**



**Figure SRC 29-1: Life of an Encounter**

*EMS conducts a coordinated set of edits and data checks to identify proactively potential data issues at the earliest possible stage of the reporting process and to course correct as necessary.*



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## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **SRC# 30 – Encounter Submission for Sub-Capitated, Subcontracted, Non-Pay and Atypical (Statewide):**

The respondent shall describe how it will work with providers, particularly subcapitated providers, subcontractors, atypical providers, and non-participating providers to ensure the accuracy, timeliness and completeness of encounter data.

#### **Response:**

Keen oversight and accountability—in every facet of administration—is paramount to both the short- and long-term success of Medicaid managed care programs. Aetna recognizes how timely, accurate and complete claims submission leads to accurate and complete encounter data submission. This process results in Florida Medicaid program's ability to review health care utilization, analyze expenditures, and monitor service delivery performance continuously.

#### **ACCURACY, TIMELINESS AND COMPLETENESS OF ENCOUNTER DATA**

Providers of all types are integral partners in the successful acquisition and exchange of enrollee encounter information. Effective provider outreach and support facilitates our compliance with all Statewide Medicaid Managed Care contractual requirements related to encounter data submission. We work with all providers, including sub-capitated providers, atypical providers, and non- participating providers. In addition, we work with subcontracted vendors (e.g., dental, vision and transportation) to produce accurate, timely, and complete encounter data.

Provider contracts require that all participating providers, including sub-capitated, atypical, and subcontracted vendors, submit complete and accurate claims or encounters in a timely manner. Providers, including sub-capitated and atypical, are educated about the submission of claims and what is required to submit a clean claim to receive payment at the time of contracting and during provider orientation.

We communicate with providers about claims and encounter submissions through orientation and training, webinars, forums, seminars, phone calls, site visits, website, newsletters, provider handbook, online provider portal, fax, email blasts, mailings, and other mass communications. All newly contracted providers receive an initial orientation after joining our network. The orientation includes training on accurate, complete, and timely claims and encounter submissions. Aetna's provider orientation kit includes the following documents:

- Welcome letter
- Information on serving the Medicaid population
- Access to our provider Web-portal
- Information regarding the provider selection process and referrals
- Clinical guidelines on wellness visits and preventive health
- Other key information to assist providers in effectively managing enrollee care
- Claims filing instructions (including encounter submission requirements)

Following the providers' orientation, we provide a variety of forums for ongoing training and education. These include:

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Routine visits to the provider's office
- Periodic provider newsletters and bulletins containing updates and reminders
- Group or individualized training sessions on select topics. Some examples are claims coding, enrollee benefits, and Aetna website navigation

During the initial contracting period, we offer multiple ways for providers to attend orientation/training meetings, including convenient, regionally located provider seminars, webinars, and one-on-one education in provider offices and rural communities. We are flexible and work to accommodate the availability of the provider within AHCA requirements. Aetna conducts orientation and trainings for newly contracted providers within 30 days of their effective date with the plan. Provider Services then follows up directly with all providers to address any questions and to help ensure they know how to reach us for assistance. To reinforce providers' billing knowledge, we offer a worksheet-based claims filing simulation for smaller offices as part of their training. For large provider offices, groups, or systems, we work to arrange a test claim submission. We recognize the provider community is critical to our success, so we make provider engagement and collaboration a cornerstone of our processes.

Aetna's provider and select subcontracted vendor orientation process, along with other provider educational materials (e.g., provider handbook, provider claims reference manuals), includes information about our claims handling process and procedures related to third-party liability (e.g., coordination of benefits and third-party recovery). Provider education and training on general claims submission and requirements (e.g., encounter submission requirements for providers participating in value-based arrangements, Electronic Data Interface [EDI] Claims, Medicaid ID registration, etc.) are easily accessed through the provider portal on our website. Other claims-specific training to providers includes claims filing instructions.

Updates on billing, coding, and claims are shared with providers through bulletins and newsletters. All provider newsletters and bulletins are available on our website. The Provider Services team performs education during new provider orientation and regularly scheduled provider visits. Education topics include, but are not limited to the following:

- Clean claim submission requirements (e.g., CMS 1500, UB-92, and UB-04 forms)
- Timeliness of claim submissions
- Claim inquiry process
- EDI requirements
- Payment timeframes
- Secured Web portal
- Coordination of benefits and third-party liability
- Subrogation
- Review of contractual obligations regarding claim submission and related provisions (e.g., HIPAA, fraud, waste, and abuse)
- Responsibility to notify Aetna of other insurance or third parties liable for payment
- Responsibility to notify Aetna upon receipt of funds from third parties or other insurance for services paid by Aetna

Provider Services is available between the hours of 8:00 a.m. to 6:00 p.m. each weekday to assist with claims and encounter submission questions and issue resolution.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Claims Submission Information and Help for Providers: The claims adjudication system requires that claims be coded appropriately with industry standard codes. Claims are reviewed by correct-coding software to help ensure that the appropriate procedures are being performed by the appropriate provider types. If patterns of incorrect coding are found, we proactively reach out to the providers and educate them on how to submit a clean claim to receive proper reimbursement from the health plan.

All encounters and claims for all provider types (fee-for-service [FFS], sub-capitated, atypical and non-participating) and subcontracted vendors are stored in our central encounter management system (EMS). All encounters pass through the same AHCA-specific edits to validate that the encounters meet the criteria for a clean encounter submission to the Agency and are consistent, complete, and accurate across all provider types and vendors. EMS offers several reports and trending tools that allow the health plan to review edits by provider so that we can educate the providers on correct claims and encounter submissions. The provider feedback loop is essential, allowing us to improve our initial acceptance rate to 98% with the Agency. In addition, response files are loaded into the EMS system so that denials can be managed and worked within the 30-day contractual timeframe. Trending reports can also be run to identify errors by provider so that we can proactively work with the providers to correct issues and increase initial acceptance rates.

We work continuously with providers to promote compliance. Correcting provider behaviors, encounters, and claims denials are discussed regularly as part of the Joint Operations Committee meetings we hold with large provider stakeholders. If providers fail to submit complete, timely, and accurate encounter data, we use training, oversight, and corrective action such as contractually appropriate sanctions to address the deficiency. Network providers must attest to the completeness, truthfulness, and accuracy of all claims and encounter data submitted to Aetna, including required medical records data. Providers are responsible for submitting information on the applicable claim form or electronic format type.

We train providers through the orientation process and are there to support them during claims submission. Additionally, our subcontracted vendors are trained on proper encounter data submission, submission frequency, acceptable data formats, and completeness. We also provide support on proper coding and present an overview of how EMS enforces accuracy. If providers or subcontracted vendors fail to meet these standards, we work with them to correct the problems.

Aetna uses contractual requirements and service performance agreements to monitor provider and subcontracted vendor compliance with all contractual responsibilities. We hold subcontracted vendors to the same data standard requirements as specified in Attachment B, Section X.E Encounter Data Requirements of the ITN.

We created a delegation oversight policy in 2010 that outlines how we monitor subcontracted vendor performance, including non-submission of encounter data. Aetna monitors subcontracted vendors and providers by approving subcontracted vendors' or providers' program operations as outlined in our quality and utilization management programs and plans; and by monitoring that reports from subcontracted vendors or providers (delegated-use organizations) are submitted according to the delegation agreement (or contract) to the medical management director or manager who reviews the report with the chief medical officer.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

We report subcontracted vendors or provider non-submission of encounter data to operations department leadership who reviews the report and shares issues with the vendor relations and provider services departments. The vendor relations, provider services, and operations department leaders assess the situation and establish a remediation plan. This includes meeting with the subcontracted vendor or provider to determine whether the performance issue can be resolved with a remediation plan or if a corrective action plan is necessary. If issues are not resolved timely and according to any remediation plans, the chief operating officer (COO) refers the matter to the Service Improvement Committee, and ultimately the Quality Management Oversight Committee for the development and oversight of the corrective action plan, which includes all actions necessary to correct deficiencies and recommendations for additional mitigation and resolution.

If the provider or subcontracted vendor does not correct the issues timely, Aetna may impose a financial penalty or terminate the relationship in accordance with the contract. If an issue is with a delegate, the issue will also be brought to the Aetna Delegation Oversight Committee, which will confirm successful completion of remediation or corrective action plans.

The delegation oversight committee and service improvement committee can recommend one of the following actions, which are reviewed by the quality management oversight committee for approval:

- Assessment of penalties against subcontracted vendors if they fail to meet designated standards for claims processing and encounters
- Pursuit of indemnification from any subcontractor for any financial penalty, fine, or interest assessed against Aetna as a result of the subcontracted vendor's failure to meet required standards, or offsetting the amount of any such penalty, fine, or interest against payments Aetna owes to the subcontracted vendor
- Termination, if other remedies fail to help the provider or subcontracted vendor meet the Agency's encounter data and submission requirements

### **ENSURING ALL NETWORK PROVIDERS ARE KNOWN TO THE FMMIS**

**CRITERION 1:** The adequacy of the respondent's approach to ensure that all network providers, including sub-capitated providers, are known to the Florida Medicaid Management Information (FMMIS) for the purposes of encounter data submission

Aetna understands that every billing and rendering provider on every encounter submitted to the Agency must be registered in the Florida Medicaid Management Information System (FMMIS) as an active enrolled or registered provider in order for the encounter to be accepted into the FMMIS system.

We use multiple approaches to help ensure contracted, including capitated-subcontracted vendors, and non-participating providers register with Florida Medicaid to attain a valid Florida Medicaid ID. A provider who wishes to contract with Aetna, and who is eligible to see Florida Medicaid recipients, must have a Florida Medicaid ID number. At the point of contracting, the provider submits to us all of the information needed for the contracting and credentialing process, including the provider's Florida Medicaid ID. If a provider is otherwise eligible for our network but lacks a Medicaid ID, we assist the provider in the enrollment process. A provider not yet aligned with the FMMIS must register to help ensure claims paid through Aetna and the

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

encounter records of those claims later submitted by Aetna to the Agency are properly validated.

**Verification:** Our process begins with verifying that providers are registered with FMMIS for the purposes of encounter submission. Specific to encounter acceptance, Aetna verifies that the provider information we submit to the Agency (National Provider Identification [NPI], taxonomy and ZIP code) is sufficient to make certain that providers are matched to the correct provider Medicaid ID in FMMIS either as actively enrolled Medicaid providers or as health plan registered providers. Providers are required to have a Medicaid ID before becoming a participating provider with the health plan. Not being registered with the Agency could cause a claim to reject back to the provider. Aetna utilizes the Provider Master List and Pending Provider Master List to verify if a provider has a valid Medicaid ID. We also use the lists to identify the correct NPI/taxonomy and ZIP code to be submitted by the provider of service on the claim in order for the encounter to match the correct provider record in FMMIS and be accepted by the Agency.

**Facilitating Registration:** We assist providers with form completion during registration. Our Provider Services team is trained to walk the providers through the enrollment process. In some cases, we have also hand delivered completed forms to AHCA. We monitor the pending Provider Master List, which tells us the status of the registration so that we can correct any errors in a timely manner.

Non-participating providers that provide services to our enrollees and do not have a valid Medicaid ID are assisted in the process of becoming known to the Agency. These providers are directed to follow the FMMIS Provider Enrollment Wizard instructions. Aetna offers technical assistance, as necessary, to facilitate the process and is works directly with non-participating providers to complete the forms on their behalf.

### **Ongoing education**

Part of our initial and ongoing provider education focuses on the need to register and maintain a Florida Medicaid ID through FMMIS. A part of the education also encourages our contracted providers to support additional provider registration for providers that may be associated with their practice. Our provider liaisons include an informational how-to presentation associated with FMMIS registration as a part of their on-site visits to provider offices.

### **Ongoing validation**

Through the ongoing validation of the State Provider Master List file against our claims and provider directory, Aetna helps ensure that all providers who submit claims and encounters to the Agency are registered. Aetna makes sure its provider network is appropriately aligned with Florida requirements in the provision and payment of Medicaid services. Further, proper alignment with the FMMIS Provider Master List enables us to properly validate 837 and achieve acceptance at the time of initial submission.

### **Continuous improvement**

If it is determined through the ongoing validation process or by encounter file feedback that a network provider does not match with AHCA's Medicaid database, Aetna corrects the information according to the Agency contract or reaches out to individual providers to verify that they have an eligible Medicaid ID number and are properly registered. If we receive an

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

encounter rejection related to provider registration or crosswalk, we work with the provider to correct it. The provider may have to fill out a form to have the Provider Master List and provider records updated or they may have to contact AHCA. We collaborate with the provider to correct it, follow up, and help ensure it is corrected and that a plan is in place for continuous improvement. We also work with the Agency to correct health plan registered providers on the Provider Master List.

### **EDUCATING PROVIDERS ABOUT THE IMPORTANCE OF KEY FIELD COMBINATIONS**

**CRITERION 2:** The adequacy of the respondent's approach to educating all providers about the importance of key field combinations in accurately identifying the service/s provided, the importance of populating all key fields, and the importance of consistency in coding across all records, providers, and provider types on encounter data submissions

All providers are required to submit properly coded claims using industry standard codes to be reimbursed by the health plan. If a key field is missing that is required to process the claim, the claim is rejected or denied back to the provider with an explanation of how to correct and resubmit the claim. For example, if a provider submits a claim line with a CPT or HCPC code that requires a modifier code, and the modifier is invalid for the CPT code billed, the claim line rejects with an explanation that the modifier is invalid. The modifier may be valid; however, may only be applicable to specific CPT or HCPC codes. If a trend is identified through claims reports, or if the provider contacts us, we will work with the provider to education them about the need to submit correct modifiers that are associated with the CPT or HCPC code.

Provider services staff work with providers on specific errors regarding claims or encounters so that the provider can submit the claim or encounter correctly. We can proudly say that we have maintained one of the highest encounter accuracy rates among all managed care organizations in Florida with an average accuracy rate of over 97% for the last three years. To help us maintain this rating, we customize training to fit the needs of each provider. For example, we offer additional claims submission support to providers who are new to managed care. It is interactive and uses technology-based platforms to help ensure each provider can experience the training in a way that meets their needs and individual learning style.

Information regarding the importance of correct and consistent coding is delivered and reinforced through a variety of modalities, including self-directed training, webinars, the provider handbook, provider Web-portal, the quarterly provider newsletter, and on-site instruction. Providers are reminded of the requirement to maintain accurate medical records that support submitted service encounters and/or claims. For more extensive resources, providers are directed to the resources available through the CMS website pertaining to National Correct Coding Initiative edits, medically unlikely event (MUE) edits and general billing practices. These resources are helpful in providing more in-depth information on procedure codes that should not be submitted together and on coding practices that are likely to result in claims or encounter denials.

Our sub-capitated, atypical providers, and subcontracted vendors are educated that key data elements are required at the claim and encounter level in order for the claim or encounter to be accepted into the system and processed. These key data elements, including, but not limited to, are the following:

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Recipient Medicaid identification number
- Provider Medicaid ID
- Provider NPI
- Claim type
- Place of service/bill type
- Revenue codes
- Procedure codes – Current Procedural Terminology (CPT 4)
- Diagnosis codes – International Classification of Diseases ICD-9 and ICD-10
- Health Care Common Procedure Coding System (HCPCS, Levels I and II)
- Modifiers
- Date of service
- Charges
- Units of service

### **ENSURING THAT ALL PROVIDERS PROVIDE AN AMOUNT OR COST OF SERVICE PROVIDED**

CRITERION 3: The adequacy of the respondent's approach to ensuring that all providers, including subcapitated providers and subcontractors, provide an amount or cost of the Medicaid service provided (including pharmacy paid amount). For pharmacy claims, this includes the adequacy of the respondent's approach to ensuring the amount or cost of the Medicaid service provided must be the amount that was actually paid to the pharmacy excluding any PBM or other administrative costs

Aetna requires all providers, including sub-capitated providers to include billed charges on their claim and encounter submissions. The claims adjudication system calculates either a FFS payment to the provider or a FFS equivalent amount for our capitated providers. Subcontracted vendors, including our pharmacy benefit manager, are required to submit a billed and paid amount that excludes administrative fees and expenses. Claims and encounters are rejected or denied back to the provider for correction if the billed amount and/or paid amount are not provided. As an additional validation check, our finance team compares the invoice of the paid amount to encounters submitted from our pharmacy and over the counter vendors for reconciliation. When discrepancies are found the health plan will conduct additional validation and will work with the vendor to correct the data.

### **EDUCATING AND SUPPORTING PROVIDERS WHO SUBMIT PAPER CLAIMS**

CRITERION 4: The adequacy of the respondent's approach to educating and supporting providers who submit paper claims

Aetna actively works with providers that submit paper claims to facilitate timely and accurate submission and associated information. During the initial orientation training, providers are given an overview of claim submission processes for both paper and electronic data interchange (EDI) claims. We maintain a process for educating providers about submitting paper claims, especially for atypical providers unfamiliar with submission to managed care payers. We employ the following approach for these providers:

- We analyze the forms used by the provider for billing services to determine what standardized form can replace their current bill format

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- We educate and train providers on the way to accurately complete forms recognized by both our claims and encounter systems to expedite their payment (the CMS 1500/or UB-04)

In addition to our paper claims support, we continue to encourage providers to submit claims electronically in an effort to enhance the associated downstream efforts connected with encounter submission. We directly, and through our clearinghouse partners, continue to educate providers on the benefits of generating and submitting claims electronically. Our current EDI rate is 91%.

Aetna offers training to providers regarding claim and encounter submission requirements and payment processes. Our goal is to help ensure providers submit accurate and timely claims and encounters. Ongoing training can be individualized or network wide depending on the need. Training development and delivery is triggered by the need for problem resolution, patterns in provider billing disputes, provider complaints, feedback from our provider survey, changes to requirements from the Agency, or any other national standards and/or through systematic analysis of denied claims and encounters.

For example, in 2015, Aetna insourced the administration and claims payment previously outsourced to a third party. As part of this transition and insourcing, Provider Services conducted statewide provider forums and trainings. At least one forum was conducted by each region, and in some regions, there were more than three forums conducted. A few of the forums focused specifically on assisted living facility administrators and billing staff. An end-to-end review was conducted on the basics of billing and on the key fields of the CMS 1500 form. In cases where training was not sufficient or the providers felt uneasy about submitting claims, our Provider Services team conducted one-to-one on-site education and shadowed the assisted living facility billing and administrators as they filled out a handful of their claims to help ensure the claim was completed properly prior to submission. This same approach was followed for durable medical equipment and home health providers that were identified as having claim payment issues and reported requiring additional guidance. The training yielded positive results as evidenced by less claims errors, favorable provider feedback, and more timely submissions.

### **ENCOURAGING PROVIDERS TO SUBMIT ACCURATE, TIMELY, AND COMPLETE ENCOUNTER DATA**

**CRITERION 5:** The adequacy of the respondent's approach to encouraging providers, particularly sub-capitated providers, subcontractors, atypical providers, and non-participating providers to submit accurate, timely, and complete encounter data, including the type and frequency of activities and any incentives/penalties

Aetna receives claims (which generate a FFS payment) and encounters (a record of service that does not generate payment) from our providers. We process encounters from our sub-capitated providers, and claims from our atypical providers and non-participating providers through our claims system. From our claims system, claims and encounter data feeds our quality and actuarial databases, and is transmitted to our EMS to be converted to HIPAA-compliant 837 and NCPDP encounter files in preparation for submission to the Agency.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Subcontracted vendors submit their encounter data for services provided to enrollees through secure FTP data transmission to Aetna. We feed this data to our EMS, where our Encounter Management unit (EMU) prepares an 837-encounter file for submission to the Agency.

### **Quality Data from Sub-capitated Providers**

Aetna pays sub-capitated providers on a capitated basis (i.e., they are paid according to the number of enrollees assigned to their facility; they are not paid specific to the quantity of services provided). Aetna Florida has approximately 47% of its enrollees assigned to primary care physicians (PCPs) reimbursed through a capitated arrangement.

Aetna enrollees not assigned to sub-capitated providers (approximately 53%) are assigned to PCPs whose services are reimbursed on a FFS basis by Aetna. We then comparatively assess utilization of services under both the capitated and FFS payment arrangements to identify and address data outliers.

We require sub-capitated providers to submit encounters and FFS providers to submit claims that include the following information: appropriate enrollees and provider information, diagnoses, procedure codes, dates of service, charges, unit of service and place of service or type of bill. Encounters from sub-capitated providers enter our claims system in the same way as a FFS claims do, and they are processed to align with the provider contract under which the encounter was submitted. After processing, our claims system generates a record of the encounter that includes a FFS equivalent amount. While the FFS provider receives a claim payment with their explanation of payment (the remit statement), the sub-capitated provider receives just the remit documenting all encounters processed. Because check runs are weekly, the sub-capitated provider receives a weekly remit for those encounters submitted and processed.

We have a weekly meeting comprised of our COO, operations directors, claims/quality analysts, market-specific encounter manager, and provider relations staff. The purpose of this cross-functional team meeting is to review claims and identify issues and trends. We also review encounter data to identify issues, trends, and resolve issues. If errors are identified, this work group then articulates the provider errors and develops a communication strategy for the Provider Services team to facilitate a prompt and productive meeting with the provider.

Beyond our weekly operations meeting as noted above, our Medical Economics team, known as Med-Econ (MEU) team, develops key reports that allow us to monitor utilization specific to sub-capitated entities. This starts with a clear understanding each month about which of our enrollees are assigned to sub-capitated entities: we do this by reconciling the enrollee population with AHCA's 820 file, and then subsequently compare this to the PCP assignments documented in our claims system.

From there, the MEU team uses actuarial, claims and encounter data to develop reports specific to both the capitated enrollee population and the FFS enrollee population. For example, we routinely review reports that track inpatient, outpatient, and emergency room utilization as well as PCP visit data. A simple comparison of this PCP utilization metric between the capitated and FFS data allows us to verify whether sub-capitated providers and FFS providers are delivering services at similar rates and volumes. A disparity in this data might lead us to question whether encounters are being submitted properly by the sub-capitated entity. In follow-up to identified

## **EXHIBIT A-4-a**

### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

trends, our Provider Services team meets with the sub-capitated provider to provide education on proper encounter submission to verify that we are receiving the most accurate and complete data and to determine if the sub-capitated entity is providing the appropriate volume of services to our enrollees.

Members of our management team (chief executive officer, chief operating officer, directors, and managers) meet monthly for the presentation of a series of MEU reports. Specific to sub-capitated provider data, the MEU utilization data allows us to review the following:

- Sub-capitated provider performance compared to other sub-capitated providers
- Sub-capitated provider utilization against actuarial expectations
- Sub-capitated provider performance against the expectation of our medical director and management team
- Sub-capitated provider performance as compared to FFS experience

Through utilization reports produced by the MEU team, our team can ascertain when the accuracy, timeliness, and completeness of encounter data may be compromised and then move to correct the problem. An example of how we have successfully used this approach to improve the completeness and accuracy of encounter submission is described as follows.

#### **Improving Subcontracted Vendor Accuracy Rate Results: A 2016 Success Story**

Aetna has examined our most common subcontracted vendor denials in an effort to help our providers and facilities prevent and overcome common challenges related to claim and encounter processing. The information shared with our vendors should help them bill claims and encounters more accurately, reduce delays in processing, as well as avoid rebilling and additional requests for information.

After reviewing our subcontracted vendor encounter submissions in 2016, we noticed some frequent denial edits with one of our subcontracted vendors, Beacon Health Options. After multiple collaboration meetings, we discussed and documented a plan on how the errors could be reduced, and then verified corrections were being made to improve acceptance rates. After the changes were made, Beacon's acceptance rates increased from 68% in January 2016 to over 95% in September 2016.

Beacon's common denial examples as well as the recommended method of corrections were:

- 835 denial code: 170/M143 (Provider Not Enrolled at Service Location for Program Billed); this error occurred because the billing provider was not enrolled/registered to provide the category of service that was submitted on the encounter. The correction was for institutional services (i.e., inpatient, outpatient, long-term care, and hospice services) to be billed on an 837-I transaction. Practitioner services (i.e., physician, optometry, laboratory services) were to be submitted using an 837-P transaction.
- Resolution: We referred them to the Provider Master List found on the Managed Care Provider Registration page of Florida Medicaid Web portal for verification of existing enrollment. In most instances, the NPI/Taxonomy/ZIP code combination on the X-12 file was mapping to the incorrect provider, thus causing the denial.
- 835 denial code: 208 (Multiple Service Locations for Billing Provider); this error occurred when the billing provider's NPI matched multiple provider records on the Florida MMIS.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Resolution: We referred them to the Provider Master List using the provider's NPI/Taxonomy/ZIP code combination to determine if there was more than one provider associated with the NPI. In most instances, the NPI/Taxonomy/ZIP code combination on the X-12 file was mapping multiple providers, thus causing the denial.

Critical to our network oversight strategy are the collaborative partnerships we have developed with sub-capitated provider leadership. We leverage these key relationships to identify and address proactively systemic issues that affect the quality of care provided to our enrollees and to address operational issues related to encounter data submissions. Our approach emphasizes the quality and access to care for the Medicaid population in a service delivery area. In addition to these effective collaborations, Aetna has instituted the following incentive programs to reward providers for meeting established performance thresholds for service delivery and encounter submission.

### **Sub-capitated Provider Incentives**

Aetna aligns performance goals and related quality and operating outcomes, including an emphasis on claim submission and accuracy, with a unique incentive program that features facility-oriented surplus distribution and an individual provider pay-for-performance focus. In our experience, aligning key metrics such as claims submission with payment incentives allows us to improve our service delivery system and enhance outcomes.

### **Provider Pay for Performance**

We establish annual performance goals related to clinical efficiency and delivery of preventive and wellness services (e.g., Healthcare Effectiveness Data and Information Set [HEDIS] measures) and offer provider incentives for meeting or exceeding established thresholds. In order to provide the claims data required for calculation of pay-for-performance incentives, our providers must submit clean claims. In this way our incentives are aligned to reward both encounter submission and the provision of high quality services to enrollees.

### **Quality Data from Non-participating and Atypical Providers**

We pay non-participating and atypical providers for the services they provide to enrollees at the point where we can process a clean, complete claim. Non-participating providers and participating providers have different timeframes to submit clean claims. Non-participating (atypical) providers must submit a claim within 365 days from date of service to be paid, and participating (atypical) providers must submit a claim within 180 days from date of service to be paid. We have found that these providers are responsive to working with us to adjust and resubmit inaccurate or incomplete claims promptly because they want to be timely paid for services.

Our Operations team meets weekly with our claims quality analysts to review claims trends and issues related to participating, non-participating, and atypical providers. At this meeting, we specifically monitor provider claims that failed to adjudicate properly. The most common issues identified by this team are related to claim submission errors (provider error) that result in rejected claims. As needed, this workgroup then articulates the provider error and develops a communication strategy for the Provider Services team to facilitate a prompt and productive meeting with the provider.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **Quality Data from Subcontracted Vendors**

Aetna verifies the quality of claims and encounters data processed locally by our subcontracted vendors, through contractual audit and review provisions. These provisions include pre-delegation operational audits, ongoing systematic claims and encounter data oversight. Key components of our delegation oversight structure include conducting audits, our Joint Operations Review Committee (JORC), and the review of utilization data:

- **Audits:** Audits, including claims audits, are performed annually by our auditors on location at the subcontractor's facilities. We prepare reports from these audits that are reviewed by our Operations leadership team (COO and directors) and our Delegation Oversight Committee. This review addresses both the successful aspects of a subcontractor's claim operation and the problem areas. Issues identified through claims audits are investigated and monitored through corrective action plans, which are tracked to resolution by our Delegation Oversight Committee.
- **JORC:** A JORC is established for each subcontracted vendor. Beacon Health Options has its own JORC comprised of management level participants from each functional area at Aetna and each functional area at Beacon Health Options. A JORC has been established for MCNA, comprised of management level participants from each functional area at Aetna and each functional area at MCNA. Each JORC meets once a month to review the reports addressing each of the functional areas, including claims and encounters. Data issues are addressed at the JORC and recommended improvements are tracked by the JORC and reported to our Delegation Oversight Committee. Subcontracted vendors who fail to correct data problems could trigger an audit, a CAP, or a sanction.
- **Utilization Review:** Our subcontracted vendors submit their processed claims data through secure data transmission to Aetna and we feed this encounter data to our actuarial and quality databases for utilization review, quality management, and performance indicator tracking. From our actuarial databases, the MEU team generates utilization reports that allow us to compare subcontracted services against trends, expectations, and personal insight by highly qualified Aetna colleagues such as our medical director, behavioral care specialist, and consulting dentists, as needed. This systematic review of sophisticated utilization and financial data by our qualified staff enables us to identify irregularities and other potential data issues proactively.

Aetna is well positioned to identify and address a lack of completeness, accuracy, or timeliness in claims or encounter data from subcontracted providers through audits, JORC reviews, and the systematic analysis of utilization data. As needed, our delegation oversight structure facilitates timely resolution through on-going monitoring of the accuracy, timeliness, and completeness of subcontractor encounter data and prompt communication, collaboration, and corrective action. We specifically incorporate performance guarantee contract language into our subcontractor's agreement that effectively aligns incentives for a subcontractor to provide accurate encounter information with a pass-through provision that affects the subcontractor with any sanctions or penalties that may result from the subcontractor's lack of performance.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **Connecting Claims to Encounters**

Our contracted providers are required to submit complete claims based on industry standard clean claims guidelines. These guidelines are enforced through plan clearinghouse for paper and electronic claims. Contracted clearinghouse review claims and encounters and enforce clean claim edits. Because claims and encounters are reviewed at the field level to verify that all required data elements are present (e.g., each field has the correct data type, related fields are completed properly, and the control fields in the headers and trailers match), we produce accurate encounter submissions to AHCA as non-compliant claims/encounters are returned to providers and subcontractors for correction and resubmission at the point of entry.

Repeated resubmission errors generate notifications to our claims quality analysts so that follow-up with providers can be scheduled to educate them on preventing error reoccurrence. Errors that are repeated by more than a nominal amount of providers may also be reviewed by the claims quality analysts to determine if these errors could be addressed with appropriate front-end edits.

We expect providers to submit claims timely. As part of ongoing quality assurance practices, we check monthly to compare open authorizations versus claims received and paid. This triggers a follow-up with the provider if there is more than a three-month delay in submission.

### **Engaging Providers**

Our provider liaison serves as an important resource responsible for educating contracted and non-contracted providers regarding proper claims and encounter submission. Our provider liaison works with analytics support to identify provider-specific submission issues and/or associated trends and guides the development/implementation of strategies to improve performance. Our education and provider onboarding process related to claims and associated encounter education features an initial provider orientation delivered in multiple forums (face-to-face, community provider forums, and webinars) that highlight our operating requirements, including the timing and accuracy needs associated with claims submission. During these sessions, we conduct training specific to claims submission.

In cases where a provider demonstrates a pattern of claim or encounter errors, problems, or omissions identified during the adjudication process, our claims management personnel develop recommendations to improve timeliness, completeness, and accuracy. Staff from our Provider Services department follows up on these recommendations and provides on-site technical assistance, as needed. If the provider fails to improve the timeliness, completeness, or accuracy of their claims or encounter submissions, we may take additional corrective action, including sanction (withholding of enrollee assignment), penalty, or contract termination.

A variety of controls are in place to address the issues of timeliness, completeness, and submission accuracy. For example, information of pended encounters from the Agency is promptly reviewed, and we analyze and respond to any encounter rejected by AHCA. Our encounters processing team reviews all claims, encounters, and associated acceptance/rejection rates. Any rejected encounters are reviewed to identify root causes to increase acceptance rates. We use encounter denial reasons as a tool to identify opportunities for improvements in training of staff and providers, encounter processes, protocols and/or operations. Each opportunity for performance improvement is tracked and trended and process

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

improvements are implemented to address data validity and integrity as appropriate, in coordination with the claims/encounter manager, other management, and/or representatives from the Quality Management Oversight Committee.

### **CONNECTING WITH PROVIDERS TO REVISE ENCOUNTER SUBMISSIONS TIMELY**

**CRITERION 6:** The adequacy of the respondent's description of how it will connect with providers to revise encounter submissions in a timely manner

Our EMU is an important contributor to the timely, accurate, and complete processing and submission of 837 encounter data to the Agency. Any encounter error that can be corrected will be resubmitted within 30 days of the denial date.

Our EMU has specially trained correction analysts with experience, knowledge, and training in encounter management, claim adjudication, and claim research. This substantial skill base allows us to research and adjust encounter errors accurately and efficiently. If additional information is needed from the provider in order to resolve an encounter rejection, the EMU will reprocess the claim within the claims processing system, sending notification to the provider by way of the remit as to why the claim was reprocessed and what is needed. Additionally, the unit includes analysts who perform data interpretations and extracts that Provider Services uses to work with providers to improve their submission accuracy.

Because we have the technical advantage of a single system, we can streamline encounter analysis. We designed our EMS reports to provide timely, complete, and accurate data that can be used for provider trending and education. These reports are valuable tools in analyzing encounter data. Examples of the reports we use to work with our providers to gain compliance include:

- **Encounter Aging Reports:** These reports show the aging and status of encounters, and they are used to track provider performance for targeted remediation efforts. Through these reports, our EMU works with the Provider Services department to identify providers that have issues with complete, timely, and accurate claims/encounter submissions.
- **Encounter Tracking Reports:** These reports show the status of all encounter records in the EMS and allows for the monitoring of encounter performance by provider based on the date of service and/or our claims system paid date.

These reports and other analysis tools allow for identification of trends or submission problems, including providers or vendors that consistently provide inaccurate or incomplete claims or encounter data. Our EMU and provider services personnel have the skills, training, and experience to use available data to identify providers that need additional training or technical assistance. Once identified, staff from our Provider Services department work with the provider to resolve the issue associated with their submission, and employ one-on-one provider training and education activities to gain the appropriate compliance associated with claims/encounter submissions going forward.

We meet every month with each of our subcontracted vendors to review accuracy, timeliness, and completeness of their encounter data submissions as well as to review any top errors and provide assistance with remediation of errors.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **WORKING WITH PROVIDERS TO COMPLY WITH CORRECT CODING**

**CRITERION 7:** The adequacy of the respondent's approach to work with providers to comply with correct coding

Challenges to a successful encounter submission process are directly correlated to our success in educating providers on the importance of submitting clean claims. The likelihood of attempts to submit claims to us via standard retail invoicing methods without compliant diagnosis or procedure code/modifier combinations remains. For these provider types, we address these potential pitfalls early in the provider onboarding process through a provider education program. Non-participating providers with encounter errors are also educated if encounters are rejected. Provider education and training on claims submission requirements is included in our provider manual, on our Website via our secure portal, and in provider newsletters. We offer provider education and face-to-face training during new provider orientation and at regularly scheduled provider visits. Our general provider education and training addresses claims/encounter submission requirements, including requirements for CMS 1500, UB-04, and UB-92 claim forms. This education and training provides an overview of claim development requirements and includes the process for submitting claims (paper and EDI), timeframes for submission, clean claim requirements, standard Centers for Medicare and Medicaid Services (CMS) codes, HIPAA requirements, coordination of benefits and third party liability, balance billing, provider complaint and appeal processes, fraud and abuse, and reporting suspected abuse, neglect or exploitation of an enrollee.

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. The system uses algorithms from Cotiviti to detect potential claims up coding, with follow-up procedures for chart audits as appropriate. Cotiviti clinically edits claims to assist Aetna to assist the Agency in promoting proper and fair payment of claims. Examples of applied edits include coding accuracy, durable medical equipment editing, and procedure code guidelines.

Cotiviti supports correct coding based on the definition or nature of a procedure code or 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 re-code procedures based on the appropriateness of the code selection. For example, if a provider attempts to unbundle procedures, Cotiviti applies editing logic that bundle all of the procedures billed into the most appropriate code. For example, if a provider bills an office visit and bills separately for heart monitoring with a stethoscope at the same visit, Cotiviti rebundles the service into the appropriate Evaluation and Management or office code.

Utilizing the edits and tools listed above, 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 to and comply with the Agency's coverage and payment policies. Aetna complies with the National Correct Coding Initiative editing programs and claims processing requirements of 42 CFR 433.116 and 45 CFR 95, subpart F, as required. When we deny claims at the time of submission, configuration is added to align with AHCA's guidelines. In such instances, we require providers or subcontractors to resubmit the claim with valid information to receive payment. Following adjudication and payment, we export claims data into the EMS twice per week.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **ENSURING THAT ALL ENCOUNTERS ARE INCLUDED IN SUBMISSIONS**

**CRITERION 8:** The adequacy of the respondent's approach to ensure that all encounters are included in submissions

As stated earlier, all encounters and claims for all provider types and subcontracted vendors are stored in EMS. All encounters pass through the same AHCA-specific edits to validate that the encounters meet the criteria for a clean encounter submission to the Agency and are consistent, complete, and accurate across all provider types and vendors. We work continuously with providers to promote compliance.

We periodically conduct chart audits as part of our medical records review to help ensure all of our encounters are included in submissions. The purpose of chart audits is to compare a provider's medical records against claims data and to monitor provider practices of submitting timely, accurate, and complete information.

Our medical record review process includes, but is not limited to the following:

- Statistically valid random sampling identification of participating medical home/primary care providers
- Steps to obtain medical record copies from providers
- Selection of medical record entries to be tested
- Error rate calculations
- Health plan comments and feedback

Through reporting mechanisms discussed earlier in this section, our team can validate the accuracy, timeliness, and completeness of encounter data submission. The following reports in our EMS are valuable tools in analyzing encounter data to help ensure that all encounters are included in submissions to the Agency:

- **End-to-End Financial Reconciliation Report:** This report compares finalized claim volume and dollars against accepted encounters.
- **Monthly Vendor Completeness Report:** This report compares finalized vendor claim volume and dollars against accepted encounters.

The agency periodically reviews the completeness of our encounter data feeds and on our latest report card from our Special Encounter Data Feed submission in January 2017, Aetna received straight As from the Agency on plan-submitted encounter data (Statewide Medicaid Managed Care Managed Medical Assistance services payments from May 1, 2014, to December 31, 2016). We were one of only two plans to receive straight-A's on the following: timeliness, use and reporting on valid codes, reasonable sub-capitation reporting, consistency with sub-capitation reporting, consistency with annual statistical reports (ASR), valid hospital Medicaid IDs, diagnosis, procedure and revenue codes, service dates, adjustments and duplicates.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **Evaluation Criteria:**

1. The adequacy of the respondent's approach to ensure that all network providers, including subcapitated providers, are known to the Florida Medicaid Management Information System (FMMIS) for the purposes of encounter data submission.
2. The adequacy of the respondent's approach to educating all providers about the importance of key field combinations in accurately identifying the service/s provided, the importance of populating all key fields, and the importance of consistency in coding across all records, providers, and provider types on encounter data submissions.
3. The adequacy of the respondent's approach to ensuring that all providers, including subcapitated providers and subcontractors, provide an amount or cost of the Medicaid service provided (including pharmacy paid amount). For pharmacy claims, this includes the adequacy of the respondent's approach to ensuring the amount or cost of the Medicaid service provided must be the amount that was actually paid to the pharmacy excluding any PBM or other administrative costs.
4. The adequacy of the respondent's approach to educating and supporting providers who submit paper claims.
5. The adequacy of the respondent's approach to encouraging providers, particularly subcapitated providers, subcontractors, atypical providers, and non-participating providers to submit accurate, timely, and complete encounter data, including the type and frequency of activities and any incentives/penalties.
6. The adequacy of the respondent's description of how it will connect with providers to revise encounter submissions in a timely manner.
7. The adequacy of the respondent's approach to work with providers to comply with correct coding.
8. The adequacy of the respondent's approach to ensure that all encounters are included in submissions.

**Score:** This section is worth a maximum of 40 raw points with each of the above components being worth a maximum of 5 points each.

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**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**SRC# 31 – Fraud and Abuse/Compliance Office (Statewide):**

The respondent shall describe its compliance program including the compliance officer's level of authority and reporting relationships. The respondent shall describe its experience in identifying subcontractor fraud and internal fraud and abuse in managed care programs. The respondent shall include a résumé or curriculum vitae for the compliance officer. The respondent shall also include an organizational chart that specifies which staff are involved in compliance, along with staff levels of authority.

**Response:**

Every year, billions of dollars in Medicaid funds are lost to fraud, waste, and abuse—funds that could and should be spent on meeting the needs of vulnerable populations. As the Agency's partner in integrity—a core value within the Aetna organization—Aetna takes seriously our responsibility as stewards of the State's Medicaid funds. We employ comprehensive policies and procedures along with education and training to prevent fraud, waste, and abuse proactively, while taking appropriate, timely, and thorough corrective actions whenever there are instances of non-compliance. We enforce a zero-tolerance policy toward any form of fraud, waste, and abuse by staff, subcontractors, providers, enrollees, or others with whom we conduct business.

**COMPLIANCE PROGRAM**

Aetna and its subcontractors will comply with all current and future State and federal laws and regulations related to program integrity and disclosure requirements, and we will provide timely, complete, and consistent exchange of information and collaboration with the Agency.

The foundation of Aetna's compliance program is the federal Department of Health and Human Services Office of the Inspector General's Seven Elements of an Effective Compliance Program. Specifically, we implement written policies, procedures, and standards of conduct that articulate Aetna's commitment to compliance. Our Code of Conduct informs all staff of their compliance responsibilities. A designated compliance officer and Compliance Committee encourage collaboration and cross-training with an established, effective system for escalating and resolving issues. Our oversight and monitoring programs verify adherence to our policies. Aetna conducts effective training and education with the delivery of meaningful training programs to help staff members understand how compliance responsibilities relate to them.

Aetna develops effective lines of communication about our values and policies in a targeted manner to strengthen our culture and reinforce our standards during quarterly employee town hall events and team meetings, on our intranet, and in printed communications. We conduct internal monitoring and auditing, and we maintain accessible systems for staff to ask questions and raise concerns. Aetna enforces standards through well-publicized disciplinary guidelines and publishes disciplinary standards and our Code of Conduct on the Aetna intranet. We respond promptly to detected offenses and undertake corrective action with clear and efficient systems of investigating and correcting compliance violations.

Dedicated, Florida-based Compliance and Special Investigations unit (SIU) staff members conduct investigations and recovery activities, as well as engage with the health plan's

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

leadership and other team members to perform fraud, waste, and abuse prevention actions and requirements. They lead audit preparation and are accountable for audit performance.

### **COMPLIANCE WITH STATE AND FEDERAL REQUIREMENTS**

**CRITERION 1:** The extent to which the respondent's compliance program complies with all State and federal requirements

Our Statewide Medicaid Managed Care (SMMC)-approved compliance plan and anti-fraud plan meets the requirements of applicable State and federal law, including but not limited to, 42 CFR § 438.608 and additional requirements as described in Subtitle F, Section 6501 through 6507, of the Patient Protection and Affordable Care Act (PPACA) of 2010. Our anti-fraud plan sets forth specific procedures to prevent health care fraud, waste, and abuse, including claims, subcontractor, and internal and external fraud. It includes, but is not limited to, the following elements:

#### **Anti-fraud, Waste, and Abuse Policy**

Our anti-fraud, waste, and abuse policy applies to employees as well as vendors performing services on behalf of our plan and clearly states our commitment to program integrity. In accordance with State and federal law and our contract with the State, we identify, report, monitor, and where appropriate, refer instances of suspected fraud or abuse to the appropriate regulatory agency for possible prosecution.

#### **Education and Training**

We provide comprehensive and ongoing fraud, waste, and abuse education and training activities for employees, SIU investigators, providers, and enrollees.

**Detection and Prevention:** We work with Aetna's SIU and designated vendors to identify persons and organizations involved in suspicious claims or eligibility activity using a variety of techniques, including detecting and investigating suspected fraud, waste, or abuse by providers, employees, and enrollees. Our SIU also investigates referrals made by providers, enrollees, and vendors. In addition, pharmacy benefit vendors are responsible for detecting and investigating instances of fraud, waste, and abuse involving pharmacy claims.

#### **Investigations**

We conduct medical provider, pharmacy, and enrollee claim investigations, as well as investigate suspected employee fraud. Our SIU investigator investigates instances of suspected fraud or abuse and develops a case using the National Health Care Anti-Fraud Association database, Universal Web Information Delivery application, ad hoc reports, medical records and other supporting documentation, OIG Exclusion database, OPM debarment list, and the General Service Administration Excluded Parties Listing System. The investigator may interview enrollees, research provider or billing entity information, and conduct clinical reviews of medical records as part of the investigative process.

**EXHIBIT A-4-a**  
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Reporting

We comply with all State and federal reporting requirements. When we reasonably suspect fraud or abuse either has occurred or is occurring related to an enrollee or the Medicaid program, we report such incidents to the Agency within the timeframes defined in the SMMC contract and as stated in the Reporting Guidelines. On a quarterly basis, we provide a comprehensive fraud and abuse prevention activity report regarding our investigative, preventive, and detective activity efforts. Annually, we report on our experience implementing our anti-fraud plan and investigating possible fraudulent or abusive acts. The report includes information such as the dollar amount of health plan losses and recoveries attributable to overpayment, abuse, and fraud, and the number of health plan referrals to Medicaid Program Integrity.

Review and Revision

We routinely evaluate the effectiveness of our anti-fraud plan. If we find that changes must be made to training protocols and procedures or to personnel responsible for the anti-fraud, waste, and abuse program, we will revise the anti-fraud plan and submit it to the Agency for approval at least 45 days prior to implementation.

Auditing

We cooperate fully with governmental agencies responsible for fraud, waste, and abuse detection and prosecution activities in arranging for or participating in any audit or review to determine compliance. Along with the SIU, Aetna cooperates fully in all reviews, investigations, and in any resulting subsequent legal action brought by appropriate governmental agencies against providers or enrollees relating to fraud, waste, and abuse issues. We maintain and retain complete records in accordance with applicable law and Aetna and the Agency's policies.

As a subsidiary of Aetna Inc., Aetna Better Health of Florida receives support for many elements of the anti-fraud plan. However, responsibility for ensuring implementation of the anti-fraud plan, and providing oversight of all activities related to program integrity, resides with Aetna. We work closely with Aetna's Enrollee Service Operations Unit and national SIU team for health care fraud prevention, detection, and investigation.

COMPLIANCE OFFICER

CRITERION 2: The extent to which the respondent has identified a qualified individual with sufficient authority and adequate corporate governance reporting relationships to effectively implement and maintain the compliance program

CRITERION 3: The extent to which there are sufficient staff to implement the compliance program

A disciplined oversight process is the key to assuring accountability, transparency, and two-way communication between Aetna and the Agency. Our experienced and qualified Medicaid compliance officer, [REDACTED], helps to provide this oversight. She reports directly to [REDACTED], senior director of compliance, Aetna Medicaid division. She has unrestricted access to Chief Executive Officer Heidi Garwood and the board of directors for compliance

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reporting, including fraud, abuse, waste, and overpayment. She is a full-time Aetna employee, and she will dedicate 100% of her time to serving as the compliance officer for this contract.

██████████ has 21 years of managed care experience and more than 15 years of managed care regulatory compliance experience and has extensive knowledge of management theories and practices with respect to federal and state regulatory contracts. Throughout her career, she has served in management positions such as director of government relations, regulatory compliance, and manager of regulatory compliance. She actively works with health plan employees, senior management, and State regulators to ensure regulatory compliance.

With her knowledge of relevant State and federal regulations, ██████████ promotes, implements, and oversees the compliance program and oversees the plan's compliance with contract requirements, including non-discrimination requirements. She is designated as the staff member who reports to the functional area of Program Integrity within the Agency. She helps to ensure program integrity, including fraud, waste, and abuse prevention and detection. In her efforts to address non-compliance issues, including those related to fraud, waste, abuse, and overpayment, ██████████ can access Aetna's investigative services, internal audits, and the national corporate compliance office as resources.

██████████ works directly with Compliance and Regulatory Affairs and the Ethics and Communications Office to address suspected internal fraud, waste, and abuse issues. She coordinates with these departments to open a case and provides information needed for the investigation, including contractual and regulatory requirements. She reports new cases to the Agency within 15 days and keeps AHCA informed of the outcome. ██████████ also monitors our Domestic Commercial Compliance department's provider watch list. If one of our providers appears on the watch list, she works with provider network to verify the individual is a match. If confirmed, she will halt claims payments and terminate the provider in accordance with applicable requirements.

She chairs the Compliance Committee, which is comprised of representatives from senior leadership and from the Medical Management, Quality, Health Services, Provider Services, Enrollee Services, Special Investigations Unit, Operations, Grievances and Appeals, Pharmacy, Provider Network, and Long-Term Care departments. In this role, ██████████ collaborates with the Compliance Committee to identify trends of fraud, waste, and abuse pursuant to the Contract, as well as in compliance with State and federal law.

The Compliance Committee meets on a quarterly basis, at a minimum, and its major responsibilities include reviewing and monitoring internal controls and metrics such as compliance issues involving fraud, waste, and abuse; external quality review oversight activities and audits; regulatory and contractual compliance; and corrective action plans. The committee identifies potential compliance gaps and reports any instances of non-compliance to the Quality Management Oversight Committee on a monthly basis. As compliance officer, ██████████ also provides an annual compliance report to the board of directors.

Senior Compliance Consultant ██████████ works alongside ██████████ to promote program integrity. She helps to ensure the health plan is compliant with applicable statutory and regulatory requirements, including contract amendments or regulatory changes. She also develops and communicates routine compliance procedures. ██████████ serves as co-chair for the health plan's quarterly compliance and fraud, waste, and abuse meetings.

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Fraud Investigation Unit Staff

Working in collaboration with [REDACTED] to promote program integrity, dedicated Senior Investigator [REDACTED] has over 30 years of experience in law enforcement. He served for 20 years as a New York Police Department officer and detective investigator. He served for 11 years on the Florida Attorney General's Medicaid Fraud Control unit and has been an SIU investigator with the plan for 6 years. Putting his law enforcement background to work, he not only investigates cases of suspected fraud, but also trains team members from departments such as Care Management and Provider Services about methods for detecting fraud, waste, and abuse. A member of the National Health Care Anti-Fraud Association, [REDACTED] is the health plan's designated point person for all referrals of suspected instances of fraud, waste, and abuse.

As the local investigator, [REDACTED] reports directly to the plan CEO and has access to [REDACTED] as well as to Aetna's corporate SIU division. He works closely with Aetna's Medicaid-specific SIU team at the national level and reports indirectly to SIU Supervisor [REDACTED], who is an accredited health care fraud investigator. The national team is comprised of senior investigators, senior analysts, a business project program manager, an information technology project lead, and supervisors who report to the Medicaid special investigations manager. These staff members possess backgrounds in pharmacy, coding, fraud examination, Medicaid compliance, nursing, law, and law enforcement. This team also has a dedicated senior medical director who reviews and consults on fraud, waste, and abuse issues.

Having the support of national-level SIU resources enhances program integrity work at the local level. When emerging trends and schemes are identified in one state, the SIU communicates this information locally so that we can leverage those data to detect similar schemes in Florida. In addition, [REDACTED] communicates the status of current investigations to the health plan during monthly fraud, waste, and abuse committee meetings.

Along with the compliance officer and the SIU supervisor, [REDACTED] attends quarterly AHCA Medicaid Program Integrity meetings. These meetings provide an opportunity to receive and share information about emerging schemes and trends identified by other managed care organizations, law enforcement, or regulatory agencies. [REDACTED] and [REDACTED] also attend monthly and quarterly Joint Operations Review Committee meetings with vendors and subcontractors, in which they address program integrity issues and discuss fraud, waste, and abuse prevention and detection.

In addition, [REDACTED] is a member of the Federal Bureau of Investigation's Healthcare Fraud Working Group for the Tampa Bay region. The working group is comprised of representatives from the Department of Insurance Fraud, the Florida attorney general's office, state regulatory agencies, and other law enforcement agencies. The group meets quarterly to discuss trends and share information and best practices.

**EXPERIENCE IDENTIFYING SUBCONTRACTOR AND INTERNAL FRAUD AND ABUSE**

**CRITERION 4:** The extent to which the respondent's compliance program has experience identifying subcontractor fraud and internal fraud and abuse in managed care programs

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

In our 30 years of experience serving Medicaid enrollees, Aetna has learned that education, outreach, and hotlines, along with robust data management and analytics, are the keys to fraud and abuse identification and reporting. We make it easy for staff, providers, and enrollees to report anonymously suspected fraud and abuse by calling our fraud hotline, a toll-free number featured prominently on explanation of benefits documents, provider remittance advices, and on our Website.

Our staff, enrollees, providers, and contractors are more likely to report suspected or known fraud, waste, and abuse issues when they know the process is safe and confidential. Therefore, we keep all complaints reported by staff, enrollees, providers, contractors, or other persons confidential to the extent possible during and following the investigation. We enforce a zero-tolerance policy for any retaliation against individuals who make reports regarding known or suspected violations of federal and State laws and regulations. Violations result in disciplinary actions up to and including termination.

Managers and supervisors are in a unique position to influence staff members' behavior and raise awareness about compliance and ethics. Our executive-level leaders facilitate quarterly Compliance and Ethics discussions with team members to reinforce annual compliance training. Our Compliance and Regulatory Affairs Webpage provides an extensive video and resource library for facilitating those discussions. The materials and the discussions they prompt are highly effective learning tools that promote Aetna's values and strengthen the culture of compliance.

Our local SIU senior investigator conducts in-services with various departments, such as Customer Service, in which he offers AHCA-approved training about methods for identifying and reporting fraud, waste, and abuse. He is also called upon to conduct the compliance portion of departmental meetings and is available to providers and their staff to provide fraud, waste, and abuse detection and prevention training upon request.

In addition, we are able to tailor our monitoring and reporting to meet the Agency's program integrity needs. Our compliance team uses Model Office Business Analytics Reporting (MOBAR) tracking to ensure that all required reports and contractual deliverables are tracked and submitted to regulators accurately and timely. MOBAR operates in two phases:

**Informatics:** Our Informatics team builds reports for each contract deliverable. These reports can be generated automatically or entered manually, and their frequency and method are determined in accordance with State program requirements. For example, our operations team tracks the type and number of enrollee and provider telephone calls; whether all enrollees receive their identification cards and welcome packets timely; and whether all providers receive training. Operational and medical management reporting is compiled and reported to various oversight committees including the Service Improvement Committee, the Quality Management Oversight Committee, and the Quality Management/Utilization Committee. These committees review program outcomes and make recommendations for program changes in an effort to increase each program's effectiveness.

**Compliance:** Our Compliance department tracks and documents contract deliverables as well as reports on the timeliness and accuracy of our reporting. Plan compliance officers retain copies of signed attestations and final reports in MOBAR for archive and auditing. Compliance

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

reviews the contractual reporting responsibilities of the plan to ensure all requirements are met in a timely manner.

The information we obtain from our data integration, predictive analytics, and management information systems helps to assure the State that program integrity decisions are data-driven and effective. By using these tools to collect and analyze data from multiple sources, we are able to assess the effectiveness of strategies we have implemented and make course corrections when necessary.

### **Identifying Subcontractor Fraud**

Our team members are the front line in combatting subcontractor fraud. Armed with the knowledge they gain through compliance training as discussed previously, Aetna team members in every department know that they play a key role in promoting program integrity and monitoring for fraud, waste, and abuse. For example, if an enrollee complaint suggests a possible fraud, waste, and abuse issue, our Grievance and Appeals team will report their suspicions to the compliance officer or SIU investigator. Our collaborative approach to program integrity is efficient and effective in ensuring necessary investigations and subsequent recovery actions. Other examples of red flags that may trigger an investigation include:

- Discrepancy between the submitted diagnosis and the treatment
- Claims that are resubmitted with coding changes to gain benefits
- Alterations on claim submissions
- Medical necessity of services rendered
- High volume or high percentage of dollars paid in one or two procedures
- Providers using a post office box as service address
- Pressure for quick claim payment

To further promote program integrity and prevent fraud, Aetna requires that vendor, subcontractor, and provider staff complete our compliance and fraud, waste, and abuse training at the time of initial contracting and annually thereafter. We review key vendors' and subcontractors' fraud, waste, and abuse programs to verify that they provide fraud, waste, and abuse training to their employees. Annual AHCA-approved provider training is conducted electronically by way of online training modules and webinars. Our Provider Services department provides information about the training to providers via facsimile blasts each year and collects the providers' signed attestations for themselves and their staff. This information is provided to the Agency in our annual anti-fraud plan revision and in the board report.

Our monthly Joint Operations Review Committee meetings afford us the opportunity to meet with behavioral health, dental, and transportation providers to review claims and discuss program integrity and compliance issues. We monitor for fraud, waste, and abuse activity, including whether the vendor or subcontractor is delivering the required reports, review findings during our monthly and quarterly subcontractor meetings, and report activity to our Compliance Committee.

We monitor all of our subcontractor partners for performance using compliance monitoring tools, audits, and performance reports. At a minimum, vendors are audited annually by Aetna's National Vendor Delegation Oversight Committee (DOC) in accordance with Florida-specific requirements. The DOC will provide audit reports and findings to the local DOC for action. We

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

perform additional audits if an audit or assessment reveals a compliance issue. We perform reconciliation to confirm that services billed were actually rendered to the enrollee and to identify and refer vendors that require heightened oversight or investigation.

As previously noted, our compliance officer and plan-based SIU investigator have open and immediate access to Aetna's corporate SIU leadership, tools, and supports, and collaborate with SIU investigators who monitor commercial and Medicare lines of business to leverage corporate-wide data. This creates economies of scale and improves our ability to detect and remedy incidents of fraud, waste, and abuse. For example, if a provider improperly bills Medicare, the SIU checks all lines of business for the same allegation, including Medicaid. This allows us to review allegations we receive through data mining and gives us additional leads we may not otherwise find. Similarly, Aetna's national Medical Economics department advises the plan regarding current trends and schemes occurring around the country.

### **Pre- and Post-payment Review**

Aetna collaborates with industry leaders such as McKesson ClaimCheck and Cotiviti Healthcare for front-end automation of correct-coding and medical-policy decisions specific to Medicaid and Medicare and for supporting the detection of coding irregularities, conflicts, or errors while making recommendations for correction. Our claim system and editing vendors perform edits for the following: enrollee data (e.g., age, gender), provider data, current coding protocol, assistant surgeon, place of service, type of bill, medical visit logic, medical unlikelihood, durable medical equipment, new-visit frequency, and professional, technical, and global services.

Our data analytics system provides efficient and proactive discovery of new fraudulent schemes, allowing for near real-time prepayment review capabilities to flag suspicious claims prior to adjudication. This saves money by eliminating the need for pay-and-chase methods of recovery. It allows for a comprehensive approach to addressing both enrollee and provider fraud by leveraging all available data sources to detect emerging fraudulent patterns.

### **Provider Credentialing, Re-credentialing, and Oversight**

Our oversight of providers includes using business intelligence software to identify providers whose billing, treatment, or patient demographic profiles differ significantly from their peers. We review claims and encounter data to investigate situations in which providers demonstrate a pattern of submitting falsified or overstated reports, misrepresent medical information, or otherwise appear to be non-compliant. We run outlier reports of known fraudulent schemes based on specialty and on Current Procedural Terminology codes to identify the top providers of certain services. We also perform targeted audits such as daily high-dollar audit reviews. In addition, we check providers against sources such as the National Practitioners Data Bank, Office of the Inspector General List of Excluded Individuals or Entities, and the System of Award Management on a monthly basis to confirm their eligibility to participate in Florida's Medicaid program.

### **Verifying That Billed Services Were Delivered**

We use a variety of methods ensure that our enrollees actually received the services for which the vendor or provider has billed. Aetna sends explanation of benefits statements to a statistically valid sample of enrollees advising them to call or write to us if they did not receive

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

the identified services. All services that are disputed are sent to our SIU and Compliance departments for full investigation. If we determine there is suspected or confirmed fraud, waste, or abuse, we take appropriate action such as recoupment of payment, contract termination, or other disciplinary action. The case is also referred to the appropriate regulatory agencies: AHCA MPI, Medicaid Fraud Control Unit, or the National Benefit Integrity Medicare Drug Integrity Contractor.

To monitor and validate the delivery of personal care services and home health services, Aetna will use electronic visit verification through Tellum. We will be able to confirm the visit and services authorization via geolocation.

### **Prior Authorization and Utilization Management**

Prior authorization enables Aetna to monitor utilization of defined outpatient services and procedures as well as non-emergent/elective hospitalizations before the enrollee receives the service. Prior authorization confirms requested services are for eligible enrollees; included in the defined benefits; provided at an appropriate level of care and place of service; appropriate, timely, and cost-effective; coordinated with medical management and communicated to applicable operations areas (e.g., finance, enrollee services, provider services) or per contractual requirement with external vendors; and documented accurately to facilitate timely reimbursement and reporting.

Our goals are not only to prevent provider and enrollee fraud, waste, and abuse, but also to provide quality care and promote enrollee safety. Whenever possible, we want to avoid the risks associated with overuse, underuse, and misuse of health care interventions while removing barriers to accessing care. Decisions to require prior authorization for certain services are based on data, such as utilization data, which identifies services likely to be over- or underutilized and signals conditions (e.g., diabetes or depression) likely to require extensive clinical or care management interventions.

We perform prospective, concurrent, and retrospective drug utilization review (DUR), for example, as methods for identifying suspicious activity. DUR also enables us to achieve improved health outcomes, helps prevent negative outcomes, improves quality of care, and reduces costs by preventing inappropriate or unsafe drug use. Our prospective and concurrent DUR processes are executed using computerized algorithms built into CVS Health's claim adjudication system, which performs key checks to identify conflicts based on the enrollee's claim history. The system creates alerts and prevents dispensing without further review and/or action by the dispensing pharmacists at the point of sale. Our retrospective DUR processes strengthen the integration of pharmacy and care management, monitor the quality and appropriateness of care, and promote cost-effective outcomes. Based on the various monitoring and trend analysis described above, we implement or refine interventions to improve prescribing and utilization patterns and control costs. These interventions may include, but are not limited to the following:

- Identifying prescribing patterns of specific practitioners that warrant outreach and/or education to review inconsistency with nationally recognized treatment protocols
- Referrals to the Lock-in Review Committee to evaluate identified enrollees' utilization to determine whether they are candidates for pharmacy/prescriber lock-in
- Referrals to the Aetna SIU and/or Office of the Inspector General investigation of enrollees, prescribing practitioners, and pharmacies

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Identification and referral of enrollees to care management for outreach and engagement with a focus on adherence to medication regimens

### **Identifying Internal Fraud and Abuse**

Aetna staff members adhere to a culture of compliance and are an integral part of our efforts to identify and combat subcontractor fraud and abuse. We train, expect, and require our staff across all levels of the organization to comply with all provisions of our compliance program, including fraud, waste, and abuse prevention. Staff members must complete our compliance training program within 30 days of hire and annually thereafter. Our Web-based training focuses on fraud awareness, detection, and reporting. The training aims to increase employee awareness of suspicious claims or ineligible beneficiaries and to assist in deterring the payment of fraudulent claims or claims for ineligible beneficiaries.

Aetna's fraud, waste, and abuse policies are designed to ensure that employees conduct business in a legal and ethical manner. These policies are designed in part to detect, prevent, and investigate embezzlement, internal theft, and other forms of employee fraud. All employees receive yearly education and training on these policies and the Code of Business Conduct and Ethics. Employees are required to report any suspected violations of the Code of Conduct to their immediate supervisor, Aetna's chief compliance officer, an Aetna compliance officer, or the Aetna Alert Line. If he or she wishes to remain anonymous, the employee may report his or her suspicions via the Aetna SIU hotline.

The Investigative Services department investigates suspected internal fraud and abuse as well as that of brokers and vendors. This department conducts background checks and performs data mining to identify incidents of internal fraud and misuse of Aetna resources. The Investigative Services department also has a hotline for employees to report suspected fraud and abuse anonymously.

### **RÉSUMÉ OF COMPLIANCE OFFICER**

Please refer to Attachment SRC 31: Compliance Officer Resume, which follows.

### **ORGANIZATIONAL CHART**

Please refer to Figure SRC 31-1: Compliance Organizational Chart in Attachment SRC 31, which follows.

### **Evaluation Criteria:**

1. The extent to which the respondent's compliance program complies with all State and federal requirements.
2. The extent to which the respondent has identified a qualified individual with sufficient authority and adequate corporate governance reporting relationships to effectively implement and maintain the compliance program.

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3. The extent to which there are sufficient staff to implement the compliance program.
4. The extent to which the respondent's compliance program has experience identifying subcontractor fraud and internal fraud and abuse in managed care programs.

**Score:** This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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## **Attachment SRC# 31**



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# **Compliance Officer Resume**



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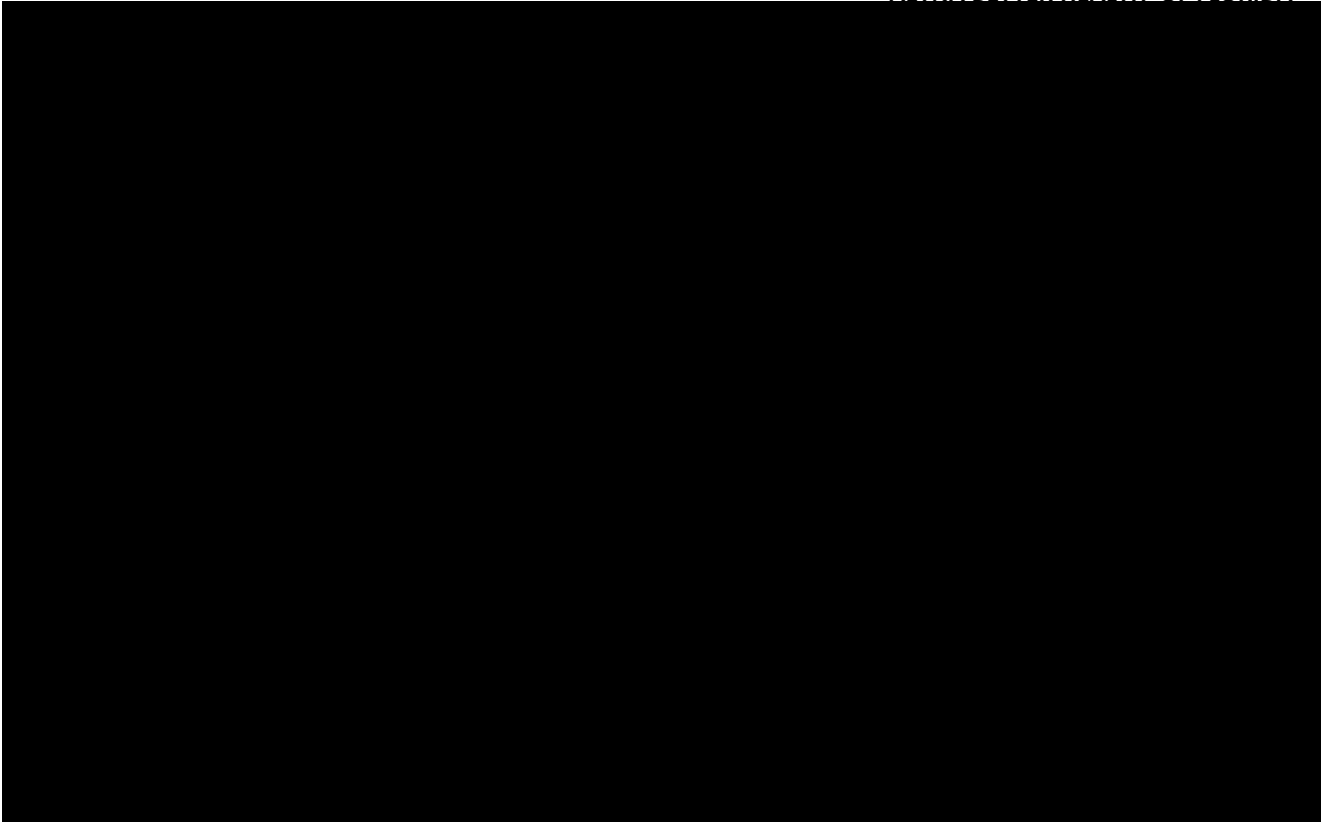
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**SRC# 32 – Fraud and Abuse Special Investigations Unit (SIU) (Statewide):**

The respondent shall describe its Special Investigations Unit (SIU) program and its controls for prevention and detection of potential or suspected fraud and abuse and overpayment, including the use of biometric or other technology to ensure that services are provided to the correct enrollee, including verification of home-based visits and services, to ensure those services are being appropriately provided and that services billed were received by the correct enrollee.

**Response:**

Our core values of excellence and integrity align with the Agency's objectives to promote responsibility and accountability in the delivery of high-quality, cost-effective health care. Prevention, detection, and correction of instances of fraud, waste, and abuse and overpayment are vital to that commitment. In 2016, our Medicaid Special Investigations unit's (SIU) avoidance, recovery, prevented loss, overpayment recovery, and overall vendor cost avoidance activities resulted savings in Florida of \$2,870,905.

Aetna has the expertise and is committed to collaborating with State and federal agencies to combat Medicaid fraud, waste, abuse, and overpayment. We were a founding member of the National Health Care Anti-Fraud Association (NHCAA) and the Medical Identity Fraud Alliance. In addition, we are a member of the National Association of Medicaid Program Integrity, the Centers for Medicare & Medicaid Services (CMS) Health Care Fraud Prevention Partnership, and the CMS Healthcare Anti-Fraud Task Force. As part of our strategy for preventing health care fraud, our SIU detects fraud, abuse, waste, and overpayment through a number of activities and sources.

**SPECIAL INVESTIGATIONS UNIT PROGRAM**

Aetna's corporate SIU senior director oversees Aetna-wide activities related to the prevention, investigation, prosecution, and reporting of health care fraud, as well as to the recovery of lost funds. Medicaid investigations supervisors assist with activities related to fraud, waste, and abuse for all Aetna Medicaid plans, and they report and coordinate activities with the local compliance officer. The SIU has Medicaid-dedicated staff who support all of our health plans, including senior investigators, senior analysts, a business project program manager, an information technology project lead, and supervisors who report to the Medicaid special investigations manager. These staff members possess backgrounds in pharmacy, coding, fraud examination, Medicaid compliance, nursing, law, and law enforcement. This team also has a dedicated senior medical director who reviews and consults on fraud, waste, and abuse issues. SIU investigators receive specialized training focused on the investigative process, key State and federal regulations, processes and procedures for addressing suspicious claims, and the procedure for facilitating communication among the health plan, appropriate authorities, and the SIU. In-person and Web-based training sessions held by NHCAA provide additional opportunities to improve investigator skills as well as learn about new schemes trending in the industry.

The SIU presents case reports to Aetna's compliance director and the Fraud, Waste, and Abuse Committee, which includes senior plan leadership and representatives from the Compliance,

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Medical Management, Provider Services, Finance, and Legal departments. The committee reviews the case and develops a corrective action plan to resolve the issue in a fair, effective, and appropriate manner. Aetna employs a process for timely, complete, and consistent exchange of information and collaboration with the Agency's designated agents and contracted external quality review organizations.

Upon detection of potential fraud, waste, or abuse at the local level, Florida-based investigator [REDACTED] works closely with our Compliance Officer [REDACTED], and leads the investigative process. When our compliance officer receives referrals, she will forward them to [REDACTED], who notifies [REDACTED] when an investigation is opened so that she can help to ensure compliance with State guidelines, rules, and regulations. She will report new cases to AHCA within 15 days. The investigation is documented in a case-tracking database and stored securely. The database allows easy access to all case files and contains pre-programmed reporting to track and manage the investigations. At the conclusion of an investigation, [REDACTED] files a report, including the allegation, an executive summary, case notes, and recommendations such as a recovery figure and suggested corrective actions. He provides updates to [REDACTED] regarding the status of open cases, and she reports the status to AHCA's Medicaid Program Integrity division on a quarterly and annual basis.

**CONTROLS AND AUTOMATED APPROACHES FOR PREVENTION AND DETECTION**

**CRITERION 1:** The extent to which the respondent uses various types of controls and automated approaches as part of a comprehensive approach to prevent and detect potential or suspected fraud and abuse and overpayment

Aetna uses a variety of controls and automated approaches as part of our comprehensive approach to prevent and detect potential or suspected fraud and abuse and overpayment. A brief discussion of some of these controls follows.

**Front-end Claims Editing**

We collaborate with industry leaders such as McKesson ClaimCheck and Cotiviti Healthcare for front-end automation of correct-coding and medical-policy decisions specific to Medicaid and Medicare and for supporting the detection of coding irregularities, conflicts, or errors while making recommendations for correction. Our claim system and editing vendors perform edits for enrollee data (e.g., age, gender), provider data, current coding protocol, assistant surgeon, place of service, type of bill, medical visit logic, medical unlikelihood, durable medical equipment, new-visit frequency, and professional, technical, and global services.

**Data Analytics and Predictive Modeling**

The SIU profiles providers by peer group, specialty, product, and geography, among other relevant groupings. We use business intelligence software to identify providers whose billing, treatment, or patient demographic profiles differ significantly from those of their peers. Our SIU's internal analytics staff runs case- and scheme-specific reports using structured query language, Statistical Analysis System software, and Crystal reporting technology to support current investigations and identify new cases. The SIU performs an annual review of the plan to identify high-dollar specialties, providers, and procedures codes. This can suggest to our SIU investigators which specialties to review for outlier behavior.

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In addition, on a quarterly basis, the SIU runs a minimum of 18 outlier reports of known fraudulent schemes based on specialty and on Current Procedural Terminology (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. Therefore, we run quarterly outlier reports to identify the top 40 providers billing 10 or more paid claims for adult day care services, the top 40 paid providers of durable medical equipment, and the top paid providers of physical therapy evaluations. The reports are referred to SIU investigators for further review and appropriate action. At data mining meetings, SIU staff members, the medical director, clinicians, and certified coders discuss and prioritize data mining studies to better analyze trends and schemes identified through various sources.

Our data analytics system provides efficient and proactive discovery of new fraudulent schemes, allowing for near real-time prepayment review capabilities to flag suspicious claims prior to adjudication. This saves money by eliminating the need for pay-and-chase methods of recovery and allowing a comprehensive approach to addressing both enrollee and provider fraud by leveraging all available data sources to detect emerging fraudulent patterns.

#### **Identification of Third-party Liability Resources**

Early identification and reporting of third-party liability (TPL) resources is a key component of Aetna's cost-avoidance strategy so that Medicaid is the payer of last resort. Aetna directs third-party information to our Third-Party Liability and Coordination of Benefits (COB) departments under our affiliate and subcontractor Aetna Medicaid Administrators, LLC. Our TPL/COB analysts are guided by written policies and procedures that maximize use of other available sources of payment and recovery.

Effective use of other available sources of payment requires collaboration across multiple departments within Aetna. In addition to the COB and TPL departments, we involve Provider Services, Claims Inquiry/Claims Research, and Enrollee Services. This collaborative approach enables us to identify other available sources of payment and capture them in our business processing system to position Medicaid as the payer of last resort.

Aetna begins TPL/COB efforts at the earliest point possible and educates providers on their responsibility to identify other existing coverage to maximize TPL/COB identification and recovery opportunities. The early identification of possible TPL resources significantly increases our ability to research those resources effectively, process claims as payer of last resort, and pursue recovery of medical expenses paid. We appropriately deny claims for services rendered to an enrollee with documented other insurance and no explanation of benefits attached. The claim is returned to the provider with instructions to submit to the other insurance entity. Aetna stores data on cost-avoided claims in our data warehouse, from which we generate required TPL cost-avoidance reports.

#### **Targeted Audits**

Aetna performs targeted audits (e.g., contract, benefit, provider, diagnosis, procedure, specific service, and place of service) as needed to detect fraud, waste, and abuse. Claims with billed charges of \$50,000 or greater are subject to 100% pre-pay high-dollar audit review on a daily

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

basis. As of July 31, 2017, our pre-pay high-dollar review program in Florida has saved \$429,575. Each audit includes key departmental issues identified in addition to a summary of financial and procedural accuracy. Aetna finalizes, publishes, and distributes monthly and quarterly audit results to the business units. These reports include trends by error type, claim ID, and analyst ID. This data enables the Claim Operations department to conduct continuous quality improvement discussions. Based on audit findings, management staff provide and track additional training as needed.

### **Subcontractor Oversight**

We monitor all of our subcontractor partners for performance using compliance monitoring tools, audits, and performance reports. At a minimum, vendors are audited annually; we perform additional audits if an audit or assessment reveals a compliance issue. We perform reconciliation to verify that services billed were actually rendered to the enrollee, and we identify vendors that require heightened oversight or investigation. We meet with key delegates such as behavioral health and transportation providers to review claims, discuss program integrity, and compliance issues on a monthly basis. In addition, we meet with our dental providers on a regular basis and include fraud, waste, and abuse prevention and detection as part of those discussions.

### **Confirming Medicaid Program Eligibility**

We also have a process to check our enrollee and provider profiles against the Social Security Death Master File to identify proactively deceased enrollees and providers. This helps to prevent health care fraud by reducing the possibility that someone else could take advantage of a deceased enrollee's benefits. Aetna will notify the Agency upon learning of any change in an enrollee's status or circumstances that could affect the enrollee's eligibility for the program, such as changes in the enrollee's residence or notification that the enrollee's mail has been returned as undeliverable, a change in the enrollee's income, or the death of the enrollee.

On a monthly basis, we check providers against sources such as the National Practitioners Data Bank, Office of the Inspector General List of Excluded Individuals or Entities, and the System of Award Management. If a provider is found to be on one of these lists, Aetna's Compliance, Provider Services, and Enrollee Services departments work together to remove the provider and reassign the enrollee. We promptly notify the Agency when we receive information about a change in a provider's circumstances that may affect the provider's eligibility to participate in Florida's Medicaid program, including termination of the provider agreement with us.

### **Referrals**

Fraud, waste, and abuse are detected through a number of other activities and sources. The following are additional methods we use to identify instances of fraud, waste, and abuse proactively:

- Use of an internal application that enables our SIU staff to generate case-specific and scheme-specific reports directly from their desktops
- Acceptance of referrals of suspected fraud, waste, and abuse by enrollees, providers, and Aetna departments outside of the SIU

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- Receipt of case referrals from law enforcement and State regulatory agencies such as Florida's Office of the Inspector General and the Florida State Police
- Monitoring of national trends and specific case referrals through Aetna affiliations with national industry groups, including the NHCAA
- Offering a toll-free, 24-hour telephone hotline for reports of actual or suspected fraud, waste, and abuse
- Maintaining an email address for enrollees and providers to report fraud, waste, and abuse

#### **METHODS USED AT THE POINT OF SERVICE DELIVERY**

**CRITERION 2:** The extent to which the respondent uses biometric or other technology at the point of service delivery to prevent and detect potential or suspected fraud and abuse and overpayment

Aetna has adopted Fast IDentity Online (FIDO) authentication to improve the security of our online services for enrollees, and is in the midst of a multi-year rollout of the platform across Web-based and mobile applications. With this next-generation authentication platform, we are developing new industry best practices for improving health care access using a two-tiered approach. First, FIDO authentication uses biometrics rather than passwords to verify enrollees' online account credentials. Second, continuous, behavior-based authentication ensures that the authenticated user remains the same throughout the duration of the session. The platform analyzes multiple user attributes, such as how the user is holding the phone, to determine how much access to provide the user during a session.

This next-generation authentication platform improves enrollee and provider access to sensitive health care data while simultaneously increasing the security of that data and simplifying the authentication process for enrollees. It helps to block phishing and other data attacks that are often used to harvest traditional user credentials, decreasing the potential for data breaches and identity theft, as well as preventing enrollee fraud and abuse.

We use real-time electronic health record data to identify enrollees and confirm the accuracy of their contact information as part of our ongoing efforts to ensure that services are provided to the correct enrollee. This creates an opportunity to verify the enrollee's identity as well as engage our integrated care model to promote enrollee safety and quality health care. For example, we subscribe to the Florida Health Information Exchange's event notification service to receive timely notice when one of our enrollees has an encounter with a hospital. The service securely transmits information about the enrollee's visit, including demographic information, information about the facility, and the primary complaint. This helps us to better serve our enrollees by providing opportunities for care coordination and utilization management, as well as to verify service delivery.

Similarly, our prospective and concurrent drug utilization review (DUR) programs enable us to prevent and detect fraud, as well as help to prevent negative outcomes, improve quality of care, and reduce costs by preventing inappropriate or unsafe drug use at the point of sale. Our prospective and concurrent DUR processes are executed using computerized algorithms built into CVS Health's claim adjudication system, which performs key checks to identify conflicts based on the enrollee claim history. The system creates alerts and prevents dispensing without further review and/or action by the dispensing pharmacists.

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Soft block alerts provide messaging to the pharmacist to evaluate the enrollee's drug profile and offer considerations to the enrollee for discussion with their provider, counseling on appropriate drug use, and/or consultation with the provider concerning the appropriateness of the medication. These edits are built to allow the pharmacist the ability to override them if the medication is appropriate. Hard block alerts result in a rejection that would require the pharmacist to reach out to the prescribing provider to submit a request for prior authorization and/or to contact the pharmacy help desk for an override prior to dispensing the requested medication. These blocks allow us to certify appropriate utilization and safety, avoid duplication, and detect and prevent fraud, waste, and abuse.

Aetna is committed to working with the Agency to identify new and innovative methods of surveillance, identification, and prevention of fraud and abuse.

**USE OF CLINICAL REVIEWS AND SIU INVESTIGATIONS**

**CRITERION 3:** The extent to which the respondent conducts clinical reviews and SIU investigations to detect potential or suspected fraud and abuse and overpayment

Aetna is committed to helping our enrollees receive the services they need in an appropriate and timely manner, and conducting clinical reviews and SIU investigations to detect potential or suspected fraud, waste, and abuse, and overpayment helps us to verify that we are meeting that goal. Surveillance and utilization control programs and procedures help to safeguard against over- and under-utilization, as well as avoidable or inappropriate use of and excess payments for services. The SIU employs clinicians and medical coders who perform prepay reviews of medical records flagged by our system. If the prepay review findings indicate that the claim was not supported by the medical record, the claim will be denied. Clinical review is a critical part of identifying potential fraud and abuse, and a necessary step in determining if what appears to be an aberrant pattern of claims submissions could be a special accommodation for medically necessary care.

If a paid claim is flagged, SIU Senior Investigator [REDACTED] will request the relevant medical records and forward them to the medical director with his comments. If the medical director determines that the claim was improper, [REDACTED] will send a provider education letter in an effort to help change behaviors and attempt to recover the overpayment from the provider. Compliance Officer [REDACTED] will often use recent cases as a catalyst for discussion about current fraud, waste, and abuse issues during provider forums.

We receive case referrals from our hotline, our intranet reporting system, SIU data mining and analytics, and quarterly AHCA Medicaid Program Integrity meetings. At one such meeting, AHCA alerted us that the State had discovered through its data mining process that CPT code 92015 was being billed by primary care practitioners. This code is normally billed for ophthalmology services, so its use in a primary care practice is likely erroneous or improper. The SIU ran a data mining report for use of the CPT code and found that one of our pediatricians was billing code 92015.

[REDACTED] opened an investigation and visited the pediatrician's office to perform a verification of service. The provider explained that he and his staff used a WelchAllyn SureSight device to conduct vision screenings for pediatric patients. [REDACTED] called the device's manufacturer to

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

find out more about the proper use of the device, such as who should operate it, how often it should be calibrated, and which CPT code the manufacturer identified as appropriate. He pulled the relevant medical records and forwarded them to the medical director for a determination of whether the use of code 92015 constituted misrepresentation of the pediatrician's service, or there was a question of medical necessity.

The investigation showed that our provider's use of code 92015 was improper. The reviewer found that CPT code 92015 is billable only by ophthalmologists and optometrists because it involves interpretation and treatment. A pediatric vision screening is part of a well-child visit, and it would be appropriate for the provider to bill code 99177 for the type of vision screenings he was performing. We recovered the overpayment and used the incident as an educational opportunity to prevent similar coding errors in the future.

In addition, our pharmacy benefit manager, CVS Health, has a Medicaid Quality Assurance team that monitors claims and performs audits daily to detect fraud, waste, and abuse at the pharmacy, prescriber, and enrollee levels. Monitoring claims and performing trend analysis enables us to implement interventions such as pharmacy or prescriber lock-in programs to prevent misuse or overutilization of the pharmacy benefit, as well as to refer enrollees to care management for outreach and engagement to promote adherence to medication regimens in cases of suspected under-utilization. Our system also identifies practitioner prescribing patterns that are inconsistent with nationally recognized treatment protocols, prompting provider outreach and education efforts including corrective action plans.

Our pharmacy advisor support, safety and monitoring, and retrospective DUR programs help to prevent fraud, waste, abuse, and overpayment while keeping enrollees' safety and health care needs at the forefront. As part of our integrated care management model, our pharmacy advisor support program promotes adherence to prescribed drug therapies and addresses gaps in care for enrollees with chronic conditions. For example, our system alerts prescribers when there is an opportunity to improve care for enrollees with conditions that are best treated with combination therapy. Our safety and monitoring program reduces instances of fraud, waste, and abuse through regular claims monitoring and prescriber outreach. The retrospective DUR program involves a pharmacist review, within 72 hours, of retail and mail claims to identify potential safety issues such as serious drug interactions that were not addressed or identified at point of sale. If an issue is identified, the pharmacist will fax a patient profile and recommendations to the prescriber and will call the prescriber in serious cases.

Our rules-based claims adjudication system maintains and processes health care administration data, providing increased efficiency. The provider module contains the unique provider identification number generated by the system, plus all billing and tax reporting information. The claims module shows the date of receipt, the history of actions taken on each claim, and the date of payment, including the check number. The system accumulates claims by specific benefit limits and lifetime benefit rules. It scrubs and edits this data for accuracy during claims processing and payment. Aetna's Medicaid claim quality control independently assesses the effectiveness of the Medicaid claims system configuration and claim procedures against the resulting adjudication process.

We flag provider records whenever we require a closer review of billing for potential fraud and abuse using the prevention technique known as "provider watch," which places an alert on a provider's file. This alert directs workflow, routing, and review of provider billing with an elevated

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fraud risk. Provider flags trigger action during claims adjudication. Such action may vary from full auto-denial to a referral for pre-payment review. In instances of detected fraud, waste, and abuse, the compliance director initiates corrective actions, up to and including payment suspension, in instances of detected fraud, waste, and abuse. Payment is also suspended to any provider whenever we are instructed to do so by the State or other authorized agency.

#### **VERIFYING HOME-BASED VISITS AND SERVICES**

**CRITERION 4:** The extent to which the respondent uses innovative technology for the purposes of verifying home-based visits and services

We recognize the increased potential for instances of fraud, waste, and abuse among providers who supply home- and community-based services (HCBS). Therefore, we are contracting with Tellum to provide electronic visit verification (EVV) for verifying home-based visits and services. Using innovative mobile technology, the home health agency logs in on site. We are able to confirm the visit and services authorization with geolocation. By doing so, we help to ensure that the home-based services are being appropriately provided and that services billed were received by the correct enrollee.

In addition, our fiscal employer agent, PCG Public Partnerships, LLC, has a state-of-the-art information technology platform for supporting enrollee-directed care options with built-in fraud detection and prevention mechanisms. The system decreases the opportunities for fraudulent timesheet submission, such as forged signatures or false times. Participants and direct service workers log into the system's Web portal using their personal and separate username and password to submit and approve timesheets. The Web portal is integrated with the financial management system to ensure validation in real time. It checks for common timesheet errors and potential fraudulent submissions, such as conflicting timesheet submissions. For example, the direct service worker is only able to submit time with the authorized codes that are connected to the individual for whom they are working. Workers are not able to submit more time than approved on the authorization, and they cannot submit time for two separate enrollees at once.

The SIU runs and analyzes data mining reports to identify claims inappropriately submitted for caregiver services while our enrollees are in an inpatient facility. In such cases, our SIU investigator will request time sheets for the dates in question, hold discussions with the provider, and communicate with the enrollee. If we identify discrepancies, we educate him or her about how to verify accuracy of time sheets prior to signing and how to report the provider to the appropriate State authority. We also work with enrollees to reassure them that they will not be subject to any retaliation if they report an issue with a provider.

We mail Enrollee Verification of Services letters to verify the delivery of services consistent with the requirements of 42 CFR § 438.608(a)(5) to confirm whether enrollees have received services from the providers the letters identify. The letters ask the enrollee to call a toll-free hotline if the provider named on the notice did not provide services.

For example, in one of our plans, an enrollee's mother called the fraud hotline after receiving an Enrollee Verification of Services letter indicating that services had been rendered by a counselor for her minor son. The mother stated that the provider had not seen her son in over two years. A review of additional dates of service with the mother determined that there were 40 dates of

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

service for which the counselor billed but for which services were not rendered to her son. This information was reported to the SIU for further investigation. The SIU identified an overpayment of \$202,897. Both the counselor and her assistant were convicted of Medicaid fraud.

In addition to sending Enrollee Verification of Services letters to sample procedures for high-risk services, we use hands-on auditing techniques to help identify cases where billed HCBS services have not been performed. Each quarter, we audit a random sample of self-directed care attendant time cards supplied by our participating HCBS agencies. Our care managers perform the audit by comparing the services recorded on the timecard against the enrollee's service authorization. If discrepancies are identified, the care manager refers the case to our SIU investigator for investigation.

### **Evaluation Criteria:**

1. The extent to which the respondent uses various types of controls and automated approaches as part of a comprehensive approach to prevent and detect potential or suspected fraud and abuse and overpayment.
2. The extent to which the respondent uses biometric or other technology at the point of service delivery to prevent and detect potential or suspected fraud and abuse and overpayment.
3. The extent to which the respondent conducts clinical reviews and SIU investigations to detect potential or suspected fraud and abuse and overpayment.
4. The extent to which the respondent uses innovative technology for the purposes of verifying home-based visits and services.

**Score:** This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**SRC# 33 – Disaster Recovery Requirements (Statewide):**

The respondent shall demonstrate its capability and approach to meet the requirements described in **Attachment B**, Scope of Services, **Section X.D.4.h**.

**Response:**

National events such as Hurricane Irma serve as startling reminders of the disruption these events can cause, and the importance of disaster planning, preparedness, and providing business continuity and access to services during times of crisis. Aetna understands the importance of being fully prepared to respond to any emergency or disaster situation, particularly where hurricanes such as Irma are a significant threat, to ensure the safety of our enrollees, compliance with all contract requirements during a natural disaster, and the safety of our staff.

We are always willing and able to meet all Agency requests on a timely basis whether before, during or after the disaster. Because we have been in Florida for several years now, we are able to anticipate crises and emergencies by completing risk and business impact analysis. Our ultimate goal is to mitigate risks associated with any disruption or potential disruption of operations and to plan and implement the delivery of services at predefined levels following a disruptive incident. We have completed a business impact analysis to understand fully how those potential risks could affect our mission-critical business processes.

Our disaster recovery/business continuity processes and procedures were tested, and they have been extremely successful in responding to the most recent hurricane events. With recent hurricanes Harvey (August 26, 2017) that affected Texas and Louisiana, and Irma (September 9, 2017) that affected Florida, Georgia, Alabama, North Carolina, South Carolina, Virginia, Puerto Rico and the U.S. Virgin Islands, we have invoked our disaster recovery protocols to make it easier for all the people in these areas to access Aetna services and receive the care, medication, and support they need.

Hurricane Irma exposed a statewide vulnerability when the evacuation left some enrollees (who did not evacuate), particularly those enrolled in a long term care (LTC) program, at risk for losing access to evacuated caregivers. After identifying this potential concern, constant contact with our providers and these enrollees was established to close the gaps left by unavailable caregivers.

During Hurricane Irma, we opened our Resources for Living Services to those who were impacted (whether Aetna enrollees or not). We offered telephone consultations to cope with the emotional impact or assistance with finding resources such as shelters, government resources, and referrals. Teladoc, Aetna's telehealth provider, offered free general medical services to anyone impacted by Hurricane Irma through its hotline. We delivered emergency meal packages (14 shelf stable meals) to over 1,400 home enrollees as part of our existing expanded benefit that Aetna LTC provides to our enrollees.

Prior to the hurricane, we reached out to all enrollees to ensure they were following their emergency plan or had alternate evacuation plans. We began with all special needs enrollees, then home and facility enrollees. Post hurricane, we connected with every single enrollee to see

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### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

if any needed assistance. We compiled a pre- and post-contact script, documented the same in our system, and reported this information to AHCA daily. When we could not reach enrollees post-hurricane by telephone, we visited them to ensure they were safe and had supplies and water, etc. If they could not return home, we assisted with finding alternate temporary housing.

Our enrollees were able to refill prescriptions early, as needed. Enrollees who used Aetna's mail-order pharmacy could either get a prescription at an alternate delivery location or refill a prescription that may have been lost, damaged, or destroyed. Aetna also expanded claim and appeal filing times in areas affected by Hurricane Irma. We monitored the impact Hurricane Irma had on our network doctors, hospitals, and other health care providers. Further modifications to our policies are always made as necessary to help ensure enrollees have access to care. For instance, during Hurricane Irma, as planned in the business continuity plan (BCP) and in compliance with the state of emergency declared by the Governor, we modified how the drug utilization review edits appeared to dispensing pharmacies so that adjudication of claims would not be impeded and enrollees would be able to access their refill immediately. Instead of requiring intervention by the pharmacy helpdesk, we changed these edits to alerts to the dispensing pharmacist, which empowered the pharmacist to utilize their expertise to work with enrollees if there were any drug safety concerns and proceed with filling the prescriptions, if appropriate.

A special handling process was implemented for claims to be quickly identified and handled. We waived the waiting period for stop-payment procedures and reissuance of benefits. Leniency was exercised with regard to providing notice of loss, proof of loss, medical record due dates, and appeal deadlines. Short-term disability payments were made through direct deposit. The Aetna Foundation announced its initial donation would be a \$100,000 contribution to the American Red Cross. Through Aetna's Disaster Response Matching Gift program, the Aetna Foundation is also matching employees' disaster relief donations dollar-for-dollar (up to \$5,000 per donor per year) to any U.S.-based nonprofit providing hurricane-related disaster relief.

#### **General Strategies and Plans**

We maintain incident management, business continuity, and disaster recovery plans that leverage the planning, knowledge, and skillset of the National Aetna Disaster Recovery teams as well as the Florida team. In addition, we support the entire Aetna organization to help ensure our access to mission-critical systems, business processes, and communications. Our plans and risks mitigation strategies are designed to make certain of the safety of our staff and enrollees and, most importantly, minimize interruption in care and service.

We incorporate mission-critical business procedures, along with assumptions, risk mitigation strategies, and recovery process steps into our processes, which are then disseminated to all relevant staff, enrollees, and providers, including enrollees' legal guardians for coordination of services during and after any disasters to avoid and minimize any care interruptions. We have an established communication plan to validate coordination of services with our subcontractors, vendors, and providers to minimize care interruption. Aetna prepares business continuity and disaster recovery strategies for natural hazards (i.e., severe weather, hurricanes, tornadoes, floods, storms, earthquakes, extreme temperatures, wildfires, and pandemics); man-made hazards (i.e., malware, bomb threats, civil unrest, infrastructure failures, explosions, fires, hazardous materials, chemical spills, criminal acts, acts of terrorism, and workplace violence); proximity hazards (i.e., airports, highways, railroads, flood plains, and nuclear sites); and

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technology issues (i.e., application outage, network disruption, telephone disruption, hardware failure, cyber-attack on critical infrastructure and critical service providers such as AT&T, and utility disruption).

Aetna works closely with all applicable government-funded entities, the Department of Elder Affairs, and AHCA, in the event of an emergency or disaster to make certain that enrollees continue to receive their services before, during, and after the event to the greatest extent possible. Through our disaster recovery measures for Florida, our key objective is to maintain customer service support communication with our enrollees and providers via phone lines and our online portals. During and following a disaster, our messaging assures providers and subcontractors that necessary care and treatment is authorized.

Aetna is proactively meeting the Centers for Medicare and Medicaid Services' new rule (42 CFR Parts 403, 416, 418, etc.) to help build resiliency by becoming the first health plan to join the Tampa Bay Health and Medical Preparedness Coalition, which encompasses nine counties in Florida Region 4. This validates that our organization and our staff prepare for and quickly respond to disasters of any kind, and that we serve our enrollees and providers even in the most difficult situations. The coalition brings together community-based organizations to collaborate and build capabilities to respond to disasters and meet the emergency preparedness needs of more than 2,000 health care organizations, first responders, and 75,000 healthcare workers. It focuses on risk assessment and planning, policies and procedures, communication planning, and training and testing. Several members of our team will represent Aetna in working with the following network collaborators to help ensure the health and safety of the Tampa Bay community along with our enrollees:

- Ambulatory care organizations
- Ancillary services
- Behavioral health providers
- First responders
- Hospitals
- In-home services
- Long-term care providers
- Pediatric care providers
- Public health authorities

Specifically, we work with: American Red Cross, Brandon Regional Hospital, Florida Department of Health in Hillsborough County, Florida Hospital – Carrollwood, Florida Hospital – Tampa, H. Lee Moffitt Cancer Center and Research Institute, Hillsborough County Director for Mass Casualty, Hillsborough County Fire Rescue – Office of Emergency Management, Hillsborough County Trauma Agency, Hillsborough County Medical Reserve Corps, James A. Haley Veteran's Administration Hospital, Kindred Hospital Bay Area – Tampa, Kindred Hospital Central Tampa, Memorial Hospital, NuVista Living in Tampa, Shriner's Hospital for Children – Tampa, South Bay Hospital, South Florida Baptist Hospital, St Joseph's Hospital, St Joseph's Hospital North, St Joseph's Hospital South, Sun Coast Community Health Centers, Tampa Community Hospital, Tampa Fire Rescue, Tampa Fire Rescue Office of Emergency Management, and Tampa General Hospital.

Aetna intends to expand our participation in similar coalitions throughout the State of Florida. Please refer to Attachment SRC 33 for our business continuity and disaster recovery plan.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **CAPABILITIES AND GENERAL APPROACH**

Aetna uses a three-pronged, integrated business approach to continuity management that includes incident management for site and staff, business continuity management for essential business processes, and disaster recovery for systems application and data.

Our incident management strategy goes into effect as soon as a disaster occurs. We immediately seek shelter or evacuate the building and contact emergency responders and office security (e.g., fire department, police department, home office security). Leadership establishes a command center and accounts for the location, well-being, and safety of all our staff. Appropriate elements of the business continuity plans are activated; site security, damage assessments, and recovery processes are initiated. To verify that our plan works, we conduct and evaluate our performance in simulation drills for a shelter-in-place scenario and an evacuation emergency annually. We also perform annual tabletop exercises that simulate different types of disasters with all identified first responders within our plan to enhance our processes and procedures.

Our business continuity strategy includes over 75 plans to address mission-critical business workgroup operations. These plans focus on resiliency, preparation, business continuity, and quick activation of our disaster recovery response when a natural or manmade disaster occurs. They identify and document critical business processes/functions and associated maximum allowable downtimes, recovery time objectives, vital data, master files, manuals, forms and documents, information technology (hardware and software), voice and data connectivity requirements, critical third-party entities, and workspace requirements (special equipment needs). This strategy also includes multiple planning scenarios, such as total loss of a building, system failures, a widespread staffing shortage, loss of telework connectivity, and a loss of critical third-party services. For each scenario, we outline response strategies and procedures for both short-term and long-term business disruptions.

Our business continuity strategy for Florida accomplishes the following:

- Provides leadership and direction so that we can appropriately manage business disruptions or potential business disruptions, including a pandemic outbreak
- Assesses and identifies the risks and affects to critical business processes
- Establishes procedures to promptly recover required electronic and hard copy data
- Creates the infrastructure and actions required to enable critical business processes to continue with minimal impact to our customers
- Restores normal business operations once the disruptive event has been resolved

We place significant focus on enrollee and employee safety. In the event of a natural, man-made, or proximity hazard or technology issues, the executive management team is prepared to take necessary precautions to close and reopen the office in an organized fashion and execute our business continuity and disaster recovery plan to help ensure the continuity of enrollee care, where needed.

There are yearly tabletop exercises that simulate invoking the business continuity and disaster recovery plan (using different types of disasters), reviewing all steps of the plans, and identifying opportunities for improvement.

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### **Managed Medical Assistance (MMA) Enrollees**

Aetna takes proactive measures for our MMA enrollees by requesting providers to text affected enrollees to advise them that they can seek emergency care anywhere (as needed) with no authorization required. For example, Aetna proactively offers early prescription refills for our enrollees before an imminent hurricane; those who use Aetna's mail-order pharmacy can either get a prescription at an alternate delivery location or refill a prescription that may have been lost, damaged, or destroyed.

For Hurricane Irma, our preparedness steps included the following:

- We collaborated with critical vendors to help ensure enrollees received necessary, crucial services during the storm.
- Care managers reached out to all enrollees in care management to make sure that they had their emergency plans in place. Enrollees were educated about the need to fill their prescriptions, obtain food and water, and secure their homes. Special-needs enrollees were advised to evacuate to the shelters at which they were registered.
- As of Friday, September 8, 2017, our MMA transportation vendor, ATC, had cancelled all scheduled non-emergency transportation with the exception of dialysis and chemotherapy. Their care coordination team had identified enrollees going to dialysis and chemotherapy and worked with these enrollees quickly and as needed. They also worked with facilities to reschedule appointments.
- Our durable medical equipment (DME) vendor, Surfmed, reached out to all of our enrollees whom they serve and delivered equipment throughout the days leading up to the hurricane. They made sure that our enrollees on oxygen and vents to oxygen or ventilator dependent had adequate supplies.
- Our home health vendor, Caring Associates, contacted all Aetna enrollees whom they serve. All enrollees were with available trained caregivers and had been advised to go to the emergency department prior to the storm if necessary.
- Any home health enrollees who were in an evacuation zone were contacted by Caring, who took information regarding emergency relocation; that information was updated in Caring's system, so we could follow up after the hurricane. Caring also educated the enrollees to have at least two weeks of medication available as well as food and water.
- Our care managers continued to outreach those enrollees they could not reach up until the hurricane hit, focusing on late-term pregnancies and dialysis patients.

In addition to ensuring our own business continuity and disaster recovery plans are in place, we also ensure that our subcontractors also have robust plans as well. Our subcontractor's business continuity plans are reviewed as part of yearly audits, and they discussed in monthly or quarterly joint operations meetings. The ability of the health plan to coordinate with our partners during a disaster was tested recently during Hurricane Irma. We worked well together to maintain constant communication and to provide statuses and support for our enrollees before, during, and following the storm.

### **Long-Term Care (LTC) Enrollee Business Continuity and Disaster Recovery**

Aetna prepares for emergencies for LTC enrollees who are unable to perform activities of daily living by themselves. We are proactive in obtaining an initial health risk assessment by

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

gathering pre-disaster information from enrollees and updating it at least annually. This information includes the enrollee's emergency contact name, address, telephone number, and email address. Additionally, we identify special needs that require ongoing attention such as oxygen or the need for shelter, and we make note of the enrollee's preferences should such a situation become necessary in an emergency. All enrollees who qualify and agree are registered with the Special Needs Registry, and they are assessed for nutritional risk in case of disaster. For enrollees at significant nutritional risk, an emergency supply of shelf-stable meals is provided by Aetna so that enrollees have nutritional resources on hand in case of unplanned loss of power.

For Hurricane Irma, our preparedness steps included the following:

- As of Thursday, September 7, 2017, all regional care managers had completed their first round of enrollee calls and were continuing to call enrollees they had not been able to reach. Calls to enrollees started as early as Sunday, September 3. Our enrollees with special needs were moved out of evacuation areas. Shelf-stable emergency meals for 14 days had already been delivered to all LTC enrollees in July.
- Special needs enrollees that are ventilator dependent had been outreached by their care managers early in the week to help ensure that their emergency plans and/or evacuation plans were complete.
- Surfmed, our DME vendor, contacted all of our enrollees whom it serves and delivered services until the hurricane hit; this vendor also assured our enrollees on oxygen and vents had adequate supplies.

### **General Process for LTC**

Whenever a state of emergency is declared, our emergency program manager activates established emergency procedures. An employee emergency hotline is activated providing staff members with instructions. All department heads are mobilized to implement the emergency plans. Leadership informs all care managers of the emergency status, and the care managers contact their assigned enrollees to identify possible need for services, medical care, and/or evacuation. In accordance with the business continuity and disaster recovery plan, our clinicians and care managers are prepared to implement and execute the following:

- Communication with all at-risk enrollees on a priority basis before and following a disaster
- Plans for managing referrals, assessments, and coordination of services before and after a disaster for enrollees in need
- Plans for after-hours coverage of network services, as necessary
- Plans for assisting at-risk enrollees to register with the Special Needs Registry within their local area
- Plans for coordinating meal delivery to enrollees before and after the disaster
- Plans for assigning staff to emergency operation centers and/or declared assistance centers to make sure that elderly and/or at-risk victims in the disaster area receive assistance

All care managers and management staff remain on call during and after an emergency until the emergency status has been lifted, as specified in our business continuity and disaster recovery plan and by the emergency program manager. After the status is lifted, the care managers

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

attempt to contact all enrollees by telephone to determine their status and the need for rescue services. The care managers then contact all service providers to determine what issues or gaps may have been created by the emergency. The Care Management team, in conjunction with the Provider Services team, collaborates to match available services to enrollees with the most urgent need, defined as having the greatest difficulty with activities of daily living and instrumental activities of daily living. Leadership determines when employees can resume services and operations as usual. The health plan maintains communication with our vendors following the disaster to monitor status until the vendor's service is fully restored and operational.

For our disaster recovery strategy, we maintain and implement a detailed disaster backup and recovery plan to operate and manage information technology and data management system disruptions. Our disaster backup and recovery plan originates from more than 100 detailed IT infrastructure plans maintained by each critical support area. These plans contain processes and procedures to recover all functions, services, and equipment needed to recover the data center. The plans are centrally maintained by our Disaster Recovery Planning Services team, are stored at each data center and offsite, and are updated semi-annually or as needed by the respective infrastructure area. These plans:

- Document technical and management contacts, application recovery specifics, application dependencies, integrated system synchronization, and checkout procedures; plans are maintained routinely and use automated recovery processes to verify appropriate data resilience. Application owners and business users, using periodic integrated tabletop simulations, validate our disaster recovery plans annually.
- Identify escalation and notification procedures that help verify and notify recovery team enrollees, affected partners, and business unit owners
- Identify crisis communications to address various business continuity and disaster recovery events

In addition, per the Invitation to Negotiate, our in- and outbound mail gateways are configured to send and receive emails to and from the Agency only over an encrypted connection (currently TLS).

### **DISASTER RECOVERY PLAN**

**CRITERION 1:** The adequacy of the respondent's proposed approach and capability to develop and maintain a disaster recovery plan for restoring the application of software and current master files and for hardware backup in the event the production systems are disabled or destroyed

Aetna employs a comprehensive risk-based business continuity and disaster recovery plan that includes contingency planning for a variety of potential incidents that could occur in Florida. When developing our business continuity and disaster recovery strategies, we applied experience gained in Florida from our Florida plan. We also studied how others responded to varied types of crisis in Florida in addition to drawing from the experience of our affiliates. Emergency and disaster situations reaffirm our commitment to the public health system. Our ability to maintain systems and connect to people in need contributes to the public good in Florida and across all the states we serve. Our plan:

## **EXHIBIT A-4-a**

### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Specifies that our core platform applications utilize mirroring and redundancy between load-balanced data centers to avoid service interruptions that exceed AHCA's 24-hour requirement
- Specifies how to restore the application of software, current master files, and hardware backups in the event the production systems are disabled or destroyed
- Specifies onsite dedicated business continuity and disaster recovery resources accountable for the success of the plan
- Specifies the staff responsible for oversight and administration
- Specifies applicable situations and emergencies and the extent to which strategies vary for each situation
- Identifies the resources needed based on the type and duration of event
- Identifies and documents critical business processes/functions and associated maximum allowable downtime/recovery time and priorities
- Identifies escalation and notification procedures that help verify and notify recovery team enrollees, affected partners, and business unit owners
- Identifies crisis communications to address various business continuity and disaster recovery events
- Indicates the order in which essential parties are notified of the situation/ emergency and timeframes for notification
- Describes how enrollees and providers are notified and how they access information and services

Beyond these minimum requirements, our business continuity and disaster recovery plan addresses central computer installation and resident software if destroyed or damaged; system interruption or failure resulting from the network, operating hardware, software, or current master files; operational errors that compromise or do not compromise the integrity of transactions or data maintained in a live or archival system but do prevent access to the system (i.e., cause unscheduled system unavailability); or malicious acts including malware or manipulation.

The business continuity and disaster recovery plan also includes multiple planning scenarios, such as total loss of a building, system failures, a widespread staffing shortage, loss of telework connectivity, and a loss of critical third-party services. For each scenario, we outline response strategies and procedures for both short- and long-term business disruptions. We develop and document our business continuity and disaster recovery plan for each business area's critical processes based on availability requirements, impact, and operational complexity.

Aetna uses specific scenarios to focus our planning efforts as well as to provide consistent testing and training. These scenarios include loss of facility, technology, suppliers, staff, or telework capabilities. Expected outcomes include improved resiliency, increased capability to deliver service during a disruption that negatively affects operations, and a defined framework to follow.

Because the severity of a disaster is significant in determining the impact, monitoring plays a critical role in business continuity. Awareness of a situation that threatens sites, staff members, plan enrollees, critical suppliers, or technology enables us to make decisions and reallocate resources. For example, we use security guards to reduce exposure to criminal acts and workplace violence and triple-redundant phone servers to reduce the probability of an outage. Additionally, we establish relationships with non-governmental organizations before a disaster.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Aetna is committed to providing actionable contingency plans that minimize the need to improvise. We design our business continuity and disaster recovery plan to enable rapid user implementation. The plan considers potential risks, identifies assumptions used in creating recovery strategies, and includes detailed recovery steps along with key contact information.

Our business continuity and disaster recovery plan:

- Creates the infrastructure and actions required to enable critical business processes to continue with minimal impact to plan enrollees
- Creates an organized and effective approach for business resumption after an event that interrupts normal business processes
- Minimizes the impact of a business interruption
- Recovers critical processes and activities within specified timelines
- Provides leadership and direction so we can manage business disruptions or potential disruptions
- Identifies and assesses the risks and effects to critical business processes
- Establishes procedures to promptly recover required electronic and hard-copy data
- Maintains alternate means of operation for extended periods of time
- Restores normal business operations once the disruptive event is resolved

Aetna's Customer Service Organization (CSO) is fully engaged with the business continuity and disaster recovery plan. In the event of an uneven distribution of call volume coming into the call center, calls can be readily re-allocated to other call centers. Aetna has nine major CSOs dispersed around the country. The CSOs are capable of supporting each other's customer calls in the event of a failure. Telephone traffic can be rerouted to any of these facilities to provide service while repairs are underway. This type of back-up service helps ensure enrollee access to Aetna at all times.

Aetna's state-of-the-art call centers make sure that enrollees always have access to an Enrollee Services representative even in the event of a disaster at one site. Should any one of our call centers experience an emergency, Aetna routes inbound calls to an alternative site. The routing of calls to an alternative site is one part of our formal business continuity plan. This plan includes the following:

- Ensuring call center staff in other offices around the country have Florida-specific training and access to our systems, workflows, policies, and procedures to validate their ability to effectively handle our calls
- Formal management communication among site leadership to ensure for appropriate staffing and site management
- Daily debriefing sessions to ensure all operational areas are kept current on status

### **LIMITS TO SERVICE INTERRUPTION AND COMPLIANCE WITH REQUIREMENTS**

**CRITERION 2:** The adequacy of the respondent's proposed approach and capability to ensure the disaster recovery plan limits service interruption to a period of twenty-four (24) hours and ensures compliance with all requirements under the resulting Contract

**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

Aetna has a long-standing history of caring for our enrollees in disaster situations. We understand the importance of being fully prepared to respond to any emergency or disaster situation, especially in Florida where hurricanes are a significant threat, to ensure the safety of our enrollees, compliance with all contract requirements during a natural disaster, and the safety of our staff. We are always willing and able to meet all Agency requests on a timely basis whether before, during or after the disaster. Because we have been in Florida for several years now, we are able to anticipate crises and emergencies by completing risk and business impact analysis. Our ultimate goal is to mitigate risks associated with any disruption or potential disruption of operations and to plan and implement the delivery of services at predefined levels following a disruptive incident. We have completed a business impact analysis to understand fully how those potential risks could affect our mission-critical business processes.

At the heart of our information systems are our rules-based eligibility, enrollment, and claims processing system and our Web-based care management application. Our system supports claims adjudication, provider contract configuration, electronic data interchange processes, quality management, utilization management, prior authorization, and concurrent review. Our Web-based care management application is our care management business system. To ensure minimal impact to enrollees and providers, these systems allow remote and offsite access (providing full system functions if another site is incapacitated).

Our telecommunications infrastructure consists of triple-redundant servers that enable us to connect phone calls if two of the three servers fail. [REDACTED]

To help respond to the growing threat of complex cyber-attacks, Aetna has a robust security event logging and monitoring solution to identify risks on Aetna IT systems and mitigate network-borne attacks against Aetna Web applications and IT systems. This solution makes sure that attacks are prevented where possible and monitored in real time to help ensure rapid response and resolution if an attack does occur. The solution includes:

- Database access security monitoring leveraging Guardium (an industry leading database security audit solution), including real-time database vulnerability detection, security monitoring and alerting; for example, provides privileged access and additions of database accounts with elevated privileges. All actions taken by users with elevated privileges are logged and tracked.
- Database, Web, and application server security monitoring includes alerting and security logging of all key user, system, and enterprise security management system activity into a centralized Security Information and Event Management (SIEMs) with 24/7 monitoring by both Aetna's security operations center and several third-party security operations centers.
- Host intrusion detection and prevention (HID/PS) is provided by industry leading CrowdStrike Falcon Host and supporting security operations monitoring services.
- Network intrusion detection and prevention (NID/PS) solutions include redundant signature and event-based NIDS, network packet security analytics and forensics, network traffic behavioral analysis, and monitoring.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Near real-time security threat, intelligence data integration to all supporting security management and monitoring solutions
- F5 BIG-IP Application Security Manager (ASM) and f5 WebSafe provide resilience for Aetna applications against Web attacks, including automated application Layer-7 activity, mitigation of remote access Trojan risks, and filtering for common Web attacks that could affect the confidentiality, integrity, or availability of an Aetna applications and/or data.

All facilities are equipped with fire suppression systems, dual incoming power feeds, uninterruptible power supplies (UPS) and backup diesel generators that provide 24/7/365 operations. Physical access is strictly controlled and monitored and access to vital areas is segregated by floor and business function where appropriate. The data centers house computer processing capabilities of major platforms including mainframe (Z/OS), mid-range, Unix, Linux, Citrix, and Windows.

The data centers are load-balanced and supplemented by quick ship in the event of a disaster. We exceed the requirement of limiting service interruption to a period of 24 hours because we do not experience service interruptions due to the mirroring and redundancy of our data centers. Due to the mirroring and redundancy of our data centers, we have the capability of receiving, processing, and disseminating data and reports immediately after a critical disaster. Mirroring of data between the data centers occurs in real-time, and no more than one minute of data would be lost in the event of a loss of a data center.

Service Interruptions: If service interruptions prevent staff from reaching their primary work location to carry out essential functions, we expand existing telework arrangements to enable them to do so. All Aetna workstations are equipped with applications that enable remote connectivity using a secured virtual private network. In the event of a disaster, employees can take their workstations home, connect to a high-speed Internet network, and connect securely to our network.

Our Florida office has a voice data closet that consists of telecommunications switches and multiple file servers with UPS to support office-based staff members. Employees who work from home are supported by equipment housed in one of the two Aetna data centers in Connecticut. In a worst-case scenario, we use the next available Aetna location as an alternate operating site. In such instances, we send non-essential staff from both our primary location and from the alternate operating location to work from home, and we use the network infrastructure and repurposed hardware to restore mission-critical business functions. We train staff members in Health Insurance Portability and Accountability Act privacy regulations to protect health information and confidentiality, regardless of their work locations. Most staff members already have the ability to work from home. This capability mitigates the risk of having all employees working onsite. If remote employees are unable to work from home, site leadership prioritizes those resources permitted to come into the office.

The following examples of disasters/events indicate our resilience. In each instance, we employed a seamless transition and experienced no interruption to services:

- During Hurricane Matthew (October 7, 2016) and Hurricane Sandy (October 25, 2012), (unplanned events, but ones for which we had warning), heavy rain, and power outages affected some of our employees, providers, and enrollees. The following emergency

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

processes were activated: an employee emergency hotline was deployed to provide the staff with instructions for evacuation; our chief executive officer prioritized those employees and identified workstations for them to use; department heads implemented emergency plans; care managers contacted their enrollees to identify evacuation needs; and services were coordinated for transportation, meals, and assessments. Staff was assigned to emergency operation/assistance centers to help victims in the disaster areas. Our call center staff in other areas of the country, who are trained specifically for Florida and have access to our systems, workflows, policies, and procedures, were notified that we would be rerouting calls to them (as needed). The MMA and LTC business continuity plans were mobilized.

- We responded to both Hurricanes Irma and Hurricane Harvey. Throughout these disasters, Aetna took steps to help ensure the safety and well-being of our enrollees and provided resources and support to the community in areas of Texas and in all parishes in Louisiana affected by the hurricane. We made monetary contributions and matched employee contributions to assist with disaster relief. As part of our disaster procedures, we performed the same tasks in response to Hurricane Harvey as we did with Hurricane Irma in Florida.
  - Took proactive measures as soon as we heard about the imminent hurricane by offering early prescription refills for our Aetna enrollees; those who use Aetna's mail-order pharmacy could either get a prescription at an alternate delivery location or refill a prescription that may have been lost, damaged, or destroyed
  - Contacted roughly 1,000 Aetna associates to make sure they were safe
  - Helped enrollees who had been evacuated from their homes find care and behavioral health support and collaborated with other State agencies
  - Extended claim and appeal filing times
  - Enabled affected Aetna enrollees to seek emergency care anywhere, as needed
  - Leveraged outside vendors that were not affected by this event to handle enrollee and provider phone calls; important 1-800 numbers were communicated
  - Monitored the impact on our network doctors, hospitals, and other health care providers
  - Worked closely with providers to make further modifications to its policies as necessary to help ensure enrollees had access to care
  - Opened our Resources for Living services to the community regardless of whether they were Aetna enrollees or not
  - Affected individuals could call our toll-free line for telephonic consultation to help cope with the emotional impact of this event or for assistance with finding resources such as available shelters, government resources, and referrals

These are important examples of the services and resources currently offered in Florida that will continue to be offered Florida in the future.

During other key events that occurred during these disasters/events, we did all of the following:

- Implemented phone tree notifications and mass emails upon initial notification of event
- Moved all capable staff to work at home
- Obtained backup resources to augment work-at-home staff for critical functions (Enrollee Services, Prior Authorization)
- Worked with facilities to evaluate the extent of damage and to determine outage period
- Notified food/transportation vendors and coordinated with them

## **EXHIBIT A-4-a**

### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Made sure all directors/managers/executive team had hard copies of their business continuity and disaster recovery plan and advised them to keep it with them at all times
- Notified staff to take home Skype phones, laptops, and Jetpacks (portable 3G/4G mobile hotspots that allow 10 Wi-Fi devices to share its high-speed internet connection)
- Made sure enrollees and providers had plans and are prepared
- Upon notification of extended office closure, worked with facilities and IT coordinators to establish workstations at an alternate Aetna office
- Worked with IT to ensure appropriate access to all critical systems
- Distributed cash, food, water, drinks delivered to sites
- Bought tarps, cleaning supplies, toiletries, housing (hotels) to help providers and enrollees
- Monitored all information released by State and local agencies, contacted direct emergency contacts, identify needs (i.e., pharmacies and medical needs)
- Contracted providers helped provide services (i.e., food, transportation, durable medical equipment) to help enrollees
- Requested employees to help affected employees by opening up their homes for them to rest, cool off, shower, eat a hot meal, charge cell phones, etc.
- Contacted security and placed outage notification on AetNet (the Aetna internal intranet) and via MIR3 (our business continuity alert system)
- Maintained emergency employee notification via MIR3's color-coding system, which gave us the ability to identify affected areas and offices and to overlay current weather conditions (real time weather patterns) on the map for notifying employees through text messages, and we provide short-term housing assistance for all staff members. MIR3 is an intelligent Web-based notification system offering immediate and simultaneous one-to-many communications using wired and wireless communication devices (Short Message Service (SMS) devices, email, pagers). It provides automated and remote problem-solving capabilities to improve communication and send an alert to resolve any issue and/or convey a new status condition to the appropriate person(s). Aetna has used MIR3 for eight years providing IT, BCP, and security announcements and alerts. MIR3 is supported by seven data centers throughout the country to ensure flawless service, reliability, and no system down-time. During Hurricane Irma, we attempted 5,387 notifications with only 10 failures providing 99% contacted with 1,196 responding (22%) within one hour. We also sent MIR3 notifications to the relevant individuals for the Florida Business Continuity Plan, attempting 87 notifications with only one failure, providing 99% contacted and 53 responding (61%) within one hour. Another MIR3 notification sent to the Florida Business Continuity Plan for Quality Management attempted 10 notifications with no failures (100%) and 10 responding (100%) within one hour.

#### **DEVELOPMENT, MAINTENANCE, AND SUBMISSION OF THE PLAN FOR REVIEW**

**CRITERION 3:** The adequacy of the respondent's proposed approach and capability to ensure the records backup standards and a comprehensive disaster recovery plan are developed and maintained by the respondent for the entire period of the resulting Contract and submitted for review annually by the anniversary date of the resulting Contract

The business continuity and disaster recovery plan addresses recovery steps in a predetermined order, identifies Aetna and AHCA responsibilities for those steps, and designates recovery timeframes. We update the plan whenever there is a change (at a minimum annually)

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

and provide an update to AHCA. Aetna maintains the records backup standards and comprehensive disaster recovery plan throughout the contract at no additional charge to the Agency. We make the plan available for review by State or federal officials upon request, and we submit the business continuity and disaster recovery plan to AHCA for review and approval annually by the anniversary date of the contract, understanding that the Agency has the right to request revisions and the changes are due to AHCA within 10 business days after the change.

### **RESTORING DAY-TO-DAY OPERATIONS**

**CRITERION 4:** The adequacy of the respondent's proposed approach and capability to ensure it maintains a disaster recovery plan for restoring day-to-day operations including alternative locations for the vendor to conduct the requirements of the resulting Contract

Our business continuity strategy for Florida helps ensure daily restoration of normal business operations once the disruptive event has been resolved. This includes any alternative sites where we are conducting requirements of the contract. By testing our plans, we develop specific actions necessary to decrease the time to recover following a disaster. Different roles within our plans are responsible for restoring and recovering the business, as compared to accounting for employees and securing the building. Testing and exercising our plans and training our resources inside and outside of Florida on Florida-specific training allow us to identify and document better restoration and recovery processes. The goal of this continuous improvement process is to reduce the amount of time spent in recovery and restoration, which reduces the impacts to operations, staff, and enrollees.

For Hurricane Irma, we opened our Resources for Living Services to those who were impacted (whether Aetna enrollees or not). We offered telephone consultations to cope with the emotional impact or assistance with finding resources such as shelters, government resources, and referrals. Teladoc, Aetna's telehealth provider, offered free general medical services to anyone impacted by Hurricane Irma through its hotline. Our enrollees were able to refill prescriptions early, as needed. Enrollees who used Aetna's mail-order pharmacy could either get a prescription at an alternate delivery location or refill a prescription that may have been lost, damaged, or destroyed. Aetna also expanded claim and appeal filing times in areas affected by Hurricane Irma. We modified how the drug utilization review edits appeared to dispensing pharmacies so that adjudication of claims would not be impeded and enrollees would be able to access their refill immediately. Instead of requiring intervention by the pharmacy helpdesk, we changed these edits to alerts to the dispensing pharmacist, which empowered the pharmacist to utilize their expertise to work with the enrollee if there were any drug safety concerns and proceed with filling the prescriptions, if appropriate.

Aetna's Customer Service Organization (CSO) is fully engaged with the business continuity and disaster recovery plan. In the event of an uneven distribution of call volume coming into the call center, calls can be readily re-allocated to other call centers. Aetna has nine major CSOs dispersed around the country. The CSOs are capable of supporting each another's customer calls in the event of a failure. Telephone traffic can be rerouted to any of these facilities to provide service while repairs are underway. This type of back-up service helps ensure enrollee access to Aetna at all times.

Aetna's state-of-the-art call centers make sure that enrollees always have access to an Enrollee Services representative even in the event of a disaster at one site. Should any one of our call

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

centers experience an emergency, Aetna routes inbound calls to an alternative site. The routing of calls to an alternative site is one part of our formal business continuity plan. This plan includes the following:

- Ensuring call center staff in other offices around the country have Florida-specific training and access to our systems, workflows, policies, and procedures to validate their ability to effectively handle our calls
- Formal management communication among site leadership to ensure for appropriate staffing and site management
- Daily debriefing sessions to ensure all operational areas are kept current on status

In a worst-case scenario, we use the next available Aetna location as an alternate operating site. In such instances, we send non-essential staff from both our primary location and from the alternate operating location to work from home, and we use the network infrastructure and repurposed hardware to restore mission-critical business functions. We train staff members on HIPAA privacy regulations to protect health information and confidentiality, regardless of their work locations. Most staff members already have the ability to work from home. This capability mitigates the risk of having all employees working onsite. If remote employees are unable to work from home, site leadership prioritizes those resources permitted to come into the office.

### **DATABASE BACKUPS**

**CRITERION 5:** The adequacy of the respondent's proposed approach and capability to ensure it maintains database backups in a manner that eliminates disruption of service or loss of data due to system or program failures or destruction

Infrastructure and application production data is secured and stored offsite on a daily basis; therefore, a localized disaster would not wipe out both production and backups. Backed-up data are cross-vaulted between data centers and is stored primarily on disk media or is backed up to tape and stored in a secured environment. If needed, our backup system/site may act as the primary site as we establish a new secondary backup system/site in the case of a disaster. Data backup frequency is at minimum a full backup weekly, with nightly incremental backups or remote replication. Database administrators also back up each application database separately as an additional step in redundancy. Additionally, all mainframe disk and tape data is mirrored to the alternate data center providing a simplified and timelier recovery in that platform of the environment. Any customer data lost because of a data center catastrophe are recovered through resubmittals by service providers and/or recovery reconciliation teams.

### **FINALIZATION OF THE PLAN**

**CRITERION 6:** The adequacy of the respondent's proposed approach and capability to ensure the disaster recovery plan is finalized no later than thirty (30) calendar days prior to the resulting Contract effective date

The business continuity and disaster recovery plan is in place now. Directors are required to review and attest to the accuracy of business continuity and incident management plans on a quarterly basis. As requested herein, we will finalize our business continuity and disaster recovery plan no later than 30 days prior to the contract start date. If the plan has not changed

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

from the previous year, we submit a certification to the Agency that the prior year's plan is still in place May 1 of each contract year.

We will use the statewide lessons learned from Irma to improve upon our disaster recovery plan by:

- Engaging in more in-depth planning with our high-volume providers proactively to share resources and more effectively collaborate in emergency care coordination efforts pre and post emergencies
- Retaining additional off-site space in the event of facility closures
- Continuing to establish relationships with special needs shelters and local emergency management offices
- Developing a more organized emergency supply distribution for both enrollees and Aetna staff needs

### **AMENDING AND UPDATING THE DISASTER RECOVERY PLAN**

**CRITERION 7:** The adequacy of the respondent's proposed approach and capability to ensure it amends or updates its disaster recovery plan in accordance with the best interests of the Agency and at no additional cost to the Agency

Our business continuity and disaster recovery plan details the processes and timeframes for amendments and updates. New disaster types of varying magnitudes are identified every day, which requires constant monitoring and updating of the plan. When significant changes are made to the plan, we submit it to the Agency. At a minimum, we update the plan quarterly or within 30 days of substantial changes (i.e., hiring additional enrollee services call agents; within 30 days of go-live, they would be added to the plan) at no additional charge to AHCA. Annual testing of our plan, employing simulated disasters and lower-level failures, affords local business process owners and our site leadership the opportunity to demonstrate and validate system recovery capabilities for the Agency. Following each simulation, we also update our plan with any identified improvement opportunities. Every year, the Business Continuity and Disaster Recovery team participates in tabletop exercises that stimulate different types of disasters (e.g., fire, hurricanes, bomb threats, etc.) to identify any changes to incident management strategies, roles of team, temporary hotels or facilities for command centers; and we update findings in the business continuity and disaster recovery plan. Business continuity and incident management plans are living documents that are regularly reviewed, updated, and quarterly attestations to validate thoroughness and accuracy.

Through testing our business continuity and disaster recovery plan, we develop improved contingency planning. When tests reveal that resiliency and recovery planning are insufficient, we document better contingency planning. We test plans using basic scenarios— such as loss of site, technology, critical suppliers, or staff—to exercise the resiliency of our plans and the validity of our recovery planning. During the test, we change the scenario and add additional information and challenges, forcing participants to re-evaluate their assumptions, recovery tasks, and communication plans. The addition of an unexpected scenario during the testing of our emergency plans enabled us to improve our contingency plans and increases the expectation that we must remain flexible to demonstrate prompt and effective decision-making during crisis situations.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Aetna's role during a disaster is to lead, manage, and staff the various recovery teams, which is augmented by additional subcontractor specialists under contract for certain supplemental recovery technologies that we coordinate.

### **AVAILABILITY OF THE DISASTER RECOVERY PLAN TO THE AGENCY**

**CRITERION 8:** The adequacy of the respondent's proposed approach and capability to ensure it makes all aspects of the disaster recovery plan available to the Agency at all times

Our business continuity and disaster recovery plan meets all requirements for industry standards and best practices. Our plan is provided to the Agency each time it is significantly updated, annually, and available upon request.

### **ANNUAL DISASTER RECOVERY PLAN TEST AND RESULTS**

**CRITERION 9:** The adequacy of the respondent's proposed approach and capability to ensure it conducts an annual Disaster Recovery Plan test and submits the results for review to the Agency

We test our business continuity and disaster recovery plan no less than annually and at all levels through simulated disasters and lower-level failures per the standards outlined in the contract, and we submit the results to the Agency. If we fail to demonstrate success through the tests, we submit to AHCA a corrective action plan (delivered within 10 business days from the end of the test) that describes how the failure will be resolved. We produce After Action Reports, which we use to analyze our sequence of goal-oriented actions to an incident and will share them with AHCA upon request. Our comprehensive testing strategy includes the following:

- Change Management: Testing after system changes such as new product implementation and unit, system, integration, user acceptance testing, regression testing, and performance/load testing
- Testing Business Continuity and Disaster Recovery Plan: Onsite simulations with all staff, onsite tabletop reviews of multiple scenarios with key staff, building evacuation simulations and fire drills, and business continuity and disaster recovery exercises
- Testing for Software Applications: For change management, testing is part of the software development life cycle throughout the course implementation; we also complete testing on an as-needed basis during ongoing operations and production support after system implementation is complete.

To avoid a conflict of interest, Aetna does not test its own business continuity and disaster recovery plan. Instead, we use a third party, Archer EGRC, to test the validity of the plans created by Aetna and the applications, data, and infrastructure used. Archer EGRC provides unbiased assessments and feedback data that helps improve the content and effectiveness of our disaster recovery plan.

Our onsite business continuity and disaster recovery resources deliver exercises, conduct testing, and helps to ensure that maintenance is completed to meet all requirements. Each mission-critical business process conducts an annual tabletop exercise or simulation to validate plan content and strategies. Team contacts are updated quarterly. Our plan review confirms that

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

all major plan components remain current. Our plans are tested during simulation exercises. A minimum of three tests are performed annually in each office.

Testing is performed across a variety of applications and infrastructure components regularly to verify ongoing disaster recovery readiness. We routinely test recovery elements of technology components, critical processes, and access points.

### **Evaluation Criteria:**

1. The adequacy of the respondent's proposed approach and capability to develop and maintain a disaster recovery plan for restoring the application of software and current master files and for hardware backup in the event the production systems are disabled or destroyed.
2. The adequacy of the respondent's proposed approach and capability to ensure the disaster recovery plan limits service interruption to a period of twenty-four (24) hours and ensures compliance with all requirements under the resulting Contract.
3. The adequacy of the respondent's proposed approach and capability to ensure the records backup standards and a comprehensive disaster recovery plan are developed and maintained by the respondent for the entire period of the resulting Contract and submitted for review annually by the anniversary date of the resulting Contract.
4. The adequacy of the respondent's proposed approach and capability to ensure it maintains a disaster recovery plan for restoring day-to-day operations including alternative locations for the vendor to conduct the requirements of the resulting Contract.
5. The adequacy of the respondent's proposed approach and capability to ensure it maintains database backups in a manner that eliminates disruption of service or loss of data due to system or program failures or destruction.
6. The adequacy of the respondent's proposed approach and capability to ensure the disaster recovery plan is finalized no later than thirty (30) calendar days prior to the resulting Contract effective date.
7. The adequacy of the respondent's proposed approach and capability to ensure it amends or updates its disaster recovery plan in accordance with the best interests of the Agency and at no additional cost to the Agency.
8. The adequacy of the respondent's proposed approach and capability to ensure it makes all aspects of the disaster recovery plan available to the Agency at all times.
9. The adequacy of the respondent's proposed approach and capability to ensure it conducts an annual Disaster Recovery Plan test and submits the results for review to the Agency.

**Score:** This section is worth a maximum of 45 raw points with each of the above components being worth a maximum of 5 points each.

**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

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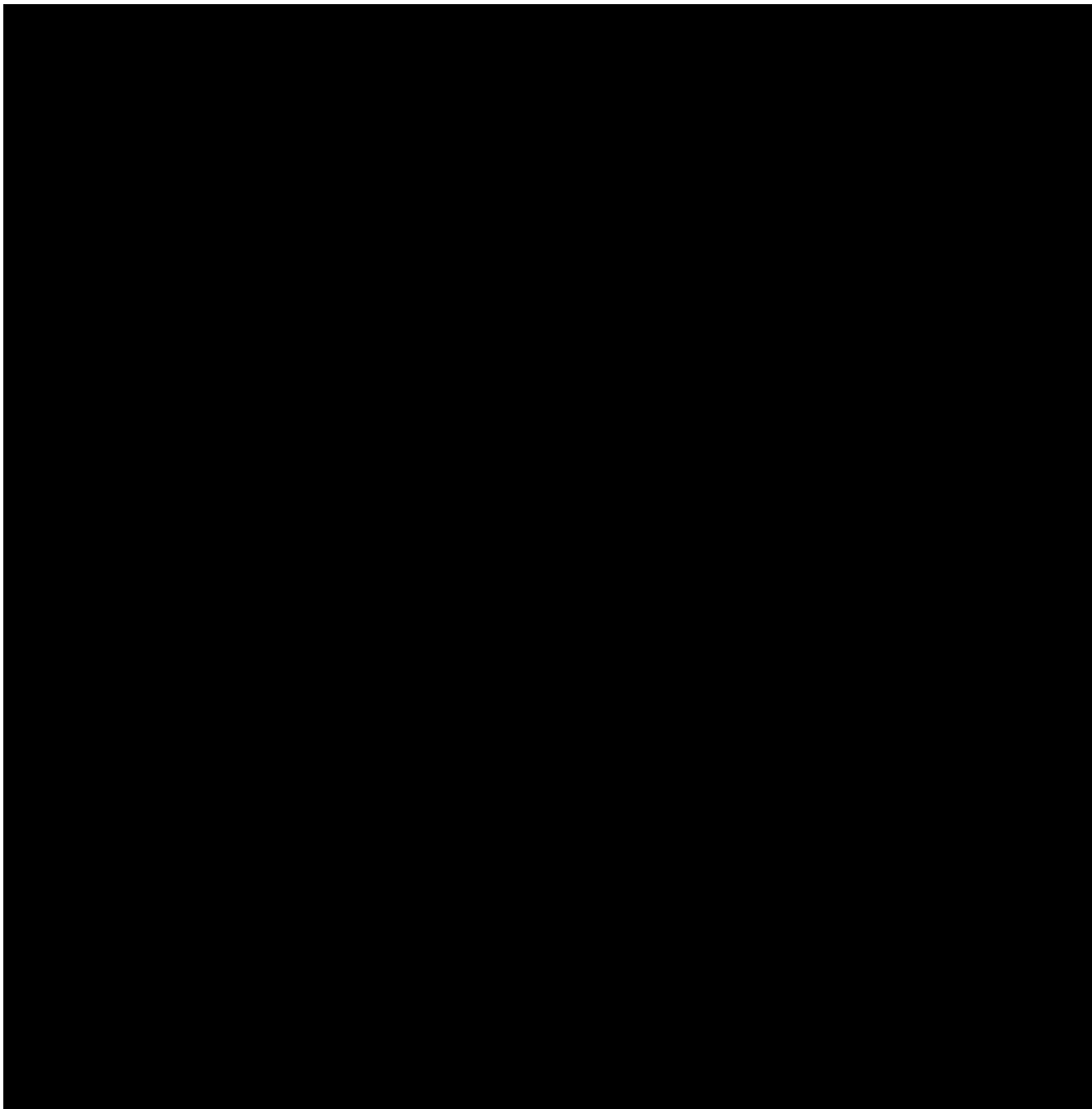
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AETNA BETTER HEALTH® OF FLORIDA

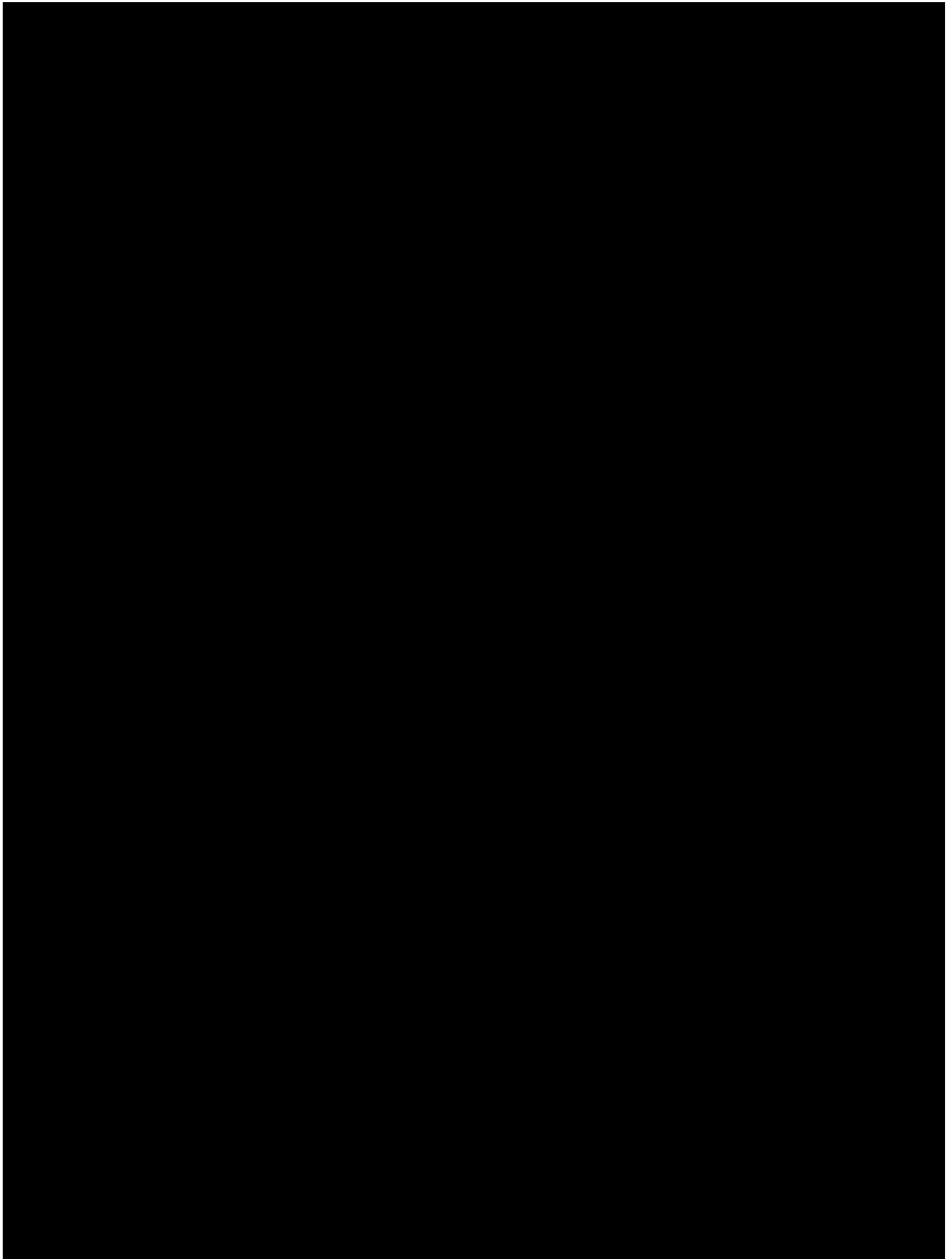
## **Attachment SRC# 33**



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AETNA BETTER HEALTH® OF FLORIDA

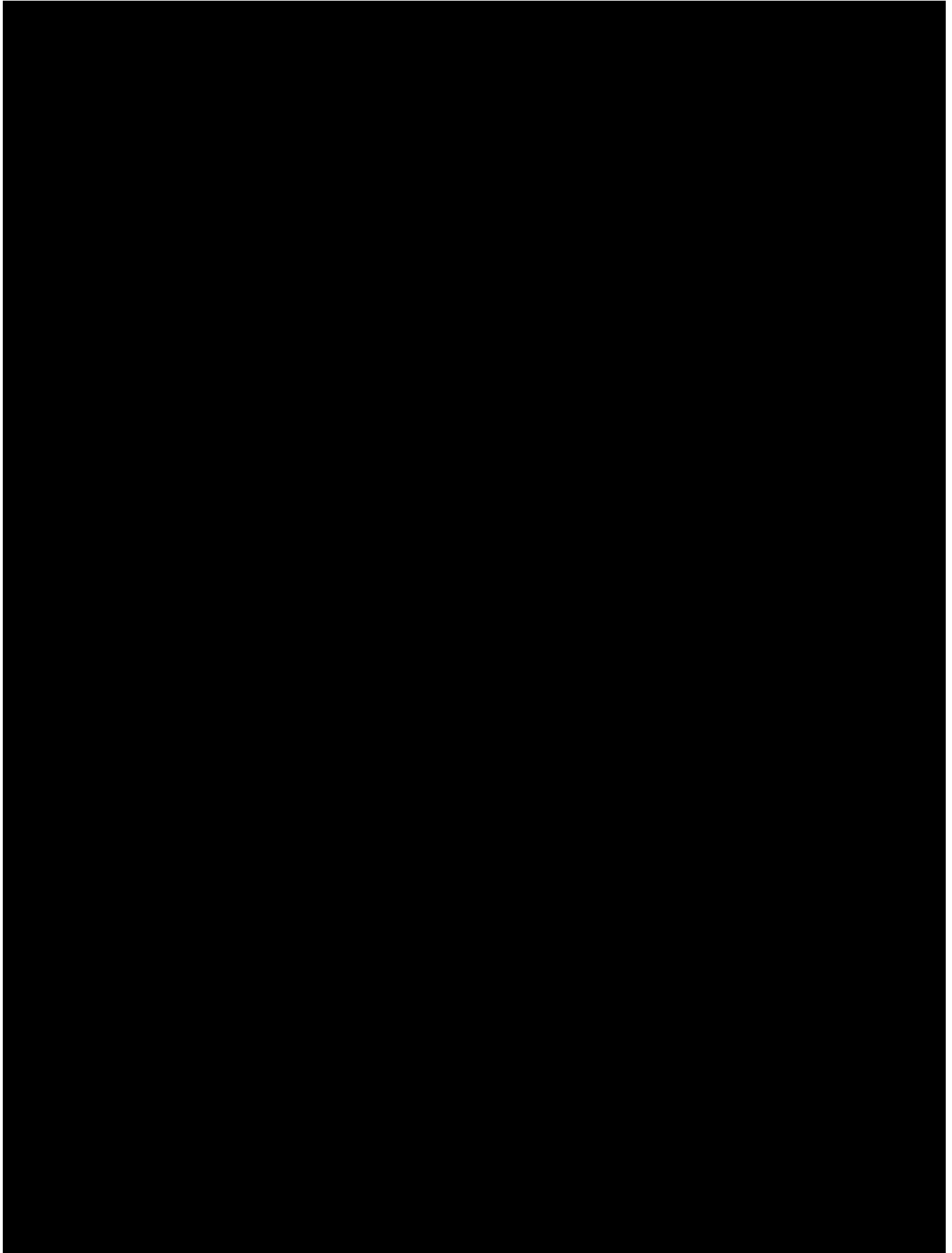
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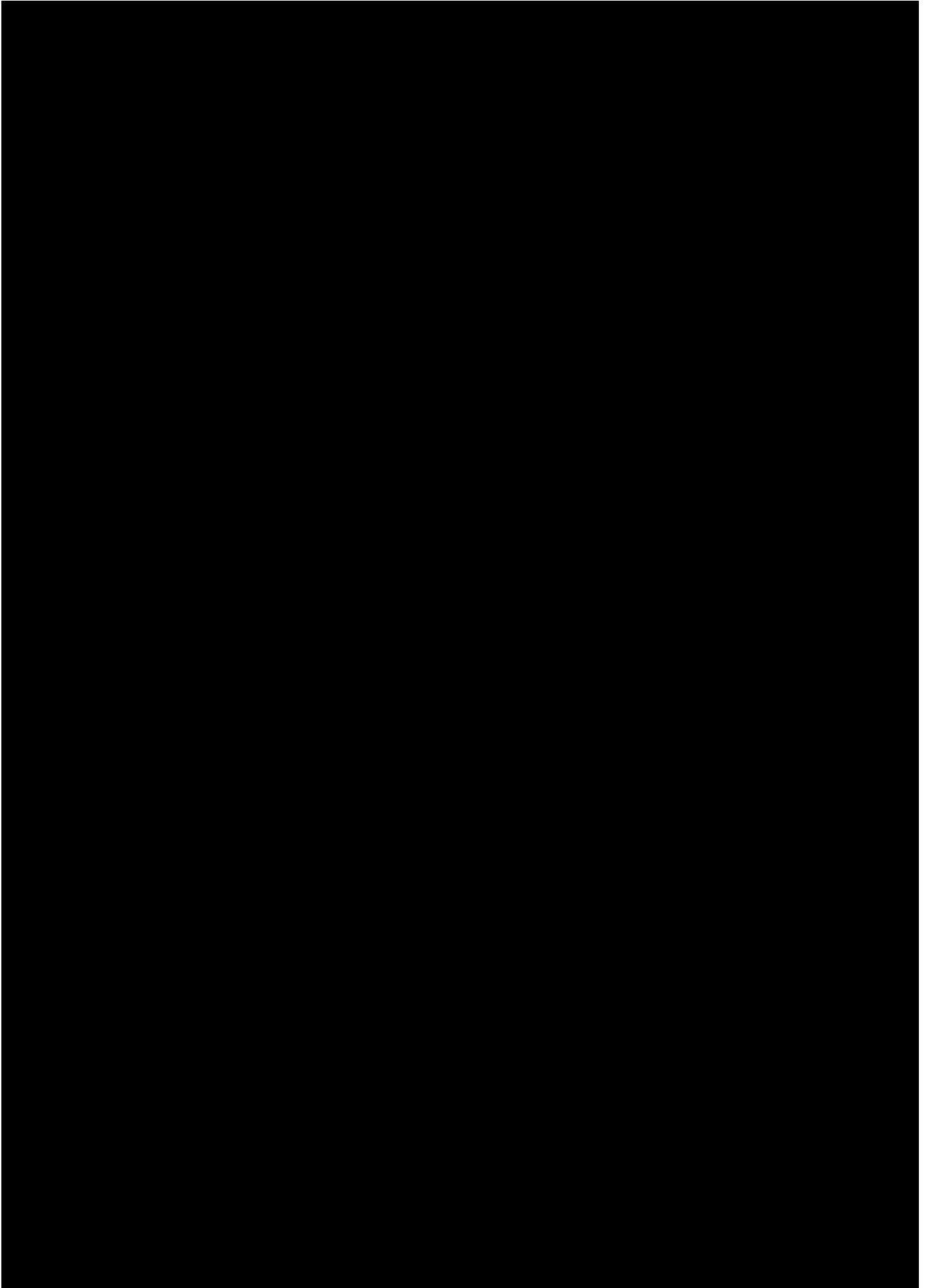


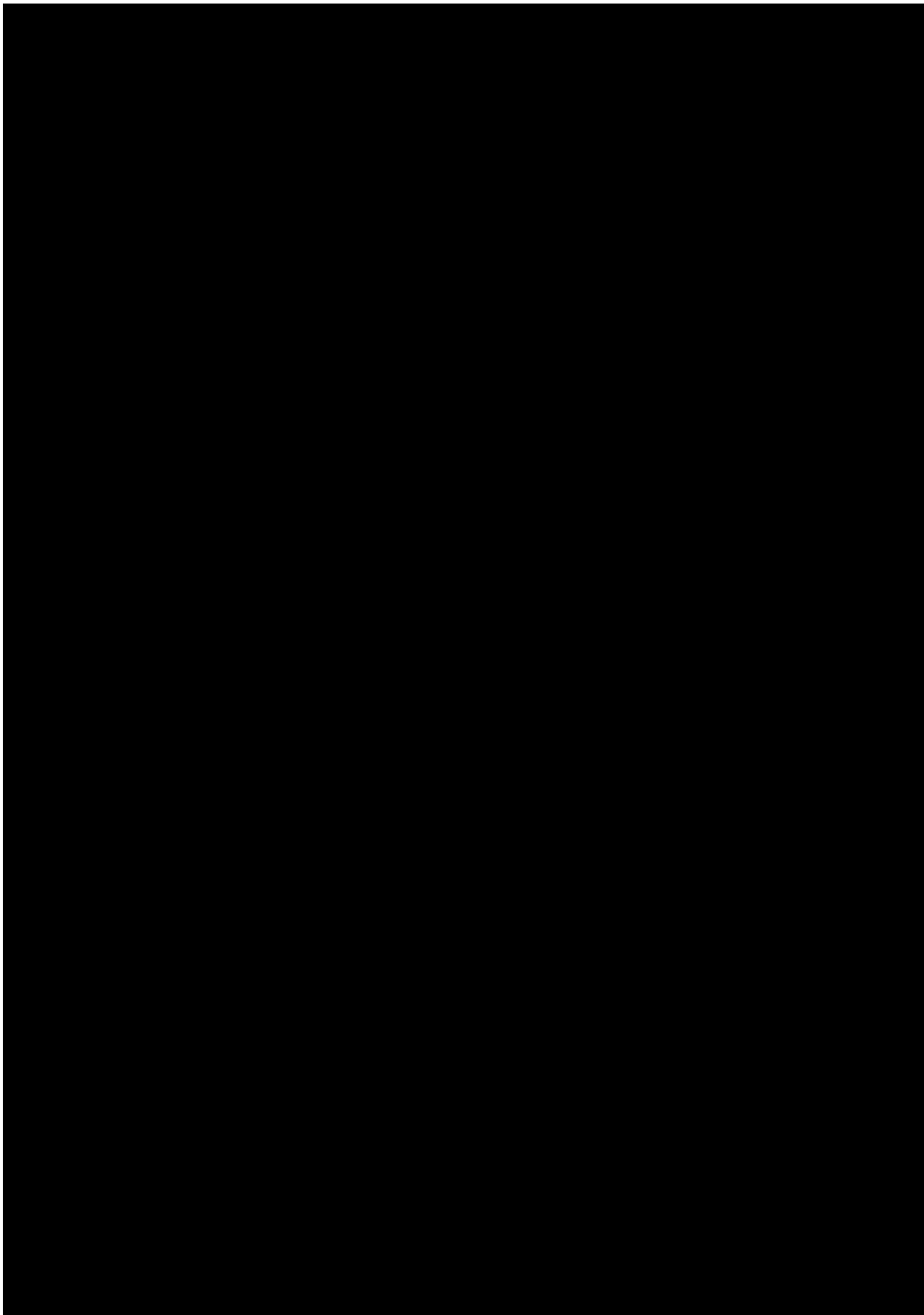
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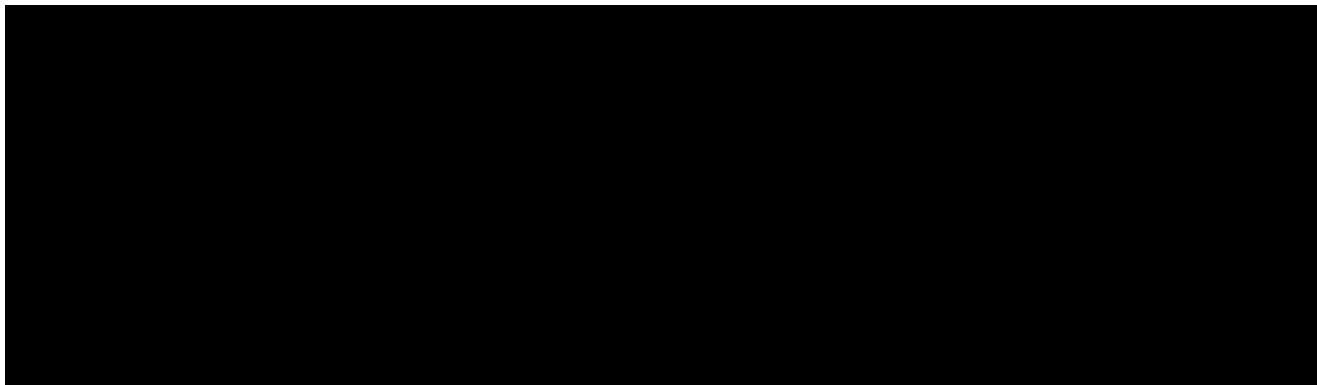
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**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**G. STATUTORY REQUIREMENTS**

**SRC# 34 – Statutory Community Partnerships (Regional):**

The respondent shall describe the extent to which its organization has established community partnerships with local providers or agencies that create opportunities for reinvestment in community-based services that play a critical role in improving the health and quality of life for enrollees, including:

- a. Participation by senior executive leadership staff on local health and human service boards, councils, and commissions.
- b. Partnerships with local community organizations focused on addressing the following social determinants of health:
  - (1) Access to Food;
  - (2) Employment;
  - (3) Housing Stability;
  - (4) Education; and
  - (5) Exposure to Crime/Violence.
- c. Participation in both grass-roots and grass-tops provider initiatives.

**Response:**

Over the years, Aetna has been afforded the opportunity to embrace fully the diverse, multi-dimensional nature of the State of Florida and its citizens. We have listened to and truly connected with each of them in an effort to gain increased understanding of the ways in which we can promote positive, sustainable change in their lives and well-being.

Our community partnerships are strategically developed based on stated needs, indicators, and outcomes of the enrollees we serve and those who also have a stake in our enrollees' health and well-being. An extension of our efforts to provide integrated, holistic, person-centered care for Medicaid enrollees in Florida, our community partners serve a vital role in helping to address their social, economic, and environmental needs. As an example, we worked to address the health care needs of a struggling enrollee, while our community partner, the Lotus House shelter in Miami, worked to meet her food and housing needs.

As stated by Aetna President Karen Lynch,

“All health care is human care. We can never forget that we’re in the business of people, and their ability to achieve their life’s ambitions through overall good health.”

To this end, we continually seek opportunities to develop initiatives with community partners to improve accessibility, close health care gaps, promote health literacy, and address the social determinants of health for all enrollees.

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WORKING COLLABORATIVELY TO DRIVE POSITIVE CHANGE

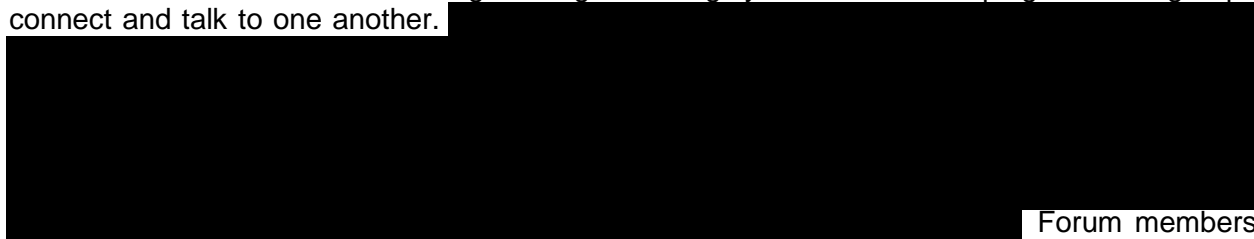
CRITERION 1: The extent to which the respondent provides details on how their local community partnerships, activities and initiatives support the local system of care

In our decades of experience as a Florida health plan, we have established relationships with local providers and agencies because we recognize we cannot build a healthier world without the services, support, and involvement of community stakeholders. Many organizations have a long-term stake in community health, including hospitals and health systems; federally qualified health centers (FQHCs) and rural and community health centers; community mental health centers and certified community behavioral health clinics; county health, public health, and human services agencies; and community-based organizations. We remain firmly committed to establishing meaningful relationships with these stakeholders and participating in local community activities and initiatives that support the local system of care. Aetna has collaborated with health care entities, rural hospitals, family physicians, county health departments, community and faith-based organizations, and health care coalitions throughout the State of Florida for many years and continues to do so.

Aetna's population health and prevention strategy seeks solutions at the individual, population, and community levels. We reach beyond the traditional model of addressing individuals' needs only when they visit their providers. Instead, we seek the root causes of adverse health conditions, examining the social determinants of health, illness, and disability, to inform our integrated care management model and to address the needs of our enrollees with innovative and effective programs. To that end, and recognizing that community organizations and providers are vital to understanding our enrollees, improving the services we provide, and increasing our enrollee and provider engagement, we created a Community Action Forum in Region 11 to bring stakeholders together to jointly develop and implement change.

Our Forum members are Medicaid providers and health care professionals, community leaders, Aetna staff members, and other community organizations and advocates with experience serving Medicaid enrollees. These members come together every quarter to share the challenges of engaging enrollees, discuss potential health plan changes and innovations, and brainstorm ideas for improving the health and well-being of our communities. These forums not only help the health plan develop new ideas and identify ways to improve what we do—they foster relationships among providers, community organizations, and the health plan that result in innovative collaborations, bringing additional health and social services to enrollees. To foster common ground among community stakeholders for improving the delivery of health care, we will incorporate this as a best practice in every region we are privileged to serve.

The Forum's quarterly meetings afford Aetna opportunities to listen to our providers, community organizations, and other stakeholders, solicit their feedback, and incorporate their ideas into our work. These somewhat informal gatherings are highly effective in helping diverse groups connect and talk to one another.



Forum members

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keep the needs of our enrollees and their communities at the forefront, as we coordinate our efforts to find solutions to enrollees' health and social challenges. Additionally, through the personal connections made at these meetings, members form their own relationships, come together, and learn from one another.

By taking the time to listen, we learn about the issues with which our enrollees are confronted. At our very first meeting in 2015, Forum member Sant La Haitian Neighborhood Center—an organization that helps to strengthen the Haitian-American community of south Florida through coordinating social services, education, economic self-sufficiency, and access to health care—helped us to understand that we needed to have materials printed in Haitian-Creole. We used that suggestion to improve our service to enrollees, and did not stop there. Often, community-based partners know our enrollees better than do their providers or we. For example, at one recent meeting, we were discussing our concern that enrollees were not receiving dental services because of access issues. A representative from Urban Strategies, one of our community partners for housing, explained that the reason some enrollees were not obtaining dental care was because they were fearful about visiting the dentist—not because they were experiencing access issues. Following that discussion, we developed materials aimed at reducing fear of the dentist, which we have shared with our dental providers.

**Acting Upon Opportunities to Strengthen Community Partners**

The relationships we form with our Community Action Forum members lead to opportunities for reinvestment in the community-based services that play a critical role in improving the health and quality of life for enrollees. We are dependent upon our community stakeholders to help us identify the ways in which we can help reinforce, enhance, and expand their efforts to address the social determinants of health. By working to develop strong relationships with these organizations, we create a space for them to discuss challenges and obstacles they may be facing in serving their communities. For example, one of our Forum members for housing, the Chapman Partnership, shared with us that there was an opportunity for health education regarding Zika virus at their shelters. The southern part of Florida was one of the first areas in the nation affected by the virus. We solicited the assistance of our medical director, Dr. Darwin Caraballo, to provide Zika prevention training to their residents. He provided participants with detailed information about the symptoms, what they should do if they believed they are affected, and how to protect their children and unborn babies.

[REDACTED]

This organization works to help communities build safe neighborhoods, enhance schools, and provides a variety of human services. A member of our Community Action Forum since 2015, Urban Strategies approached us about a program they wanted to implement to help improve the health of residents in the newly revitalized Northpark at Scott Carver community (formerly Scott and Carver Homes) located in the heart of Liberty City in Miami. Over 93% of residents are African American, and many are living with chronic conditions that lead to premature death such as diabetes, cardiovascular disease, and obesity. Urban Strategies asked for our help in funding a full-time position to develop and lead the Healthy Eating Active Living (HEAL) program to promote positive lifestyle behaviors, such as healthy eating and exercise to their residents.

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Bringing the HEAL program to the attention of the Aetna Foundation, we secured funding for the program, thus enabling Urban Strategies to develop this innovative health improvement program in Miami. HEAL participants commit to participating in an exercise regimen and monthly weigh-ins, they receive health screenings and attend educational workshops on healthy eating, meal preparation, and managing or preventing chronic illnesses. They participate in team exercise activities such as walking clubs, aerobics, and aqua fitness classes, and are developing a community garden.

[REDACTED] Earlier this year, we helped provide funding for materials and staff support for the program. Executive Director, Nadie Mondestin, wrote:

“On behalf of Haitian Youth and Community Center of Florida (HYCCF), I would like to thank you for your contribution of \$3,000 for our literacy program. The financial support helps us continue our mission and vision during our 2017 HYCCF literacy program to support creative reading and written expression in our community. A total of 65 children and parents benefited from the program. The generous support of organization like your makes it possible for our organization to exist and to make the community a great place to live.”

These are just a few examples of how the relationships we forge with community organizations through the Community Action Forum help to inform our decisions regarding outreach initiatives and support through volunteerism and sometimes funding. Without the invaluable feedback of these and other our Community Action Forum members, we might not know this type of training and support is important to them and those they serve. This kind of deep collaboration supports the local system of care by helping to identify and address enrollees’ needs, promote the kinds of healthy behaviors that prevent disease, and increase community members’ health literacy.

**Region 1**

To bring Community Action Forums to each region we will be privileged to serve, we have endeavored to understand each region better, its communities, and the local organizations that support the needs of Medicaid enrollees. Over the past year, we have personally met with over 400 community-based organizations across the State of Florida. These groups support their communities and local system of care by addressing their communities’ most pressing social determinants of health needs, thereby empowering individuals to play an active, purposeful role in their health and well-being. Through this work, we have identified several key stakeholders that can and are making a difference in their communities.

In Pensacola, 49% of all households in the county are rent-burdened, meaning they pay 50% or more of their income for housing. [REDACTED]

[REDACTED] It also provides a recovery and self-sufficiency program for individuals with substance abuse disorder. We recently provided supportive funding for the Mission’s work in Escambia, Santa Rosa, and Okaloosa counties.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Several other organizations we met that we will invite to serve on the Community Action Forum in Region 1 include:

- United Ministries of Pensacola, which provides financial and emotional crisis support for individuals and families experiencing hardship such as unemployment, divorce, or high medical bills
- Loaves and Fishes soup kitchen and shelter, which serves the residents of Escambia and Santa Rosa counties. This group provides emergency shelter for up to 10 families, for up to 3 weeks at a time, and their kitchen serves approximately 4,600 meals to the homeless each month.
  - Their Living Well Parent Child Center offers free tutoring and homework support for shelter children, as well as day camps during the fall, winter, and summer school breaks.
  - And, Loaves and Fishes has joined with area churches and individuals to help families struggling with housing by providing a furnished home and supportive services for up to two years through their temporary housing program. To support the program, Loaves and Fishes runs a thrift store selling low priced clothing, furniture, household goods, and appliances.

### **COMPREHENSIVE APPROACH TO ADDRESSING SOCIAL DETERMINANTS**

**CRITERION 3:** The extent to which the respondent has partnerships with local agencies that focus on addressing social determinants of health

As part of Aetna's integrated care management model and in accordance with the recommendations of Healthy People 2020 and the Centers for Disease Control and Prevention, we consider how conditions in the places where people live, learn, work, and play affect a wide range of factors that influence the way enrollees define their personal health. Because an individual's ZIP code is often as meaningful as his or her genetic code, we focus on addressing social determinants of health and resulting health inequities in all aspects of our enrollee support and engagement. We draw upon our local experience and our familiarity with Florida's geography, provider communities, area resources, and community organizations to tailor support for each of our enrollees' unique needs in order to address known and emerging risks with a focus on prevention. By engaging the support and expertise of numerous stakeholders, we promote enrollee empowerment in making the daily decisions that influence an individual's personal health and well-being.

Our long history as a Florida Medicaid health plan has enabled us to influence population health issues in positive and meaningful ways, as we invest in communities through grants and volunteerism in service to lower-income populations in the regions we serve.

The Aetna Foundation focuses its grant making on combating health inequities. Initiatives include increasing access to fresh fruits and vegetables for people living in low-income neighborhoods, diversifying the health care professions, and prenatal care for at-risk expectant mothers. We also conduct the annual Voices of Health Program, a national competition that recognizes nonprofit agencies that are working to encourage racial and ethnic equality in health care.

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The Aetna Foundation's Healthiest Cities and Counties Challenge joins CEOs for Cities, the American Public Health Association, and the National Association of Counties to improve the health of communities and neighborhoods. The Challenge awarded \$1.5 million in prizes this year to communities across the country for developing and implementing programs to address education, housing, transportation, and access to fresh food; all social determinants of health. St. Petersburg (Region 6), Miami (Region 11), and Hillsborough (Region 6) and Leon (Region 2) counties are among the Healthy Community 50 finalists that each received a \$10,000 seed grant to support their unique approaches to addressing food deserts and lack of opportunity for exercise, and the health problems associated with these issues. [REDACTED]

[REDACTED]

Lack of access to healthy foods has a negative impact on the health of everyone affected by it, but seniors are particularly vulnerable because they often are dealing with multiple chronic conditions and other poverty related factors such as housing instability and lack of transportation. Aetna and the national Meals on Wheels organization are collaborating on a new program to improve care coordination, integrating Meals on Wheels' daily nutritious meals, social support, and critical safety checks into a continuum of care to support enrollees as they age. Meals on Wheels and Aetna will test the program in several markets, and identify best practices to improve vulnerable seniors' health outcomes. From this, we will develop a model that will encourage healthcare entities across the country to utilize home- and community-based service providers to help seniors.

As Mark T. Bertolini, Aetna chairman and CEO, noted regarding the elder population:

"Having a reliable support system in place to observe their health on a regular basis can be just as important as the care they receive at the doctor's office. Our work with Meals on Wheels America will help us make better connections with seniors in their homes and communities, and enable us to establish truly meaningful relationships that can improve the lives of this vulnerable population."

[REDACTED]

[REDACTED] These mobile clinics provide high-quality vision, dental, and medical services at no cost to children, individuals, and families who do not have access to or cannot afford a visit to a doctor. [REDACTED]

**Meeting with Community Stakeholders to Identify Concerns**

We continuously seek opportunities to build and maintain effective community partnerships in order to support a local system of care that proactively addresses several critical social determinants of health. The Aetna Medicaid organization employs a researcher who utilizes a suite of databases and research to identify the highest social determinant needs within each region and community. This research informs our Community and Business Development teams

**EXHIBIT A-4-a**  
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as to which needs and organizations serving those needs to collaborate with in each region. In Attachment SRC 34 Letter of Support, we provide a few of the letters of support we have received from community organizations we have met.

The Sunshine State is culturally, geographically, and socioeconomically diverse, which provides opportunities for the health care community to address a number of social determinants of health. As part of our effort to engage with community stakeholders, we held focus groups early this year to check the pulse of Florida communities. Some common themes emerged from focus group participants' assessments of their communities' most pressing needs. In terms of accessing care, participants identified a lack of transportation and an insufficient number of providers, particularly those who provide behavioral health, dental, prenatal, and other specialty services, as major barriers. Focus group participants also highlighted issues with poverty, homelessness, food insecurity, housing instability, and the need for more educational services such as life coaching and health literacy.

Subsequently, we traveled across the State and met with 420 community organizations from every region in an effort to find new and better ways to address the gaps tied to social determinants that enrollees encounter every day. In our conversations with many community stakeholders, it became clear that enrollees often struggle to seek out and find information about the services that are available to them in their local community. Furthermore, many of the best-in-class providers of these services are local and may not advertise, or their services may not be sufficiently well known for enrollees to know to seek out their services. Finally, enrollees often are faced with a crisis or are in a position where they have to make a quick decision about how and where to seek services. These circumstances leave them too little time to fully assess and understand the resources that exist in their community.

Innovative New Collaboration to Connect Enrollees to Resources

[REDACTED]

[REDACTED]

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[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Providing Compassionate, Person-Centered, Integrated Care

[REDACTED]

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GENERAL SUBMISSION REQUIREMENTS  
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[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

**PARTICIPATION IN PROVIDER INITIATIVES**

**CRITERION 4:** The extent to which the respondent jointly develops and incorporates change from grassroots and grass-tops provider initiatives

[REDACTED] As part of this effort, this year we planned, promoted, and participated in the Prematurity Symposium, an educational event held in Miami. The symposium agenda, confirming our clinical contributions and involvement, follows in Attachment SRC 34 Prematurity Symposium Agenda. This two-day event was available at no cost to pediatricians, general and family practitioners, neonatologists, midwives, and obstetricians and gynecologists their office staff. Social workers, care managers, and other staff involved in maternal and child health services were made welcome. Aetna Senior Medical

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Director [REDACTED] was one of many well-respected presenters at the event. Through this program, participants learned how to engage with enrollees and communities to help prevent premature births through evidence-based best practices.

Aetna will provide financial support and sponsorships for the Food Is Medicine program, initiated and hosted by Florida Hospital – West Florida Division, to supply fresh fruits and vegetables and to set up classes such as diabetes prevention and fitness for enrollees living in targeted areas. Collaborating with local community organizations, the Food Is Medicine program's innovative approach is to improve health behaviors and increase access to affordable and nutritious food through health education, biometric screening, and produce vouchers. Participants attend weekly evidence-based classes on a range of topics, such as chronic disease, healthy eating, and physical fitness. They receive free pre- and post-biometric screening for body mass index (BMI), blood pressure, and blood sugar. In addition, participants are provided a \$10 produce voucher distributed once per week, as long as the participant regularly attends classes and completes screening. Vouchers are redeemable for fresh fruit, vegetables, and dry goods at a produce truck. The produce truck is also open to non-participants who are allowed to purchase the same produce and goods at a fair price, thereby expanding access to the entire community.

Another innovative program, called the Fruit and Vegetable Prescription (FVRx) program, is offered by Community Action Forum member Jessie Trice Community Health Center (Jessie Trice). Jessie Trice is the oldest FQHC in the state and is comprised of a series of large medical facilities located across Miami-Dade County in low-income cities and communities. It serves approximately 700 Aetna enrollees, and over the years, we have participated in Jessie Trice's grassroots efforts to combat diseases related to food insecurity such as diabetes. For example, through a combination of volunteerism and funding, we support Jessie Trice's diabetic nutrition workshops, in which participants take part in a diabetic-friendly cooking demonstration and receive cookbooks filled with healthy, low-sugar recipes.

Through the Aetna Foundation, we are able to strengthen Jessie Trice's efforts in this area further with funding that will support the FVRx program for the next three years. The FVRx program is for individuals living with diabetes, elevated BMI, obesity, and other nutrition-related illness; they are referred to the program by their physician or an on-site nutritionist. Participants receive an initial assessment and are given a recommended diet and exercise plan, as well as fruit and vegetable "prescriptions," which are produce vouchers valid at Target or Farmers Market. Participants return every two months for nutrition education events such as customized healthy eating food demonstrations and a guided trip to the supermarket to learn how to evaluate and select foods for maintaining a healthy lifestyle. Jessie Trice nutritionists will also measure their BMI and overall health. This data is collected through their secure electronic medical records (EMR) to provide cumulative data on the relationship between nutritional food, health, literacy, and behavior.

Through our participation and sponsorship of the American Heart Association First Coast Heart & Stroke Ball, we support grass-tops provider initiatives. The Heart & Stroke Ball is attended by approximately 400 corporate, community, and philanthropic leaders from around the region. Supported by diverse industries including healthcare, finance, construction, education, manufacturing, technology, and retail, the Heart and Stroke Ball convenes executive leaders to create system changes that result in overall improvements in health outcomes. While the event is one night of celebration, it makes other heart health events and initiatives possible throughout

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the year, such as Friends of Heart Research receptions, PULSE Young Professionals events, or national initiatives like National Wear Red Day, National Eating Healthy Day, and CPR Week.

**PARTICIPATION BY SENIOR EXECUTIVE LEADERSHIP**

**CRITERION 2:** The extent to which the respondent has senior executive leadership staff who will be assigned to the resulting Contract who also participate on local health and human service related boards, councils, and commissions

For four consecutive years, Aetna has been recognized as one of America's most community-minded companies in the Civic 50, an annual initiative from Points of Light that recognizes companies that invest talent, time, and resources to improve the communities in which they do business. One of our core values as an organization is caring, and our senior executive leadership staff encourage team members to make a personal investment in serving the community. Aetna staff members nationwide have logged 4.3 million volunteer hours and counting since 2003.

Every year, we sponsor Deliver the Dream's retreat for families who have a child with cancer. Deliver the Dream is a nonprofit organization that provides families from all over Florida with a free weekend retreat experience that is designed to help participants escape the overwhelming stress of a serious illness, reconnect with one another in a fun and supportive environment and cultivate relationships with other families who are going through a similar situation. Since 2012, Aetna has supported Deliver the Dream's retreat program, contributing more than \$150,000 to the nonprofit organization and providing more than 6,500 volunteer hours.

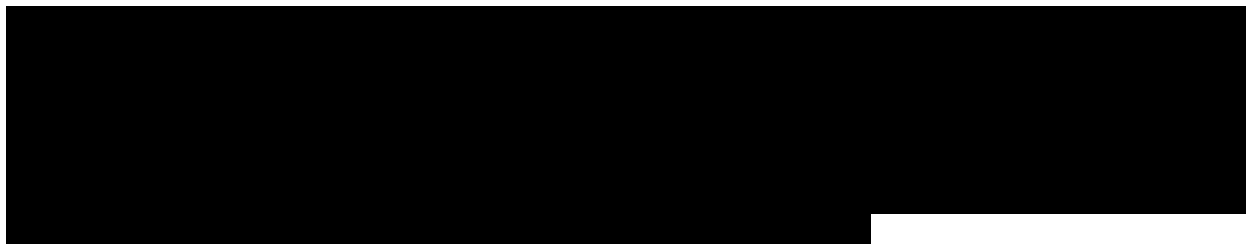
Our leaders participate in local outreach events and serve on state and local health and human service boards, councils, and commissions. They share their passion, expertise, and financial resources to make a positive impact in every community.

[REDACTED]

[REDACTED] The Coalition brings together various public health authorities, health care practitioners, and service providers to build disaster-response capabilities and meet the emergency preparedness needs of more than 2,000 health care organizations and 75,000 health care workers. Director of Long-Term Care Debra Wingo and Manager of Long-Term Services Tammy Twenhofel, along with members of our Provider Services team and our contract manager, serve the Coalition in working to improve the health and safety of enrollees in the Tampa Bay community.

[REDACTED]

**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**



**Evaluation Criteria:**

1. The extent to which the respondent provides details on how their local community partnerships, activities and initiatives support the local system of care.
2. The extent to which the respondent has senior executive leadership staff who will be assigned to the resulting Contract who also participate on local health and human service related boards, councils, and commissions.
3. The extent to which the respondent has partnerships with local agencies that focus on addressing social determinants of health.
4. The extent to which the respondent jointly develops and incorporates change from grassroots and grass-tops provider initiatives.

**Score:** This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.



COVENTRY HEALTH CARE OF FLORIDA, INC. DBA  
AETNA BETTER HEALTH® OF FLORIDA

## **Attachment SRC #34**



COVENTRY HEALTH CARE OF FLORIDA, INC. DBA  
AETNA BETTER HEALTH® OF FLORIDA

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COVENTRY HEALTH CARE OF FLORIDA, INC. DBA  
AETNA BETTER HEALTH® OF FLORIDA

## Letters of Support



COVENTRY HEALTH CARE OF FLORIDA, INC. DBA  
AETNA BETTER HEALTH® OF FLORIDA

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*Serving the Community  
Since 1967*

September 6, 2017

Ms. Heidi E. Garwood  
Chief Executive Officer  
1340 Concord Terrace

**BOARD OF DIRECTORS** Sunrise, FL 33323

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PAUL ROBERTS

TERRELL WEST

DAVID WILLIAMS, JR.

LENORA YATES, ED.D.

Dear Ms. Garwood:

This letter of support and acknowledgement confirms the willingness of Aetna Better Health® of Florida to support and collaborate with Jessie Trice Community Health Center, Inc., (JTCHC, Inc.) in the coordination of health education activities and initiatives aimed at improving the health of individuals who live in some of the most challenging neighborhoods in the Miami/Hialeah areas.

JTCHC, Inc., also acknowledges that without the support of Aetna Better Health® of Florida our organization would be unable to continue providing health education activities and initiatives to our clients. This letter is neither binding nor exclusive to the signatory, and creates no contractual duties or relationship between JTCHC, Inc., and Aetna Better Health® of Florida.

We look forward to working with Aetna Better Health® of Florida to further support individuals and families in Miami/Hialeah areas.

Sincerely,

Annie R. Neasman, MS, RN  
President & CEO

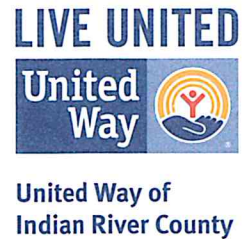
/c

JESSIE TRICE COMMUNITY HEALTH CENTER, INC.  
5607 NW 27th Avenue, Suite 1, Miami, Florida 33142  
Tel: (305) 805-1700 • Fax (305) 805-1715  
Email: JTCHC@jtchc.org  
Website: www.jtchc.org

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P.O. Box 1960  
Vero Beach, FL 32961-1960  
tel: 772-567-8900  
UnitedWayIRC.org  
VolunteerIndianRiverCounty.org

United Way Center  
1836 14th Avenue  
Vero Beach, FL 32960



September 6, 2017

Heidi Garwood, Chief Executive Officer  
Aetna Better Health® of Florida  
1340 Concord Terrace  
Sunrise, FL 33323

To Whom It May Concern:

This letter of support and acknowledgement confirms the willingness of the United Way of Indian River County to support and collaborate with Aetna Better Health of Florida in coordination with health education activities and initiatives aimed at helping the individuals and families in our communities.

The United Way of Indian River County also acknowledges that an Aetna Better Health of Florida representative has met in person with our organization. This letter is neither binding nor exclusive to the signatory, and creates no contractual duties or relationship between the United Way of Indian River County and Aetna Better Health of Florida.

We look forward to working in partnership with Aetna Better Health of Florida to further support individuals and families in Vero Beach and the surrounding communities. **Aetna was the only company during the RFP process that took the time to reach out to United Way of Indian River County to discuss community concerns and ask for community level information.**

Sincerely,

A handwritten signature in blue ink, appearing to read "Nate Bruckner", with a long horizontal flourish extending to the right.

Nate Bruckner  
Director of Community Impact

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September 6, 2017

Ms. Heidi Garwood  
1340 Concord Terrace  
Sunrise, Florida 33323

Dear Heidi,

This letter of support and acknowledgement confirms the willingness of Aetna Better Health® of Florida to support and collaborate with Sant La, Haitian Neighborhood Center, in coordination of health education activities and initiatives to improve the health of individuals who live in some of the most challenging neighborhoods in Miami Dade County.

I also acknowledge that without the support of Aetna Better Health® of Florida Sant La would not have been able to continue providing the much needed community outreach and education in the Haitian community of Miami Dade County. This letter is neither binding nor exclusive to the signatory, and creates no contractual duties or relationship between Sant La, Haitian Neighborhood Center and Aetna Better Health® of Florida.

We look forward to working with Aetna Better Health® of Florida to further support individuals and families in Miami Dade County.

With Warm Regards,

A handwritten signature in blue ink, appearing to read "Gepsie M. Metellus".

Gepsie M. Metellus  
Executive Director



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***The Embrace Girls Foundation, Inc.***

*Embrace Girl Power! After School Programs & Camps*

18520 N.W. 67<sup>th</sup> Avenue #340

Hialeah Gardens, Florida 33015

(877) 466-4769 Phone - (305) 556-1329 Fax

[embraceu1@aol.com](mailto:embraceu1@aol.com)

[www.embracegirlpower.org](http://www.embracegirlpower.org)

September 26, 2017

HEIDI GARWOOD, ESQ.  
Chief Executive Officer  
AETNA Better Health of Florida  
1340 Concord Terrace  
Sunrise, Florida 33323

Dear Heidi Garwood,

This letter of support and acknowledgement confirms the willingness of Aetna Better Health® of Florida to support and collaborate with The Embrace Girls Foundation, Inc., ([www.embracegirlpower.org](http://www.embracegirlpower.org)) in coordination of health education activities and initiatives aimed at improving the health of individuals who live in some of the most challenging neighborhoods in Miami-Dade County..

Please know, that without the support of Aetna Better Health® of Florida our organization would not have been able to continue providing key preventative educational information, resources and hands on workshops that our girls and their families, as well as the most fragile communities we serve have enjoyed.

The nutrition and healthy eating, dental hygiene, cooking healthy, healthcare insurance, our literacy initiative, character appearances, upcoming pep rallies that will reach thousands of children offering empowering health life styles information and resources as well as your awesome Community Team has been an awesome. Thank you once again for always saying yes, with much enthusiasm I must add.

Of course, this letter is neither binding nor exclusive to the signatory, and creates no contractual duties or relationship between The Embrace Girls Foundation, Inc., and Aetna Better Health® of Florida.

We look forward to working with Aetna Better Health® of Florida to further support individuals and families in Miami-Dade County.

Sincerely,

*Velma R. Lawrence*

Velma R. Lawrence, CEO  
The Embrace Girls Foundation, Inc.  
Embrace Girl Power! After School Programs & Camps  
(786) 587-9747 – Personal Cell



September 15, 2017

**Officers**

Stephen Enriquez  
Treasurer

Willie Ivory  
Chairman

Andrea Ivory  
Executive Director

Leda Silver  
Secretary

Andrea Ivory  
Executive Director  
The Women's Breast & Heart Initiative, Florida Affiliate, Inc.  
14125 NW 80<sup>th</sup> Ave, 306  
Miami Lakes, FL 33016

Dear Heidi Garwood,

**Members of the Board**

Maria Elena Abate, Esq

Sabriya Ishoof, MD

Bini Jacob

Carol Lawrence

Patrick Lee

Alex Orellana

Ana Vigilante

I am pleased to write this letter of support and acknowledgement which confirms the willingness of Aetna Better Health® of Florida to support and collaborate with The Women's Breast & Heart Initiative, Florida Affiliate, Inc. in coordination of health education activities and initiatives aimed at improving the health of individuals who live in some of the most challenging neighborhoods in Miami-Dade, Broward, and Palm Beach counties.

The Women's Breast & Heart Initiative, Florida Affiliate, Inc. acknowledges that without the support of collaborating partners like Aetna Better Health® of Florida, our organization continue to provide breast cancer and heart disease prevention and wellness through targeted door-to-door educational outreach, screening referrals, ongoing recommend screening referrals, care coordination and navigation.

**Advisory Committee**

Dr. Carmen Calfa

Harriet Spivak

This letter is neither binding nor exclusive to the signatory, and creates no contractual duties or relationship between The Women's Breast & Heart Initiative, Florida Affiliate, Inc. and Aetna Better Health® of Florida.

We look forward to working with Aetna Better Health® of Florida to further support individuals and families in Miami-Dade, Broward, and Palm Beach counties.

Sincerely,

Andrea Ivory  
Executive Director

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**HOUSE OF HEALING**  
hope • guidance • support

*"Making a difference in the lives of women, children & families"*

September 6, 2017

Heidi Garwood, Chief Executive Officer  
Aetna Better Health® of Florida  
1340 Concord Terrace  
Sunrise, FL 33323

To Whom It May Concern:

This letter of support and acknowledgement confirms the willingness of House of Healing to support and collaborate with Aetna Better Health of Florida in coordination of health education activities and initiatives to promote healing, infuse hope and foster the restorative process of individuals and families in our communities.

House of Healing also acknowledges that an Aetna Better Health of Florida representative has met in person with our organization. This letter is neither binding nor exclusive to the signatory, and creates no contractual duties or relationship between House of Healing and Aetna Better Health of Florida.

We look forward to working in collaboration with Aetna Better Health of Florida to further support individuals and families in Orlando.

Sincerely,

Shaleana Eubanks-Worlds, MS  
CEO

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September 5, 2017

Heidi Garwood, Chief Executive Officer  
Aetna Better Health® of Florida  
1340 Concord Terrace  
Sunrise, FL 33323

To Whom It May Concern:

This letter of support and acknowledgement confirms the willingness of Bay Area Early Steps to support and collaborate with Aetna Better Health of Florida in coordination with health education activities and initiatives aimed at improving the health and wellbeing of our residents.

Bay Area Early Steps also acknowledges that an Aetna Better Health of Florida representative has met in person with our organization. This letter is neither binding nor exclusive to the signatory, and creates no contractual duties or relationship between Bay Area Early Steps and Aetna Better Health of Florida.

We look forward to working in partnership with Aetna Better Health of Florida to further support individuals and families in Kissimmee and the surrounding area.

Sincerely,

A handwritten signature in black ink, reading "Emily Shaffer-Hudkins, Ph.D.", written over a horizontal line.

Emily Shaffer-Hudkins, Ph.D., NCSP  
Bay Area Early Steps Assistant Clinical Director

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September 6, 2017

Heidi Garwood, Chief Executive Officer  
Aetna Better Health® of Florida  
1340 Concord Terrace  
Sunrise, FL 33323

To Whom It May Concern:

This letter of support and acknowledgement confirms the willingness of the Metropolitan Ministries to support and collaborate with Aetna Better Health of Florida in coordination with health education activities and initiatives aimed at improving the health and wellbeing of individuals who may be homeless, poor, or in crisis.

The Metropolitan Ministries also acknowledges that an Aetna Better Health of Florida representative has met in person with our organization. This letter is neither binding nor exclusive to the signatory, and creates no contractual duties or relationship between the Metropolitan Ministries and Aetna Better Health of Florida.

We look forward to working in collaboration with Aetna Better Health of Florida to further support individuals and families in Tampa and the surrounding area.

Sincerely,



Christine Long  
Chief Programs Officer

Providing comprehensive care for poor and homeless families in Tampa Bay  
2002 North Florida Avenue | Tampa, Florida 33602 | 3214 US Highway 19 North | Holiday, FL 34691 | [metromin.org](http://metromin.org)

METROPOLITAN MINISTRIES IS A 501(C)(3) NONPROFIT ORGANIZATION. A COPY OF THE OFFICIAL REGISTRATION (#SC-02820) AND FINANCIAL INFORMATION MAY BE OBTAINED FROM THE FLORIDA DIVISION OF CONSUMER SERVICES BY CALLING TOLL-FREE WITHIN THE STATE 1-800-435-7352. REGISTRATION DOES NOT IMPLY ENDORSEMENT, APPROVAL OR RECOMMENDATION BY THE STATE.

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September 5, 2017

Heidi Garwood, Chief Executive Officer  
Aetna Better Health® of Florida  
1340 Concord Terrace  
Sunrise, FL 33323

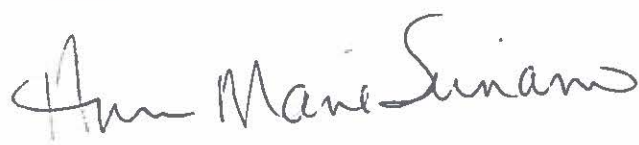
To Whom It May Concern:

This letter of support and acknowledgement confirms the willingness of the Indian River County Hospital District to support and collaborate with Aetna Better Health of Florida in coordination with health education activities and initiatives aimed at helping the individuals and families in our communities.

The Indian River County Hospital District also acknowledges that an Aetna Better Health of Florida representative has met in person with our organization. This letter is neither binding nor exclusive to the signatory, and creates no contractual duties or relationship between the Indian River County Hospital District and Aetna Better Health of Florida.

We look forward to working in partnership with Aetna Better Health of Florida to further support individuals and families in Indian River County.

Sincerely,



Ann Marie Suriano  
Executive Director

**BOARD OF TRUSTEES**

Marybeth Cunningham, *Chairwoman*

Dr. Michael Weiss, *Vice Chairman*

Allen Jones • Ann Marie McCrystal • Karen Deigl • Barbara Bodnar • Omar Hussamy, M.D.

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## Big Brothers Big Sisters

of St Lucie, Indian River & Okeechobee Counties, Inc.

403 N. US Hwy 1  
Fort Pierce, FL 34950

Phone: 772-466-8535  
Fax: 772-828-2098

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Judi Miller

CEO

September 5, 2017

Heidi Garwood, Chief Executive Officer  
Aetna Better Health® of Florida  
1340 Concord Terrace  
Sunrise, FL 33323

To Whom It May Concern:

This letter of support and acknowledgement confirms the willingness of Big Brothers Big Sisters of St. Lucie, Indian River and Okeechobee Counties to support and collaborate with Aetna Better Health of Florida in coordination of health education activities and initiatives for individuals participating in the mentorship and learning programs that BBBS provides to the youth of Port St. Lucie and the surrounding areas.

### Board of Directors

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Gail Kavanagh

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Willie Roundtree

Joe Smith

Joe Wallace

Olivia Watkins

Harry Williams

Amber Woods

Big Brothers Big Sisters of St. Lucie, Indian River and Okeechobee Counties also acknowledges that an Aetna Better Health of Florida representative has met in person with our organization. This letter is neither binding nor exclusive to the signatory, and creates no contractual duties or relationship between Big Brothers Big Sisters of St. Lucie, Indian River and Okeechobee Counties and Aetna Better Health of Florida.

We look forward to working in collaboration with Aetna Better Health of Florida to further support individuals and families in St. Lucie, Indian River and Okeechobee Counties.

### Honorary Board

#### Members

Judy Hamner

Paul Hiott

Paul LiCausi

Jane Rowley

Sincerely,

Judi Miller

Chief Executive Officer

Think of the possibilities. **What will you start?**



**start** something

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**BOYS & GIRLS CLUBS**  
OF INDIAN RIVER COUNTY

September 6, 2017

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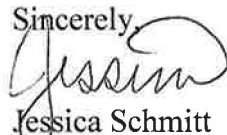
Heidi Garwood, Chief Executive Officer  
Aetna Better Health® of Florida  
1340 Concord Terrace  
Sunrise, FL 33323

To Whom It May Concern:

This letter of support and acknowledgement confirms the willingness of the Boys & Girls Clubs of Indian River County to support and collaborate with Aetna Better Health of Florida in coordination of health education activities and initiatives for individuals participating in the mentorship and learning programs that are provided to the youth of the Indian River County.

The Boys & Girls Clubs of Indian River County also acknowledges that an Aetna Better Health of Florida representative has met in person with our organization. This letter is neither binding nor exclusive to the signatory, and creates no contractual duties or relationship between the Boys & Girls Clubs of Indian River County and Aetna Better Health of Florida.

We look forward working with Aetna Better Health of Florida to further support youth and families in Vero Beach and the surrounding areas.

Sincerely,  


Jessica Schmitt  
Director of Resource Development

Boys & Girls Clubs  
of Indian River County, Inc.  
1729 17<sup>th</sup> Avenue  
Vero Beach, FL 32960

Tel 772-299-7449  
Fax 772-299-3840

[www.BGCIRC.org](http://www.BGCIRC.org)



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September 20, 2017

Heidi Garwood, Chief Executive Officer  
Aetna Better Health® of Florida  
1340 Concord Terrace  
Sunrise, FL 33323

To Whom It May Concern:

This letter of support and acknowledgement confirms the willingness of Guiding Star Tampa, a DBA of LifeChoices Women's Care, Inc. to support and collaborate with Aetna Better Health of Florida in coordination with health education activities and initiatives aimed at improving the quality of life for women in the Tampa area.

Guiding Star Tampa also acknowledges that an Aetna Better Health of Florida representative has met in person with our organization. This letter is neither binding nor exclusive to the signatory, and creates no contractual duties or relationship between Guiding Star Tampa and Aetna Better Health of Florida.

We look forward to working with Aetna Better Health of Florida to further support women and families in Hillsborough County.

Sincerely,

A handwritten signature in black ink that reads "Ana Stooks".

Ana Hidalgo Stooks  
Executive Director

**18560 North Dale Mabry Highway, Lutz, FL 33548**

**(813) 948-7734**

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## Board of Directors

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### Chief Executive Officer

Jeffrey Shearer, CAP, LCSW, ACSW

HOBE SOUND  
COMMUNITY CHEST, INC.



September 6, 2017

Heidi Garwood, Chief Executive Officer  
Aetna Better Health® of Florida  
1340 Concord Terrace  
Sunrise, FL 33323

To Whom It May Concern:

This letter of support and acknowledgement confirms the willingness of Tykes and Teens to support and collaborate with Aetna Better Health of Florida in coordination of health education activities and initiatives aimed at improving the health of individuals and families who are battling depression, substance abuse or other debilitating mental health issues.

Tykes and Teens also acknowledges that an Aetna Better Health of Florida representative has met in person with our organization. This letter is neither binding nor exclusive to the signatory, and creates no contractual duties or relationship between Tykes and Teens and Aetna Better Health of Florida.

We look forward to working in partnership with Aetna Better Health of Florida to further support individuals and families in Palm City and the surrounding area.

Sincerely,

Eric Garza, LCSW, CAP, CST  
Chief Operating Officer

Jeffrey Shearer, ACSW, CAP, LCSW  
Chief Executive Officer

Mental Health Matters, Every Day!

Tykes & Teens is a registered 501c3 non-profit agency  
Supporting and strengthening our community through quality prevention, education and  
social-emotional healing services for children and their families  
3577 SW Corporate Parkway, Palm City, FL 34990 (772) 220-3439 fax (772) 220-3484



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## **Main Office**

**2814 South U.S. Hwy. 1, Ste. D-4, Ft. Pierce, FL 34982 ♦ Tel: 772.489.4726 ♦ Fax: 772.466.5578**

**September 14, 2017**

**Heidi Garwood, Chief Executive Officer  
Aetna Better Health® of Florida  
1340 Concord Terrace  
Sunrise, FL 33323**

**To Whom It May Concern:**

**This letter of support and acknowledgement confirms the willingness of the Suncoast Mental Health Center to support and collaborate with Aetna Better Health of Florida in coordination with health education activities and initiatives aimed at ensuring the health, success and safety of the children and families we serve.**

**The Suncoast Mental Health Center also acknowledges that an Aetna Better Health of Florida representative has met in person with our organization. This letter is neither binding nor exclusive to the signatory, and creates no contractual duties or relationship between Suncoast Mental Health Center and Aetna Better Health of Florida.**

**We look forward to working in tandem with Aetna Better Health of Florida to further support women, children and families of the Treasure Coast.**

**Sincerely,**

*Debra Scuderi Engle, MS*

**Debra Scuderi Engle, MS  
Acting CEO**

---

**Stuart Office**  
850 North Federal Hwy. #125  
Stuart, FL 34994  
Office: (772) 221-8585  
Fax: (772) 221-8371

**Okeechobee Office**  
408 NW 3<sup>rd</sup> Street  
Okeechobee, FL 34972  
Office: (863)-824-0300  
Fax: (863) 824-0024

**Vero Beach Office**  
1456 Old Dixie Hwy.  
Vero Beach, FL 32960  
Office: (772) 564-8616  
Fax: (772) 299-3757

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COVENTRY HEALTH CARE OF FLORIDA, INC. DBA  
AETNA BETTER HEALTH® OF FLORIDA

# **Prematurity Symposium Agenda**



COVENTRY HEALTH CARE OF FLORIDA, INC. DBA  
AETNA BETTER HEALTH® OF FLORIDA

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## 2<sup>nd</sup> Annual Miami-Dade Prematurity Symposium

Thursday, August 24, 2017

5:30 PM – 8:45 PM

### Agenda

- 5:30 PM**      **Registration and Dinner**
- 6:30 PM**      **Welcome and Introductions**  
*Kelli Wells, MD, Deputy Secretary for Health, Florida Department of Health*
- 6:45 PM**      **The National and Florida Summary of Preterm Birth and Evidence-Based Interventions (CME & CEU)**  
*Karen E. Harris, MD, MPH, Chair, ACOG District XII*
- 7:45 PM**      **Managed Care Organization (MCO) Collaboration to Improve the Use of Immediate Post-partum Long-acting reversible contraceptives (LARC) (CME & CEU)**  
*Amy Richardson, MD, MBA, CPC, Senior Medical Director for Pediatric Strategy, Aetna Medicaid*
- 8:15 PM**      **Florida Perinatal Quality Collaborative: An Opportunity to Improve Care (CME & CEU)**  
*William Sappenfield, MD, MPH, Director, Lawton and Rhea Chiles Center for Healthy Mothers and Babies, College of Public Health, University of South Florida*
- 8:45PM**      **Closing Remarks**

*This symposium is partially sponsored by unrestricted educational funds provided by Aetna Better Health of Florida to the Healthy Start Coalition of Miami-Dade.*

**Continuing Education Units (CEU):** This program has been independently approved for a **maximum of 5 hours of continuing education credit** by the Florida Board of Nursing, Florida Council of Midwifery, the Florida Board of Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling, and the Florida Council of Dietetics and Nutrition (ND, NC) under CE Broker Provider Number 50-18147.

**Continuing Medical Education (CME):** This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education through the joint providership of the Florida AHEC Network and the Healthy Start Coalition of Miami-Dade. The Florida AHEC Network is accredited by the Florida Medical Association to provide continuing medical education to physicians. The Florida AHEC Network designates this live activity for a **maximum of 4.0 AMA PRA Category 1 Credits™**. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Dr. Amy Richardson owns Aetna stock and has reported this financial disclosure. No other planners or presenters have any relevant financial disclosures.





## 2<sup>nd</sup> Annual Miami-Dade Prematurity Symposium

Friday, August 25, 2017

9:00 AM – 2:30 PM

- 9:30 AM**      **Welcome and Introductions**  
*Manuel E. Fermin, MPA, Chief Executive Officer, Healthy Start Coalition of Miami-Dade*
- 9:40 AM**      **Keynote Speaker**  
*Kelli Wells, MD, Deputy Secretary for Health, Florida Department of Health*
- 10:15 AM**      Breakout sessions (select one):  
    **The National and Florida Summary of Preterm Birth and Evidence-Based Interventions** (CME & CEU)  
    *Karen E. Harris, MD, MPH, Chair, ACOG District XII*  
  
    **Prescription Drug Abuse during Pregnancy and Neonatal Abstinence Syndrome, and the impact on premature birth** (CME & CEU)  
    *Connie Morrow, PhD, Research Associate Professor of Pediatrics Associate Director, Perinatal CARE Program, University of Miami Miller School of Medicine*
- 11:30 AM**      Breakout sessions (select one):  
    **Managed Care Organization Collaboration to Improve the Use of Immediate Post-partum LARC** (CME & CEU)  
    *Amy Richardson, MD, MBA, CPC, Senior Medical Director for Pediatric Strategy, Aetna Medicaid*  
  
    **Improvement of Feto-Maternal Well Being in Pregnancy** (CME & CEU)  
    *Marcus Cooke, PhD, Professor and Head of Department, Dept. Environmental and Occupational Health, Florida International University*
- 12:30 PM**      **Lunch** - Boxed lunch provided
- 1:15 PM**      Breakout sessions (select one):  
    **Florida Perinatal Quality Collaborative: An Opportunity to Improve Care** (CME & CEU)  
    *William Sappenfield, MD, MPH, Director, Lawton and Rhea Chiles Center for Healthy Mothers and Babies, College of Public Health, University of South Florida*  
  
    **Interconception Care as a Strategy to Prevent Prematurity** (CEU)  
    *Louise Reiter, RN, CLC, LCCE, Consultant, Healthy Start Coalition of Miami-Dade*
- 2:15PM**      **Closing Remarks**

*This symposium is partially sponsored by unrestricted educational funds provided by Aetna Better Health of Florida to the Healthy Start Coalition of Miami-Dade.*

**Continuing Education Units (CEU):** This program has been independently approved for a **maximum of 5 hours of continuing education credit** by the Florida Board of Nursing, Florida Council of Midwifery, the Florida Board of Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling, and the Florida Council of Dietetics and Nutrition (ND, NC) under CE Broker Provider Number 50-18147.

**Continuing Medical Education (CME):** This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education through the joint providership of the Florida AHEC Network and the Healthy Start Coalition of Miami-Dade. The Florida AHEC Network is accredited by the Florida Medical Association to provide continuing medical education to physicians. The Florida AHEC Network designates this live activity for a **maximum of 4.0 AMA PRA Category 1 Credits™**. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Dr. Amy Richardson owns Aetna stock and has reported this financial disclosure. No other planners or presenters have any relevant financial disclosures.



**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**SRC# 35 – Organization Commitment to Quality (See Section 409.966, Florida Statutes) (Statewide):**

The respondent shall describe its organizational commitment to quality improvement, including active involvement by the respondent's medical and administrative leadership, and document its achievements with two (2) examples of completed quality improvement projects, including description of interim measurement and rapid cycle improvement processes, and a summary of results.

**Response:**

Aetna's commitment to quality is a clear, unwavering outgrowth of our health plan's values. The success we have achieved over the past 30 years is reflected in our dedication to train an exceptional workforce of quality leaders. We continue to offer quality care that adheres to best practices in health plan administration demonstrated by Aetna's recent top National Committee for Quality Assurance (NCQA) ranking among all Florida Medicaid plans for the second consecutive year. Additionally, we rank among the top 15 Medicaid plans in the country and hold the highest Consumer Assessment of Healthcare Providers and Systems (CAHPS) composite score of 4.0. Aetna provides quality care that adheres to best practices delivered in the most expeditious manner by a network of quality physicians and service vendors.

**ORGANIZATIONAL COMMITMENT TO QUALITY IMPROVEMENT**

Aetna plans, implements, and administers continuous quality assurance and performance improvement (QAPI) in clinical and operational programs in the 14 states in which Aetna currently manages Medicaid health plans. The measurable increases in enrollee and provider satisfaction achieved by our QAPI program illustrate the effectiveness of our processes and positions Aetna to support fully Florida's Statewide Medicaid Managed Care (SMMC) program and its goal of achieving optimal quality outcomes while containing costs.

Under the direction of our chief medical officer (medical director) and chief executive officer, the program focuses on improving the enrollee's biological, psychological, and social well-being with an emphasis on quality of care, including the non-clinical aspects of all services. Whenever an enrollee's condition is unlikely to improve, our goal is to implement measures to help the enrollee live safely in the least restrictive setting of his or her choosing. Aetna's person-centered approach means we strive to make our enrollees more self-sufficient by empowering them. Through Aetna's benefits and supports, we give enrollees the tools they need to become better health care consumers and to get the care they want and need, when and where they need it. Ultimately, better-informed consumers lead to improved outcomes and lower costs.

While the Quality department provides guidance and measurement, every Aetna colleague is tasked with ensuring quality. Lean Six Sigma white belt quality certification is mandatory for all Aetna employees; all managers and supervisors are required to have Lean Six Sigma yellow-belt quality certification. Lean Six Sigma methodology keeps us focused on understanding the needs of our enrollees, developing and improving processes to serve them effectively and efficiently.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **Active Involvement by Leadership**

**CRITERION 1:** The extent to which the respondent's description demonstrates that the medical director has substantial oversight in the assessment and enhancement of quality improvement activities, and the Chief Executive Officer is actively involved in quality management

Aetna's Florida board of directors governs all aspects of our QAPI program, including the evaluation and oversight of our efficiency, effectiveness, and outcomes. The board provides strategic management direction and evaluates the degree to which the philosophy and scope of the QAPI program is incorporated within each operational/management unit and across Aetna's operations. The board delegates dual authority to Chief Executive Officer Heidi Garwood and Chief Medical Officer Jorge Cabrera, M.D. to design and administer the QAPI program in accordance with Florida guidelines. In addition, Heidi and Dr. Cabrera are woven into the operation of all our different provider, enrollee, and operations committees, and they have oversight of them.

Dr. Cabrera directs the development and implementation of the QAPI program in partnership with Heidi Garwood and the remainder of our leadership team. Specific responsibilities of Dr. Cabrera include:

- Serving as chair of the Quality Management Oversight Committee (QMOC)
- Serving as the liaison to the board of directors
- Ensuring accountability for all QAPI activities and initiatives
- Allocating and managing the resources necessary to successfully carry out all QAPI activities, in collaboration with our chief executive officer (CEO)
- Reviewing and approving all QAPI activities
- Consulting with health plan staff on all aspects of the organizational quality program, including accreditation, clinical quality, quality of care, quality measure, referrals, care management, denials, grievances, appeals, and other issues
- Providing input and oversight regarding provider recruiting and credentialing activities
- Ensuring plan compliance with local standards of medical practice and nationally accepted standards of practice

Aetna's quality management program is a health plan-wide endeavor. Our management team uses an integrated and collaborative approach that involves each functional area. Quality improvement (QI) activities that support the goals and objectives of the QAPI program are coordinated on an annual basis. The quality management program cycle is based on the calendar year. The QM department provides the administrative support for the coordination of committee meetings, meeting preparation, and follow-up activities. Under the direction of our chief medical officer and chief executive officer, an annual QAPI evaluation is completed that is used to evaluate the success of the quality program and to make recommendations for changes, improvements, and enhancements. The QAPI evaluation and resulting program changes has direct oversight and approval by both Dr. Cabrera and Heidi Garwood, who bring all aspects of the evaluation to the QMOC.

### **Provider and Enrollee Representation on Quality Committees**

In recognition of the value of their input and contributions to our continuous improvement efforts, providers are selected from a cross-section of specialties, including primary care provider

## **EXHIBIT A-4-a**

### **GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

medical homes (PMHC), pediatricians, behavioral health practitioners, obstetrician/gynecologists (OB/GYNs), Home and Community Based Services (HCBS) providers, and other specialists. The chief medical officer will suggest outstanding providers who are a good fit for the various quality committees and talk to them about the meetings' purpose and their potential responsibilities. We also encourage our staff in Contracting, Provider Services, and Medical Management departments to put forward any providers who would add value to one of our quality committees. Aetna aims for at least 10 providers on the QIC in addition to the providers represented on the CPC, PAC, and the P&T committees.

As we expand beyond Region 11, we will develop advisory boards to cover every region, and each board will have at least 14 participants. The majority those participants will be plan enrollees. Our boards will be diverse in terms of age groups and health statuses, and geographically diverse, with both rural and urban representatives.

#### **Quality Committees**

Quality is central to our culture and organization. The QMOC, chaired by our chief medical officer and chief executive officer, provides executive oversight of quality activities and their integration across the plan through receipt and review of reports and minutes from each subcommittee. Subcommittees and workgroups, under the auspices of the QMOC, include membership from all areas of the organization, local and national, as well as external stakeholders, providers, and delegates. A description of the committees and subcommittees and their role in our quality program follows.

#### **Quality Management Oversight Committee (QMOC):**

- Ensures QAPI program is integrated throughout the organization, among its departments, contractors, and stakeholders
- Ensures that quality activities are designed to improve the quality of care and services provided to enrollees
- Reviews and revises the QAPI program description and work plan annually, submits a recommendation for their approval to the board of director, and ensures they are implemented as planned
- Reviews and approves committee reports from all medical committees
- Reviews, evaluates, and makes recommendations on the results of QAPI initiatives; reviews enrollee/provider satisfaction survey results
- Advises or makes recommendations to improve the health plan
- Assists in developing action plans; reviews and approves submitted action plans/progress reports

#### **Quality Management/Utilization Management Committee (QM/UM Committee)/Provider Advisory Committee:**

- Includes, in addition to representation from every plan functional area, a diverse group of providers and provider specialties
- Reviews and evaluates data sets and other information, such as enrollee demographics, costs, and performance indicator results with recommended actions
- Reviews and approves studies, standards, and clinical guidelines

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Reviews trends in quality and utilization management measures and outcomes; reviews results of provider medical record reviews
- Reviews and recommends approval, revision, or denial of medical review criteria
- Reviews and evaluates the results of QAPI activities
- Reviews and approves the QAPI and medical management program description, work plan, and annual evaluations
- Conducts peer review and investigates quality of care or service and enrollee safety issues, make recommendations

### **Delegation Committee:**

- Evaluates each delegate's or prospective delegate's quality assurance plan and ongoing reporting (such as prior authorization time standards and customer service)
- Reviews the results of oversight assessments conducted by Aetna to monitor the performance of delegated or prospective delegated entities and makes recommendations to the QMOC regarding delegation status and corrective action plans
- Requests and monitors corrective action plans (CAP) from delegated entities as needed
- Monitors and evaluates delegated functions via regular reports, at least semi-annually through reporting as defined in the delegation agreement

### **Aetna Credentialing and Performance Committee (CPC):**

- Credentials practitioner providers for the enterprise and the reports comes to the Quality Oversight Committee (QOC)
- Receives and reviews, at a minimum, health practitioner/professional and provider credentials that do not meet Aetna's credentialing criteria (i.e. that are not complete, clean as defined by Aetna, and approved by the Aetna medical director)
- Conducts peer review evaluations
- Makes decisions regarding actions on the credentialing or recredentialing information presented

### **Aetna Practitioner Appeals Committee (PAC), subcommittee to CPC:**

- Conducts professional review hearings of providers who appeal decisions made by the Aetna CPC
- Includes issues of professional competence or conduct of the provider
- Is facilitated by an Aetna medical director
- Consists of providers appointed on an ad hoc basis by the Aetna Credentialing and Performance Committee
- Reports through CPC and to the Aetna QMOC

### **Aetna Quality Oversight Committee (QOC) for facilities, institutional providers, and vendors:**

- Reviews and evaluates identified potential quality-of-care concerns related to facilities/organizational providers/vendors
- Makes decisions regarding actions on the credentialing and recredentialing of facilities/organizational providers/vendors

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **Committee for Service Improvement:**

- Reviews and evaluates data, surveys, and trends in enrollee and provider complaints, grievances and appeals to identify opportunities for improvement in enrollee and provider satisfaction; formulates initiatives and recommendations to drive continuous improvement
- Reviews/evaluates and makes recommendations about operational measures (such as prior authorization time standards, claims payment standards, customer service time standards, enrollee enrollment and disenrollment reconciliation)
- Reviews/evaluates and makes recommendations about compliance with standards for claim reporting
- Reviews reports from the Member Advisory Committee and recommends action

### **Grievance Committee:**

- Reviews and evaluates enrollee grievances on an ongoing basis
- Reviews, evaluates, and makes recommendations on identified opportunities for improvement
- Maintains records according to applicable regulations and contractual requirements

### **Appeals Committee:**

- Reviews and renders decisions on appeals
- Renders decisions in accordance with contractual requirements
- Maintains records according to applicable regulations and contractual requirements

### **Member Advisory Committee (MAC):**

- Includes enrollees who receive our services, their caregivers, family members, and other community stakeholders; we invite a random group of enrollees, as well as any enrollees suggested by our Health Services team and our care management staff. Enrollees must agree to participate in four quarterly meetings throughout the year. Committee members receive a welcome letter and an agenda before each meeting.
- Uses care manager to identify PCPs and long-term care (LTC) facility administrators to represent our LTC enrollees
- Reviews and recommends strategies to improve clinical performance measures, cultural competency, enrollee outreach plans, enrollee educational materials (e.g. readability, content), prevention programs, satisfaction survey tools, and other initiatives requested by the QMOC
- Solicits enrollee feedback and opinions regarding issues related to access and the quality of care and services provided to enrollees as well as potential programs, activities, and educational materials

### **Pharmacy and Therapeutics Committee (P&T):**

- Reviews and assists in development and maintenance of the formulary
- Advises and makes recommendations on enrollee and provider educational materials and programs related to medications and other pharmacy products
- Monitors contracted pharmacy services and makes recommendations for improvements

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Participates in the evaluation of new technology related to medications and other pharmacy products

### **Compliance Committee (CC):**

- Reviews and approves an annual or compliance plan, identifies yearly priorities, areas of risk, and vulnerabilities, including those areas identified by the Office of Inspector General / Medicaid Program Integrity (MPI)
- Confirms health plan is meeting all contract requirements
- Analyzes identified compliance risks, potential compliance risks, and related corrective actions
- Reviews External Quality Review (EQR) activities, audits, and related corrective action plan activity and advises accordingly
- Reviews all auditing and monitoring activities conducted by any regulatory agency and recommends and/or reviews internal monitoring and corrective action plans
- Strategizes to determine best practices for identifying non-compliant activity or fraud, including anonymous hotline or other reporting mechanisms
- Reviews fraud reports and follow-up actions
- Reviews information regarding the performance of delegates related to compliance and/or fraud and abuse

### **Policy Committee (PC):**

- Facilitates the development, implementation, approval, and dissemination of policies in accordance with all applicable accrediting and regulatory requirements
- Uses standard policy and procedure templates to ensure comprehensive and consistent approach to policy development
- Serves as the repository for all policies and provide interdepartmental integration
- Facilitates annual review and approval of appropriate revisions by applicable committees
- Facilitates exchange of knowledge of departmental policies
- Identifies any gaps in departmental policies

## **QUALITY IMPROVEMENT INFUSED IN OUR CULTURE AND OPERATIONS**

**CRITERION 2:** The adequacy of the respondent's approach to incorporating quality improvement activities into the culture and operations of the organization

For Aetna, quality assurance and improvement is a health plan-wide endeavor. Our Florida plan employs a dedicated Quality department that is supported by shared resources and knowledge at the corporate level. Across all of our health plans, we invest in skilled staff and make ongoing training our highest priority. White-belt quality certification is mandatory for all Aetna employees. Colleagues in our Quality department engage in mandatory, comprehensive, weeklong, role-based core quality management training program organized by our Learning and Performance department. We take an integrated and collaborative approach that encompasses each functional area, including the Medical Management, Quality Management, Informatics, Provider Services, Enrollee Services, and Claims departments. We define, identify, and implement improvement activities to enhance our clinical and program efficiencies, provide effective utilization, correct deficiencies, and identify opportunities to improve outcome management, thus achieving meaningful advancement of our quality goals.

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Quality is infused in our culture and operations in a number of ways:

- Comprehensive organizational and clinical quality work plan that includes all functional areas; the work plan is reviewed and approved by the Quality Committee and its subcommittees, distributed to all department leads and leadership, is maintained on the SharePoint, accessible to all staff, and is contributed to by all plan functional areas.
- Cross-functional, quality-focused meetings and training are conducted across the organization.
- All managers, department heads, and key staff members serve on quality committees and subcommittees.
- Internal communications and town halls, meetings, and trainings, focus on quality and quality improvement projects, including the minimum schedule for routinely planned meetings:
  - Quarterly all-staff town halls
  - Weekly executive team meetings
  - Monthly provider initiative meetings
  - Monthly management team meetings
  - Monthly training
  - Bi-weekly performance improvement plan (PIP) intervention workgroup
  - Monthly enrollee satisfaction/CAHPS workgroups
  - Annual potential quality of care training
  - Annual quality staff training

### **PROCESSES AND STRATEGIES TO RECOGNIZE AND RESOLVE PROBLEMS**

**CRITERION 3:** The extent to which the respondent describes proactive processes and strategies that are utilized to recognize and solve problems before they occur or are exacerbated

Aetna consistently gathers accurate, timely, and relevant information about the quality of our operational, administrative, and health care delivery through our provider network to help us pinpoint favorable and unfavorable quality patterns. Anyone on our team can identify an issue. Issues are discussed in workgroups or subcommittees, and usually with consultation with the quality team to provide expertise on measurement, documentation, and management of mitigation. The length of time we study, analyze, and resolve a quality-related issue varies depending on what it is. In some cases, we receive data weekly and act on it weekly. Aetna's quality team engages in constant cycles of measurement, followed by intervention, and intervention impact measurement. For example, although we receive data weekly for the ADD (attention deficit disorder) HEDIS measure, we studied the data for four months before we took action to improve, following a period of intervention trial and error. In the case of improving adult access, more data analysis was needed; so, we employed a longer study period. Following the analysis, we took part in a brief period of intervention then conducted a follow-up study a few months later. There have also been situations where we have addressed issues affecting quality within a week.

Our strategy for addressing issues is to customize the solution to the issue, apply the applicable skill set, and staff expertise to the problem. Our review and analysis is flexible, based on the needs of the issue. We benchmark and compare our outcomes to all types of plans: the

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Medicaid plans Aetna manages in other states; Aetna's Medicaid plan in Florida; commercial and Medicare Advantage plans; other internal, national, and state benchmarks; and NCQA HEDIS regional and national benchmarks.

As part of our quality improvement process, problems are identified by both internal and external stakeholders and presented to either an internal decision-maker and/or Aetna committee. We strive to resolve all problems at the point of intake; however, problems that are more complex are vetted by cross-functional teams wherein information is gathered, analyzed, and presented to workgroups and committees. A plan is then proposed to take action on the problem, assignments are planned, a work plan is created, and reporting to the work groups or committees is planned. The duration of the process is dependent upon the amount of time and activities required to resolve the problem, as well as the enrollees' and providers' vital needs and concerns.

Our quality and program evaluation processes are embedded throughout our organization to produce improved outcomes for enrollees through systematic enhancements. Through our continuous quality improvement model, we use the annual evaluation results to establish quality management and performance improvement goals for the upcoming year. Opportunities for improvement identified in the evaluation or articulated by regulators or other key stakeholders drive the development of the goals and objectives.

### **Reviewing Data Monthly for Rapid-Cycle Improvement**

Our quality team regularly monitors all key HEDIS measures, along with certain measures that indicate the status of our enrollee population. Every year, we prioritize key measures for focus based on trends revealed by our analysis and the status of our enrollee population. We identify areas of focus that will have the most positive impact on enrollees. When we identify areas of opportunities, we look at what is working for other measures and apply those approaches as applicable.

Our quality management and leadership team monitors performance measures, including HEDIS, throughout the year to assess the impact of our efforts to improve rates, identify disparities, and adjust strategies that are not working based on our interim measurement of our HEDIS metrics/rates. Clinical quality and other performance measure rates are tracked monthly and compared to the previous year's rates on a rolling 12-month and year-to-date basis. All organizational metrics are tracked at least quarterly by the QMOC to ensure close monitoring of organizational goals. Through effective monitoring, an agile organizational structure, and plan-organization-wide Six Sigma experts, root causes can be identified and change can be introduced quickly.

### **Our Committees and Workgroups**

As a proactive measure, data for all of our performance indicators and quality metrics (including HEDIS data) is tracked and trended for patterns and opportunities for improvement. The data is reviewed monthly and at least quarterly in our Quality committee or subcommittees. The results are shared with the board of directors for accountability. An example of our dedication to quality is demonstrated by a year-over-year improvement in meeting 80% of our HEDIS goals this year improving 8 percentage points over 2016, 18 percentage points over 2015, and 32 percentage points over 2014. Moreover, we include participating providers and enrollees in our quality

**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

subcommittees. Enrollee and provider recommendations, feedback and suggestions on our initiatives, communication, quality processes, and metrics are critical to our success.

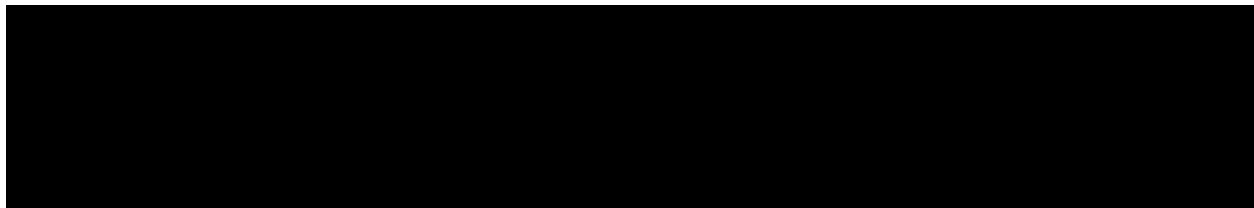
Community Relationships

The primary function of our community relationships is to build trust, understanding, and in many instances, to problem solve issues impacting the Medicaid community. All of our community partners are located in the communities we serve. As a result, they have a pulse on the needs and concerns of the local population. Many bring their concerns to us and look to us to resolve critical social and other health issues affecting their communities strategically.

A case in point is our partnership with one school, Biscayne Elementary, which is located in the inner city community of North Miami. We learned that 90% of their students were at or below the federal poverty level, and many did not have an understanding of proper nutrition, particularly fruits and vegetables. They suggested we assist them by planting a vegetable garden. Aetna helped the children in the actual planting of vegetables and fruit trees in the center of the school. Additionally, our team and the children participated in a hands-on food demonstration provided by Aetna in association with Florida Introduces Physical Activity and Nutrition to Youth (FLIPANY), a non-profit organization that educates and empowers youth through nutrition and physical activity programs for a healthier community. The food demonstration included preparing a healthy pita pizza and a healthy fruit pizza with vegetables grown in their garden. While making the meals, the students learned the benefits of each ingredient. Aetna also gave away goodie bags to all the students, which included notebooks pencils, healthy eating cookbooks, and jump ropes. Students were instructed to share their educational cookbooks with their parents or guardians.

Another example of a proactive community partnership occurred during the 2016 Zika virus outbreak in Miami-Dade County, which had the highest recorded cases in Florida. Approximately 31 of recorded cases occurred in the communities of Wynwood, Overtown, North Miami Beach, Little River, and South Miami Beach. Our Outreach team saw the need to educate the community about the dangers of the Zika virus. We collaborated with The Lotus House, a homeless shelter for women, youth, and children in the Overtown area of Miami-Dade County. In one of the first areas affected by the Zika virus, the Outreach team had our medical director, Dr. Darwin Caraballo, present Zika prevention training to the residents of Lotus House. Dr. Caraballo showed the women how to identify the virus in adults, children, and newborns. He also provided detailed information on the symptoms, including what to do if infected. Dr. Caraballo discussed how to prevent the virus and provided tips on how to protect their children and unborn babies. The residents were engaged and many had questions and concerns, which the doctor addressed. Several participants told us they found the presentation and training useful in understanding how to curb the spread of the virus.

Enrollee Outreach – A Pulse on Performance



**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
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[REDACTED] In our experience, whenever we resolve enrollee issues, it influences other enrollees, too. For instance, by helping us understand misconceptions about benefits, we can figure out ways to address and reduce misunderstandings by communication more effectively through individual enrollee education, enrollee newsletters, the enrollee handbook, enrollee Website, provider education, internal training, and more.

**ACHIEVEMENTS WITH COMPLETED QUALITY IMPROVEMENT (QI) PROJECTS**

**CRITERION 4:** The extent to which the respondent provides two examples of completed quality improvement projects that incorporated a data-driven quality improvement cycle

**CRITERION 5:** The extent to which the respondent provides data on the results of the quality improvement projects that demonstrates the efficacy of the interventions

**CRITERION 6:** The extent to which one of the quality improvement projects described by the respondent is related to reducing potentially preventable events or improving birth outcomes

By fully investing in our enrollees, we empower them to become invested in their own health and well-being, as we help them better consumers of their benefits and care. The success of our approach is evidenced by our CAHPS rating of 4.0 and our NCQA rating—both of which make us the highest-ranking Florida Medicaid plan for CAHPS and overall NCQA rankings—as well as the increasing longevity of our enrollees.

Quality improvement projects incorporate data-driven quality improvement cycles using rapid cycle or standard Plan-Do-Study-Act processes. Our projects utilize all data sources to determine performance, efficacy of interventions, and statistically significant improvements. Data sources include claims, care management data, medical record review data, and other sources depending on what is being measured.

The projects that follow represent data-driven quality improvement cycles using HEDIS measures for two critical areas of plan performance.

**QI Project Example 1: Diabetic Retinal Eye**

**Summary of Results:** Our final HEDIS score improved (statistical significance measured by Fisher's exact P-value of 0.000) by over 8 percentage points from the prior year, and allowed us to meet the 50th percentile rate for the first time.

Diabetic eye exams are critical screenings to prevent blindness, which occurs because of unmanaged diabetes. In 2016, with the help of our chief medical officer, Dr. Cabrera, we designated a quality improvement pilot to improve our continued low rates for such a critical screening (to preserve enrollees' vision). Monitoring monthly rates year-over-year, we noticed a decline in our rates in April 2016. Our analysis revealed we were without a specific population that was less compliant or could be a focus for additional intervention. We had a high level of confidence in our encounter data after testing. To mitigate further rate decline, a rapid cycle improvement activity for diabetic retinal eye exams was completed based on our interim measurement of this rate. We reviewed our ongoing interventions, which included letter

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

campaigns, automated outreach, text messaging programs, enrollee newsletters, and provider education and assistance. The team identified live outreach as an intervention proven successful for other measures. We implemented an intervention to outreach enrollees, educating them on their gap in care and assisting them obtaining care. This initiative also included chart collection from eye providers with enrollees who reported completion of the exam. After two months, re-measurement showed a statistically significant increase of six percentage points. The pilot program was completed in four months during 2016.

Our intervention for diabetic eye exam began in July 2016, when our rate was 35.21%. The intervention was to outreach to enrollees and collect charts as evidence of service, and determine any correctable reasons why we did not have claim evidence of services provided. Our rate generally increased by three percentage points per month, which if consistent, would not allow us to meet goal. We implemented our initiative to call every enrollee without an exam. Initially, we identified 774 enrollees with this gap. Our team made phone calls to 567 enrollees and reached 403. Our analysis also revealed that 42 had no phone number and 121 had voice mail issues, so they could not be reached. We found 292 enrollees who reported they had actually completed the test; we requested 260 charts and received 203. For enrollees we did not reach by phone, we sent letters. We sent 359 letters, which resulted in some enrollees contacting us. We did not collect charts as supplemental data in 2016 as we were migrating to Aetna systems and did not have that option at the time. Instead, we collected the charts to use during HEDIS medical record collection. In prior years, we were able to close the gap with medical record reviews (hybrid measurement) by approximately 3 percentage points. However, in 2016, we improved our rate during hybrid review by approximately 8 percentage points, a statistically significant improvement as indicated by a P-value of 0.000.

### **QI Project Example 2: Well-Child 1 to 15 Months and Prenatal – Improving Birth Outcomes**

Summary of Results: Our HEDIS rates for well-child visits 1 month to 15 months improved by more than 13 percentage points in one year, achieving the 90th percentile rate. Results for the timeliness of prenatal care measure (PPC-prenatal) increased by almost 8 percentage points, bringing the plan to the 95th percentile rate for HEDIS.

Aetna implemented a well-child visits project as part of our statewide, collaborative well child first 15 months/prenatal PIP after monitoring monthly rates and determining that many enrollees were enrolling at an age after at least two to three visits would have occurred. With the help of our chief medical officer, Dr. Cabrera, our QI department launched a rapid cycle short-term medical record project in 2015 to test the theory. We confirmed visits had occurred, but not with our plan; so, no claims were received. We also confirmed some gaps were related to neonatal intensive care unit (NICU) stays where the enrollee was an inpatient when visits would have normally occurred. While it was not possible to close the gap with NICU babies, we were able to close the data gaps. Our intervention was to outreach to enrollees and providers for gap closure, diagnose specific reasons why enrollees did not have service or we did not have a record of service, and mitigate those issues and ensure enrollees received timely care. The quality outreach team started outreach to physicians to determine if enrollees received service, to educate providers on gaps and billing for services, and to collect medical records for those that completed timely service. In 2015, supplemental data was needed to help raise scores because of a claim deficit. A major goal of this project was to eliminate the need for supplemental data. In 2015, 29 of our enrollees had supplemental data. In 2016, zero supplemental data was needed to support well-child rates (first 15 months), indicating a

## **EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

successful intervention. Because this was the only new plan-initiated intervention in 2016, the statistically significant improvement can be attributed to the efficacy of the intervention.

### **Evaluation Criteria:**

1. The extent to which the respondent's description demonstrates that the medical director has substantial oversight in the assessment and enhancement of quality improvement activities, and the Chief Executive Officer is actively involved in quality management.
2. The adequacy of the respondent's approach to incorporating quality improvement activities into the culture and operations of the organization.
3. The extent to which the respondent describes proactive processes and strategies that are utilized to recognize and solve problems before they occur or are exacerbated.
4. The extent to which the respondent provides two examples of completed quality improvement projects that incorporated a data-driven quality improvement cycle.
5. The extent to which the respondent provides data on the results of the quality improvement projects that demonstrates the efficacy of the interventions.
6. The extent to which one of the quality improvement projects described by the respondent is related to reducing potentially preventable events or improving birth outcomes.

**Score:** This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

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**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**SRC# 36 – Health Plan Accreditation (See Section 409.966, Florida Statutes) (Statewide):**

The respondent shall specify its current accreditation status by a nationally recognized accrediting body. This shall include the name of the accrediting body, the most recent date of certification, the effective date of the accreditation, the type and/or level of accreditation, and the status of accreditation (i.e., provisional, conditional, etc.). The respondent shall attach documentation that supports this information.

**Response:**

Aetna remains committed to continuous quality improvement to fulfill the aim of improved health outcomes for all of our enrollees. Our proven results are evidenced in our achievement of consistently high National Committee for Quality Assurance (NCQA) status ratings across our Quality, Medical Management, and Health Equity programs. Recently, Aetna received the highest NCQA ranking among Florida Medicaid plans for the second consecutive year. We are also ranked among the top 15 Medicaid plans in the nation. We continuously strive to improve our quality performance and our accreditation status; for example, our 2017 total score was 89.7486, just .25 points below the Excellent accreditation threshold.

**CURRENT ACCREDITATION STATUS**

CRITERION 1: Evidence that the respondent has:

- (a) Full health plan accreditation by a nationally recognized accrediting body; e.g., full three (3) year accreditation for the National Committee for Quality Assurance (NCQA), full three (3) year accreditation for Utilization Review Accreditation Commission (URAC), or full three (3) year accreditation for Accreditation Association for Ambulatory Health Care, Inc. (AAAH); or
- (b) Partial/conditional health plan accreditation (e.g., provisional for NCQA, conditional or provisional for URAC, or one (1) year or six (6) months for AAAHC); or
- (c) No health plan accreditation or denied accreditation.

NCQA accreditation demonstrates a commitment to quality, outstanding clinical performance, and consumer experience. In Florida, Aetna has achieved an NCQA accreditation level of Commendable for three years in a row—awarded to those organizations with well-established programs for service and clinical quality that meet rigorous requirements for consumer protection and quality improvement. This demonstrates our in-depth understanding of quality, both in terms of the enrollee experience and of clinical and operational excellence.

**NCQA Accreditation**

- Name of accrediting body: NCQA
- Most recent date of certification: April 28, 2017
- Effective date of accreditation: April 28, 2017
- Type and/or level of accreditation: Commendable
- Status of accreditation: Full three-year accreditation

**EXHIBIT A-4-a**  
**GENERAL SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**DOCUMENTATION**

Please refer to Attachment SRC 36 for a copy of our current NCQA certification.

**Evaluation Criteria:**

1. Evidence that the respondent has:
  - (a) Full health plan accreditation by a nationally recognized accrediting body; e.g., full three (3) year accreditation for the National Committee for Quality Assurance (NCQA), full three (3) year accreditation for Utilization Review Accreditation Commission (URAC), or full three (3) year accreditation for Accreditation Association for Ambulatory Health Care, Inc. (AAAHC); or
  - (b) Partial/conditional health plan accreditation (e.g., provisional for NCQA, conditional or provisional for URAC, or one (1) year or six (6) months for AAAHC); or
  - (c) No health plan accreditation or denied accreditation.

**Score:** This section is worth a maximum of 5 raw points as outlined below:

- (a) 5 points for full health plan accreditation.
- (b) 3 points for partial/conditional health plan accreditation.
- (c) 0 points if health plan accreditation denied or no accreditation.

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COVENTRY HEALTH CARE OF FLORIDA, INC. DBA  
AETNA BETTER HEALTH® OF FLORIDA

## **Attachment SRC# 36**



COVENTRY HEALTH CARE OF FLORIDA, INC. DBA  
AETNA BETTER HEALTH® OF FLORIDA

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# National Committee for Quality Assurance

has awarded

*Coventry Health Care of Florida, Inc.*

*Medicaid HMO*

an accreditation status of

**COMMENDABLE**

for service and clinical quality that meet or exceed  
NCQA's rigorous requirements for consumer  
protection and quality improvement.



*Doris Chir, MD*

CHAIR, BOARD OF DIRECTORS

*Margaret S. J. K.*

PRESIDENT

*Valerie H. H. H.*

CHAIR, REVIEW OVERSIGHT COMMITTEE

*April 28, 2017*

DATE GRANTED

*April 28, 2020*

EXPIRATION DATE



## Exhibit A-4-b: MMA Submission Requirements and Evaluation Criteria and Applicable Attachments/Exhibits



Employee volunteers eagerly await the commencement of a health fair sponsored by Aetna Better Health® of Florida and the opportunity to serve the community.

*All photos herein are presented with the express and written consent of the individuals in them.*

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**EXHIBIT A-4-b**  
**MMA SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**RESPONDENT NAME:** Coventry Health Care of Florida, Inc. dba Aetna Better Health of Florida

**A. RESPONDENT BACKGROUND/EXPERIENCE**

**No SRCs in this Category for MMA.**

**B. AGENCY GOALS**

**MMA SRC# 1 – Potentially Preventable Events (Regional):**

The respondent shall describe its organizational commitment to quality improvement as it relates to reducing potentially preventable events. More specifically, the respondent shall describe its overall approach and specific strategies that will be used to ensure a reduction in potentially preventable hospital admissions and readmissions, a reduction in the use of the emergency department for non-emergent/urgent visits, and a reduction in the use of unnecessary ancillary services during hospitalization and outpatient visits. The respondent's approach shall also include:

- A description of the respondent's assessment (using available data sources) of hospital utilization rates and the potential for improvement;
- A description of performance benchmarks for each area of focus;
- A description of incentives that will be implemented for providers and enrollees aimed at diverting care to more appropriate and cost-effective settings; and
- A description of evidence-based interventions and strategies that will be used to target super-utilizers, particularly related to pain management and behavioral health conditions.

**Response:**

Aetna recognizes the importance of one of the State's major goals, which is the reduction of potentially preventable events (PPE). The manner in which we approach quality improvement, utilization and care management reflects the importance we place on engaging, educating and empowering our providers and enrollees in the process of decreasing PPEs.

The Agency's 2017 report, "Analyzing Potentially Preventable Healthcare Events of Florida Medicaid Enrollees" provides a compelling overview of health care utilization in the State's 11 regions. The report enabled analysis of data from August 2014 to July 2015, the first year of the Managed Medical Assistance program, and revealed the following outcomes:

- More than 77% of 4.5 million emergency department (ED) visits during the review period were identified as potentially preventable
- 42% of hospital admissions were conditions that might be managed with outpatient care
- 46% of hospital readmissions were considered potentially preventable because they involved a continuation or recurrence of a condition from the initial hospital admission

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Aetna's organizational commitment to quality improvement helps guide our strategies for reducing potentially preventable events. Our approach centers on developing true partnerships with our enrollees and providers. We collaborate with enrollees to engage and educate them to invest in their health. We support enrollees by helping them understand their benefits, the treatment for their medical conditions and the resources they have at their disposal. The goal is to assist enrollees in feeling empowered and confident in the choices they make pertaining to their care. Additionally, providers are engaged through value-based contracts that align practitioners with Aetna's quality, cost, and access goals.

Our provider and enrollee engagement enabled Aetna to receive the top NCQA ranking for the 2016 calendar year among all Florida Medicaid plans for the second consecutive year. Our commitment to quality is evidenced by our ranking among the top 15 Medicaid plans in the United States.

### **OVERALL APPROACH TO REDUCE POTENTIALLY PREVENTABLE EVENTS**

Aetna uses a comprehensive approach to address and improve outcomes for potentially preventable events. This approach begins with person-centered, integrated care management—complimented by value-based contracts that engage and incentivize providers to provide care that addresses enrollee health care needs and access. Both provider and enrollee engagement are supported by powerful technological resources with real-time functionality. CareUnify<sup>SM</sup>, our population health platform, enhances communication, care coordination, and data integration among enrollees, providers, Aetna, and the system of care. Working in concert with tools such as the State's Event Notification Service (ENS), CareUnify provides an instant view of enrollees' utilization events and changes in health status, thus enabling us to follow up with appropriate care.

Our approach to reducing potentially preventable events includes:

- A focus on enrollee education through integrated care management interventions, the use of educational tools such as the MyActiveHealth enrollee portal, mobile application, and condition-specific materials and newsletters
- The use of thorough analytics and root-cause analysis to help determine the reason for ED visits, hospital admissions and readmission
- Providing support to enrollees with post discharge follow-up interventions through the use of dedicated transition of care nurses
- Conduct a review of enrollees' needs and personal goals within the context of social determinants of health (e.g., employment, access to healthy foods, homelessness/home stability)
- The facilitation of interdisciplinary care teams for a holistic approach within a collaborative model
- Promotion of an integrated system of care to provide enrollees a comprehensive set of services that support their individualized needs
- A 360-degree assessment and dashboard of enrollee care plans and services through CareUnify to promote prompt clinical interventions
  - Formal quality improvement processes for monitoring, measuring, and reporting quality and clinical outcomes at the member and provider level

**EXHIBIT A-4-b**  
**MMA SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

- Provider engagement and support through value based contracts, regular sharing of data, training, and enhanced communication
- Network development focused on identifying and maintaining providers delivering quality care
- The use of advanced data analytics capabilities for hospital utilization review and evaluation

We recognize the uniqueness of each of our enrollees and tailor our support and services to help them achieve improved health outcomes. Our approach has resulted in improved hospital admission rates in Florida. For a 24-month measurement period of Aetna's 100,000 Medicaid enrollees in the State ending April 2017, Aetna realized the following outcomes:



Aetna remains committed to improving utilization outcomes to support the Agency's goal of reducing potentially preventable events.

**SPECIFIC LOCALIZED OPPORTUNITIES FOR IMPROVEMENT**

**CRITERION 1:** The extent to which the respondent identified specific localized opportunities for improvement in achieving a reduction in potentially preventable events and subsequent steps the respondent will implement to overcome any barriers across and within different systems of care (i.e., medical, behavioral health)

Aetna has a thorough understanding of the State's diverse populations and regional makeup based on more than 20 years of experience serving Floridians. Currently, we support enrollees in nine regions (1, 2, 3, 5, 6, 7, 8, 9, and 11) from the following populations: aged, blind and disabled, Florida Healthy Kids, dually eligible, long-term care (LTC), and Temporary Assistance to Needy Families (TANF). Aside from using internal, proprietary data to inform our decision-making, we use multiple external data sources to gather intelligence about health trends for the State's population. They include the Florida Department of Health's "Florida Health Charts" and "County Health Rankings and Roadmaps" as well as the aforementioned Agency report on potentially preventable events.

We have identified two issues that cross regional boundaries and that affect every region of the State: high patterns of utilization for ED visits and prenatal and perinatal risks for mothers and their children. Provided is an overview of how we are addressing these critical issues, as well as our approach for conditions such as substance use, serious mental illness, obesity, and cancer, which have high prevalence in certain regions.

Preventable Emergency Department Utilization

**EXHIBIT A-4-b**  
**MMA SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

Region 1 ranks first in ED visits, according to an Agency report. The most frequently diagnosed conditions in all regions are upper respiratory infections, gastroenteritis, nausea and vomiting, and abdominal pain. Nearly 60% of ED visits are acute episodes that might have been treated in a primary care setting, according to the Agency's report, "Analyzing Potentially Preventable Healthcare Events of Florida Medicaid Enrollees."

In 2015, Aetna implemented a strategy to reduce preventable ED visits and increase enrollee involvement in self-management of acute and chronic conditions, resulting in a decrease in ED visits and costs per-member-per-month. We target enrollees who have been to the ED three or more times in a quarter. The enrollee's care management team sends written notification to the PCP with the number of visits completed in the quarter, identifying both the enrollee and facility.

In addition, our care managers contact enrollees to determine the root cause of the ED visits. If the issue is that the enrollee does not like his or her PCP or the provider cannot accommodate the enrollee (e.g., extended hours, special needs, language), the care manager assists the enrollee in selecting another PCP and scheduling an appointment. If the issue is transportation-related, we educate the enrollee about access and assist the enrollee with arranging for transportation. Care managers use these outreach opportunities to educate enrollees regarding PCP offices with extended and weekend hours, availability of urgent care options, appropriate use of the ED, and Aetna's 24-Informed Health line. In addition, our care managers work with enrollees to address social determinants such as homelessness, and complete referrals for behavioral health services, including substance use concerns. The goal of PCP notification is so the provider can outreach the enrollee and schedule visits in lieu of ED visits.

For 24-hour support, Aetna offers the Informed Health line and a behavioral health crisis line staffed by our behavioral health vendor. The Informed Health line serves as a means of providing health information to enrollees and helps them to avoid avoidable use of ED services. The Informed Health line is staffed by nurses who can provide clinical support and education for enrollees. If enrollees do not require ED services, our clinicians can assist them on how they can self-manage their condition prior to seeing their primary care physician or specialist. The behavioral health crisis line is staffed by behavioral health clinicians who are experienced and trained to assist enrollees requiring support or in urgent or emergent situations. Our clinicians aim to stabilize enrollees as needed, refer them to their primary care physician or behavioral health practitioner as appropriate, or facilitate emergency assistance.

To reduce avoidable ED utilization further, we also encourage our primary care physicians to offer extended hours during the week and/or on weekends. This addresses one of the primary causes of avoidable ED utilization - that Medicaid enrollees often work in jobs that do not allow them the necessary flexibility to visit a doctor during normal business hours.



FIGURE MMA SRC 1-1: Reduction in ED Visits in Attachment SRC 1 provides an illustration of outcomes achieved by Aetna for ED visits from 2014 to 2016 statewide, as measured per 1,000 enrollees and per-member-per-month costs.

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **Emergency Room Utilization Reduction through Dental Care**

Enrollees in Regions 2 and 8 can be challenged with access to dental care because of the dentist-to-population ratio. Untreated dental issues can lead to ED utilization. In fact, untreated dental problems are one of the top causes of avoidable ED visits nationally. To support improved outcomes for dental preventive services and help prevent avoidable ED visits, Aetna's care managers monitor enrollee utilization and work together to enlist primary care physicians to provide screenings, apply varnish, offer anticipatory guidance (e.g., peer-to-peer and dentist-to-PCP or -pediatrician), and refer enrollees to dentists. PCPs play an important role in identifying children at risk for early childhood caries who may not yet have seen a dentist and in encouraging all children to find a dental home, preferably prior to age one as recommended by the American Academy of Pediatrics and American Academy of Pediatric Dentistry.

Aetna implemented a value-added restorative treatment benefit to adult dental care in 2016. Previously, adult enrollees, through State Medicaid benefits, received annual exams and X-rays, but if cavities were identified, restorative treatment was not covered. For a 12-month period beginning April 1, 2016, 1,967 adult enrollees received restorative services. Total cost of services was \$179,989 or \$91.50 per enrollee. Although it is difficult to pin down the ED reductions that resulted from adding this dental benefit, emergency department visits for this period decreased year over year. Based on this favorable experience and overall health improvements expanded dental benefits provide enrollees, Aetna will continue to offer the restorative expanded dental benefit to adult enrollees in all regions, in addition to a periodontal benefit for pregnant women.

### **OB Initiatives**

#### **Prenatal, Perinatal, and Postpartum Risks**

High incidences of pre-term births, resultant NICU admissions, maternal mortality, teen births, and infant mortality are issues throughout the State to which Aetna is committed to addressing. These prenatal, perinatal, and postpartum risks are prevalent in all Regions:

- Region 1: Highest percentage of preterm births
- Region 2: Highest rates for maternal mortality, teen births, and post-neonatal infant mortality
- Region 3: Highest percentage of low birth-weight births and births to mothers who smoked during pregnancy, plus highest infant mortality and child mortality rate
- Region 4: Highest rate for high-risk pregnancy care
- Region 6: Highest rate for neonatal infant mortality and births with an inter-pregnancy interval of less than 18 months
- Region 7: Lowest percentage of births with adequate prenatal care (54.35%) based on the Kotelchuck index
- Region 10: Highest percentage of mothers receiving initial prenatal care third trimester or no prenatal care, as well as highest percentage of very low birth-weight neonates
- Region 11: Highest cesarean section rate

All of these issues can result in high ED utilization, admissions, readmissions, and use of ancillary services. The cost of NICU admissions resulting from pre-term births is also significant.

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Aetna understands that a woman's health before, during, and after pregnancy can be positively impacted by the support and services we offer. To that end, Aetna employs and/or advocates for the following targeted programs:

### **Long-Acting Reversible Contraception (LARC)**

Aetna supports the Agency's LARC quality initiative. LARCs are a significant evidence-based strategy to reduce unintended pregnancies in the State. Unintended and/or closely spaced pregnancies contribute to delayed initiation of prenatal care, higher risk of preterm birth and small for age children, higher risk of maternal depression and child neglect, and lower breastfeeding rates. Florida's rate of unintended pregnancies is 59%, which is above the national average.

During prenatal and postpartum contact, care managers talk with our enrollees about contraception and birth spacing. They also send educational materials as part of a self-paced enrollee education strategy. Because up to 40% of patients do not return for a six-week postpartum visit, development of an option to provide LARC as an immediate application after delivery when new mothers are more motivated to obtain contraception.

### **Cesarean Section Reduction**

C-sections are the most common major surgery performed in the United States and C-section rates for low risk pregnancies vary tremendously by hospital and geographic location. Region 11 has one of the highest, if not the highest C-section rate in the country with Hialeah Hospital's rate the highest overall at 64%. Beyond the increased costs associated with C-sections, they also are associated with increased rates of maternal mortality as well as increased complications from surgery.

Through our experience as a managed care organization in Region 11, we have firsthand knowledge of the barriers across and within different systems of care that make the reduction of non-medically indicated C-sections and early elective delivery a challenging issue to impact both systemically and culturally.

Work to improve performance benchmarks for reducing non-medically indicated C-section sections in five key ways: enrollee education, data-driven discussions with providers, reimbursement parity between C-sections and vaginal deliveries, financial incentives, and implementation of the LARC program.

Educating our providers to encourage appropriate utilization to prevent a first occurrence of a non-medically indicated C-section is top priority. Aetna uses value based payment incentives including the Managed Medical Assistance Physician Incentive Program (MPIP) to discourage providers from performing non-medically indicated cesarean sections. A C-section rate under 35% is one of the quality criteria a provider must meet to qualify for the MPIP enhanced Medicare payment rate.

In addition, we currently reimburse hospitals the normal delivery rate when they bill for a non-medically indicated C-section. In this way, we actively dissuade providers from performing

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

avoidable C-sections. We are also developing value-based contracts with large OB groups that include targeted C-section rates as part of the quality bonus.

### **High-Risk Obstetrics (OB) Enrollees**

Beyond the PPEs related to C-sections, there are also preventable events such as inpatient hospitalizations and ED visits associated with high-risk obstetrics, which Aetna has strategies to address. Aetna contracts with a high-risk obstetrical home health agency that provides clinical services to this at risk population. These services include:

- Pregnancy prolongation services with obstetrical registered nurse (OB RN) support: For enrollees with a history of spontaneous preterm birth, services include 17P/Makena administration and nursing care management in home or at work, weekly in-person maternal-fetal nursing assessments, and intensive follow-up resulting in average 98% injection compliance rate. For enrollees with current or at-risk preterm labor, we have a preterm labor program that includes home visits by an OB RN who educates enrollees on maintaining a healthy pregnancy, signs and symptoms of preterm labor and self-palpation, access to 24/7 telephonic nurse support, related patient education materials, and a 30-day program with weekly outbound calls for preterm labor assessment.
- Nausea and vomiting of pregnancy (NVP): Our enrollees are offered continuous antiemetic therapy utilizing micro-infusion pump technology with nursing support, system of care with holistic approach, clinical OB pharmacist dosing oversight, home-based triage, access to nutritional assessments, and dietician recommendations.
- Diabetes in Pregnancy: For enrollees newly diagnosed with non-insulin-dependent diabetes, we offer support from an obstetrics registered nurse to help maintain normal blood sugar levels during pregnancy, daily monitoring and clinical evaluation, customized meal planning, and compliance monitoring. For enrollees with insulin-dependent diabetes in pregnancy, we offer daily insulin injections or continuous insulin infusion, in-home assessment and education, nutritional education with assessment and meal planning, dosing and adjustment according to physician parameters, counseling and support by experienced diabetes educators, and comprehensive out-of-range reporting to their physician.
- Hypertensive disorders in pregnancy: For enrollees diagnosed with gestational hypertension or preeclampsia, we offer home-based comprehensive nursing surveillance with device management, an interactive device that guides enrollees in assessment activities, and daily reports on results, including any out-of-range or non-compliance.
- Coagulation disorders in pregnancy: For enrollees with a current or history of thrombosis, we offer continuous subcutaneous anticoagulant therapy via micro-infusion pump, which eliminates the need for daily self-injections. Enrollees are intensively monitored and managed by clinical OB pharmacists in conjunction with physician orders.

### **Neonatal Abstinence Syndrome (NAS) Program**

Integrated care management goals for expectant mothers include optimizing the health of women during their pregnancies. Specific outreach with the objective of engaging pregnant women who have significant opiate use or opiate addiction and enrolling them in our prenatal care management facilitates the provision of support through our NAS program. With the

**EXHIBIT A-4-b**  
**MMA SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

incidence of maternal opiate use increasing dramatically in the last decade, Aetna believes it is important to identify and engage expectant mothers with substance use disorders as soon as possible in prenatal care, screen them for co-occurring behavioral health diagnoses, and provide and coordinate appropriate referrals to optimize care for these women and their babies. Our clinical care management team works with expectant mothers throughout their pregnancy to engage them in substance use treatment and help them stay in treatment for the duration of their pregnancy and the year after delivery. These women are also screened for other mental health disorders and referred for behavioral health specialty care as needed. Since we know that social determinants of health are critical for these enrollees, we work with a holistic person-centered approach to identify all of their needs and connect them to corresponding community based resources and support systems. The same care manager follows the baby in the hospital and for the first year of life, whether or not the baby has NAS.

**Neonatal Intensive Care Unit Admissions**

Aetna's dedicated neonatal intensive care clinician reviews NICU admissions throughout the enrollee's stay. If an enrollee has been admitted to NICU for a problem (e.g., rule out sepsis) and our medical director has determined that the enrollee does not require the highest level of NICU, we will advise the hospital that we approve a specific and appropriate level in the NICU. When we identify that an enrollee no longer requires NICU, we notify the hospital that we will pay a normal nursery rate. These decisions are made in cooperation between our medical director and the neonatologist at the hospital.

Aetna's chief medical officer participates in weekly NICU rounds with the NICU clinician, concurrent review supervisor, transition-of-care (TOC) clinician, and a medical director. The focus of these rounds is to ensure the enrollee is placed properly, monitor the enrollee's progress, and work on discharge planning to ensure that these high-risk enrollees are discharged appropriately with needed services in place. If it is determined that the enrollee will require private-duty nursing or skilled facility placement upon discharge, the Enhanced Care Coordination care manager also participates in NICU rounds.

[REDACTED]

[REDACTED]

**Baby and Parents Showing Positive Signs with Care Management Support**

[REDACTED]

**EXHIBIT A-4-b**  
**MMA SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Enrollees with Serious Mental Illness (SMI)

Mental health conditions account for nearly 40% of the initial hospital admissions that result in a readmission, according to data from the Agency's report, "Analyzing Potentially Preventable Healthcare Events of Florida Medicaid Enrollees." Schizophrenia is the leading diagnosis in enrollees with SMI followed by bipolar disorders and major depression. Enrollees with SMI mostly identified in Regions 1, 4, 5, 6, 7, 8, 9, 10, and 11.

Aetna's integrated care management model coordinates the enrollee's physical, behavioral, and social needs in an individualized, person-centered, holistic manner. All aspects of these needs are linked, and an enrollee's complexity is determined by his or her unique physical and behavioral health conditions, along with social determinants. Our integrated care management approach promotes the full integration of behavioral health and physical health services and assists providers in anticipating services that may be required for enrollees with serious mental illness.

Aetna's mental health disease management program aims to improve enrollees' health status, their ability to self-manage their mental health, and reduce or delay morbidity and mortality associated with mental health. The program seeks to decrease the incidence of ED visits and inpatient admissions related to mental health and achieve improvement in HEDIS measures that relate to mental health issues, including medication management and follow-up after hospitalization for mental illness.

During inpatient admissions, we meet with enrollees admitted for mental illness and collaborate with the treatment teams for discharge planning to address root causes of admissions. We encourage use of depot neuroleptics (long-acting antipsychotic medications), identify comorbid substance use needs, and connect enrollees with the full continuum of system of care services. CareUnify will enhance integration, communication, and coordination among Aetna's Care

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Management team, Beacon Behavioral Services (our behavioral health services provider), and the interdisciplinary care team. Because of the potential for urgent changes in health status, CareUnify's real-time functionality can be especially critical for enrollees with a mental health diagnosis.

Care managers are trained to support behavioral health disorders and they can use evidence-based job aids for reference tools. Additionally, they can make referrals to behavioral specialists for support, coordinate care between the enrollee's primary care physician and behavioral health practitioner. For example, if an enrollee being treated for metabolic syndrome is prescribed an antipsychotic medication by a behavioral health practitioner, we can share that information with the enrollee's PCP to ensure the enrollee's treatment plan is aligned with and supporting improved health outcomes. We can also support a measurement-based treatment approach for enrollees who are prescribed antidepressants by their PCP. We will educate PCPs on the use of a measurement tool like Patient Health Questionnaire-9 for depression severity to treat enrollees for full remissions of conditions rather than an initial response. This approach supports our effort to prevent unnecessary ED utilization.

### **Evidence-Based Practices for High-Utilizing Individuals**

Aetna supports the following evidence-based practices for high-utilizing enrollees with SMI and works to identify, provide access to, and collaborate with providers of these services and practices in Florida:

- Assertive community treatment (ACT): A multidisciplinary, mobile outreach treatment model for adults who have serious and persistent mental health issues; it was founded to provide the same kind of ongoing support and treatment clients receive in inpatient hospitals. The Florida Assertive Community Treatment (FACT) program is a service of the Florida Department of Children and Families (DCF). There are 33 FACT teams staffed with a psychiatrist, licensed mental health professionals, nurses, a vocational specialist, a substance abuse specialist, peer specialists, and care managers, according to DCF. The program delivers individualized, supportive services directly to individuals in their own environment 24 hours a day. It emphasizes coordinating needed treatment services locally for individuals, providing ongoing follow-up with no time limit, and delivering support to individuals within their own settings.
- Targeted care management (TCM): Services assist people in gaining and maintaining access to necessary medical, social, and other direct care services through assessment, care management planning, referral, and monitoring/follow-up. Depending on enrollee history and need, TCM may be provided in a long-term, intensive care management model (with direct service provision, assignment to a single care manager, but a less medication-focused approach than is typical of ACT), or be part of a short-term, targeted approach (with indirect service provision) aimed at coordinating focused interventions to address a limited number of issues for a period of up to 30 days.
- Psychiatric rehabilitation process model: A process guiding the interaction between a practitioner and an individual with SMI; manually driven, the model is an enrollee-centered, strengths-based intervention designed to build enrollees' positive social relationships, encourage self-determination of goals, connect enrollee to needed human service supports, and provide direct skills training to maximize independence. One-on-one sessions are used to help individuals access assistance in obtaining physical health,

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

mental health, dental, and social services and to develop and implement individual rehabilitation plans.

- Dialectical behavior therapy (DBT): A cognitive-behavioral treatment that targets emotional dysregulation and teaches adults with borderline personality disorder to replace dysfunctional behaviors with positive alternative behaviors; the goals of DBT are to reduce the patient's life-threatening behavior, to reduce behaviors that interfere with the process of therapy such as treatment non-adherence, and to reduce factors that interfere with the enrollee's quality of life such as impulsivity and repeated hospitalizations. In addition, DBT aims to increase general coping skills such as interpersonal effectiveness and emotional regulation.

### **Peer Support Specialists**

We use peer support specialists as an important resource for enrollees' emotional support. Peer support specialists are persons in recovery from a behavioral health condition who have completed specific training that enables them to support an enrollee's wellness and recovery by providing peer support. Peer support specialists encourage the voices and choices of our enrollees. They work in a variety of locations, such as peer support centers, crisis stabilization units, respite programs, psychosocial rehabilitation programs, and in psychiatric hospitals. Peer support can be a one-on-one experience or a group of people sharing together.

Objectives of peer support specialists include:

- Engagement of enrollees in a person-centered, strengths-based dialogue focused on achieving long-term recovery
- Supporting enrollees in identifying and working toward recovery-centered goals
- Identifying whole-person solutions that meet enrollees where they are on their health journey
- Improving linkages to community supports and services
- Assisting the enrollee in navigating the service delivery system
- Connecting the enrollee to community-based care services

These objectives often lead to enrollees gaining self-efficacy in their recovery, which in turn will result in cost savings, enabling pathways, and increasing adherence to treatment plans since the enrollee's voice is represented.

### **Pain Management and Substance Use Disorder**

Pain management and the associated potential for substance use are among the leading causes of utilization in the State. Abdominal pain, for example, is among the top three causes of ED visits in the State's 11 regions, according to the Agency's 2017 report, "Analyzing Potentially Preventable Healthcare Events of Florida Medicaid Enrollees." The three most common causes of chronic pain are low back, neck, and headaches/migraines, with many people affected at multiple sites.

Aetna's integrated care management program includes an assessment for chronic pain, which we complete with enrollees if they self-report a history of chronic pain or if there are indicators in their medical history. Care managers discuss with enrollees their current and past treatments and identify any gaps in care. This assessment might reveal that the root cause of the pain is

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not being addressed by the enrollees' primary care physicians, prompting us to follow up with the PCP. In addition, we make referrals for enrollees to pain management clinics in our network, following up to determine their level of satisfaction with the provider and ensure that they are reaching their pain management goals.

The misuse of opioid pain relievers can result in dependence, overdose incidents, and deaths. Heroin, fentanyl, and oxycodone were directly responsible for the deaths of nearly 3,900 Floridians in 2015, or 12% of the opioid overdoses in the United States, according to Florida Department of Law Enforcement statistics. Florida Governor Rick Scott officially declared the opioid epidemic a public health emergency in May 2017, and proposed legislation that includes a three-day limit on prescriptions, unless conditions are met for a seven-day supply. The opioid epidemic is symptomatic of substance use challenges facing the State, where Region 5 has the highest drug overdose mortality rate.

In response to the nationwide opioid epidemic, Aetna, Inc. created an enterprise-wide Opioid Taskforce chaired by our Corporate Chief Medical Officer Hal Paz, M.D. Aetna's strategy includes data-driven goals that benefit our enrollees; encouraging effective pain management, reducing abuse, and supporting long-term addiction recovery. We aim to reduce inappropriate opioid prescribing by 50%; increase opioid use disorder treatment with medication-assistance treatment and other evidence-based treatments by 90%; and increase treatment of enrollees with chronic pain by evidence-based multi-modal approaches by 50% across all markets. In addition, Aetna, Inc. is going beyond analytics and policy to help hard-hit areas that are suffering most from the opioid epidemic directly. Aetna Better Health of Kentucky has provided 720 doses of the overdose-reversal drug Narcan to first responders in the Northern Kentucky and Appalachia regions to help prevent opioid overdose-related deaths in the area. Aetna's strategies, as well as the example set by our health plan in Kentucky, provide a model for us to adopt in Florida to address the opioid epidemic.

Opioid abuse is a complex problem requiring a comprehensive and coordinated approach to support enrollees and providers. Evidence-based practices, pharmacy oversight, care management interventions and education, provider communications, and public awareness campaigns are ways we monitor, address, and prevent the misuse and over-prescribing of opioids.

### **Medication-Assisted Treatment**

We endorse medication-assisted treatment (MAT) as an evidence-based practice and provide coverage for a variety of options for MAT to enrollees with opiate and alcohol use disorders. Services can be rendered in the office by a trained primary care physician or psychiatrist or in a facility setting. Our care managers make the enrollees aware they have an option to receive MAT treatment and can assist them in accessing an appointment with a MAT provider. In other cases where the substance abuse disorder provider is providing the therapies and the PCP is prescribing the MAT medication, we assist with the communication and coordination between the two providers.

We endorse the following medications for MAT opiate use disorders:

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- Naloxone (for opioid overdose)—as a best practice, we promote the availability of Naloxone as a covered pharmacy benefit without prior authorization
- Buprenorphine: Subutex®, Suboxone® (Buprenorphine and Naloxone: decreases risk of IV abuse by antagonizing effects of Buprenorphine; no effect if administered orally)
- Methadone: only when provided within a licensed methadone maintenance program that meets Federal requirements for opioid maintenance treatment programs
- Naltrexone (opioid antagonist: promotes voluntary maintenance of recovery)

### **Screening, Brief Intervention, and Referral to Treatment**

Aetna is adopting Screening, Brief Intervention, and Referral to Treatment (SBIRT) practices into our care model. SBIRT is an early intervention approach that targets individuals with non-dependent substance use to provide effective strategies, like motivational interviewing, and interventions 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 substance use disorder. This approach can be used by primary care and other providers. SBIRT consists of three major components:

1. Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment,
2. Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change, and
3. Referral to treatment provides those identified as needing more extensive treatment with access to specialty care.

Aetna's Illinois health plan serves as a model. In the Illinois plan's provider network, more than a dozen large Federally Qualified Health Centers (FQHC), patient-centered medical homes, and community mental health centers are trained in SBIRT, as well as smaller, independent primary care providers. In 2016, 15 staff members received train-the-trainer credentials for SBIRT. They can orient PCPs on the importance and benefits of screening enrollees on SBIRT. Through monitoring of primary care physician billing, Aetna has seen a steady increase in the number of completed SBIRT screenings.

### **Pharmacy Oversight**

Aetna regularly monitors pharmacy and utilization data to identify potential abuse, misuse, or fraud. Aetna has submitted an Enrollee Restriction Lock-In program for Agency review and approval to assist identified enrollees in better utilizing their available benefits to obtain the best overall health outcome. The focus of the program is to support enrollees with biopsychosocial needs, assist enrollees to improve their pharmacy and benefit utilization appropriate to their health care needs, and coordinate care with the enrollee's primary care physician and other providers/pharmacy as needed. Enrollee restriction or lock-in means that an enrollee must obtain select prescribed drug services from a pharmacy provider designated by Aetna, or chosen by the enrollee and accepted by Aetna. All enrollees proposed for enrollment in the program must be approved by Aetna's chief medical officer. The goal of this program is to effectively monitor services and reduce the potential for inappropriate utilization; namely the administration of excessive quantities of prescription drugs through multiple visits to different

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physicians and pharmacies. The expected outcomes of this program are reduced cost and improved patient safety.

Currently, Aetna's Drug Utilization Review program is designed to analyze enrollee and practitioner drug utilization patterns to identify educational and/or intervention opportunities that promote enrollee safety and appropriate utilization, monitor quality outcomes, and to drive cost-effective drug therapy. Aetna's care managers can review multiple pharmacy reports to monitor prescriptions for enrollees, including poly-pharmacy reports for enrollees with multiple prescribers or pharmacies. Care managers will conduct follow-up with enrollees if there are questions about their prescriptions.

**Dual-Diagnosis Screenings**

We understand one-third of individuals with a mental health diagnosis have a substance use disorder. A primary cause for readmissions and high patterns of ED utilization occurs when only one of those diagnoses is recognized and treated. When an enrollee screens positively for a mental health condition or substance use disorder we complete a full screening for a potential dual diagnosis. When co-occurring conditions are identified, the enrollee and his or her primary care physician is informed to facilitate appropriate follow-up care. Additionally, we can help coordinate care between primary care physicians and substance specialists to help ensure an enrollee's treatment plan is in alignment (e.g., preventing a situation where a substance specialist is getting an individual to detox or taper down while a PCP prescribes medication for pain management).

We work with enrollees to build sober supports. Typically, this is done with 12-step and other support groups, securing a sponsor, treatment groups including dual-diagnosis issues, sober living arrangements, etc., and assist our enrollees are assisted with identifying support group meetings to attend and follow up for their response. Enrollees with substance use disorders require ongoing emotional support. We make appropriate referrals to behavioral health practitioners for therapy services.

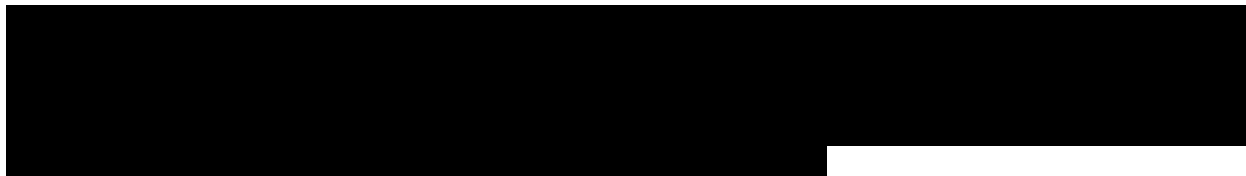
**Model Education and Awareness Campaign**

Mercy Maricopa Integrated Care (MMIC), an Arizona health plan managed by Aetna Medicaid, initiated a campaign to educate providers and the public on the treatment of pain. MMIC's medical directors and pharmacists are using the booklet, "If at First You Don't Prescribe," to educate dentists, oral surgeons, primary care, urgent care, ED, and general surgeons during face-to-face meetings. The campaign includes educating providers by presenting evidence dispelling the common myths of pain management. The campaign also includes collateral materials such as stress balls, magnets, and posters. The booklet "Power over Pain" is a companion piece intended for public consumption. MMIC distributes the booklet for display in waiting rooms in the ED, urgent care, hospital rooms, and doctors/dentists' offices, along with its accompanying poster.

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Obesity

Region 2 has the highest percentage of obese adults in the State, almost one-third of the population. Obesity is a risk factor for a variety of both physical and mental chronic conditions, including arthritis, cancer, depression, diabetes, heart disease, hyperlipidemia, hypertension, and stroke.

Aetna's integrated care management support for adult weight management is a six-month program designed to elicit changes in enrollees' health-related behaviors that positively impact their current and future health and wellness through collaboration, engagement, identification of strengths, and leveraging those strengths to enhance resiliency and result in enrollees' improved self-management and self-efficacy. The goal is for the enrollee to understand the health risks of being overweight and initiate at least one healthy behavior aimed at weight and health risk reduction.

Enrollees are referred to the program by care management staff, providers, community agencies, or self-referrals. They are also identified by medical claims with a diagnosis of obesity or morbid obesity, or with health risk questionnaire data.

Initial outreach assesses the enrollee's readiness to change and barriers to change. The enrollee is the enrollee weekly for the first month of the program to discuss progress towards the enrollee's personal goals and identify barriers, then every other week through the second

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and third months. The call interval for the duration of the program is at least monthly or more frequently based on the enrollee's status.

The enrollee may also be referred to a nutritionist or weight management group sessions in the community, as well as behavioral health support.

### **Cancer**

Region 3 has the highest cancer age-adjusted mortality rate. Aetna recognizes cancer is the leading cause of death in Florida, surpassing heart disease in 2011, according to the Florida Department of Health. Approximately one-third of the most common cancers are due to lifestyles—tobacco, poor diet, obesity, and lack of physical activity—according to the National Cancer Institute.

The program is designed to help enrollees understand and cope with a cancer diagnosis and the challenges of living with cancer. Care managers support enrollees with coordination of care among specialty providers, pharmacists, and services such as non-emergent transportation or durable medical equipment. The enrollee's care manager takes an active role in the authorization and coordination of oncology services and medications as well as monitoring the enrollee's medication adherence - understanding that the side effects of medication on an enrollee, particularly related to chemotherapy, can result in ED visits and hospital admissions.

Through communication and collaboration, Aetna's care managers help ensure the goals of an enrollee's care plan are aligned with his/her treatment plan from their oncologist or other specialty provider. We also work with an enrollee and his/her providers to coordinate hospice or palliative care, especially important for an enrollee with a life threatening or terminal illness. Our care managers also can support enrollees completing advance directives.

Understanding the duress cancer can cause to caregivers and family members, our care managers make referrals for respite care, peer support services, behavioral health, and additional support services.

### **Vaccine Benefits**

Region 10 is challenged by the lowest percentage of adults receiving a flu shot in the past year. Through outreach calls, mailings, and care management interventions, we educate enrollees prior to the flu season about our benefits. Flu shots are available at no cost to enrollees through our pharmacy benefit manager, CVS Health.

Additionally, Aetna provides adults with pneumonia and shingle vaccines as expanded benefits. These vaccinations prevent enrollees from becoming ill, decreasing ED and hospital utilization. In response to the Zika crisis, Aetna launched a Zika campaign. As part of the strategy, educational materials are provided to enrollees and providers, and our medical director has spent time in the community providing education about Zika. Care managers educate our expectant mothers about the risks and protective measures. An approved insect repellent has been included on our over-the-counter benefit list. In addition, we authorize additional ultrasounds for mothers at risk of contracting Zika.

### **RISK STRATIFICATION ALGORITHM**

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**CRITERION 2:** The extent to which the respondent describes specific care coordination protocols, including a description of the risk stratification algorithm used to identify super-utilizers

We identify individuals with high utilization in many ways, including the Consolidated Outreach and Risk Evaluation™ (CORE) predictive modeling tool; special needs reports; real-time ED and inpatient data through the Event Notification Service; health risk questionnaires; ED claims; referrals from primary care physicians, specialists, Informed Health line, behavioral health crisis line, and self-referrals.

CORE scores are generated from internally developed algorithms based on Medicaid population data and our clinical and informatics expertise. Inputs to the algorithms include demographics and medical, behavioral, and pharmacy claims data. The resulting inpatient and emergency room models provide enrollee-specific scores indicating the likelihood of the enrollee visiting the ED or experiencing an inpatient admission in the next 12 months. The model is run for our entire population monthly, and the results are reviewed by the appropriate clinical teams for enrollee contact and intervention opportunities.

CORE identifies enrollees for whom intensive care management will promote improved health and well-being, and prevent high-cost utilization. The analysis is based on three basic risk metrics:

- Predictive model (PM) general risk score—we consider enrollees who are in the top 1% of the population based on highest general risk score as high risk.
- ED risk score—Enrollees with an 80% or greater risk score we identify as high risk of an ED visit during the next 12 months.
- Inpatient admission (IP) risk score—Enrollees with an 70% or greater risk score we identify as high risk of a physical or behavioral IP admit during the next 12 months. (The risk score excludes maternity admits.)

Specific behavioral health risk indicators include behavioral health admissions and readmissions, presence of serious emotional disturbance, poly-prescriber and poly-pharmacy activity for behavioral health medications, and concurrent use of multiple medications from one behavioral health therapy class.

Through CareUnify, risk stratification information with is shared with provider partners to establish care priorities and care coordination activities— the information is well received by providers who often report challenges in identifying their highest risk patients and prioritizing the care they need.

### **Chronic Conditions**

Enrollees with chronic conditions are eligible for our disease management program and integrated care management support. Aetna's disease management program is designed to address those enrollees most likely to be high ED utilizers related to their diagnosis and severity of illness.

Multidisciplinary teams emphasize self-management to empower enrollees to assume greater responsibility for their health, address the root causes of their ED visit(s), and are healthier over

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the long term. This integrated care management approach emphasizes a holistic assessment of the enrollee's physical, behavioral, and social issues. A comprehensive approach more fully captures the enrollee's real-life issues associated with managing complex comorbid conditions that require multiple medications and coordination of social support and other services. Care managers take care of the whole enrollee as well as incorporating their social support networks and families into the care.

Care managers are the single point-of-contact for each enrollee. The care manager collaborates with the enrollee, his or her supports, and his or her interdisciplinary care team to create a plan of care that includes mutually agreed upon enrollee-centered goals. We help ensure the enrollee is attending appointments with his or her providers and we follow up to make sure he or she is receiving appropriate care. The care manager arranges for covered and non-covered services. In addition, they educate enrollees on the availability of community services and resources.

In many cases, it is social determinants such as housing instability, social isolation, employment, food insecurity, or a toxic home environment that are the root cause of poor health and high utilization rather than the proximate health condition. We work with the enrollee to distinguish the proximate cause of the admission (e.g., not taking his/her medication) from the underlying root cause (e.g., being homeless and having no place to store their medication).

### **PROVIDER SUPPORT**

**CRITERION 3:** The extent to which the respondent describes strategies to improve data exchanges and communications between practitioners to improve care coordination efforts for high-risk enrollees, using specific local examples

**CRITERION 4:** The extent to which the respondent plans to include the use of the Agency's Event Notification System as a means to extract relevant data from hospitals

Providers are offered number of resources to support their vital role in reducing potentially preventable event, including reducing the use of the ED for non-emergent/urgent visits. We work closely with providers to communicate to enrollees the importance of seeing their PCPs or specialist(s) instead of going to the ED to enhance the continuum of care. This is particularly important for enrollees who have rigid work schedules and who are challenged to see their provider during normal business hours. We have conducted mail campaigns with providers to reinforce a message of appropriate utilization.

Aetna has data integration capabilities with hospitals and healthcare systems in all 11 regions through the ENS. ENS provides secure, real-time notification of patient encounters from over 200 participating hospitals to subscribing organizations like Aetna. This includes ED visits, inpatient admissions, and observation stays in the hospital setting. Notifications are received in real time, multiple times per day indicating when our enrollees are admitted to a hospital or ED. At least two ENS summary reports are compiled daily.

The notification enables care managers to contact the enrollee timely and provide proactive follow-up care. We share utilization information with providers, who have an opportunity to contact the enrollees and schedule follow-up appointments, enhancing care coordination efforts

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and improving the provider/enrollee relationship. Aetna is developing applications for automated email notification for providers and ENS data integration with CareUnify, the external component of our electronic care management platform. Enrollees identified with ED high utilization are outreached after each ED encounter to help ensure that they are scheduled to see their PCP for follow-up.

CareUnify allows us to retrieve data from other partners, such as ENS Service for notification of hospital admissions and ED visits, a hospital's electronic health record (EHR), clinical data feeds from the State, and other relevant information from Aetna or external care management entities. CareUnify provides a mechanism for real-time alerts tied to changes in condition, notification of key clinical events, needed gaps in care, and performance trends—a true 360-degree view—with all of the essential data for an enrollee's providers, care manager, and interdisciplinary care team to use for care coordination and real-time care support.

After an enrollee's ED visit, our team will contact the enrollee's PCP and discuss the root cause of the visit, or the PCP would receive an electronic notification directly into the EHR from CareUnify. Following notification, a follow-up call by the PCP to the enrollee is recommended to address any ongoing needs, such as medication reconciliation. This information is also updated in the enrollee's CareUnify profile. By aggregating this data for our provider network and community partners on CareUnify, the information can be converted quickly to actionable data to promote care continuity, prevent duplication of services, and provide more efficient care coordination, particularly effective for complex, high-risk individuals who have more advanced care needs.

CareUnify features industry-leading and proprietary features like care paths that take information and convert it into meaningful action steps for the entire interdisciplinary care team, regardless of their affiliation and the four walls inside which sit. Care paths are specialized workflows that are designed to create simple, predefined steps shared by a team of providers around a common clinical event tied to best practices. While a care path can be created for any number of clinical events that require team coordination, a common care path successfully used in CareUnify is related to managing a transition of care after an enrollee is discharged from a hospital stay.

The power of the care path function is to ensure accountability for providing quality care and to prevent duplication of services. More importantly, by setting a care path tied to key clinical events, this helps keep the care team aligned in their effort and minimizes confusion for the enrollee about who is coordinating specific components of care. The process promotes enrollee safety to help ensure key care actions, like medication reconciliation, are completed.

Although urgent care is not a substitute for primary care, it is a cost-effective alternative to the ED when an enrollee has an urgent need that cannot be accommodated by his or her PCP. Providers and enrollees are informed about the locations of urgent care centers in their area, and Aetna has contracted with urgent care centers throughout the State to ensure access. During our outreach calls to the enrollees with high utilization of ED services, enrollees are educated about which facilities are within their ZIP code, including urgent care center addresses and contact information. When enrollees call with inquiries about EDs or urgent care centers, Aetna's Enrollee Services representatives are trained to ask why they are calling to help

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ascertain whether a referral to a PCP might be more appropriate, with the objective of encouraging enrollees first visit their PCP.

Additionally, Aetna provides monthly reporting to providers on ED utilization by their enrollee panel. Providers whose enrollees are trending with high utilization are asked to develop a corrective plan.

### **PROVIDER INCENTIVES**

**CRITERION 6:** The extent to which the respondent describes financial and non-financial provider and enrollee incentives that are aimed at diverting care to more appropriate and cost-effective settings (e.g., incentives for primary care providers that agree to extended or after-hours clinic care for their Medicaid patients)

Aetna understands that provider engagement is critical to PPE reduction and that such engagement must come from compensation arrangements such as value-based contracts, risk agreements, and quality incentive programs like the MMA Physician Incentive Program (MPIP). MPIP rewards practitioners for improved outcomes and PPE reductions. In this regard, Aetna's MPIP offers incentives for qualified primary care physicians (i.e., pediatricians, family practitioners, and general practitioners) that provide medical services to plan enrollees under 21. Physicians can earn incentives for the following measurements aimed at diverting care to more appropriate and cost-effective settings:

- ED utilization of all assigned enrollees; benchmark is less than 650 visits/1,000 enrollees for ED utilization
- Office hours after 6 p.m. Monday to Friday or weekend hours

The Awesome Provider Program is an example of a provider recognition tool through which Aetna will provide several performance indicator programs on our website offering enrollees the ability to find and evaluate the provider that best fits their needs. Currently, we offer a "Rate this Provider" capability for all provider types, which allows enrollees to rate a provider based on their experience with the provider's performance. The enrollee is asked to rate the provider on a scale from one to five, with one being the lowest score and five being the highest. Responses are averaged, and performance ratings are displayed by stars next to the provider's name. Beginning in 2018, we will also offer an Awesome Provider Program rating. The program rates PCPs based on performance under several HEDIS indicators. Also under consideration is the addition of other performance indicator functionality in the future, such as incorporating Centers for Medicare & Medicaid Services rankings or other identified performance ratings.

The Awesome Provider program offers increased transparency into the provider selection process and celebrates Medicaid Managed Medical Assistance PCPs that demonstrate high clinical quality performance. The program consists of PCPs with at least 100 assigned enrollees and a minimum of 5 enrollees in each quality measure denominator (if more than one sub-measure) and with scores within the 50th percentile rate in 75% of applicable program measures. The top three scoring practices in each category will receive the award of Aetna Awesome Provider, which will be communicated in Aetna's online provider directory and among other providers to promote a competitive atmosphere. With one of Aetna's Awesome Providers,

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enrollees will have the satisfaction of knowing they are choosing a provider that meets and/or exceeds standards.

The Awesome Provider program provides reports on HEDIS quality measures for adults (an asterisk symbol [\*] indicates a HEDIS measure that is also one of the State's required measures):

- Adults' Access to Preventive/Ambulatory Health Services (AAP)\*
- Cervical Cancer Screening (CCS)
- Comprehensive Diabetes Care – Eye Exam (CDC DRE)\*
- Medication Management for People with Asthma\*

HEDIS reporting measures for children (pediatrics) include the following (an asterisk symbol [\*] indicates a HEDIS measure that is also one of the State's required measures):

- Children and Adolescents' Access to Primary Care Practitioners (CAP) between 12 to 24 months, 25 months to 6 years, 7 to 11 years, and 12 to 19 years\*
- Childhood Immunization Status (Combo 3) (CIS)
- Lead Screening in Children (LSC)
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
- Immunizations for Adolescents

Not only will this provide valuable quality information to enrollees, it will also give providers visibility into the recognized performance of their competitors in the region, further driving competition toward quality improvement.

Because Aetna wants to provide our enrollees with as much information as possible when selecting a provider, several indicators through our online directory to assess a provider's ability to fulfill an enrollee's needs are offered, such as accepting new patients, access to after-hours care, board certifications, hospital affiliations, languages spoken, and available interpreter services. These indicators are available (as applicable) across all provider types, including the ITN-designated specialty providers. For long-term care, home health, nursing care, and home and community-based providers, we offer several additional categories that include indicators, such as NPI number (if applicable), state license number, website (if available), handicap accessibility, special training, and geographic service area. These indicators are helpful to ensure the enrollee selects the right provider for the right service and in the right setting.

Our provider directory informs enrollees of which providers meet quality standards by putting designation symbols next to the provider's name. For example, providers qualifying as patient-centered medical homes (PCMHs), may be denoted by a gold star or a trophy symbol. Providers who qualify for quality bonuses, for example, would be identified with a different symbol. All of these symbols will be explained in an easily identified legend in the directory. Providers are recognized for meeting performance goals through the following programs: Awesome Provider, PCMH, value-based quality performance, and Managed Medical Assistance Provider Incentive program enhanced payment qualifications.

An assessment of our prenatal and post-partum incentive program revealed we did not realize the participation levels for which we had hoped, triggering a change in our approach to offering

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enrollee incentives. In 2018, we are rolling out a diaper home delivery incentive program. Qualifying enrollees will receive 200 diapers of their preferred brand and size, delivered to their homes. This new incentive program is designed to respond to the feedback we received; it not only places additional resources in the hands of our enrollees, but is considerate of the time, transportation, and cultural needs of members, empowering them in their choices for their child. In this way, we model our slogan: You don't join us. We join you. We are confident the attention we pay to our enrollees' needs result in increased adherence to prenatal and postpartum visits requirements and participation in our incentive program.

#### **MEASURES USED TO EVALUATE THE EFFECTIVENESS OF INTERVENTIONS**

**CRITERION 5:** The adequacy of the respondent's description of specific indicators or measures that will be used to evaluate the effectiveness of evidenced-based programs and interventions that target super-utilizers

Using a variety of reporting, review, and referral methods, we track utilization for enrollees with patterns of high utilization. Risk scores from monthly CORE reporting are analyzed as a primary means of evaluating the effectiveness of our evidence-based interventions. Enrollees in CORE's Group 4 are targeted because they are at the highest risk based on their general risk score, ED risk score, and inpatient admission risk score. Monthly outcomes are reviewed to determine if targeted enrollees' CORE scores have been downgraded. In addition to CORE, we review the quarterly ED report for enrollees with high utilization. This report identifies enrollees with three or more ED visits in a quarter. The readmission report details 7- and 30-day readmissions by facility, provider, and diagnosis, and the daily inpatient census and discharge census provides data to both the Utilization Management and Care Management staff for discussion during daily multi-disciplinary rounds.

Additionally, CareUnify is also utilized to identify enrollees with high ED utilization. Population health specialists work directly with primary care physicians and hospital systems using CareUnify workflows to handle post-discharge care and care coordination for the enrollee and all participating in the care. CareUnify establishes common care paths to drive best practices that align to national preventable readmission programs such as Project RED (Re-Engineered Discharge), which is an enrollee-centered, standardized approach to discharge planning and discharge education, developed through research funded by the Agency for Healthcare Research and Quality. Additionally, we will use Project BOOST (Better Outcomes for Older Adults through Safe Transitions), a national initiative to improve the care of enrollees as they transition from the hospital to home. The goals of these collaborations are to ensure an evidence-based approach, prevent service duplication, and ensure the enrollee receives all critical care and services to prevent readmissions and alignment back to his or her patient-centered medical home. Further, CareUnify can send admission, discharge, or transfer messages in real-time and show all enrollees of the integrated care team those enrollees with multiple ED visits or admissions. This data will help with prioritization and tailoring of services for those enrollees with high utilization and cost trends.

#### **Reduction in Hospital Admissions and Readmissions**

Our strategy for reducing hospital admissions includes the real-time identification of any enrollee with an inpatient stay, observation stay, or ED visit. Those enrollees are treated as the highest

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risk for readmission. From day one of an inpatient stay, concurrent review clinicians and care managers review the admission medically and also identify behavioral, social, or other contributing factors or root causes of the admission, which enables us to understand and prevent discharge planning failures that can lead to readmission (e.g., not repeating the same discharge plan if there is a readmission).

Resources and processes for preventing potentially preventable admissions and readmissions include:

- TOC clinician: Aetna employs a TOC clinician to collaborate with our concurrent review staff and care managers, hospital discharge planners, and providers to offer assistance and connect with enrollees who have trigger diagnoses including asthma, behavioral health diagnoses, cancer, chronic obstructive pulmonary disorder, congestive heart failure, diabetes, and stroke. Transition planning for all enrollees begins on admission. The TOC clinician attends daily rounds with the medical director and concurrent review clinician, which enables the TOC clinician to identify enrollees that are pending discharge and will require assistance with transition. The TOC clinician reaches out to the hospital discharge planner to identify the enrollee's needs upon discharge. Relying on the orders from the attending physician, the hospital discharge planner's assessment, and the concurrent review clinician's clinical notes, the TOC clinician assesses whether the enrollee is appropriate for a safe discharge to home with or without support services or if the enrollee requires discharge to an alternative setting.
  - The TOC clinician completes face-to-face visits with the enrollee and his or her responsible parties in the acute care setting and in other care settings as needed, including the home environment. One of the goals of our face-to-face visits is to provide patient education about his or her condition and plan benefits, ensuring the enrollee is appropriately educated about what to expect after discharge and what his or her responsibilities are to support a successful transition of care.
- Concurrent review: Aetna's concurrent review function provides an initial and ongoing review of hospitalizations as well as review of an enrollee's stay in an alternative acute care facility (rehabilitation) or non-acute facility. Admissions are reviewed based on pre-established decision criteria to approve medically necessary care at the most appropriate level for continued physical health and behavioral health treatment. Our approach is about coordinating the best care of the enrollee to help prevent readmissions. The enrollee's discharge plan is initiated on the first day of admission, with a root-cause approach. Our licensed clinicians are trained to evaluate all biopsychosocial factors that resulted in an admission, with the objective of identifying the critical unmet needs that are driving utilization or crisis. Our objective is to intervene with enrollees before they become high risk, making referrals for enrollees into care management, as needed.
  - Services subject to concurrent review are those provided in acute medical and psychiatric facilities, rehabilitation and residential facilities, and skilled nursing facilities. Clinicians working under the direction of the chief medical officer or designated medical director complete initial reviews of enrollees' admissions within one business day of notification of the admission. Subsequent reviews are conducted on a schedule determined by the enrollee's reason for admission, type of facility, and its location.

## **EXHIBIT A-4-b**

### **MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Predictive modeling: We use a predictive model to identify enrollees who are not currently hospitalized but who are at high risk for hospital admission. Our CORE tool identifies each enrollee's risk (including behavioral, social, and physical) for hospital admission within the next 12 months. Based on this data, our care managers proactively reach out to those enrollees at the highest risk for admission to offer them care management, gather information on triggers and stressors, engage them in disease management, offer community-based resources, and encourage enrollees to reach out to their providers, specialists, or behavioral health providers for any needs.
- Prior authorization: Prior authorization is required for elective/scheduled hospital admissions. The prior authorization clinician will review against criteria and determine if it is medically necessary. If an enrollee has an emergency admission, the hospital must notify us of an admission within 24 business hours. The hospital calls our Utilization Management department, which is staffed 24 hours daily. A prior authorization clinician will contact the hospital and will obtain medical information and conduct a review. If the prior authorization clinician is unable to determine there is medical necessity for the admission, the case will be forwarded for medical director review.

#### **Strategies to Help Ensure Appropriate Utilization**

Aetna's enhanced observation initiative is designed to divert acute diagnosis-related group admissions into the observation setting appropriately upon review by Aetna's medical director. Enrollees with less severe conditions should be managed in this setting and usually require less than 48 hours to stabilize and start their treatment. Enrollees then can be transitioned to a home or alternate setting for completion of their care. Additionally, Aetna authorizes outpatient surgeries in ambulatory surgical centers instead of hospitals as a cost-savings measure when appropriate. If an enrollee has a complicating condition that may require a hospital, our medical director will review and make a determination. In addition, if the requesting provider believes an enrollee will require an overnight observation stay after the procedure, we will approve the hospital with an observation stay.

#### **Reduction in the Use of Preventable Ancillary Services**

Aetna utilizes various tools and data sources to report, evaluate, and intervene when over-utilization of ancillary services is identified in providers. We establish indicators that will detect over-utilization, conduct further analysis when indicated to identify root causes, develop action plans at both Aetna and the individual provider level to address over-utilization, and establish processes to monitor the results of corrective action taken, and take further action as needed. Any care or service, which is delivered or should have been delivered, to an enrollee under the enrollee's benefit package, is subject to review for over-utilization. We use many sources of data to identify potential over-utilization. Examples include, but are not limited to:

- Provider performance profiles
- Utilization management reports and key indicators such as laboratory and diagnostic utilization and outpatient utilization of services
- Medical management dashboard
- Complaints
- Grievances
- Pharmacy reports

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Practitioner audits (e.g., ambulatory medical record review)
- Prior authorization and claim reviews
- Notifications from the Agency

Results are reviewed and analyzed by the Medical Management department with the chief medical officer. Our Provider Services department works with providers with patterns of high utilization to identify root causes and educate them on correctable actions. We also can make an internal referral for a fraud, waste, or abuse investigation.

Additionally, we contract with a vendor to complete evaluations for billing errors and inconsistencies on costly inpatient hospital claims. The vendor reviews for inappropriate charges such as billed levels of care that are not supported by the enrollee's resource consumption.

### **Provider Performance Profiles**

Aetna provides a provider performance profile to practitioners and providers through a common secured electronic delivery system. This effort supports the distribution of essential clinical and enrollee information that will promote quality efforts to maximize point-of-care delivery. The provider performance profile is generally utilized to reflect panel enrollee receipt and costs of defined clinical services or health care status for the profile measurement and/or reporting period.

The provider performance profile is composed of data such as:

- Detailed utilization data
- Costs per enrollee
- HEDIS measures
- Inpatient admissions
- ED utilization trends
- Readmission rates
- Predictive modeling data
- Provider level detail on specific performance measures

### **Ambulatory Medical Record Review (AMRR)**

Aetna conducts reviews of its participating network primary care practitioner groups, high-volume obstetrical/gynecological groups with a patient panel of 50 or more Aetna enrollees, and high-volume specialists who receive 50 or more referrals per contract year from Aetna. High-volume specialists include, but are not limited to, those practitioners or providers who provide care for enrollees with special needs and specialists acting as primary care practitioners. We have developed comprehensive AMRR review tools that incorporate the Agency's required medical records standards and take into consideration professional and community standards and accepted and recognized practice guidelines. Each medical record selected is reviewed against the appropriate AMRR criteria to verify the practitioner's compliance with Aetna and Agency medical record standards and requirements. Deficiencies are noted and a review score is determined.

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

If the review score does not meet the established Aetna standards for the practitioner/provider category, Aetna requires the practitioner/provider group to develop and implement a corrective action plan.

### **Quality Management/Utilization Management Committee**

Aetna's Quality Management/Utilization Management (QM/UM) Committee provides intervention strategies to address both over- and under-utilization of health care services. The committee collects, monitors, analyzes, and evaluates utilization data. Variances are interpreted and outcomes for reporting interventions established and then continuously analyzed to determine the effectiveness of the interventions. The effectiveness of interventions and data interpretation is used to assess the effectiveness of measures taken and the impact on quality of care for enrollees.

### **PERFORMANCE BENCHMARKS**

**CRITERION 7:** The extent to which the respondent proposed local performance benchmarks for:

- (a) Reducing potentially preventable hospital admissions and readmissions;
- (b) Reducing use of the emergency department for non-emergent/urgent visits; and
- (c) Reducing the use of unnecessary ancillary services during hospitalization and outpatient visits.

Aetna is driven by the opportunity to make a significant impact on utilization rates in every region of the State. Improved rates are a reflection of many components, including enhanced coordination of care for enrollees through direct primary and specialty care interventions, and use of evidence-based practices and advanced technology for deeper integration.

Aetna is proposing the following rates for each of the 11 regions over the course of a five-year period, beginning with the start of the contract date. We recognize the initial stage of our expansion into new regions will be a development process and will feature a learning curve among enrollees, providers, and Aetna, which potentially could influence outcomes.

Proposed benchmarks (reduction from current rate):

- Preventable hospital admissions: 5%
- Preventable hospital readmissions: 2%
- ED for non-emergent/urgent visits: 5%
- Avoidable ancillary services during hospitalization and outpatient visits: 5%

We recognize there will be regional influences on whether these proposed benchmarks will be achievable in each region. For example, in a region that is already high performing, a 5% reduction may not be attainable. Whereas, a region that is low performing, a step gain could be expected with effective interventions the first year. Aetna will consider these factors when developing our region by region strategy and establishing performance benchmarks. We look forward to discussing with the Agency our strategies for achieving these proposed outcomes for reducing potentially preventable events.

### **ASSESSMENT OF HOSPITAL UTILIZATION RATES AND POTENTIAL FOR IMPROVEMENT**

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Aetna uses a comprehensive reporting, advanced data analytics tools, a structured approach to data review processes, data-driven decision-making, and person-centered solutions and services that deliver outcomes as a multistep model for reducing preventable hospital admissions and readmissions, complications, and ED visits, as well as utilization of ancillary services. Measuring and reporting accurate and meaningful data is core to the overall value Aetna brings to the State and is central to our statewide Medicaid managed care program evolution process. Comprehensive data analysis reports through a combination of disparate data sources, including a comprehensive set of reports are generated, enabling us to monitor admissions and ED visits by combining diagnosis and current procedural terminology (CPT) codes.

Aetna takes a collaborative approach and an integrated, inter-departmental view to reviewing data and reports. Reports are reviewed by Aetna leadership and key decision-makers from the Medical Management, Operations, and Finance departments. Reviewers include chief medical officer, medical director(s), chief executive officer, chief operations officer, vice president of clinical health services, director of health care quality management, and additional members of the Medical Management department, including the Care Management team.

On a monthly basis, the chief medical officer and vice president of clinical health services analyze utilization data, evaluate plan performance, and identify variances in the standard of care. Established methodologies are used to measure performance by comparing data against benchmarks or goals and historical information. Recommendations for action planning are provided when variances are identified. At a minimum, the chief medical officer presents utilization reports quarterly to the QM/UM Committee, which the chief medical officer chairs. The QM/UM Committee is responsible for providing feedback to the chief medical officer and approves action plans including adjustments to the Quality Assessment and Performance Improvement program.

Aetna measures the following to identify potential areas of over- or under-utilization of medical inpatient services:

- Bed days per 1,000, monthly
- One-/two-day admissions
- Outlier day reviews
- Enrollee outcomes (readmissions, with assessment of related discharge planning)
- Consistency of application of medical review criteria as measured through the annual inter-rater reliability audit
- Quality/utilization management indicators and performance measures
- Consistency in documentation by department file audits

Aetna developed the care management outreach program for enrollees with high ED utilization as a result of data reviews and consultation with the QM/UM Committee. In the State of Florida, we achieved a decrease in ED visits per 1,000 enrollees from 2014 to 2016 and a decrease in ED cost per enrollee month in the same period, as well as cost savings exceeding \$900,000 in 2016.

Additionally utilization oversight includes:

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- The chief medical officer and vice president of clinical health services meet monthly with the Finance department to review clinical and financial outcomes. These meetings enable us to identify any issues and trends, and formulate plans of action. We identified an opportunity for improved outcomes and created the NICU nurse position, described previously in this section, as a result of this collaboration between Medical Management and Finance.
- Aetna leadership (chief executive officer, chief operations officer, and chief medical officer) meets monthly with Aetna's regional vice president to review an operating report.
- The Care Management staff conducts urgent outreach to enrollees based on daily Event Notification Service reports or other identified areas of need.

Our Utilization Management team performs retrospective reviews to understand the pattern, issues, and problems in utilization. We use our findings to improve quality and outcomes for our enrollees, while maintaining cost efficiency.

### **Evaluation Criteria:**

1. The extent to which the respondent identified specific localized opportunities for improvement in achieving a reduction in potentially preventable events and subsequent steps the respondent will implement to overcome any barriers across and within different systems of care (i.e., medical, behavioral health).
2. The extent to which the respondent describes specific care coordination protocols, including a description of the risk stratification algorithm used to identify super-utilizers.
3. The extent to which the respondent describes strategies to improve data exchanges and communications between practitioners to improve care coordination efforts for high-risk enrollees, using specific local examples.
4. The extent to which the respondent plans to include the use of the Agency's Event Notification System as a means to extract relevant data from hospitals.
5. The adequacy of the respondent's description of specific indicators or measures that will be used to evaluate the effectiveness of evidenced-based programs and interventions that target super-utilizers.
6. The extent to which the respondent describes financial and non-financial provider and enrollee incentives that are aimed at diverting care to more appropriate and cost-effective settings (e.g., incentives for primary care providers that agree to extended or after-hours clinic care for their Medicaid patients).
7. The extent to which the respondent proposed local performance benchmarks for:
  - (a) Reducing potentially preventable hospital admissions and readmissions;
  - (b) Reducing use of the emergency department for non-emergent/urgent visits; and
  - (c) Reducing the use of unnecessary ancillary services during hospitalization and outpatient visits.

**EXHIBIT A-4-b  
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**Score:** This section is worth a maximum of 45 raw points with each of the above components being worth a maximum of 5 points each.

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## **Attachment MMA SRC# 1**



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MMA SRC# 1: Figure MMA SRC 1-1: Reduction in ED Visits

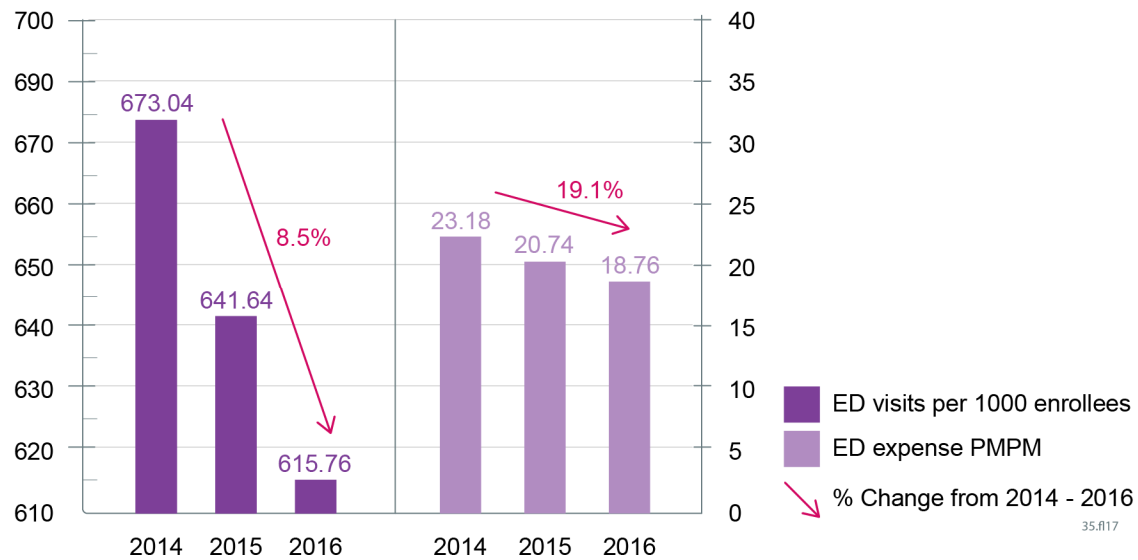


Figure MMA SRC 1-1: Reduction in ED Visits

*Aetna's comprehensive program of services and support has resulted in improved outcomes for ED visits per 1,000 enrollees and costs per-member-per-month since 2014.*



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**EXHIBIT A-4-b**  
**MMA SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**MMA SRC# 2 – Birth Outcomes (Statewide):**

The respondent shall describe its organizational commitment to quality improvement as it relates to pregnancy and birth outcomes. More specifically, the respondent shall describe its overall approach, and specific strategies, that will be used to address prematurity prevention, improve perinatal outcomes, and reduce unintended pregnancies, including:

- A description of performance benchmarks for reducing non-medically indicated cesarean sections and early elective deliveries;
- A description of incentives that will be implemented for providers and enrollees aimed at improving birth outcomes; and
- A description of strategies to decrease unintended pregnancies (e.g., increase in the use of long acting reversible contraceptives).

**Response:**

Aetna embraces our pivotal role in advancing a life-course approach to improving birth outcomes. We are passionate about the health and well-being of our enrollees—including our smallest ones—and we champion efforts to positively impact their lives for the long-term.

This philosophy, driven by a commitment to excellence, caring, integrity, and inspiration, guides our belief that the responsibility for quality improvement is a health plan-wide endeavor wherein every staff member is empowered to identify areas for improvement.

The results of our collective efforts is evidenced in our quality ranking—Aetna recently received the top National Committee on Quality Assurance (NCQA) ranking among all Florida Medicaid plans for the second year in a row, and we are among the top 15 Medicaid plans in the United States. We also hold the highest Consumer Assessment of Healthcare Providers and Systems (CAHPS) composite score of 4.0.

**ORGANIZATIONAL COMMITMENT TO QUALITY IMPROVEMENT AS IT RELATES TO PREGNANCY AND BIRTH OUTCOMES**

With a wealth of experience in Florida managing the care of pregnant women, Aetna fully understands the Florida Statewide Medicaid managed care program covered services for pregnant women, and align our priorities with those of the State related to pregnancy and birth outcomes. Because of our shared commitment to reducing early delivery and improving pregnancy and birth outcomes, significant attention and resources have been devoted to reducing non-medically indicated C-sections and early elective delivery. The negative health impacts associated with each of these practices also negatively effects perinatal outcomes.

Investment in minimizing prenatal and perinatal risk factors for mothers and children is part of that priority. Throughout the organization, actions are consistently underway, with the objective of improving quality for every facet of the enrollee's pregnancy experience—whether it is ensuring mother's safety in the home, seeing to it that she receives dental exams throughout her pregnancy, or connecting her with high-quality physicians who meet her cultural and linguistic preferences. With authority delegated by Aetna's Board of Directors, Heidi Garwood (chief executive officer) and Jorge Cabrera, M.D. (chief medical officer) lead the design,

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

administration, and implementation of our Quality Assurance and Performance Improvement (QAPI) program. Through our integrated and collaborative approach, each functional area funnels their input to be synthesized by our Quality department and various quality committees, which guide and measure quality activities. To increase the effectiveness of our staff's input on matters influencing pregnant Floridians, every Aetna colleague completes free, mandatory Lean Six Sigma quality certification, and all associates are required to achieve white-belt certification within three months of employment. The Lean Six Sigma methodology helps us develop and improve processes as we focus on understanding the needs of our enrollees and serving them effectively and efficiently.

Aetna recognizes our role in helping enrollees meet their goals of maintaining a healthy pregnancy and delivering a healthy baby. The enrollee is always in the center of every decision we make. Employing live enrollee outreach and education, risk stratification through both assessments and predictive modeling, care management that fully integrates our physical and behavioral health systems of care, and support programs help facilitate removal barriers to appropriate medical care, and more. To increase the likelihood that enrollees bring healthy children into the world, processes and strategies are evaluated using quality measures designed to increase the effectiveness of our efforts.

Aetna's commitment to improving pregnancy and birth outcomes is evident in our substantive collaborations with existing initiatives in order to break down silos that would hinder the care of our enrollees. In conjunction with the Florida Department of Health (DOH), we support DOH initiatives and programs for pregnant women, new mothers, and families through programs such as the Body and Soul Toolkit and Healthy Start. Aetna is also an active participant in the Healthy Start Coalition of Miami-Dade (HSCMD) and we will expand our participation to other county and regional Healthy Start coalitions as we prepare for potential expansion throughout the State in 2018. To demonstrate our organization's commitment to improving pregnancy and birth outcomes, Aetna leads the charge for healthy births by holistic care approach. We have developed the following innovative programs for enrollees, and training opportunities for providers, to increase the likelihood of a healthy pregnancy and delivery:

- Annual Prematurity Symposium in collaboration with HSCMD
- Dental expanded benefits
- Neonatal Abstinence Syndrome program
- Moving Beyond Depression program in collaboration with HSCMD
- Postpartum depression program in collaboration with our subcontractor, Beacon Behavioral Health

As a result of our whole person care planning approach, many of our initiatives and processes designed to improve pregnancy health and birth outcomes cross categories, such as prematurity prevention, improved perinatal outcomes, and reduction of unintended pregnancies. For the purpose of this response, we will discuss specific programs in the area most closely aligned with the identified categories.

### **HEIGHTENED PCP/OB REQUIREMENTS**

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

To provide obstetrical and infant care services, our participating providers are contractually required to comply with the requirements, as described in our contract with AHCA, which is designed to affect birth outcomes and the health of our mothers and infants positively.

In accordance with State regulations, obstetrician (OB) providers must provide the highest level of care for newborns beginning immediately after birth, which in addition to standard practices like Apgar scoring and administering vitamin K, includes:

- Newborn screening services that includes the required laboratory screening process to test for metabolic, hereditary, and congenital disorders known to result in significant impairment of health or intellect. These required laboratory tests are processed through the State Public Health Laboratory.
- Testing infants born to HbsAG-positive mothers for HbsAG and Hepatitis B surface antibodies six months after the completion of the vaccine series to monitor the effectiveness of the therapy. Providers must report to the local county health department a positive HbsAG result in any child age 24 months or younger within 24 hours of receipt of the positive test results.
- Any other necessary and immediate need for referral in consultation from a specialty physician, such as the Healthy Start (postnatal) infant screen

PCPs and pediatric providers are also required to coordinate with the local Women, Infants, and Children (WIC) office to provide the required referral data from the most recent child health checkup program (CHCUP). Each time the provider completes a WIC referral form, they must provide a copy of the form to the enrollee and keep a copy in the enrollee's medical record. PCPs and pediatric providers must test infants born to HbsAG-positive mothers for HbsAG and Hepatitis B surface antibodies six months after the completion of the vaccine series to monitor the success or failure of the therapy. Providers must report to the local county health department a positive HbsAG result for any child age 24 months or younger within 24 hours of receipt of the positive test results. Other required actions include asking each enrollee about her safety at home during the initial outreach questionnaire, pregnancy assessment, and subsequent contacts with care managers because of the known increase in domestic violence during pregnancy.

In addition to these requirements, our OB providers must provide all women of childbearing age HIV counseling and offer them human immunodeficiency virus (HIV) testing, screen the pregnant enrollee for the Hepatitis B surface antigen (HbsAG) during their first prenatal visit, and supply nutritional assessments and counseling to all pregnant enrollees. In addition, our OB providers are required to document preterm delivery risk assessments in the enrollee's medical record by week 28. If the provider determines that the enrollee's pregnancy is high risk, the provider's obstetrical care during labor and delivery must include preparation by all attendants for symptomatic evaluation and that enrollee progresses through the final stages of labor and immediate postpartum care. When delivering postpartum care, the provider must supply voluntary family planning, including a discussion of methods of contraception.

### **OVERALL APPROACH AND STRATEGIES TO ADDRESS PREMATURITY PREVENTION**

Birth outcomes, in general, and prematurity prevention specifically, are not ancillary matters to Aetna. Prematurity prevention is approached with the same commitment and drive to improve health outcomes as any other risk factor an enrollee might experience. Part of preventing

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

prematurity includes empowering enrollees to understand and take charge of their health, by providing them with the latest evidence-based recommendations, including optimizing Birth Spacing or Inter-pregnancy Interval (IPI), low-dose aspirin prophylaxis to reduce pre-eclampsia, progesterone supplementation to reduce preterm birth recurrence, smoking cessation, and use of 17-OH Progesterone. Self-paced educational opportunities are offered via mailings, care management for guidance and assistance, and clinical support is essential to enrollee success. We also work with our providers to set the bar even higher by training them to meet requirements and goals in serving enrollees and their children. The following is a summary of each of these four primary strategies encompassed in our approach to prematurity prevention.

### **SELF-PACED ENROLLEE EDUCATION**

Once we receive notification of a pregnant enrollee, our Care Management department mails a prenatal information packet, which includes:

- Information about each trimester of the enrollee's pregnancy so that she understands what to expect and how her baby is developing
- A domestic violence insert so that she can reflect and assess her safety and seek assistance if necessary. Our care managers also follow up with questions to determine the mother's safety.
- Information on normal delivery versus C-section and the potential risks to the child's health with non-medically indicated C-sections
- Information to help the mother prepare for delivery (e.g., recognizing the signs of labor, items to prepare for a hospital stay)
- Enrollment details on the Text4baby program
- Description of our prenatal and postpartum incentive program that encourage enrollees to attend all of their prenatal and postpartum visits
- Guide explaining the benefits of the Long Acting Removable Contraception (LARC) program, along with information on birth spacing

After our enrollee delivers, we mail postpartum educational materials covering topics such as:

- Enrollment details on the Text4baby program
- Postpartum depression
- Prenatal and postpartum incentive program reminder
- Well-child visits/immunization schedule
- Nutrition while breastfeeding
- Breast care after birth
- Information on how to feel healthy after giving birth
- Pre-contraception education
- Postpartum care education

### **PROFESSIONAL DEVELOPMENT FOR THE PROVIDER COMMUNITY AT-LARGE**

At Aetna, we expect that our providers and every clinician that comes into contact with our enrollees not only meets contractual obligations which support their healthy pregnancies, but that those providers have a solid understanding of the methodologies that caused these requirements, and we share our passion for achieving them. To that end, Aetna continues to

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

invest in the wider health care community by offering meaningful training opportunities for providers and clinicians in our network and others. We recognize that the work we do enhances the enrollee and provider experience and improves birth outcomes for all Florida Medicaid enrollees.

For the second year, we hosted an Annual Prematurity Symposium in Miami-Dade on August 24-25, 2017. Working with HSCMD, Aetna demonstrated our commitment to reducing high-risk pregnancy and premature birth, morbidity, and NICU admissions by raising the consciousness of providers on the issues impacting maternal and child health. Spearheaded by our Chief Medical Officer, Dr. Jorge Cabrera, we presented current strategies aimed at reducing premature birth rates and encouraging best practices in managing the care of women with maternal risk factors. Dr. Cabrera formulated the agenda and took the lead role in recruiting speakers and participants. The first day of the symposium was aimed at OB/GYNs, pediatricians, neonatologists, family physicians, nurses and nurse practitioners, and other clinical staff. More than 75 individuals participated.

The second day of the symposium focused on clinicians care managers; mental health professionals; licensed clinical social workers; and maternal, infant, and child health community leaders. More than 120 individuals participated in this symposium, which was funded solely by Aetna through an educational grant of \$14,000 to HSCD. CEUs and CMEs were also offered for both days of the symposium.

Among the six presenters scheduled for the symposium was Aetna's own Dr. Amy Richardson, Senior Medical Director for Pediatric Strategy, Aetna Medicaid. She spoke on managed care organization (MCO) collaboration to improve the use of immediate post-artum long-acting reversible contraceptives (LARCs).

### **ADDITIONAL SYMPOSIUM BREAKOUT SESSIONS INCLUDED:**

- The National and Florida Summary of Preterm Birth and Evidence-Based Interventions
- Florida Perinatal Quality Collaborative: An Opportunity to Improve Care
- Prescription Drug Abuse during Pregnancy, NAS, and Newborn Effects
- Improvement of Feto-Maternal Well Being in Pregnancy
- Florida Perinatal Quality Collaborative: An Opportunity to Improve Care
- Inter-conception Care as a Strategy to Prevent Prematurity

The Annual Prematurity Symposium was a resounding success with overwhelmingly positive feedback from those in attendance.

### **SUPPORT OF THE HEALTHY START PROGRAM**

Aetna actively supports the efforts of Florida's Healthy Start Coalition, which was developed in response to the State's high infant mortality rate, premature babies, and low birth weight infants, by educating stakeholders on the benefits of participation. One hundred percent (100%) of our OB providers are required to complete Healthy Start risk screenings for all of our pregnant enrollees and their children (upon delivery). In addition to attesting that they have completed the Healthy Start risk screening, providers must screen enrollees for HbsAG, HIV/AIDS and

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

domestic violence, as well as completing a referral to WIC and follow-up with the enrollee regarding advance directives.

The Healthy Start program has become an extension of our care management offerings—particularly for those pregnancies identified as high risk—focusing on helping prepare pregnant women with prenatal and postpartum care for themselves and their baby. In Region 11, we collaborate with the HSCMD to provide risk screening to our enrollees, monitor screening compliance by our network providers, offer home visitation to help our enrollees overcome barriers to treatment (such as adequate transportation), provide counseling, education, risk-reduction, and additional care coordination activities for our enrollees. Through HSCMD, enrollees also have access to services developed especially for pregnant and postpartum women, and screening and support for developing infants up to the age of three.

Aetna's care management team supports coordinated care management with HSCMD. An essential component of care coordination is assessment and education on prenatal care, health during pregnancy, and infant and child development. Healthy Start home visitors offer all patients education in a wide array of topics, including Zika virus prevention and testing, the importance of prenatal care, childbirth and parenting, safe sleep and infant safety, breastfeeding support, and birth spacing.

### **CARE MANAGEMENT FOR PREGANT WOMEN**

Aetna is committed to helping enrollees with varying degrees of risk achieve healthy pregnancy. Enrollees are stratified into three levels (intensive, supportive, and population health), which helps us to identify those who will most benefit from our guidance throughout their pregnancy, and helps us to determine how much guidance they will need. Care management is provided to all of our enrollees, including those in the lowest risk category of population health.

Enrollees in population health are identified as having low or no impactable prenatal risk factors and no acute service coordination needs. We call them for a scheduled trimester screening to identify new prenatal risks and if there are no new risks, we continue to stratify them in the population health level and provide continuous pregnancy education, including the importance of adhering to the treatment plan, following up with their obstetrician or primary care provider, and HEDIS and EPSDT messaging. These women are also provided information about health behaviors, co-existing medical and behavioral health conditions, and psychosocial and behavioral health issues. We encourage enrollees to communicate with their OB and other care providers regularly, as well as with care management personnel for telephonic support.

Pregnant enrollees with high prenatal risk factors and who have acute service coordination needs are stratified to supportive care management. These enrollees have identified short-term clinical needs (e.g., identified for HEDIS gaps in care or who need connections to community services, educational needs) and receive the interventions identified for population health. These activities are in addition to initial and ongoing telephonic outreach to first perform appropriate prenatal assessments, trimester assessments, and follow up based on the enrollee's needs, willingness to participate, and availability for calls. We also develop a plan of care to address enrollee prenatal concerns and in consideration of their cultural and socio-economic needs and preferences. The care plan is sent to the enrollee's care team to support communication and care coordination. We conduct behavioral health screens via the PHQ or K-

**EXHIBIT A-4-b**  
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**AND EVALUATION CRITERIA (10-2-17)**

6 depression screenings, UNCOPE, CRAFFT, and the Edinburgh Postnatal Depression Scale (EPDS). We also offer pregnancy-specific education and assistance through Krammes educational materials, additional chronic condition information, pregnancy-related information and appointment reminders via Text4baby, and WIC referrals.

Intensive care management (ICM) is the highest level of care coordination and is recommended for all enrollees who are at high risk of poor overall health outcomes due to complex health and psychosocial issues. These enrollees frequently have complex medical and/or behavioral conditions in addition to being pregnant and may or may not have specific high prenatal risk factors. Through our integrated care management approach, we aim to optimize the health of our pregnant enrollees during their pregnancies. The prenatal care management offered through ICM is specifically tailored to meet the needs of our pregnant enrollees and incorporates contractual requirements and nationally recognized clinical guidelines and standards. Clinical practice guidelines serve to assist clinicians and enrollees with appropriate decisions about health care and services that will be needed. The clinical practice guidelines adopted as the foundation for pregnant care management program and used to develop assessments and interventions include, but are not limited to the March of Dimes and the American College of Obstetrics and Gynecology (ACOG) guidelines and standards.

Aetna works with our behavioral health vendor, Beacon, to deliver behavioral health services before, during, and after pregnancy. Our approach engages priority enrollees within each population segment via ICM protocols. Enrollees receive services and supports that provide holistic interventions and education, which encourages them to engage and participate in their own treatment. These interventions effectively assist enrollees to manage the challenges and difficulties of daily life and to resolve problems before they negatively affect their health, relationships with others, and/or job performance.

Example of a High-Risk OB Care Plan in Action

[REDACTED]

[REDACTED]

[REDACTED]

**EXHIBIT A-4-b**  
**MMA SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**



**ENHANCED OFFERINGS TO IMPROVE BIRTH OUTCOMES AND REDUCE PREMATUREITY**

Our evidence-based programs help the expectant mother through a healthy pregnancy, while appropriately tending to her overall health needs so that she delivers a healthy, full-term baby.

**NEONATAL ABSTINENCE SYNDROME PROGRAM**

Through our integrated care management model, we focus on reducing the risk of preterm birth and poor newborn health outcomes, reducing substance use during pregnancy and post-delivery, reducing incidence of neonatal abstinence syndrome (NAS) and the length of stay for babies diagnosed with NAS. We also focus on the rate of NICU admissions and NICU lengths of stay. Our care managers engage pregnant women, who have significant opiate use or opiate addiction in prenatal care management, and our care managers continue care management of the mother and baby through the first year of the baby's life with our Neonatal Abstinence Syndrome program. New mothers can find it difficult and stressful to care for their infants born with NAS. Caring for these babies can cause worry, anxiety, and pressure for a new mother—increasing the possibility of a relapse into substance use. Because NAS infants and children are at risk for environmental exposure, as well as having genetic components/risk factors, early intervention and long-term monitoring are crucial to the health of the infant and mother. In the NAS program, our care managers monitor stability in the home and make sure basic needs are met to help mitigate risk factors. NAS follow-up care management continues for one year following the child's birth.

**CLINICAL SUPPORT AND RELATED PROGRAMS**

We have collaborated with a home health agency to provide clinical services to our high-risk OB population. Services include:

## **EXHIBIT A-4-b**

### **MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Pregnancy prolongation services with OB registered nurse (RN) Support
  - For enrollees with a history of spontaneous preterm birth this includes 17P/Makena administration and nursing care management in home or at work, weekly in-person maternal-fetal nursing assessments, and intensive follow-up resulting in average 98% injection compliance rate.
  - For enrollees with current or at risk preterm labor, we have a preterm labor program that includes home visits by an OB RN with instructions on healthy pregnancy, signs and symptoms of preterm labor and self-palpation, access to 24/7 telephonic nurse support, related patient education materials, and a 30 day program with weekly outbound calls for preterm labor assessment.
- Nausea and Vomiting of Pregnancy (NVP): Our enrollees are offered continuous antiemetic therapy utilizing microinfusion pump technology with nursing support, system of care with holistic approach, clinical OB pharmacist dosing oversight, home-based triage, access to nutritional assessments and dietician recommendations.
- Diabetes in Pregnancy
  - For our enrollees newly diagnosed with non-insulin dependent diabetes, we offer OB RN support to help maintain normal blood sugar levels during pregnancy, daily monitoring and clinical evaluation, customized meal planning, and compliance monitoring.
  - For enrollees with insulin dependent diabetes in pregnancy, we offer daily insulin injections or continuous insulin infusion, in-home assessment and education, nutritional education with assessment and meal planning, dosing and adjustment according to physician parameters, counseling, and support by experienced diabetes educators, and comprehensive out-of-range reporting to physician.
- Hypertensive Disorders in Pregnancy: For enrollees diagnosed with gestational hypertension or preeclampsia, we offer home-based comprehensive nursing surveillance with device management and daily reports on results, including any out-of-range or non-compliance.
- Coagulation Disorders in Pregnancy: For enrollees with a current or history of thrombosis, we offer continuous subcutaneous anticoagulant therapy via microfusion pump, which eliminates the need for daily self-injections. Enrollees are intensively monitored and managed by clinical OB pharmacists in conjunction with physician orders.

#### **DENTAL EXPANDED BENEFITS**

To address the correlation between periodontal health, premature births, and low birthweight babies, Aetna—in collaboration with our dental subcontractor, MCNA—offers enhanced periodontal services to pregnant enrollees with the goal of improving their oral health. Pregnant women with gum disease, who receive treatment every three months, are less likely to deliver a low-weight or pre-term baby—resulting in healthier babies, better outcomes, and lower medical costs. Our care managers ensure that our enrollees understand how to access their covered dental services during pregnancy (dental screenings, cleanings, restorative, and periodontal care), and educate them on the value of establishing good oral health habits for their babies. These activities will help prevent baby bottle mouth, encourage good dental hygiene habits, and improve the overall impact of oral health on physical health for mother and baby.

#### **OVERALL APPROACH TO IMPROVING PERINATAL OUTCOMES**

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

As previously discussed, Aetna's overall approach to serving pregnant women includes enrollee education, high-risk OB care management, arranging prenatal appointments, and address social determinants of health and safety issues. Aetna uses a variety of mechanisms for early identification of expectant mothers—including prior authorization, pharmacy data, and direct referrals from providers, community health workers, and peer support specialists. Establishing trusting relationships and providing a motivational framework for our enrollees are two important care management priorities for ensuring healthy mothers and babies. To address the needs of the whole person, we often link our enrollees to existing programs and services within the community such as:

- Dental services
- Behavioral health services
- Testing and counseling for HIV/AIDS and other sexually transmitted diseases (STDs)
- WIC
- Childbirth classes
- Programs for victims of domestic violence
- Housing
- Parenting classes
- Substance use treatment
- Support groups
- Child health services
- Head Start/Early Head Start
- Family planning

### **DEALING WITH DEPRESSION**

Aetna understands the serious negative impacts unmanaged depression can have on the mother during and after pregnancy. We make every effort to identify potential behavioral health risks early and work with our enrollees to ensure the health and safety of mother and child. Because this is such an important issue to us, we have leveraged our relationships with Healthy Start Coalition of Miami-Dade (HSCMD) and with Beacon to create two programs for our enrollees experiencing depression.

We collaborate with HSCMD to participate in the Moving beyond Depression program, which provides in-home psychotherapy, and monitoring of depression in pregnant women. Aetna will pay for this service as a value-added benefit for our enrollees. The initiative addresses the need for psychotherapy services for pregnant women who might not reach out for services through their OB/GYN, or who may not attend appointments or follow-up visits because of their behavioral state or comorbidities. HSCMD uses the Edinburgh Postnatal Depression Scale to prescreen expectant mothers for evidence of depression. HSCMD care managers also perform a comprehensive evaluation of the enrollee's family and living situation and check for associated maternal morbidity surrounding illness—due to or causing depression. HSCMD care managers notify Aetna care managers of any indicators of a depression so that a trained psychotherapist can intervene with therapy. The Edinburgh Postnatal Depression scale is repeated at each visit and the mother's progress is tracked to a healthy level and when it is safe to discontinue treatment. If at any time the results of the assessment reach a level, which would call for a psychiatric evaluation, we arrange for the assessment in order to keep mother and child safe.

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

The treatment received through the Moving Beyond Depression program ultimately affects the physical health of mother and newborn baby. This program helps the mother to navigate daily tasks that contribute to proper nutrition, weight, blood pressure, and adherence to medication. HSCMD also screens postpartum to determine if there are indicators of potential self-harm to the new mother and harm to her baby. We handle postpartum depression with the same processes to help the mother achieve wellness.

### **POSTPARTUM DEPRESSION PROGRAM**

Based on literature from nationally recognized organizations such as the American Psychiatric Association, the National Mental Health Association, the Agency for Healthcare Research and Quality, and the National Women's Health Information Center, Aetna collaborated with our behavioral health vendor, Beacon, to develop a Postpartum Depression Prevention program. This evidence-based program focuses on enrollees who are pregnant and/or postpartum twelve months with elevated risk factors related to socioeconomic status, ethnic backgrounds, and cultural identities, and experiencing feelings of profound sadness and lack of interest in activities. Our integrated care management team works closely with Beacon to identify high-risk enrollees and provide educational messaging, consultation, and preventive screening for depression and other behavioral health conditions in pre-natal and post-natal phases, and we refer at-risk enrollees to Beacon's postpartum team for additional screening, education, and service linkage. Not only does the Postpartum Depression Prevention program provide secondary and tertiary prevention through identification, education, and support, it is also designed to offer guidance and recommendations to obstetricians, gynecologists, and behavioral health specialists related to best practices based on scientific evidence.

### **CARE COORDINATION PROTOCOLS TO IMPROVE PERINATAL OUTCOMES**

**CRITERION 2:** The extent to which the respondent describes specific care coordination protocols, including a description of the risk stratification algorithm used to identify high-risk pregnancies (including enrollees with co-occurring behavioral health conditions).

Early identification is the key to successful perinatal outcomes. We identify pregnant enrollees through a number of different methods. During the new enrollee outreach calls, we ask female enrollees of childbearing age if they are pregnant. If an enrollee responds affirmatively, we notify our care managers for assessment and follow up. In addition, when an enrollee is seen by her PCP or OB/GYN, or is seen in the hospital, these providers are trained to ask the enrollee and to notify the health plan via the OB notification form when she is pregnant. In addition to direct contact either from Aetna or the enrollee's clinician, we receive notification of pregnant enrollees via self-referral, internal referrals (enrollee services and utilization management), and through the State enrollment files. We also identify pregnant enrollees through first-fill reports (prescriptions for prenatal vitamins) and claims data.

### **SCREENING AND ASSESSMENT**

Aetna uses several evidence-based screening and assessment tools to identify strengths and potential risks for our enrollees. We screen all pregnant women for risk factors, including substance use, mental health wellness, and high-risk conditions (e.g., diabetes, asthma, and history of pre-term delivery).

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **Maternity Risk Screening Form**

We are introducing the Maternity Risk Screening Form (which screens for socioeconomic factors, substance use, etc.) as a way to collaborate with providers on maternity care for our enrollees. The form is presented in Attachment MMA02-1 (log number 41). We are incentivizing providers to complete this form and send it to us when they make initial contact with a pregnant enrollee. Besides identifying pregnant women early in their pregnancy, this form helps us identify enrollees who may be high-risk and require further intervention through our current intensive care management and/or the Neonatal Abstinence Syndrome program, which will be available in regions into which we will be expanding. As previously noted, providers are also required to complete a Healthy Start assessment for each enrollee.

### **Healthy Start Risk Screening**

Aetna requires our OB providers to participate in the Healthy Start program. Our contract states that the providers must complete a Healthy Start prenatal risk screening for each pregnant enrollee as part of her first prenatal visit. The provider must keep a copy of the completed Healthy Start (Postnatal) Risk Screening Instrument in the enrollee's medical record and mail a copy to enrollee.

Aetna ensures that our providers are compliant with the requirements of the Healthy Start program and the other contractual obligations. During the first prenatal visit, our providers must complete and fax an OB Notification form to the Care Management department. These forms are utilized to identify those enrollees early in their pregnancy with risk factors such as age, obesity, substance use, history of tobacco use, STDs, behavioral health disorders, depression, and intimate partner violence. In addition, to attesting that they have completed the Healthy Start screening, we ensure that our providers screen for HbsAG, HIV/AIDS, domestic violence and complete a referral to WIC and follow up with the enrollee regarding advance directives. This required notification is the first step for our care management staff in identifying those enrollees who would benefit from high-risk obstetrical care management services.

Once identified, care managers reach out to pregnant enrollees to complete the following screenings and assessments:

- Health risk questionnaire
- Outreach questionnaire: in collaboration with the prospective mother, the intake and referral team assesses risk factors, current and proposed support structures, and available resources
- Short form (SF) 12 – a health survey that asks the enrollee about their views about their own health
- Trimester screening for low-risk enrollees each trimester to identify newly developed risk factors and then engage the enrollee more actively in care management.
- Condition-specific screening (e.g., diabetes)
- Perinatal assessment
- Postpartum assessment

### **RISK STRATIFICATION**

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

In addition to diagnoses and screening tools, Aetna uses several methods to identify and stratify enrollees. These methods include our Consolidated Outreach and Risk Evaluation™ (CORE) predictive modeling tool, self-reporting through our health risk assessment (HRA), and surveillance or traditional case finding through referrals, concurrent review, real-time high utilization, and more. We first identify enrollees with a high medical risk using our proprietary, evidence-based CORE application to analyze claims data. Predictive modeling uses analytic methods that identify individuals who are at risk for high cost or high utilization in the future. The scores are generated from Medicaid-specific, proprietary algorithms that we have developed internally based on data from our Medicaid populations, as well as our clinical and informatics expertise. Inputs to the algorithms include demographics, medical claims, and pharmacy claims data. The resulting inpatient and emergency department models provide enrollee-specific scores indicating the likelihood that the enrollee will visit the emergency department or experience an inpatient admission in the next 12 months. We run the model for our entire population monthly; the results are reviewed by the appropriate teams for enrollee contact and intervention opportunities.

CORE predictive modeling identifies enrollees who are candidates for intensive and supportive care management and enrollees who are candidates for high- and low-risk chronic condition management. Our predictive modeling shows that our highest-risk enrollees have multiple physical health conditions: 70% to 90% had co-occurring behavioral health conditions. We have learned that complexity is more important than diagnosis when identifying enrollees who are at high risk. Enrollees at high risk are almost always challenged by the biopsychosocial complexities inherent in their lives. As a result, they are unlikely to benefit from standard care and most likely to benefit from our integrated care management model which is built to address such complexities. The tool predicts the likelihood of integrated care management making an impact and ranks all plan enrollees from highest to lowest risk.

Initial stratification through CORE enables us to focus HRA outreach to enrollees with the greatest health care need who may most benefit from our care coordination services. We run our CORE analysis monthly and perform daily reviews of prior authorization requests, census reports, and other information to determine changes in enrollee status.

Our CORE analysis helps us to identify at-risk pregnant enrollees by stratifying them into three levels that indicate the prevalence of the risk factors. The level of care is finalized only after enrollee engagement and confirmation of needs. Examples of stratified enrollees for integrated care management at the intensive through population health levels are included as follows.

- Level 1: Intensive
  - Pregnant women current or historical high-risk pregnancy
  - Pregnant enrollees with serious mental illness with serious emotional disturbances
  - Pregnant women with a history of or currently using substances
  - Infants with NAS
  - Pregnant adults and adolescents who are homeless or have a history of residential instability (four or more residences over the past year)
  - Individuals with HIV/AIDS, cancer, chronic renal failure, and other chronic, complex conditions
- Level 2: Supportive

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Pregnant enrollees with poorly treated chronic conditions
- Individuals with mental health conditions requiring care management
- Level 3: Population Health: All enrollees not identified in intensive and supportive levels

### **EDUCATION**

In addition to the information packets mailed to our prenatal and post-partum enrollees, we offer educational information and service coordination for enrollees with low-risk pregnancies. This educational information includes:

- Benefits of optimal nutrition during pregnancy and while breastfeeding, and the availability of WIC services
- Local community programs to assist with a variety of social needs
- Role of tobacco use in preterm delivery and coaching women on tobacco cessation (We refer enrollees to tobacco quit lines and to providers for nicotine replacement therapy as needed.)
- Nutritional needs in pregnancy, including iron to prevent or treat anemia (Aetna will assist with referral to nutritionist if indicated.)
- Chronic condition management offered to any pregnant enrollee with CAD, diabetes, COPD, asthma, heart failure, or depression, which is a standard part of integrated care management
- Importance of early detection of HIV to reduce transmission of the virus to the baby

All of our enrollees are eligible to receive no-cost smartphones from the Lifeline program through Wellpass. With success offering Lifeline in 11 of our health plans, including Florida, we understand that nearly two-thirds of Americans are now smartphone owners; for many, these devices are their only entry point to the Internet. In 2016, 1,700 of our enrollee households had Lifeline phones.

This access to no-cost smartphones aids our care managers with a reliable telephone number to reach enrollees while placing an educational tool in our enrollees' hands when they sign up for Wellpass' free Text4baby program for pregnant women and mothers with infants less than one year of age. Text4baby is the largest mobile health initiative in the nation designed to promote maternal and child health through text messaging. Expectant and new mothers receive no-cost text messages containing important appointment reminders, expert health tips, and safety information—such as birth defect prevention, prenatal care, and labor signs and symptoms—timed to correspond to their due date or the baby's birth date. After delivery and until the baby's first birthday, Text4baby sends additional text messages related to postpartum depression, developmental milestones, immunizations, nutrition, safe sleep, safety, well-baby visits, and more.

### **INTEGRATED CARE MANAGEMENT**

As soon as we learn an enrollee is pregnant—through interactive voice response welcome call questionnaires, 834 enrollment files, self-reporting (by the pregnant woman or her provider), first-fill reports (prescriptions for prenatal vitamins), or claims data—we contact and engage with the expectant mother to make sure she receives timely care. We conduct care management outreach to pregnant mothers in a culturally sensitive way, addressing each pregnant woman's

## **EXHIBIT A-4-b**

### **MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

socioeconomic situation, language preferences, nutritional needs, and personal goals for birth outcomes.

Aetna's Medical Management department is responsible for coordinating all care management services, including services for pregnant women, under the leadership of the plan's chief medical officer, and/or associate medical directors, and support staff.

High-risk-identified pregnant enrollees are offered care management services with a clinical care manager for the duration of the pregnancy and the immediate postpartum period. The care manager works with the enrollee, her prenatal provider, and any other care team participants providing services or support to the enrollee.

Care managers work to establish trusting relationships with our expectant mothers to provide needed support for healthy pregnancies and healthy babies. Pregnant women at high risk receive additional support through our intensive care management program. Care managers are ready to help enrollees choose an obstetrician, make appointments, assist with scheduling transportation, and link them to additional services and resources to support them during their pregnancies. For example, if pregnant women have co-morbidities (e.g., asthma, diabetes, cancer, tobacco use, depression), we coordinate care to ensure they receive the care they need, which may include home health visits, diabetes education, and nutritional services, to address and manage their conditions during and after their pregnancy. We work with the enrollee and her OB provider or PCP to address her co-morbid conditions to increase the enrollee's chance of a full-term, healthy delivery and reducing complications and a possible NICU admission.

Pregnant women are offered the opportunity to participate in care management. Pregnant women are enrolled in our low-risk population health care management or high-risk care management programs, depending on their needs. Because we engage with expectant mothers throughout their pregnancy, we use the initial screening as a baseline for subsequent trimester screenings as an enrollee's needs may change throughout her pregnancy. We help our enrollees develop a holistic, person-centered care plan for their pregnancy. This plan of care includes and addresses social determinants of health, educational goals, nutritional needs and services, safe housing, home health care, substance use disorder services, and care coordination to address barriers to care (e.g., socioeconomic issues, which may include transportation to appointments or setting up a WIC appointment).

#### **IMPROVED CARE COORDINATION EFFORTS THROUGH DATA EXCHANGES FOR HIGH-RISK, PREGNANT ENROLLEES**

**CRITERION 3:** The extent to which the respondent describes strategies to improve data exchanges and communications between practitioners to improve care coordination efforts for pregnant enrollees that are determined to be high-risk.

When accurate enrollee information can be shared easily and timely, the potential for improved care coordination exponentially increases. In Florida, we have implemented strategies to improve the exchange of data, particularly for our high-risk OB enrollees. For example, providers are contractually required to complete the Healthy Start assessment form during the enrollee's first prenatal visit whether or not the enrollee is in the high-risk category. The form is

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

then submitted to HSCMD so that the care coordination process can begin right away. They are also required to notify Aetna through the OB notification form, which creates a system of checks and balances. Once the enrollee is enrolled in care management, care managers will communicate information to Optum, our clinical home health agency, on behalf of our high-risk OB enrollees.

After identification and enrollment into the high-risk OB program, the care manager mails a provider welcome letter to the enrollees' OB provider. This letter shares our contact information as well as our goals for the enrollee and information about our OB program. After the care manager works closely with the enrollee to develop the care plan, that care plan is shared with both the enrollee and the provider. The care plan is used to help facilitate communication between all parties, share the enrollee's goals, address any barriers, and show progress towards achieving positive birth outcomes.

Additionally, CareUnify improves the exchange of data to positively impact high-risk pregnant women: enabling the sharing of key, real-time, clinical information between the application and the platform. The application offers providers a simple and efficient way to remain connected to their patients and extended integrated care teams, and it will help monitor patient panels and receive timely notification of critical events. CareUnify features provider notifications of clinical information, such as inpatient or emergency department notifications; steps completed for shared care paths; lab data; appointment reminders; and tracking medication fills. Our network providers can pull gaps-in-care reports from the system enabling them to determine which enrollees are in need of services such as prenatal visits or postpartum follow up.

Each month, our pharmacy team provides our quality management team with a list of enrollees taking prenatal vitamins. We use this list to call enrollees and begin a conversation about whether they are pregnant or thinking about becoming pregnant.

### **OPPORTUNITIES FOR IMPROVING PERFORMANCE BENCHMARKS FOR REDUCING NON-MEDICALLY INDICATED CESAREAN SECTIONS AND EARLY ELECTIVE DELIVERIES**

**CRITERION 1:** The extent to which the respondent identified opportunities for improvement in achieving the benchmarks and subsequent steps the respondent will implement to overcome any barriers across and within different systems of care.

We embrace Florida's mandate to reduce early elective delivery and all American College of Obstetricians and Gynecologists (ACOG) guidelines for indications for use of C-sections. Florida has one of the highest C-section rates in the country with some areas as high as 60%. We would like to see those rates decrease to less than 35% and our OB/GYN's meet benchmarks of at least 67% for Frequency of Ongoing Prenatal Care and of at least 67% for Frequency of Ongoing Prenatal Care. Through our experience as a managed care organization (MCO) in Region 11, we have firsthand knowledge of the barriers across and within different systems of care that make the reduction of non-medically indicated C-sections and early elective delivery such a challenging issue to affect, both systemically and culturally.

For the health of our enrollees and their unborn children, we will continue to work to improve performance benchmarks for reducing non-medically indicated C-sections. This approach is accomplished in five key ways: 1) enrollee education, 2) data-driven discussions with providers,

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

3) reimbursement parity between C-sections and vaginal deliveries, 4) financial incentives, and 5) implementation of the LARC program.

Because vaginal births after C-section are less safe, we can predict with near certainty that once an enrollee has a C-section, her next child (should there be additional pregnancies) will also be delivered by C-section. Our focus is therefore directed to preventing the first non-medically indicated C-section via enrollee education. The prenatal educational packet mailed to enrollees contains information to increase the expectant mother's understanding of the health risks associated with C-sections (for mother and child) when compared to vaginal delivery. Our care managers also educate pregnant enrollees on this important topic.

We also educate our providers to encourage appropriate utilization to prevent a first occurrence of a non-medically indicated C-section. Aetna takes this issue so seriously, Dr. Cabrera, our chief medical officer, has personally visited hospitals and doctor's offices to educate them on the challenges that non-medically indicated C-sections pose, as well as corresponding data-driven conversation around early elective delivery and to ask for their support in educating our enrollees. Our work in this area is esteemed within the health care community as evidenced by the invitation Aetna received to attend a committee on C-section reduction at South Miami Hospital. Aetna was one of only a few MCOs to participate, and Dr. Cabrera was given an opportunity to contextualize the issue for providers and discourage them from offering non-medically indicated C-sections or early elective delivery.

Aetna actively dissuades providers from performing non-medically indicated C-sections through payment reform. We pay hospitals the normal delivery rate even when they attempt to bill for a non-medically indicated C-section. In this way, we can actively dissuade providers from this practice. We have also made this issue a part of our value-based purchasing (VBP) agreements. Providers are incentivized for maintaining appropriate quality metrics. Lastly, we are working with providers to educate our enrollees on LARCs and to encourage those who are receptive to get it immediately following birth.

### **PERFORMANCE BENCHMARKS FOR REDUCING NON-MEDICALLY INDICATED CESAREAN SECTIONS AND EARLY ELECTIVE DELIVERIES**

**CRITERION 6:** The adequacy of the respondent's proposed performance benchmarks for reducing non-medically indicated cesarean sections and early elective deliveries.

We evaluate providers as part of the physician incentive program. The current incentive criteria for the C-section quality measure is illustrated as follows. We will incentivize OB providers who meet all three criteria. OB providers who:

- Performed at least 10 deliveries in CY 2016, based on experience paid through June 2017 (currently using base period of July 2015 to June 2016, paid through December 2016 as a proxy)
- Has lowered their C-section rate to less than 35% based on CY 2016 experience (consistent with the AP)
- Meets the following HEDIS measures (based on 2015 experience until 2016 HEDIS measures are final, and requiring a minimum denominator of 20):

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Met benchmark of at least 67% for Frequency of Ongoing Prenatal Care (consistent with the AP)
- Met benchmark of at least 62% for Postpartum Care (consistent with the AP)

Moreover, Aetna has realized cost savings as a result of our efforts to discourage OB providers from performing non-medically indicated C-sections. The details of this initiative are outlined in our successful strategies that follow.

### **SUCCESSFUL STRATEGIES RESULTING IN A REDUCTION IN NON-MEDICALLY INDICATED CESAREAN SECTIONS AND EARLY ELECTIVE DELIVERIES**

CRITERION 7: The extent to which the respondent describes its experience implementing successful strategies that resulted in a reduction in non-medically indicated cesarean sections and early elective deliveries. In order to receive all points for this component, the respondent must include outcome data on specific performance metrics.

While we work on changing the views and priorities of our enrollees and providers, we have sought to influence our providers by adjusting our payment for non-medically indicated C-sections. If we identify an elective C-section that mother or provider elected, we will only pay for normal delivery rate. Since implementing this initiative in 2015, we identified 43 deliveries and saved \$73,000.

We also reduce late preterm deliveries by educating enrollees and providers that maintaining pregnancy to full-term (39 weeks or later) allows for important respiratory and neurologic development of the fetus. Our Utilization Management department imposes prior authorization requirements for early elective deliveries and cesareans, and we deny preterm C-sections unless they meet medical necessity criteria or there is a serious risk to the mother or baby (e.g. severe eclampsia or fetal distress).

### **INCENTIVES FOR EVIDENCE-BASED PRACTICES AIMED AT IMPROVING BENCHMARKS FOR BIRTH OUTCOMES**

CRITERION 5: The extent to which the respondent describes financial and non-financial provider and enrollee incentives for evidence-based practices that will contribute to hitting the benchmarks.

Aetna educates both provider and enrollees, and we implement evidence-based practices to improve birth outcomes. Additionally, we incentivize both groups to work with us for the sake of our enrollees' good health. Providers are offered financial and non-financial incentives. We pay provider incentives for completing and submitting the Maternity Risk Screening form whenever an enrollee has her first prenatal visit. Under a VBP arrangement, we also offer financial incentives to providers who meet the quality metrics for C-section rates under the provider improvement program.

We continuously seek ways to help our enrollees help themselves. Incentives are determined based on needs, as identified through our quality management team and utilization management team, feedback from our care managers who work closely with the target

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

population, and our evaluation of program effectiveness measured by uptake. This enables us to be both responsive and innovative in selecting incentives for our enrollees. For example, our previous incentive program (Family Dollar store gift cards) did not provide the results for which we hoped. Based on our analysis of the program and feedback from our staff, we learned that enrollees had several challenges affecting compliance with program requirements. When coupled with the routine daily challenges new mothers and their families faced, the added responsibility of tracking appointments and arranging transportation did not appeal to our target population. There were also limited Family Dollar locations, which meant additional time and transportation concerns at program completion.

Our assessment of the previous program led us to design an improved incentive program for enrollees who complete prenatal and postpartum doctor's visits. In 2018, we are implementing a diaper home delivery incentive program. Qualifying enrollees will receive 200 diapers of their preferred brand and size, delivered to their homes. Aetna listens to and respects the needs of our enrollees, and we strive to help ensure their success. The new incentive program not only places additional resources in the hands of our enrollees, it also considers their potential time, transportation, and cultural needs while empowering them in their choices for their child. We also reduce the burden of our enrollees to track their visits by making eligibility a claims-driven process. In this way, we model our slogan, "You don't join us. We join you." We are confident the attention we pay to our enrollees' needs result in increased adherence to prenatal and postpartum visits requirements and participation in our incentive program.

### **OVERALL APPROACH AND EVIDENCE-BASED STRATEGIES TO REDUCE UNINTENDED PREGNANCIES**

**CRITERION 4:** The adequacy of the respondent's description of specific evidenced-based programs and interventions that will be used to decrease the number of unintended pregnancies and the associated indicators or measures that will be used to determine their effectiveness.

Unintended and/or closely spaced pregnancies contribute to delayed initiation of prenatal care, higher risk of preterm and small for age birth, higher risk of maternal depression and child neglect, and lower breastfeeding rates. To minimize these risks, Aetna care managers educate enrollees on contraception and birth spacing. They also send educational materials to our enrollees as a part of our self-paced enrollee education strategy.

AHCA is actively engaging Medicaid health plans in addressing their respective internal barriers to LARC access, communicating the progress of the LARC quality initiative, and facilitating regularly scheduled steering committee calls and Webinars with interested stakeholders and key partners. Aetna agrees that LARCs will be a significant evidence-based strategy to reduce unintended pregnancies in the State of Florida. The data on the need for LARCs is quite compelling. Fully 45% of pregnancies in the U.S. are unintended; Florida's rate is 59%. Women under 30 years old account for the largest number of unintended pregnancies and nearly 35% of pregnant teens experience another pregnancy in 2 years (rapid repeat). Women with a repeat pregnancy within 5 to 17 months are at increased risk of poor pregnancy outcomes. In preparation for potential expansions across the State, Aetna has met with the Jacksonville LARC Discussion Group and the Florida Perinatal Quality Collaborative (FPQC) to cooperate on solutions, which will address the barriers related to LARC access in the State of Florida.

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Because up to 40% of enrollees do not return for six-week postpartum visit, we are working to get LARC as an immediate application just after delivery when new mothers are more motivated to obtain contraception.

To implement an immediate LARC program, Aetna is:

- Identifying barriers to implementation
- Developing strategies/tools for gaining buy-in from OB/GYN providers
- Providing targeted education to pharmacy and billing leaders on value of LARC
- Identifying Medicaid and insurance codes and billing specifications
- Identifying barriers to implementation
- Developing pharmacy procedures related to the ordering, stocking, and inventorying for LARCs
- Creating order sets/billing forms for providers

As this program is implemented, Aetna will use the following indicators to determine its effectiveness:

- Greater spacing between pregnancies
- Increased number of enrollees using LARCS (currently 4%)
- Reduction in birth rate

### **Evaluation Criteria:**

1. The extent to which the respondent identified opportunities for improvement in achieving the benchmarks and subsequent steps the respondent will implement to overcome any barriers across and within different systems of care.
2. The extent to which the respondent describes specific care coordination protocols, including a description of the risk stratification algorithm used to identify high-risk pregnancies (including enrollees with co-occurring behavioral health conditions).
3. The extent to which the respondent describes strategies to improve data exchanges and communications between practitioners to improve care coordination efforts for pregnant enrollees that are determined to be high-risk.
4. The adequacy of the respondent's description of specific evidenced-based programs and interventions that will be used to decrease the number of unintended pregnancies and the associated indicators or measures that will be used to determine their effectiveness.
5. The extent to which the respondent describes financial and non-financial provider and enrollee incentives for evidence-based practices that will contribute to hitting the benchmarks.
6. The adequacy of the respondent's proposed performance benchmarks for reducing non-medically indicated cesarean sections and early elective deliveries.

**EXHIBIT A-4-b  
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7. The extent to which the respondent describes its experience implementing successful strategies that resulted in a reduction in non-medically indicated cesarean sections and early elective deliveries. In order to receive all points for this component, the respondent must include outcome data on specific performance metrics.

**Score:** This section is worth a maximum of 35 raw points with each of the above components being worth a maximum of 5 points each.

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**MMA SRC# 3 – Patient Centered Medical Homes (Regional):**

The respondent shall describe its experience with patient centered medical homes (PCMHs) including the respondent's efforts toward the solicitation of PCMH-recognized practices to improve access, facilitate care integration and improvement in quality measures. Specifically, the respondent shall describe programs and initiatives utilizing PCMHs to promote the Agency's goals.

**Response:**

The Aetna Medicaid organization has developed patient-centered medical homes (PCMHs) and behavioral health home models as part of our value-based purchasing (VBP) strategies. We have become a national leader in the development of Medicaid-related PCMHs with over 2,500 providers in more than 600 locations, providing services to more than 105,000 nationwide enrollees in over 80% of our health plans, including Florida. Overall, over 70% of providers participating in our VBP programs are National Committee on Quality Assurance (NCQA)-recognized as PCMHs.

In Florida, 40.5% of our Managed Medical Assistance (MMA) membership is assigned to a PCMH provider. Our PCMH programs are designed to improve service delivery, care integration, care access, cost, and quality measures for all participants in the continuum, and directly align with the Agency's strategy to promote an integrated health care delivery model that incentivizes quality and efficiency.

**EXPERIENCE WITH PATIENT CENTERED MEDICAL HOMES TO ENHANCE ACCESS**

**CRITERION 1:** The extent to which the respondent's description demonstrates experience that includes contracts with patient centered medical homes in the network serving populations similar to the target population of this solicitation and demonstrates

- (a) Enhanced access
- (b) Coordinated and/or integrated care; and
- (c) Achievement of improved quality outcomes

Aetna's national experience with PCMHs, coupled with our local experience in Florida, enables us to compare outcomes and strategies in other markets similar to the various regions of Florida and to use the programs that most accurately reflect the needs and demands of the specific target population.

For example, we meet with our PCMH providers and shared savings partners at least quarterly to review performance data, discuss challenges and gaps in care, and provide technical advice where necessary to improve population health capabilities. We examine evidence-based practices and share reports to illustrate comparisons of performance. This process includes Healthcare Effectiveness Data and Information Set (HEDIS) and utilization metrics, as well as total cost of care. In our experience, providers who participate in our value-based PCMH programs perform 6.36% higher on HEDIS quality measures than do those who do not participate.

**SOLICITATION OF PCMH-RECOGNIZED PRACTICES TO IMPROVE ACCESS**

## **EXHIBIT A-4-b**

### **MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

As previously mentioned, 40.5% of our MMA membership is assigned to a PCMH provider. In order to enhance access and increase quality, Aetna continuously reviews our list of participating Florida Medicaid providers to identify potential PCMH partners. Additionally, we routinely review the NCQA website to determine which provider practices/locations within Florida have been recently recognized. Our goal is to engage providers to assist them in becoming PCMHs in order to enhance access for our enrollees and to have an impact on increasing birth outcomes, reducing potentially preventable events (PPE), and decreasing emergency department (ED) utilization. For recognized providers, we determine their panel size and initiate a dialogue to encourage participation in our PCMH program. Additionally, we explore regional differences that may indicate PCMH program changes (e.g., different metrics for different populations, provider capability differences requiring different reporting support). We also make contractual adjustments to meet changes in our providers' needs.

Aetna will utilize a proprietary readiness survey in Florida to begin the conversation and gauge the possibilities of provider adoption of a particular program path (e.g., pay-for-quality, PCMH bundles/ACO/full-risk). This survey was developed through extensive research on the capabilities a provider requires to promote success in value-based arrangements like PCMHs. The survey consists of 20 questions to serve as a first step in creating a relationship between all stakeholders (including the providers) and to assess their current capabilities. We designed this survey to promote a dialogue, as opposed to simply completing and returning a survey without interaction. Our tool captures information, such as technical capabilities, the care manager's involvement, and provider's experience with innovative payment models.

We commit to working with providers who are interested in becoming PCMH-recognized. In such instances, we meet with the potential provider to discuss exactly what it means to become PCMH-recognized. We work with them to understand their capabilities and modify our programming to assist them in their journey. Modifications may include metric and reporting assistance, additional incentives to provide infrastructure support, frequent meetings to answer questions, and the support of our population health specialists—key to helping providers transition to a PCMH. In 2012, we expanded our VBP programs into our Medicaid product lines with the development of Aetna Better Value, which offers providers an array of alternative payment methodologies designed to help ensure participation of large or small, traditional or non-traditional providers. Through participation in Aetna Better Value's PCMH program and accompanying incentives, providers not only agree to maintain an open panel, but they also agree to maintain 24/7 access to care, aligning with the NCQA PCMH recognition standards so enrollees can easily reach their physician. The Aetna Better Value PCMH program standards include night or weekend hours, offer nurse helplines or establish 24/7 access to clinical advice and appropriate care facilitated by their designated clinician/care team.

#### **POPULATION HEALTH SPECIALISTS—PROVIDING LOCAL PRACTICE SUPPORT AND COLLABORATION**

Aetna's population health strategy helps to guide our strong provider partnerships. We understand that to obtain the collective vision of achieving the Triple Aim, we have to be locally engaged and closer to our provider network. Working in close collaboration through a clinically integrated approach supports and enhances the provider-patient relationship. As part of our collective effort to drive population health support for our providers, we have created a new and innovative role—the population health specialist. Our population health specialists are assigned

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

to work directly and on-site with our provider partner care teams to support them in their overall patient management and care coordination, as well as to guide them in the use of CareUnify and our other population health tools and dashboards.

Based on our past national experience working with PCMHs and other team-based models, we understand that many providers are often resource-challenged and require assistance, particularly when it comes to a comprehensive care management approach required for the most complex enrollees. Our population health specialists will be part of a cross-functional team of experienced clinicians and transformation specialists who understand the dynamics and challenges of helping enrollees navigate the health care system, whether in a small community clinic setting or through a large integrated delivery system. In addition, these population health specialists understand health care and data-driven decisions, tied to tightly aligned and coordinated teams, which leads to the most efficient and effective care and to the success of our value-based arrangements (including PCMHs). As part of their role, Aetna's population health specialists bring their expertise and experience to PCMH practices engaged in our population health initiative. Specifically, our population health team members provide the following practice support in order to advance their transition along the VBS continuum toward their development as a PCMH:

- Serve as the dedicated relationship manager and single point-of-contact for the health plan
- Provide CareUnify education and training; support adoption through data analysis and workflow analysis; and incorporate enhancements, dashboard, and data integration into their current systems and workflows
- Provide regular data and metric reviews (daily/weekly as indicated by practice size) of performance trends on total cost of care, utilization trends, and quality outcomes
- Review and identify high-risk enrollees needing care and services; assist with aligning care and services in the right setting and to their PCMH
- Support regular care rounds, especially for complex enrollees through key clinical events (e.g., hospital discharge) and ensure all follow-up appointments are attended
- Coordinate with the health plan's care management and quality teams to ensure resources are well-coordinated
- Support the provider, enrollee, and the enrollee's circle of support by aligning to community service agencies and addressing social determinants where appropriate
- Support the provider's practice transformation with integration of our data and systems in alignment with their workflows, processes, and goals
- Align and drive additional resources and care coordination opportunities, including care coordination with a hospital system or behavioral health provider

Aetna also engages in other successful projects across the nation to support provider practice transformation. Our objective is to move toward a pay for value model. We collaborate with practices to assess and enhance population health and PCMH capabilities. Each step across the continuum represents increasing levels of responsibility and reward/risk for providers. We have experienced success with multiple approaches across the country.

As part of this commitment, we offer our providers a new learning resource that increases their practice's effectiveness in engaging our enrollees—our Cultural Competency Pilot. Part of Aetna's commitment is to help ensure every enrollee can access and understand his or her

## **EXHIBIT A-4-b**

### **MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

options necessary to lead healthier lives. Understanding care can be particularly challenging for Medicaid recipients as the enrollees we serve often face additional barriers that prevent them from accessing needed information and care.

Barriers can include living at or below the poverty level, having a mental health diagnosis or disability, primary language other than English, low health literacy, and/or cultural and religious preferences that impact how they think about their health and health care. These barriers can compromise treatment effectiveness. As staff members gain knowledge of cultural differences, provider practices can work more effectively with their diverse membership—thus increasing patient engagement, satisfaction, and helping enrollees lead healthier lives.

#### **BEACON HEALTH OPTIONS**

Aetna's subcontractor, Beacon Health Options (Beacon), recently embarked on a sub-capitated pilot program with a provider to enhance access by placing medical homes within Florida schools. Working with a large provider of school-based behavioral health services, Beacon is developing an alternative funding arrangement. Through this funding arrangement, the provider will receive a capitated rate for the management of behavioral health services to a high-risk population of elementary-, middle-, and high- school youth who are identified to participate in school-based programs. The program will establish enrollee outcomes from the enrollee experience of care and reductions of utilization of higher levels of care. Licensed behavioral health clinicians are placed in the school, all day, for 180 academic days, providing a mix of evidenced-based intervention, prevention, and primary care coordination services with identified children. These clinicians work with youths to improve social, behavioral, and wellness outcomes, including those measured by HEDIS. The program uses predictive modeling to identify at risk children, and outcome measures include school-based performance year over year to compare last year's school performance to a child without services and this year with services. Measures also include grades, attendance, school behavior, and are showing positive outcomes in these important categories.

#### **PARTNERSHIPS WITH HEALTH HOMES, PATIENT-CENTERED MEDICAL HOMES, AND RELEVANT POPULATION HEALTH MANAGEMENT PROGRAMS**

Aetna's national experience enables us to compare the most applicable strategies in other markets and deploy them in Florida. Our existing partnerships with PCMHs in Florida are designed to deliver a fully integrated management model for our enrollees. Proven results in other markets are demonstrated in the following paragraphs.

#### **ARIZONA**

Mercy Maricopa Integrated Care (MMIC) collaborated with large PCP practices and FQHCs to create comprehensive PCMH centers, thereby enhancing access to enrollees. Within these centers, behavioral health practitioners and clinicians work directly with physical health providers and each enrollee to complete an assessment and their individual plan of care. While not all enrollees connected to PCMH providers require a psychiatrist, integrated PCMHs have the competency and capacity to support enrollees who have managed behavioral health conditions and/or substance use disorder (SUD). Centralized documentation of assessments and care plans ensures a single plan of care for an enrollee. A single plan of care promotes

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alignment between all treating providers to streamline managed care programs and eliminate complexities for enrollees and providers,; thereby, assuring quality of treatment. To help ensure high standards of quality, PCMHs must become certified by NCQA or the Joint Commission.

PCMHs are funded by the Arizona Health Care Cost Containment System at 110% of the State's Medicaid fee schedule (FQHC payments are established in accordance with federal regulations). This enhanced rate is used to support the additional care coordination responsibilities of the clinics for individuals with serious mental illness (SMI). Additionally, MMIC and other managed care organizations, along with the Arizona Health Care Cost Containment System and the Arizona Council of Human Services Providers, have developed specific metrics to support value-based purchasing initiatives to drive the evolution of integration and holistic well-being further.

**ILLINOIS**

In Illinois, we have a PCMH-type agreement with Thresholds, a behavioral health care management organization. This agreement ties together both the behavioral and physical health aspects of care for enrollees. Thresholds is one of the oldest and largest providers of recovery services for persons with mental illnesses and SUD in Illinois. Last year, the organization served more than 15,000 adults and youth, with 75% of services delivered out in the community and representing more than 500,000 hours of care.

Thresholds uses evidence-based practices and a wide range of supports to treat the whole person, rather than the disease alone. This approach resonates strongly with Aetna's holistic approach to enrollees and is one of the central tenets of our PCMH program. We have an innovative agreement with Thresholds to locate Aetna enrollees and connect those enrollees to Aetna. Our phased approach includes an initial pilot consisting of at least 100 enrollees. We will review both behavioral and physical health claims for these enrollees to develop a more innovative value-based agreement—we want to see where the higher costs and utilization originate from this population—as well as identify and act on opportunities to improve quality.

**PROGRESS TOWARD HAVING PCMH PRACTICES IN EVERY FLORIDA REGION**

Aetna's ongoing effort to conclude VBP arrangements with Florida providers is progressing to plan with the following results:

**Region 1**



**FACILITATION OF CARE INTEGRATION**

PCMHs drive some of the most important reforms in health care delivery today. A growing body of scientific evidence shows that PCMHs are saving money by reducing hospital and ED visits, mitigating health disparities, and improving patient outcomes.

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Our PCMHs are service delivery models for providers whose patients (our enrollees) are best served by a medical home because they have complex needs that require an integrated behavioral health/physical health home. PCMHs help to address the complex health needs of the entire community through a highly coordinated system of care, which includes comprehensive primary care, specialty care, acute care, behavioral health integration, and community supports. Our PCMHs are supported with the following VBS payment models based largely on the practices capabilities and ability to succeed with each model:

- Fee-for-service payments with a per member per month care coordination payment and incentives/penalties based on clinical process measures
- Fee-for-service payments with a per member per month care coordination payment and incentives/penalties based on clinical outcomes measures
- A capitated per member per month payment covering both services and coordination with clinical outcomes measures

Our PCMH agreements are collaborative and outline the expectations of both stakeholders so that all share accountability for outcomes. Currently, PCMH programs are a part of, or will be part of health plans we manage in the following states: Florida, Arizona, Michigan, New Jersey, and Texas. Multiple steps allow us to offer each provider a model that works best for them. If a practice exhibits above average capabilities, we can employ either a PCMH model alone or a PCMH component.

In Florida, 40.5% of our enrollees see providers who are in some sort of value-based arrangement. The results of these arrangements are as follows:

- Medical loss ratio for these VBP providers is 80%.
- Medical loss ratio for non-VBP providers is 86%.
- For VBP PCP groups with more than 100 enrollees, ED visit/1,000 was 24% less than for non-VBP providers.

### **GENERAL INFORMATION**

We support practices to increase their cultural competency by providing training courses in the Relias system. Our cultural competency training focuses on three subject areas: social determinants of health, groundwork for multicultural care, and cultural diversity. We design the training as a resource for our providers, helping to increase our provider practices' effectiveness in engaging our enrollees and foster improved relationships. All provider groups are required to assign one clinical and one non-clinical staff member to complete the training.

### **PILOT DETAILS**

Cultural competency is included as a quality measure in the PCMH program for the 2017 performance year. The measure is only applicable to those PCMH amendments with an effective date in calendar year 2017. Our pilot program includes providers in the New Jersey, Ohio, and Texas markets, and we will use lessons learned from those states to apply to Florida. Lessons learned may include how adult learning preferences (including modalities of

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

presentation) are determined, how to apply information we provide to practices, and how to incentivize providers to operate in a culturally competent fashion.

The training program pilot is available to each provider and/or provider group who entered into the PCMH program by signing an amendment in calendar year 2017 that includes cultural competency as one of the quality measures. Completion of the training satisfies the performance requirement for the cultural competency measure for the 2017 performance year. Quality performance for the 2017 performance year in the PCMH program will be based on performance against all quality measures included in the PCMH agreement (including cultural competency).

### **PILOT MEASUREMENT**

Provider users complete a pre-course survey to determine their current knowledge level of the course material as well as a post-course test to validate the information learned within the course. Preliminary course test results have shown that users have significantly expanded their knowledge and understanding of cultural competency concepts, with some users showing as much as 100% improvement over their pre-course test scores. Early results show significant promise in our path to better educate and equip providers to be more culturally competent when providing care to each of our enrollees.

### **REDUCTION IN POTENTIALLY PREVENTABLE EVENTS FOR ENROLLEES WHO HAVE A PCMH AS THEIR PCP**

**CRITERION 2:** The extent to which the respondent's description of recognizing PCMHs addresses the reduction of potentially preventable events for enrollees assigned to a PCMH for their PCP

A report published by AHCA provided data from August 2014 to July 2015 (the first year of the MMA program) and revealed the following outcomes:

- More than 77% of 4.5 million ED visits during the review period were identified as potentially preventable
- 42% of hospital admissions were conditions that might be managed with outpatient care
- 46% of hospital readmissions were considered potentially preventable because they involved a continuation or recurrence of a condition from the initial hospital admission

The AHCA report also states that managed care provides an opportunity “to make health care more efficient by coordinating health care for enrollees. By improving access to primary care, medication management, care transitions, and monitoring the use of health care resources, managed care has the potential to improve quality of care and reduce avoidable use of health care resources.”

Aetna works to reduce potentially preventable events by encouraging our providers to become a PCMH. One simple example of such a correlation between becoming a PCMH and preventing PPEs includes the extended hours typical of our PCMH practices. By extending hours, the PCMH makes itself available to enrollees during a wider window of time, thereby offering an

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

alternative to avoidable ED visits. Additionally, enrollees can benefit from the advantages such practices provide, including a personal physician, person-centered integrated care management, and enhanced access. Our population health specialists work directly with our providers—with a focus on those in a PCMH arrangement—to assist in transition of care management with the health plan team. In addition, our population health team also coordinates and works with the provider care team on the use of CareUnify within their transition of care workflows. CareUnify is used to establish common care paths to drive best practices that align to national preventable readmission programs, such as Projects RED (Re-Engineering Discharge) and Project BOOST (Better Outcomes by Optimizing Safe Transitions). These programs ensure an evidence-based approach, prevent service duplication, ensure the enrollee receives all critical care and services to prevent any avoidable readmissions, and aligns back to their PCMH. Further, CareUnify can send admission, discharge, and transfer messages in real time and show all members of the integrated care team those enrollees with multiple ED visits or admissions, which helps with prioritization and tailoring of services for those enrollees with high utilization and cost trends.

Additionally, Aetna's use of PCMHs has been successful in reducing PPEs in our Illinois PCMH program. We examined enrollee HEDIS quality outcomes comparing providers in our Illinois PCMH program to the general Aetna network (non-PCMH providers). This 2016 comparison included the results of 23,040 Medicaid enrollees collected from more than 30 providers at nearly 200 clinic locations. This comparison demonstrated that our PCMH providers performed higher on 36 of the 58 (62%) reviewed HEDIS measures. On average, our PCMH providers performed 6.36% higher than our non-PCMH providers do. Aetna's experience and success in establishing and maintaining PCMH providers will benefit our Florida enrollees.

In addition, CMG enhanced access to over 34,000 enrollees. Of those, 1,975 patients stated that they still had an outstanding health need for which we scheduled an immediate follow-up appointment. Assuming that a portion of these patients, half, would eventually visit an ED for that need, at an average visit cost of \$1,000, CMG prevented avoidable cost of \$1 million dollars in that quarter, not including presumable savings from what in many cases would have turned into a hospital admission.

### **IMPROVEMENT IN PRENATAL CARE AND BIRTH OUTCOMES FOR ENROLLEES WHO HAVE A PCMH AS THEIR PCP**

**CRITERION 3:** The extent to which the respondent's description of recognizing PCMHs addresses methodologies and processes to improve prenatal care and birth outcomes for enrollees assigned to a PCMH as their PCP

The use of PCMHs facilitates care integration; in fact, the very definition of PCMH speaks to the model of care that emphasizes care coordination and integration at its core. For instance, PCMHs have yielded the most improvement in the areas of quality prenatal care and positive birth outcomes.

By providing a patient-centered multispecialty setting for enrollee care, an enrollee's needs with regard to maternal-child health are more easily and thoroughly met, allowing proper preventive and acute care needs to be met. This, in turn, contributes to factors that improve birth

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

outcomes, such as preconception planning, interconnection spacing, maternal health (including behavioral health), nutrition, and obstetric needs.

In Florida, Aetna currently participates in the Healthy Start Coalition of Miami-Dade (HSCMD) and other coalitions in locations where we manage Florida Healthy Kids programs. These coalitions monitor screening compliance by provider and offer counseling and education on risk reduction and care management services similar to the prenatal and infant care coalition for Miami-Dade.

Aetna encourages our providers to become a PCMH to assist enrollees in improving their quality of life, which includes improving prenatal care and birth outcomes. Aetna's approach to improving birth outcomes involves a number of other initiatives including:

- Birth outcome agreements built into Aetna's MMA Physician Incentive program
- Provider incentives for appropriate reduction of C-section rates
- Quality incentives for improvements in prenatal and postpartum care
- NICU-bundled payment programs
- Provider incentives for appropriate reduction in repeating births

Testimony of the significance of PCMHs in making real changes in outcomes are demonstrated by results from the Aetna Medicaid organization's Kentucky plan's three PCMHs, which improved HEDIS measures for Timeliness of Prenatal care as follows:

- 43.7% - a 19% improvement over plan
- 39% - a 10% improvement over plan
- 38.8% - a 9% improvement over plan

### **Evaluation Criteria:**

1. The extent to which the respondent's description demonstrates experience that includes contracts with patient centered medical homes in the network serving populations similar to the target population of this solicitation and demonstrates:
  - (a) Enhanced access;
  - (b) Coordinated and/or integrated care; and
  - (c) Achievement of improved quality outcomes.
2. The extent to which the respondent's description of recognizing PCMHs addresses the reduction of potentially preventable events for enrollees assigned to a PCMH for their PCP.
3. The extent to which the respondent's description of recognizing PCMHs addresses methodologies and processes to improve prenatal care and birth outcomes for enrollees assigned to a PCMH as their PCP.

**Score:** This section is worth a maximum of 25 raw points with each of the above components being worth a maximum of 5 points each.

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**MMA SRC# 4 – Telemedicine (Regional):**

The respondent shall describe its overall approach to utilizing telemedicine services to promote the Agency's goals, in particular as it relates to enhanced access to the following providers within the plan's network:

- a. Primary Care;
- b. Licensed mental health clinicians;
- c. Psychiatrists;
- d. Cardiologists;
- e. Pulmonologists;
- f. Endocrinologists; and
- g. Internists.

The respondent shall describe any limitations placed on telemedicine services within its network and the percentage of providers with the network that are authorized to provide telemedicine services for the specialty types referenced above and those actually providing telemedicine.

**Response:**

With an ever-changing health care landscape, telemedicine has steadily emerged as an innovative way to bridge gaps in access to providers, improve quality and continuity of care, and reduce costs. Aetna views telemedicine as a critical component of our larger innovation and population health strategy to remove barriers to care and help our enrollees gain access to high-quality primary and specialty care. Our strategy to increase access through telemedicine in the State directly aligns with AHCA'S objectives to enhance the enrollee and provider experience using an innovative and cost-effective approach.

An early adopter of emerging technologies, Aetna is expanding the use of telemedicine and remote patient monitoring as new and innovative ways to deliver person-centered, on-demand, virtual care. With our strong focus on the enrollee care experience and achieving health outcomes, Aetna is committed to improving access through telemedicine for our enrollees who have significant obstacles such as travel distance, mobility, or behavioral health considerations that prevent them from engaging in traditional in-person office visits.

Aetna and our subcontractor, Beacon Health Options (Beacon), are developing creative telemedicine solutions to meet enrollee access needs in challenging, rural areas. In accordance with Rule 59G-4.001, F.A.C., the Agency allows enrolled Medicaid providers to offer behavioral health and other services to enrollees through telemedicine technology. A provider located at a site other than where the enrollee is located may evaluate, diagnose, and treat enrollees. Enrolled Medicaid providers licensed within their scope of practice can use telemedicine to treat Medicaid enrollees.

**OVERALL APPROACH TO USING TELEMEDICINE TO PROMOTE THE AGENCY'S GOALS**

**CRITERION 1:** The extent to which the respondent describes an approach on the use of telemedicine services within its provider network that supports achievement of the Agency's goals

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In the December 2016 Florida Report on Telehealth Utilization and Accessibility (AHCA Telemedicine Report), AHCA, Department of Health (DOH), and OIR outlined several opportunities to improve usage and access through the expansion of telemedicine and telehealth technologies. The report addressed several areas in which providers typically struggle with adoption, including a lack of understanding of how telehealth can be used within their existing clinic workflows, financing and billing for telemedicine, and where telemedicine investments can yield a return on investment. In our experience with telemedicine in Florida and other markets, the concept is somewhat new for many providers who are challenged by the initial requirements for infrastructure and financing. However, we also found that our network is eager to engage the new modes of delivery that telemedicine offers.

Recently, Aetna initiated telemedicine collaboration with Jessie Trice Community Health Center, Inc. Working with [REDACTED] at the Trice Centers in Region 11, Aetna is implementing telemedicine to deliver a cost-effective solution to Trice Center providers, which is both secure and easy to use. As the providers and centers adopt the telehealth platform, Aetna will coordinate all training and support with our telehealth vendor to facilitate effective implementation. [REDACTED]

In our Louisiana Medicaid market, telemedicine is growing as an accepted care model, with the number of enrollees seeking telemedicine services doubling this year. We have seen positive outcomes with telemedicine, including cost savings of \$260,000 in 2016 and savings already reaching \$280,000 in 2017. These savings are largely driven by diverted emergency department (ED) visits. In our follow-up surveys, 95% of individuals noted their virtual care experience was favorable, with 79% stating they would have visited the ED if telemedicine were not available.

Our approach to using telemedicine and remote patient monitoring is well aligned with AHCA's goals and addresses several areas addressed in the AHCA telemedicine report, particularly scaling the telemedicine infrastructure to improve cost savings and access. In Florida, we are offering a diverse approach that encompasses financial and infrastructure support that has been embraced by our network providers in Florida and other markets, and we recently expanded our telehealth effort to include behavioral health. We will also offer remote patient monitoring as part of a broader telehealth approach where we have successfully addressed early intervention and self-management, particularly for enrollees with chronic conditions or in need of monitoring after hospitalization. As the aftermath of Hurricane Irma proved, telemedicine and mobile technologies can support disaster plans and get emergency care to remote locations. In some of our other markets, we are giving enrollees virtual access to individual therapy and medication management from their homes or from their primary care provider's office. To realize AHCA's vision and goals for telemedicine, our program will feature the following foundational elements:

- Easy-to-use options and/or a secure telemedicine platform through which our providers deliver care
- Virtual access to key specialty services including primary care, behavioral health, internal medicine, cardiology, pulmonology, and endocrinology

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Connectivity to our network and optimized care coordination with primary care providers and patient-centered medical home or health home
- Virtual provider-to-provider channel to increase the care team's effectiveness in treating complex conditions
- Enhancement of the care manager/enrollee relationship through virtual, real-time outreach capabilities directly to aid treatment plan adherence and enrollee safety
- Expansion and adoption of telemedicine core competencies across Florida, with provider education on billing and benefits
- Telehealth platform innovations, including use of remote patient monitoring and mobile technologies

### **Behavioral Health Providers with Telemedicine Capabilities**

Aetna's subcontractor, Beacon, currently reimburses for telemedicine services to Medicaid enrollees through nine community mental health centers. This program has increased access to psychiatry in rural areas where an organization such as Apalachee Center has performed these services for many years. For example, Apalachee covers 13 predominantly rural counties, enabling an experienced provider in telepsychiatry to improve access for Medicaid enrollees. Beacon has developed telepsychiatry pilot programs in targeted rural locations to ensure its use is appropriate. Over the past year, Beacon has expanded this service appropriately. Currently, the majority of Community Mental Health Center (CMHC) contracts include telemedicine. The CMHCs include:

- Apalachee Center
- Changing Tree Wellness Center
- David Lawrence Center
- Intervention Services (IMPOWER)
- Life Management Center
- Meridian Behavioral Health Care
- SalusCare
- The Centers
- The Harbor (BayCare)

In accordance with Florida administrative code, the CMHCs submit claims with a GT modifier to indicate a telemedicine service and are reimbursed by Beacon on behalf of Aetna. These services include those delivered by licensed mental health clinicians and psychiatrists.

### **IDENTIFYING PROVIDERS AND OVERCOMING BARRIERS TO EXPAND TELEMEDICINE**

**CRITERION 2:** The extent to which the respondent describes the methodology it will use to identify providers eligible for participation, limitations/barriers in its proposed use of telemedicine and proposed strategies to overcome those limitations/barriers

Based on our experience with telemedicine, a multifaceted approach engages providers across the care continuum to manage cost and access and to reach scale quickly. Aetna's telemedicine program supports several access points for care management, coordination, and consultation. Those access points include:

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Promoting provider-to-enrollee telemedicine service expansion, including specialty care
- Supporting provider-to-provider peer consultation
- Virtually connecting the care team to optimize enrollee care coordination

For each access point, we describe the application, how we will identify providers and make enrollee linkages to overcome the common barriers and to support and scale telemedicine across the Region and State.

### **APPLICATION 1: PROVIDER TO ENROLLEE—BUILDING NEW ACCESS OPPORTUNITIES THROUGH TELEMEDICINE**

To support telemedicine expansion for direct enrollee virtual care, we offer two approaches. First, for providers with an existing infrastructure for a telemedicine platform or who are part of a network that can provide safe and secure telehealth services, we pay for the delivery of select telehealth and related services. For providers with the ability to bill and deliver telemedicine services, we offer payment as negotiated in our provider fee schedule. Aetna will continue to support payment using consultation codes 99241 through 99255 with the GT modifier for providers who have existing telemedicine capabilities programs for covered services. Secondly, for our network providers who lack an existing platform, we offer, where appropriate, access to our web-based virtual video platform through a preferred telemedicine vendor. We will build upon our current relationships with innovative, local providers who have already invested in telemedicine infrastructure in conjunction with regional academic centers throughout the State who will serve as the source for specialty consultation to serve our enrollees.

### **INTERVENTION SERVICES (IMPOWER)**

Our subcontractor, Beacon, is currently expanding its contract with IMPOWER, a provider of telebehavioral health services, to extend telehealth services coverage statewide for licensed mental health clinicians and psychiatrists, including enrollee initial assessments and medication management. Together, Beacon and IMPOWER have worked to develop telemedicine capabilities since 2013.

In addition, IMPOWER has undertaken outcomes studies of telemedicine (IMPOWER study, 2013). Since 2013, approximately 2,000 clients have received mental health care via IMPOWER's telehealth program. This population includes children and adults. IMPOWER's telehealth services adhere to the guidelines set forth by the American Telemedicine Association. To assess and ensure quality service delivery, IMPOWER completed a comprehensive analysis of telehealth services. Two cohorts were identified—telehealth clients and non-telehealth clients. The telehealth cohort comprised 661 clients, 1,497 telehealth appointments, and 5,010 prescriptions written. The mean number of prescriptions written per telehealth appointment was 2.25. The non-telehealth cohort consisted of 1,385 clients, 4,699 appointments, and 11,591 prescriptions. The mean number of prescriptions written per non-telehealth appointment was 2.47. These numbers reflect 10.4% fewer prescriptions written during telehealth appointments. Controlled substance prescriptions written were .3% lower versus the non-telemedicine group. This was accompanied by high levels of client satisfaction with the telemedicine services delivered by IMPOWER, as evidenced by a satisfaction survey results on a five-point scale. With five indicating "strongly agree," participants indicated they were satisfied with the services they received from IMPOWER (the average score was 4.67 out of 5).

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **Provider Eligibility**

Our network development team surveys and tracks all providers who desire to and are able to deliver telemedicine services. As part of our eligibility analysis, we assess the entire primary care network, as well as specific specialties, including psychiatrists and licensed behavioral health specialists, cardiologists, pulmonologists, endocrinologists, and internists, to identify who is best situated to offer telemedicine services. We review each provider's panel size and current capabilities, how it uses any existing telemedicine platform, whether it is aligned with an existing telemedicine program or network as part of a hospital or other integrated delivery system. To recruit new providers, we contact our network using paper and web-based education tools to solicit feedback regarding interest and current activities. As part of our outreach effort, we also offer face-to-face education through our network, provider services, and population health teams to discuss the opportunities and benefits of using telemedicine within State regulatory and billing requirements. We will work closely with each provider that chooses to participate to develop a road map and implementation plan to begin a new telemedicine service for its practice or to add the provider to an existing network and telemedicine platform.

### **ADDRESSING LIMITATIONS AND BARRIERS**

Like many states, Florida requires an enrollee to be located in a recognized clinical setting to receive telemedicine services, which can impede access to virtual care on demand in the community. As we have with other Medicaid agencies, we welcome working with the AHCA and our provider and community partners to develop regulatory changes that would allow enrollees access to telemedicine services on demand from their homes or in community settings and enable them to connect with their primary care provider or specialty consultant. In the past two years, we have seen significant changes in state regulations that encourage more telemedicine use. Many states recognize telemedicine as a standard method for delivering care and are updating their regulations so that enrollees can receive services virtually and securely from their homes and on demand.

Within the current regulatory environment, there are several opportunities to build out a robust telemedicine network and offering for the State. Central to this effort is outreach and education to our provider network. As previously discussed, the critical first step is to address provider education, as providers typically lack a full understanding of the financial ramifications and how telemedicine can be integrated into their practice workflows. Our education and outreach process, led by our Network and Provider Services teams, will address concerns and answer questions about how to initiate and implement telehealth services and how to adapt to billing and reimbursement procedures. Our ongoing network assessment will determine where natural referral patterns are occurring to orient primary care and specialty practices around the use of a telemedicine platform where appropriate. For example, where a primary care provider's office regularly refers to a cardiology group or behavioral health provider, we will assess whether patient volume warrants the use of telemedicine services. We have found that when we initiate this discussion and offer network analysis, providers are enthusiastic about the possibility of telemedicine referrals, which can reduce long wait times for enrollees and provide enhanced access to care in underserved areas and remote sites. Providers quickly realize that care can be given in a more coordinated fashion with all parties connected in real time.

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

For many providers, a key barrier to offering virtual services is the lack of a reliable telemedicine platform. For select providers without telemedicine infrastructure, we are prepared to offer access to our secure, web-based telemedicine platform through our preferred vendor at no cost. Providers will receive full implementation support from our vendor and our team, including education on system use, real-time billing and scheduling support, ongoing reviews on system and utilization performance, and continuity of care compliance. Staff members, from both Aetna and our vendor, will make sure the care teams at the originating site and the remote site have the proper technology to use the web-based application. In our experience, telemedicine system requirements are minimal, and the majority of providers with even basic Internet access and computer systems can use the platform. We will also explore working with local telemedicine vendors with established networks to determine whether other providers in our network can participate. Where these relationships can be established, we will explore on a vendor-by-vendor basis either contracting for platform access or paying the vendor directly for covered services.

For enrollees, apprehension about the technology or their inability to access and use telemedicine technology can be a significant barrier. For many of our enrollees, the concept of telemedicine is new, and they trust or fear it. Our care management and enrollee services teams educate enrollees about telemedicine offerings and ways to request and access telemedicine services. Our current preferred telemedicine vendors have toll-free telephone and Web support resources for enrollees. However, because of current State requirements that care be given in a clinical setting, providers are a critical link to telemedicine education and care. We will give enrollee education materials and information directly to our providers and place information on our website that our network providers can use to encourage enrollees to see the benefits of telemedicine.

Aetna's subcontractor, Beacon, does not place limitations on the use of telemedicine services with the exception that telehealth providers must work within the AHCA Region they are located. While Beacon does not limit telehealth to specific diagnoses, there are certain clinical requirements and exclusions to determine if an enrollee is appropriate for telehealth, particularly for home-based services. Beacon has implemented telehealth for enrollees who do not have a serious functional impairment related to a mental health disorder.

Beacon defines telehealth services (also known as "telemedicine") as services provided by a Beacon contracted and credentialed provider at a remote location to a remote enrollee at the originating site using a combination of interactive video, audio, and externally acquired images through a networking environment. The services must be of sufficient audio and visual fidelity and clarity be functionally equivalent to a face-to-face contact. Telehealth services do not include telephone conversations or most Internet-based communication between providers or between providers and enrollees. Providers must use a HIPAA-compliant tool for the networking environment when providing telehealth services. Telehealth may apply to all outpatient codes listed within the provider services agreement (PSA) including psychotherapy and evaluation and management codes. Coverage is determined by the executed PSA. Reimbursement for these services is subject to the same restrictions as face-to-face contacts.

Beacon monitors for provider fraud and abuse for telemedicine and maintains the Agency's standards for reimbursable and non-reimbursable services. By Florida statute, telemedicine services are reimbursable if providers use interactive telecommunications equipment that

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

includes audio and video equipment that enables two-way, real time, interactive communication between an enrollee and a provider. Providers must submit a GT modifier on their claim form to be reimbursed for telemedicine. The Agency does not reimburse for equipment required to provide telemedicine services. Non-reimbursable services include telephone conversations, chart reviews, electronic mail messages, or facsimile transmissions.

### **Addressing Barriers to Expanding Specialty Care**

Locating and engaging specialists with telemedicine can be a significant challenge, as many specialists are already overbooked and may not have enough volume with specific providers to set time aside to see a few patients virtually. As part of our specialty network development, we assess the existing referral relationships between primary care providers (PCPs) and specialists to identify where telemedicine might expedite and coordinate care. We examine our claims and referral patterns to see if patient volume between the originating (typically the PCP) and remote sites is sufficient to warrant the use of telemedicine. We continuously assess referral patterns for key specialists, including behavioral health, cardiology, pulmonology, endocrinology, and other internists to determine where high-volume relationships exist and where we can offer use of our telemedicine platform or support payment to increase specialty care access. Finally, we will collaborate with providers to offer online counseling and therapy sessions with licensed behavioral health professionals in a secure environment as allowed under State regulations.

We see telemedicine as critical to the integration of on-demand access to comprehensive primary and specialty care, especially for behavioral health services. Our desire is to create a provider network in which new technology solutions can be seamlessly incorporated to complement the traditional in-person office visits, where an enrollee can easily receive virtual care in their local PCP office or other authorized setting, and perhaps eventually even from home. This approach supports the Agency's objective for enrollees to receive better access to care and all medically necessary services in a timely manner in the most appropriate setting.

### **APPLICATION 2: PROVIDER-TO-PROVIDER CLINICAL PEER CONSULTATION TO ENHANCE SPECIALTY CARE**

Another aspect of our telemedicine model for Florida under new contract involves using a web-based virtual video platform to encourage real-time, peer-to-peer clinical interactions to expand the specialty care footprint. The model has been featured in nationally recognized programs such as Project ECHO™, which supports specialists by providing virtual consults to PCPs and patient-centered medical homes (PCMHs) managing enrollees with complex diagnoses. A specialist can meet virtually for a session with multiple PCPs for treatment and care guidance using Project ECHO's one-to-many, hub-and-spoke model. We have worked with Project ECHO programs around the country, and we will promote this model in Florida by offering our telemedicine platform for providers to consult directly with each other. This model has been successful in addressing acute or newly diagnosed issues with enrollees in real time, providing expert consultation, medical therapy management, and guidance for the PCP/PCMH team.

Our experience with this model shows that PCPs and their staff become more competent over time at independently treating more advanced and complex physical and behavioral conditions. PCPs often learn an enrollee's condition is not as complex and can handle the bulk of care without making a referral to already over-extended specialists. This approach results in more availability for specialists to treat enrollees that are more complex and reduce wait times for

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

enrollees to receive care, thereby reducing complications and unintended hospitalizations stemming from delays in accessing specialty care. The model also encourages collaborative case rounds, where the entire team, often including clinicians, pharmacists, social workers, dietitians, and physical therapists, can engage in multidisciplinary learning that ultimately leads to a more enrollee-centered approach to the plan of care.

As part of the peer-to-peer model, we will recruit specialists and PCPs to establish a pilot with a focus on specialty care. We will commit to supporting models like Project ECHO and, where appropriate, will seek consultation with the Project ECHO founder, Dr. Sanjeev Arora and his team. Dr. Arora pioneered the virtual specialist consultation model at the University of New Mexico. The model has been shown to address the limitations of improving the capabilities of PCPs to treat patients that are more complex.

### **PROVIDER ELIGIBILITY**

In our experience, large academic medical centers are often willing to offer dedicated specialty consultation times. Through our network analysis, we will identify specific specialists and hospital systems willing to teach and consult with the PCP community. We will also recruit network PCPs willing to participate in case round consultations. For the initial rollout, we will explore establishing and financing a pilot program in each region. We will focus first on AHCA-defined key specialties, including behavioral health, pulmonology, cardiology, and endocrinology. We will fund the pilot and examine financing options such as paying providers for the consultation time or a case rate consistent with our fee schedule and State regulations.

### **ADDRESSING LIMITATIONS AND BARRIERS**

Using the peer-to-peer model, we will recruit specialists and PCPs to establish a pilot with a focus on specialty care. If warranted, we will also commit to bringing in the Project ECHO team and its founder, Dr. Sanjeev Arora. The model addresses the limitations of PCPs in treating patients that are more complex. The peer consultation model has a magnifying effect on specialty expertise that can be shared with PCPs to help them manage care for enrollees with complex conditions. By increasing their competency, we can reduce demands on specialty care and improve their clinical bandwidth in treating individuals that are more complex. Most importantly, enrollees in rural or underserved areas with transportation, geographic, or mobility challenges will have access to care to improve their health outcomes.

### **APPLICATION 3: CREATING A CONNECTED TEAM – VIRTUAL CARE COORDINATION FOR THE ENROLLEE**

Another approach Aetna champions is empowering and connecting our care managers and the larger integrated care team directly with our enrollees to drive more effective care coordination and hand-offs. Aetna is leveraging telemedicine technology to promote virtual care coordination that can significantly enhance the effectiveness of our care management teams as well as the PCP and the PCMH team to coordinate care in real time with a closer relationship with the enrollee. As part of our telemedicine strategy, Aetna will offer care coordination through our preferred telemedicine platform to select provider PCP/PCMH care teams at no cost. This feature enables an authorized user (e.g., care manager, patient advocate, nurse navigator) to

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

schedule online and on-demand video sessions or appointments for the enrollee in their home environment to:

- Connect enrollees with support professionals and licensed health providers such as dietitians and pharmacists, or community service agencies such as housing support
- Enable secure provider-to-provider communication via real-time video in a HIPAA-compliant environment
- Monitor enrollee progress through virtual visits to the enrollee's home to monitor progress and track clinical events such as a transition of care or wound healing
- Encourage enrollees to close care gaps and impact HEDIS measures using virtual follow-up visits
- Initiate virtual case rounds with the ability to join up to six participants in a shared video session
- Examine new opportunities to use the technology to connect with enrollees wherever they reside, including homeless shelters and daycare/respite or drop-in centers
- Communicate and triage during statewide emergencies such as hurricanes

### **PROVIDER ELIGIBILITY**

Aetna will immediately use this telemedicine platform for our care managers to conduct virtual visits with enrollees in their homes as part of our standard care management model. We will also initiate a pilot using this model with our expanded network, including community service agencies where appropriate, to develop a network of providers oriented toward engaging frontline staff care managers and care coordinators for care coordination rounds. In setting up the pilot, we will assess which team members of our provider groups and community service agencies are best suited to use our telemedicine platform for one-to-one enrollee consultation or as part of a virtual care coordination meeting.

### **ADDRESSING LIMITATIONS AND BARRIERS**

We use the virtual care coordination feature now in other markets and find it an effective way to engage enrollees, especially in their homes after an inpatient stay. We are also examining ways to use telemedicine to resolve trust issues that prevent enrollees from engaging with our team. By virtually connecting face-to-face, enrollees can engage in care management services and proactively participate in their care. We are also examining how a virtual visit may allow us to improve the completion of health risk and disease assessments; for example, using virtual technology to scan the enrollee's living environment for safety and food security issues or to examine an enrollee's gait stability or how he or she executes activities of daily living. This approach can also enhance maternal/child care with virtual visits to check on both mothers and babies and their home environment. We can use the platform for medication reconciliation with our clinical and pharmacy teams, especially for post-acute care. Our Lifeline phone program can help our enrollees obtain a smartphone if they do not already have one so that they connect to the web-based application to initiate and participate in virtual visits. Finally, we are also experimenting with collaborative case rounds virtually, using our telemedicine platform to create deeper levels of engagement with the enrollees' entire circle of support to improve the overall quality of care.

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **LEVERAGING REMOTE PATIENT MONITORING AS PART OF OUR COMPREHENSIVE STRATEGY**

Aetna offers a remote patient monitoring program for enrollees with specific chronic diseases such as congestive heart failure, diabetes, hypertension, respiratory disorders, and high-risk pregnancy. We use remote monitoring in several states to prevent hospitalizations, avoidable readmissions, and health regression by focusing on early detection and intervention. Early outcomes from our pilot program in Michigan include:

- Enrollee appointments with their PCP reduced by 54%
- Enrollee appointments with a physician who is not their PCP reduced by 40%
- Emergency department visits reduced by 65%
- Inpatient admissions reduced by 37%
- Almost all of the participating enrollees (96%) found the equipment easy to use
- Increased enrollee confidence in condition management after 30 days was 93%, and 96% of enrollees said the program made them more comfortable caring for themselves at home

For our first phase of implementation, we will provide identified high-risk enrollees with diabetes, hypertension, congestive heart failure, and high-risk pregnancies with our in-home remote monitoring technology package. We contract with national remote monitoring expert Care Innovations, a joint venture between GE and Intel. Enrollees in the program receive a remote monitoring bundle and kit, iPad mini™, and up to four peripheral devices, including a weight scale, pulse oximeter, blood pressure cuff, and glucometer. These devices are automatically 4G-enabled with call center and delivery support both to and from the enrollee's home. The unit is designed for a simple setup, with the iPad personalized for each enrollee, listing their name on the landing page with easy-to-follow instructions and videos on how to use the devices, how and when to contact their provider and care manager, and how to seek emergency help. The tablet provides educational content on disease management, and warning signs of worsening conditions, and it enables our care managers to videoconference using Facetime with enrollees to check in and provide assistance when needed. We use the tablet to send assessments that can be completed in real time, such as our new social determinants assessment, which identifies enrollee needs such as food insecurity or transportation problems, or mood assessments to monitor for emerging or acute mental health issues. Care managers and the care team can then address these issues as they occur.

The devices are plug-and-play and easy for enrollees to use with a wireless network. Enrollees do not need any technology or Web access, but do need standard cell tower reception. The enrollee simply attaches the devices or stands on the scale and biometric readings will automatically transmit to a secure HIPAA-compliant database monitored by the 24/7 Informed Health Line. Based on the PCP or other provider's recommendations, devices are programmed to alert the enrollee if a reading is abnormal. Simultaneously, the Informed Health Line can enact outreach for any high or abnormal readings so the enrollee can access care and help if needed. Our care managers and the enrollee's PCP, care team, or other designated providers can access the device readings and alert notifications to identify an abnormal or critical reading that requires action.

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Remote patient monitoring holds much promise as an entirely new approach to using technology for disease and condition management, as well as post hospitalization stabilization and monitoring. Enrollees learn to manage proactively their health to avoid preventable admissions and emergency department visits. Additionally, members of our care management team and larger interdisciplinary team benefit by receiving notifications that allow them to address directly issues in real time, leading to higher quality care and earlier intervention.

### **CAREUNIFY<sup>SM</sup>: CONNECTING THE DATA**

To share information related to our telemedicine and telehealth programming, we will use CareUnify, our population health platform. CareUnify is a web-based application designed to aggregate data from multiple sources to expose the information at the individual and panel level to the entire care team. Within each CareUnify enrollee profile, we will upload the consent, reports, and assessments from telemedicine visits as they occur. We anticipate that by the second quarter of 2018, CareUnify will allow a provider or enrollee to initiate a telemedicine or virtual visit from the platform. The enrollee profile will display current device readings in real time. When an enrollee has heart failure and is scheduled to take twice-daily readings from their scale and blood pressure cuff, the readings and their location in expected ranges will be prominently featured in CareUnify. Where readings are concerning, the tracker will show action taken by the call center and whether follow-up is needed by the care team. Using CareUnify as the data center, we can keep the entire care team informed on enrollee health status and trigger early interventions and response.

### **TELEMEDICINE TO SUPPORT EMERGENCY AND DISASTER RESPONSE**

After the recent Hurricane Irma, individuals living in Key West were stranded with minimal access to necessities or care. In many instances, cell towers did make it through the storms or became operational shortly after the storm passed. On-demand virtual network or telemetric in-home devices can serve an important role in the State's disaster preparedness and emergency relief plans. Providers can be deployed virtually via our web-based platform so acute health needs can be quickly triaged and addressed. While physical care cannot be delivered, the provider can quickly assess an individual's condition and give advice on treatment or guide local emergency workers to the enrollee's home. We welcome working with AHCA and the State to tie our virtual telemedicine network to statewide emergency response efforts.

### **LIMITATIONS, PERCENTAGE AUTHORIZED, AND NUMBER PROVIDING TELEMEDICINE**

**CRITERION 3:** The extent to which the respondent has already made significant achievements in the deployment of telemedicine within its network as evidenced by:

**CRITERION 3.a:** The percentage of providers authorized to provide telemedicine services for the provider types referenced

A telemedicine provider network that includes diverse provider types is critical to a successful program. Aetna is committed to facilitating the creation of telehealth provider relationships that complement each other as well as support the enrollee care experience and achieving health outcomes. Therefore, as long as a provider has the equipment capable of providing a telehealth appointment, Aetna does not place restrictions for authorization to provide services via

**EXHIBIT A-4-b**  
**MMA SUBMISSION REQUIREMENTS**  
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telehealth beyond those set forth in the Florida telemedicine regulations. This means that 100% of providers with the proper equipment will be permitted to conduct telehealth appointments, as long as they are licensed to practice medicine in the State of Florida, including PCPs, psychiatrists, cardiologists, pulmonologists, endocrinologists, and internists.

CRITERION 3.b: The percentage and type of authorized providers that provided telemedicine services during the 2016 calendar year

Aetna's telehealth provider network currently providing telemedicine appointments comes from the existing provider panel. Physicians who conduct telehealth appointments simply include the -GT modifier when submitting a claim to identify that appointment was completed via telehealth. A review of all Florida claims submitted with a -GT modifier showed that the majority of telehealth claims submitted were for primary care consultations (80%). The remaining claims submitted were for pediatrics (8%), internal medicine (6%), and behavioral health (5%). As stated previously, this utilization came from multiple regions throughout Florida.

Aetna continues to work to identify providers in each region using the methodology described earlier to ensure that our telemedicine provider network expands. In addition to our outreach efforts for identifying individual specialists, providers, and provider groups, Aetna will work with academic organizations and hospitals in regions throughout the State. [REDACTED]

According to the 2016 "Florida Report on Telehealth Utilization and Accessibility" (AHCA Telemedicine Report) 45% of responding hospitals provide telemedicine services. Including hospitals into our telemedicine provider panel can increase opportunities to expand telemedicine throughout Florida. Using this approach, we will leverage our hospital network and the expertise of and relationships we have with large hospital systems to expand telemedicine statewide.

**IN-NETWORK BEHAVIORAL HEALTH PROVIDERS PROVIDING TELEMEDICINE**

The following in-network behavioral health providers are authorized to provide telemedicine services for specialty types, as well as those who are actually providing telemedicine. Provider types include the following:

- Licensed mental health clinicians authorized to provide telemedicine services: 19.42% (n = 600 / 3,089)
- Psychiatrists authorized to provide telemedicine services: 17.36% (n = 172 / 991)
- LMHCs actually providing telemedicine: 0.84% (n = 26 / 3,089)
- Psychiatrists actually providing telemedicine: 2.72% (n = 27 / 991)

Licensed mental health clinicians and psychiatrists are reimbursed for telemedicine services. This includes practitioners with the following licensures in the State of Florida: ARNP, DO, LCSW, LMFT, LMHC, MD, PHD, PsyD. The list that follows indicates the number of licensed mental health clinicians and providers by region (2,646 total) who are authorized to provide telemedicine services in Beacon's current telemedicine network, which will expand in the new contract term.

**EXHIBIT A-4-b**  
**MMA SUBMISSION REQUIREMENTS**  
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- Region 1: 15
- Region 2: 328
- Region 3: 188
- Region 4: 527
- Region 5: 518
- Region 5: 264
- Region 7: 410
- Region 8: 2
- Region 9: 290
- Region 10: 14
- Region 11: 90

Beacon's current network of telemedicine providers includes notable providers such as:

- Apalachee Center
- Changing Tree
- Charlotte Behavioral Health Center
- Children's Home Society
- Circle of Friends
- Dade Family Counseling
- David Lawrence Center
- Emerald Coast Behavioral Health Hospital
- Florida Mentor
- Infinite Ways Network
- ISI (IMPOWER)
- Lakeview Center
- Life Management Center of Northwest Florida
- Meridian Behavioral Health
- Mission Medical Associates
- One Source Solutions
- Peace River Center
- River Region Human Services
- SAAFE Behavioral Services
- SalusCare
- SequelCare
- The Centers
- The Harbor
- Vericare of Florida
- Zepf Center

**Evaluation Criteria:**

1. The extent to which the respondent describes an approach on the use of telemedicine services within its provider network that supports achievement of the Agency's goals.

**EXHIBIT A-4-b**  
**MMA SUBMISSION REQUIREMENTS**  
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2. The extent to which the respondent describes the methodology it will use to identify providers eligible for participation, limitations/barriers in its proposed use of telemedicine and proposed strategies to overcome those limitations/barriers.
3. The extent to which the respondent has already made significant achievements in the deployment of telemedicine within its network as evidenced by:
  - (a) The percentage of providers authorized to provide telemedicine services for the provider types referenced; and
  - (b) The percentage and type of authorized providers that provided telemedicine services during the 2016 calendar year.

**Score:** This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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**MMA SRC# 5 – Provider Network Development (Statewide):**

The respondent shall submit a draft network development and management plan demonstrating how it will ensure timely access to primary and specialty care services, necessary to promote the Agency's goals, including:

- a. Identification of network gaps (time/distance standards, after-hours clinic availability, closed panels, etc.);
- b. Strategies that will be deployed to increase provider capacity and meet the needs of enrollees where network gaps have been identified;
- c. Strategies (including a description of data sources utilized) for measuring timely access to appointments with the following provider types:
  - (1) Cardiologists (pediatric and adult);
  - (2) Pulmonologists (pediatric and adult);
  - (3) Endocrinologists (adult);
  - (4) Internists (adult);
  - (5) Psychiatrists (pediatric and adult);
  - (6) Obstetricians/Gynecologists (adult); and
  - (7) Licensed mental health clinicians (pediatric and adult).
- d. Strategies for recruitment and retention efforts planned for each provider type, including the quality and/or performance metrics that will be used to determine a provider's success in making progress towards the Agency goals.

**Response:**

The Aetna Medicaid organization has built effective networks for health plans it currently manages, such as networks providing similar services in Arizona, Texas, Ohio, Illinois, Michigan, New York, Louisiana, Kentucky, and Virginia, serving Medicaid enrollees. Additionally, we have created plans for statewide expansion efforts in Louisiana and Virginia for the LTSS populations, New Jersey, Michigan, and Texas for its STAR Kids program. Aetna has conducted more than 20 successful implementations meeting all state adequacy requirements over the past two years alone, including programs that meet the diverse and complex needs of the Medicare and Medicaid populations.

Aetna's experience in Florida includes developing networks for Medicaid over the past 30 years. Aetna has extensive experience coordinating Medicare and Medicaid and serving the MMA and LTC complex population needs throughout the State. Currently, we serve the MMA population in Region 11 and the LTC populations in Regions 6, 7, 9, and 11. We have also served the Florida Healthy Kids contract in Regions 1, 2, 3, 5, 6, 7, 8, 9, and 11 for over 20 years.

**NETWORK DEVELOPMENT AND MANAGEMENT PLAN**

Aetna's network development and management plan to facilitate a statewide expansion (beyond the services provided in the regions we already serve) is based on our experience in building effective networks throughout our Florida business lines. We can readily accomplish the network needs under a new contract by expanding on our successes and building on the

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foundational networks that already exist. We have spent the past year meeting with providers and enrollees to understand network needs. Our draft network development and management plan is provided as Attachment MMA SRC 5.

Our network development and management plan ensures timely access to primary and specialty care services and promotes the Agency's goals, including identifying network gaps; increase provider capacity to meet enrollee needs where gaps are identified; timely access to appointments for the various provider types including cardiologists, pulmonologists, endocrinologists, internists, psychiatrists, obstetricians/gynecologists, and licensed mental health clinicians; and includes recruitment and retention strategies including quality and performance metrics.

In Florida, our network development work plans began a year in advance of the ITN, continues throughout ITN and contracting processes, and extends past go-live to make sure we are meeting the entire system of care needs in a culturally compliant manner and accounting for all the unique regional variations as determined by the demographic differences across the State.

Our Florida leadership team, many of whom have lived in Florida for most of their lives, brings expertise that helps to build and refine our network throughout the contract term. Our Florida team also has access to more than 25 national personnel to assist with implementations, providing a seamless transition for existing enrollees with little to no disruption in service. By utilizing our existing product footprints within the State (Florida Healthy Kids, Medicare, Medicaid, and commercial contracts), we can readily expand our current network to reflect statewide needs.

**BUILDING AETNA'S EXPANDED FLORIDA NETWORK**

Aetna has an extensive contracted statewide provider network with

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Aetna leverages our subcontractor, Beacon Health Options, to garner its broad behavioral health network, while improving quality, improving access, and controlling costs. We seek PCPs who currently serve a large number of Medicaid enrollees and have the necessary experience to improve access and quality of care while reducing avoidable cost. We also contract with FQHCs that serve as a vital one-stop shop because they meet the needs of enrollees in specific markets by providing primary and specialty services as needed. We fully appreciate the fact that it is vital for enrollees to avoid provider disruption, so our approach to network development mitigates any disruption of services.

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

We are expanding our network through Aetna's Medicaid physician incentive program. Certain board-certified pediatric practitioners are eligible to be reimbursed at 100% of the Medicare. This increase in rate serves to remove reimbursement as an obstacle to accepting Medicaid patients. Our research shows reimbursement is the most significant obstacle to getting providers to accept Medicaid contracts. We can increase the number of providers willing to participate in our network if we address the reimbursement level. We are exploring ways to expand the incentive program to incorporate other specialty types. Aetna is working with a pre-eminent medical institution on customizing a nationally recognized program that measures standard practice protocols. It is our intent to be able to incentive providers who are delivering quality care, institute best practices and who are practicing within established protocols. Through this program, we will be able to measure practice patterns and clinical outcomes and share this data with providers so they have a better understanding of their own practice patterns. Ultimately, our goal is to build a reimbursement structure to align incentives based on health outcomes. Aetna will be able to fund incentives at no additional cost through the anticipated decrease of unnecessary emergency care and more efficient and targeted care.

### **IDENTIFICATION OF NETWORK GAPS**

**CRITERION 1:** The adequacy of the respondent's methodology for identifying and resolving barriers and network gaps; including ongoing activities for network development based on identified gaps and future needs projection

**Identify gaps or barriers:** To ensure network adequacy and identify any gaps or potential gaps, Aetna conducts enrollee density analysis to determine areas of focus. The goal is to recruit providers that understand the needs of the Medicaid population and that are in close proximity to our enrollees. We diligently work with community resources and stakeholder groups to identify and respond to enrollee needs. Aetna monitors complaints and survey enrollees (especially on timely access) to identify and mitigate any issues. We continually review GeoAccess reports to determine if we can add any new providers to the network and make future network projections. GeoAccess reports are run monthly, and are reviewed by network development leadership. The results of the reviews are shared with the service improvement committee. Network Development makes recommendations to the Network Development team and formulates a plan to close any identified gaps.

We review utilization data to identify clusters where providers are needed (i.e., for specialty services, or areas where complaints have been made), and we conduct outreach to begin contracting with these providers to close any gaps or potential gaps. Aetna also identifies any barriers or potential barriers to access (e.g., transportation, language, or cultural barriers) and remedies those issues. In the event there is a service gap and timely access is needed or a specialty is required not currently in the network, Aetna pays an enhanced fee schedule to providers willing to accept Medicaid patients.

Aetna uses assessment and measurement programs as the primary means of determining network adequacy and our level of compliance with Florida access requirements. These assessments analyze compliance with travel distance standards, appointment availability, after-hours access, open panel status, and cultural competency for key provider types. Currently, we are in compliance with contract requirements for travel times and distances for all providers including vision, pharmacy, and behavioral/mental health.

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

In Regions 1, 3, 4, 5, 6, 7, 8, 9, and 10 we currently meet 100% of the contractual time/distance standard for hospitals, PCPs and all required specialists. There are no gaps based on the Florida MMA contractual time/distance standards

In Region 2, we currently meet 100% of the contractual time/distance standard for hospitals, PCPs, and required specialists, except for pediatric nephrology (urban and rural ) in which 37% have access, Pediatric neurology (urban and rural) in which 89% have access, pulmonology (urban) in which 65% have access and urology (urban) in which 65% have access. Aetna uses a very conservative access model, assuming one enrollee per ZIP code when analyzing network adequacy. We understand that in this region, the traditional pattern of care for these pediatric subspecialties, not locally available, require travel to Shands in Gainesville, or Nemours provides some satellite services at Doctors Hospital, or use of telemedicine consults in which are partnering to provide as well. For the ZIP codes without access to pulmonology, we identified two targets; however, one has declined to participate in any Medicaid program. We continue to pursue a contract with the remaining one pulmonologist to close this gap. For the ZIP codes without access to urology in the time/distance standard, we have identified two specialists in which contracting efforts continue.

In Region 11, we currently serve MMA enrollees throughout the Miami-Dade service area and meet 100% of the contractual time/distance standards for hospitals, PCPs, and required specialists as determined by AHCA. There are no gaps based on our Florida MMA contractual requirements.

### **Ongoing Monitoring Plan to Identify Network Gaps**

In Florida, we use a variety of mechanisms to verify compliance with network standards and develop interventions to address gaps. We use our suite of monitoring tools and reports to identify network gaps as follows:

- Provider-related enrollee complaints: Complaints including those identifying network gaps or barriers are reviewed weekly as part of our grievance process and are referred to the appropriate area for investigation and resolution. Our call center monitors trend reports that are shared with operations conducting weekly meetings to review phone center feedback as well as outreach by Provider Services staff to determine any network gaps or barriers.
- Conducting network panel studies using open/closed panel report: Assessing network access and availability needs
- Conducting provider directory audits: Monthly audits confirm the accuracy of listings and make weekly updates to online directories with changes in demographics and panel status
- Conducting provider phone surveys: Query providers on appointment availability and after-hours care
- GeoAccess reports: Monthly reports measure against the State's access standard requirement for each ZIP code
- Interdisciplinary team collaboration: Identify any access or capacity concerns and addressing special needs
- Network adequacy: Review utilization data for prevalent conditions, single case agreements, provider referral issues (availability of specialties), providers-gained-and-

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

lost report, and unplanned network exits report to confirm sufficiency of the type and number of providers

- Reviewing PCP-to-recipient status: Review ratios by provider type and region to confirm availability of an adequate number of PCPs
- Reviewing providers' panel status: Review open panel status to confirm where new enrollees can be assigned and identify providers who have reached their capacity and/or referral limits
- Review grievances and feedback: Review quarterly analysis and trending of enrollee grievances to identify potential availability or accessibility issues, perform root-cause analysis, and develop corrective action plans, receive committee findings, and survey results on access, appointment availability and wait times, non-participating prior authorizations, and out-of-network requests.

### **Identifying and Meeting the Need for Specialists**

Aetna reviews GeoAccess and provider data to determine the number of specialists in a geographic area so we know if we have an adequate number of providers to meet enrollee needs. We look to provider 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 solutions or community solutions to increase access, especially in rural markets or in limited specialties. We monitor behavioral health provider access on a monthly basis to see if we can add new providers or mitigate any network gaps. For vision and pharmacy access, we use GeoAccess data to monitor the number of providers in the various geographic areas to ensure we meet the required enrollee-to-provider ratios.

### **Identifying and Meeting Future Needs**

We continually assess our network's ability to meet future projections on enrollee needs using the following methods:

- 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/Utilization Management (QM/UM) Committee meeting process.
- Invite provider participation and input on future network needs through our Enrollee Advisory Committees, Provider Engagement Committee, LTC Advisory Committee, and Quality Management/Utilization Management Committee.
- Invite participation and feedback in stakeholder meetings composed of health care professionals, advocates, enrollees to discuss issues, including network adequacy, provider complaints, and recruitment priorities for growing the network.
- Obtain stakeholder feedback on network composition, operations, and quality improvement initiatives to make sure we meet the cultural needs of the community and assess any areas of concern.
- Invite provider participation in a variety of educational forums and webinars to share ideas, questions and concerns, as well as future network needs/projections.
- Constantly seek suggestions and innovative ideas from providers to help offer better access, and increase enrollee convenience.

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- The local network team is crucial in identifying needs to expand the network to ensure timely access for enrollees. As they receive referrals from the integrated care team/medical management and other community agencies and organizations, they determine whether additional recruitment efforts are needed. If so, they begin to conduct outreach to providers in that area or specialty to mitigate any potential gaps in care.
- Enrollee and provider referrals also trigger recruitment activity.
- Quarterly and annual monitoring plan review will trigger recruitment action as we review GeoAccess reports.
- Evaluate projected population needs against the current contracted provider network to identify any opportunities to recruit services and providers. Aetna maintains a recruitment database to help us track who is being recruited, and it shows our progress in obtaining signed agreements and applications. We offer providers an opportunity to sign an electronic contract using the Adobe e-sign capability to make it as convenient as possible for a provider to return and sign their document, decreasing turnaround time on a signed agreement from days to hours.

Aetna's Florida network meets all contract requirements, including access standards; appointment times; type and number of facilities; ancillary, specialty, behavioral health, and vision providers; and pharmacies. We successfully manage our networks for high-quality, culturally diverse, credentialed, and physically accessible provider groups to increase access and choice. For the past 30 years, Aetna Medicaid has gained experience using value- and risk-based payment methodologies with performance incentives to encourage participation and wide-scale adoption in the Florida network.

### **STRATEGIES TO INCREASE PROVIDER CAPACITY AND MEET THE NEEDS OF ENROLLEES**

**CRITERION 2:** The adequacy of the respondent's plan to meet the needs of enrollees if it is unable to provide the service within its provider network; including immediate, short-term and long-term interventions

If a contracted network provider is unable to provide services in the timeframe needed, we use a number of methods to determine if availability and/or access to timely care are problematic:

- Our care managers, responsible for managing the day-to-day care needs for complex enrollees, determine the need for services. Care managers send provider referrals to the Network Development department when a participating provider is not immediately available to serve an enrollee's needs.
- Enrollee services representatives assist enrollees in scheduling appointments, coordinating transportation and calling provider offices when they are any barriers to the enrollee obtaining the care they need in the applicable timeframe.
- Aetna's Provider Services and Contracting teams research and conduct outreach to both contracted and non-participating providers to identify providers who offer the unique services needed. We arrange for transportation as appropriate and required. We work closely with the provider and enrollee to make sure services are delivered as planned and expected. Then, through our regular monitoring plan activities, we track and measure availability and access.

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

When a participating provider is not available to meet an enrollee's immediate needs, we develop one or more of the following:

- Immediate solution: Authorize the use of the closest qualified non-participating provider able to provide the service and determine if the provider is willing to accept Medicaid reimbursement and qualifies for Medicaid payment. If necessary, we also provide transportation.
- Short-term solution: Offer and enter into a negotiated single-case agreement with the service provider to meet the enrollee's current and recurrent needs until the time when the service can be transitioned to a participating provider or the provider becomes contracted with our network.
- Long-term solution: Recruit all willing and qualified providers offering a short-form complaint agreement or long-form participating agreement to expand availability and access for needed services within that specific geographic area.

We employ several strategies including recruiting or adding providers through the normal recruitment process to increase provider availability and access. We use innovative strategies to improve access to the following services:

- Short-form agreements that are fully compliant with State requirements offered to providers who may be reluctant to join a new managed care organization or to providers who are new to managed care. By offering providers the ability to sign an electronic contract using Adobe e-sign, we make it as convenient as possible for a provider to return and sign their document within hours.
- Using our existing regional offices in Tallahassee, Tampa, Orlando, Jacksonville, Sunrise, Boynton Beach, and Miami, we can conduct face-to-face engagement activities to encourage providers to participate in our network. Here they can meet one-on-one with our provider staff to help them understand their managed care contract, Aetna's policies and procedures, how to file claims and receive electronic payments. Our conveniently located offices throughout the State also provide a place where we can host advisory committee meetings, training events, and more. These regional offices have helped us offer a more personal approach to building long-term relationships and expanding provider networks.
- Adopting telepsychiatry solutions by working in collaboration with Beacon to grow access to these services and capabilities will improve timely access to behavioral health care, especially for those in the state for whom distances might present a challenge to access to care.
- We have also contracted with the Florida-based program My Home Doctor to improve access, especially in rural areas and for the medically fragile, so patients can see a physician from the convenience of their home. The program improves access to clinicians, dramatically reducing the use of 911, emergency department visits, and costly preventable hospitalization admissions and readmissions.

### **STRATEGIES FOR MEASURING TIMELY ACCESS TO APPOINTMENTS**

**CRITERION 3:** The adequacy of the respondent's approach for measuring timely access for the specified provider types and the extent to which the respondent's approach includes clear methodology for determining the following:

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- (a) Average wait time for an urgent appointment
- (b) Average wait time for a routine appointment.

The network monitoring plan provides regular reports on access to timely care for urgent and routine care appointments for each provider type (i.e., cardiologists, pulmonologists, endocrinologists, internists, psychiatrists, obstetrician/gynecologists, and licensed mental health clinicians) by:

- Conducting telephone surveys of enrollees and secret shopper calls to providers to determine access to timely care on a monthly basis, including provider counts by region and average wait times for both urgent and routine appointments
- Monitoring complaints from enrollee or Provider Services department on an ongoing basis
- Using our suite of tools and reports (described in more detail as follows) to monitor ongoing timely access for the specified provider types
- Conducting outreach to referring providers on the integrated care team, medical management, and community agencies to determine where there are access-to-care issues such as long wait times for urgent and routine appointments
- Conducting community outreach to referring agencies and organizations to identify any access issues, concerns or needs throughout the year

Participating physicians and other providers are contractually obligated by provider agreements to adhere to access and appointment standards and are required to provide services in the same manner as all non-Medicaid enrollees. Standards for wait times and appointments, disability access, competency, expertise, cultural sensitivity, and hours of operation are communicated through the provider manual, newsletters, during site visits, and in training documents.

### **Tools to Track and Monitor Wait Times**

We use our suite of tools to track and monitor excessive office wait times and complaints about wait times to identify providers who may be non-compliant. Any changes to standards or policies are communicated through updates to the provider manual, fax blasts, email communication, website updates, and provider site visits. If our national policy standards are more stringent than State requirements, we hold ourselves to the higher standard while also meeting NCQA standards.

Aetna's monitoring tools and processes can improve access to care and wait times on an ongoing basis through:

- Appointment availability surveys that monitor appointment availability, wait time in the office, and after-hours accessibility
- General feedback from routine operations by Provider Services liaisons, Enrollee Services staff, Care Management, Utilization Management, advisory committees, and anyone who serves as a touchpoint for enrollees or providers with concerns about appointment access or wait times
- Telephone provider surveys about their appointments and after-hours access

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Reviewing quarterly trends in enrollee grievances to identify any potential availability or accessibility issues, performing root-cause analysis, and developing corrective action plans, if necessary
- Input from Enrollee Advisory Committee findings, and enrollee survey results that include questions regarding access, appointment availability and wait times, non-participating prior authorizations, and out-of-network requests
- Enrollee performance indicators obtained from the online provider directory functionality
- Random sampling of providers to ensure they meet access and appointment availability standards
- Enrollee Advisory Committees and provider participation in our Quality Management/Utilization Management Committee

Appointment Availability Survey results, trended complaint and survey data, and other findings from routine activities are presented to the Service Improvement Committee and the Quality Management/Utilization Management Committee. The Committee reviews recommendations, make suggestions, monitor status of corrective actions, and assist in prioritizing resources within the organization to achieve our goals.

If we determine that more providers or specialties are needed in a specific area, we proactively conduct outreach to providers in that area to expand our network and mitigate any potential network gaps or non-compliance with access or wait-time standards.

### **Resolving Wait Time Issues**

When we identify an issue involving appointment access or wait times, our Provider Services liaisons, care managers, and Enrollee Services staff are willing and able to assist in resolving the issue by contacting the provider or locating another provider, and then working closely with the provider to resolve any future availability issues. For example, our care manager assisted an enrollee who was referred to an orthopedic surgeon but unable to schedule a timely appointment in locating a provider who could see him or her within the standard timeframe to the satisfaction of the enrollee, surgeon, and referring physician. Aetna's staff are trained and educated to an enrollee-centered focus on the right care at the right time.

### **STRATEGIES FOR RECRUITMENT AND RETENTION**

**CRITERION 4:** The extent to which the recruitment efforts outline the frequency and specific measures to be used to track the need to deploy recruitment activities for the provider types listed

The local network team is crucial in identifying needs to expand the network to increase timely availability for enrollees to cardiologists, pulmonologists, endocrinologists, internists, psychiatrists, obstetricians, and licensed mental health clinicians. 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.

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

In addition to our immediate resolution strategies, we undertake extensive ongoing monitoring efforts to determine network needs quarterly at a minimum, including:

- Provider-related enrollee complaints: Complaints, including those identifying network gaps or barriers are reviewed weekly as part of our grievance process and are referred to the appropriate area for investigation and resolution. Our call center monitors trend reports that are shared with operations conducting weekly meetings to review phone center feedback as well as outreach by Provider Services staff to determine any network gaps or barriers.
- Conducting network panel studies using open/closed panel report: Demonstrate network access and availability needs
- Conducting provider phone surveys, which include provider queries on appointments and after-hours care including 24/7 availability.
- GeoAccess reports: Monthly reports measure against the State's access standard requirement at the ZIP code level.
- Interdisciplinary team collaboration: Identify any access or capacity concerns and addressing special needs
- Network adequacy: Review utilization data for prevalent conditions, single case agreements, provider referral issues (availability of specialties), providers-gained-and-lost report, and unplanned network exits report to confirm sufficiency of the type and number of providers, including need for specialty providers
- Reviewing PCP to recipient status: Review ratios by provider type and region to confirm availability of an adequate number of PCPs
- Reviewing providers' panel status: Review open panel status to confirm where new enrollees can be assigned and identify providers who have reached their capacity and/or referral limits
- Review grievances and feedback: Review quarterly analysis and trending of enrollee grievances to identify potential availability or accessibility issues, perform root-cause analysis, and develop corrective action plans, if necessary; receive committee findings, and survey results on access, appointment availability and wait times, nonparticipating prior authorizations, and out-of-network requests
- General feedback from routine operations from Provider Services liaisons, Enrollee Services staff, Care Management, Utilization Management, advisory committees, and anyone who serves as a touchpoint for enrollees or providers noting issues or concerns with appointment access or wait times, as well as identifying network needs or gaps
- Input from Enrollee Advisory Committee findings, and enrollee survey results, including questions regarding access, appointment availability and wait times, non-participating prior authorizations, and out-of-network requests
- Review enrollee and provider satisfaction survey data to identify issues and concerns as well as opportunities for improvement
- Enrollee Advisory Committees and provider participation on our Quality Management/Utilization Management Committee to provide feedback on issues, concerns, additional network needs, or opportunities for improvement

Additional indicators that also trigger recruitment activity, including:

- Enrollee and provider referrals
- Quarterly and annual monitoring plan review based on review of GeoAccess reports

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Projected population needs are evaluated against the current contracted provider network to identify any opportunities to recruit services and providers.
- Provider services liaisons meet regularly with all large health systems and key provider groups in their respective regions to stay informed of new services being added or services being discontinued and update our provider database with geographical and service level designations to provide the most accurate and timely reports and directories.
- Working with community outreach liaisons and other community-based organizations on a regular basis to identify services and providers who we can contract with or develop innovative solutions to meet enrollees needs.

Our strategy is to build the most effective, experienced, and highest-quality network that offers provider selection and meets the needs of enrollees, as evidenced by the robust network in the regions where currently operate. Providers are identified from a number of different sources (including our current vast commercial and Medicare provider networks), and we actively pursue new providers for participation in our Medicaid network. We use our comprehensive contracting methodology, value-based purchasing programs, technology/telehealth services, and an ongoing level of engagement and diligence to continuously recruit providers and scale our provider network.

### **Approach to Keeping Providers Satisfied and in Good Standing**

**CRITERION 5:** The extent to which the retention efforts outline the approach to keeping providers satisfied and in good-standing with the respondent

Provider satisfaction is dependent on a solid partnership between the health plan and the provider, so we work to ensure we proactively address providers' needs and any potential concerns proactively. Because provider satisfaction is paramount, we obtain proactive feedback from our provider community related to new program initiatives on an ongoing basis. Aetna conducts semi-annual provider advisory forums to discuss and review satisfaction ratings and new program initiatives to get immediate feedback that enable us to adjust, where warranted, based on provider input.

We collaborate with providers to understand their issues and determine opportunities for improvement, including incorporating provider feedback into Aetna's committee to improve processes and procedures. A recent example of how we use provider feedback to implement change is demonstrated by the addition of lab services that can be performed appropriately in an office setting. We met with providers and listened to their suggestions to add specific in-office lab tests including finger/heel sticks for newborns, lead testing, hemocult test, fecal occult blood, cholesterol screening (lipid test), and mononucleosis tests. The feedback was taken back to our clinical leadership and the codes were effectively implemented. As a result, we received positive provider feedback.

Aetna is committed to developing innovative ways to improve the provider experience. Technology-based solutions make up a significant part of our strategy; most recently we began a project to streamline the ability for providers to submit request for authorization in any format which will result in a direct upload of data into our clinical system. This project decreases the

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

turnaround time for processing authorization requests. Our goal is to simplify requirements so providers can focus on providing quality care while decreasing administrative work.

Our strategy of implementing value-based contracting will make a positive impact to provider engagement and satisfaction. In value-based contracting, we are working with our providers to align goals and incentivize performance. Real-time reports and enrollee engagement tools are made available to facilitate successful outcomes that lead to improved health for our enrollees. In complimenting provider efforts through our own care management resources and program, we build strong partnerships that ultimately lead to highly effective collaboration.

We collect information about the satisfaction level of our provider community through several communication forums, including the following:

- Regular provider site visits and/or scheduled telephonic meetings
- Annual provider satisfaction surveys
- Monthly provider pulse surveys
- Monthly post-site visit survey
- Feedback from our Community Action Forums
- Feedback from the QM/UM Committee, which includes representatives from the provider community
- Feedback from provider training sessions
- Review of data outcomes from our Provider Claims Inquiry team
- Feedback from Care Management staff
- Grievances and appeals
- Community meetings

### **PERFORMANCE METRICS THROUGH UTILIZATION MANAGEMENT**

CRITERION 6: The extent to which the quality and/or performance metrics it will use to gauge progress toward the Agency goals are transparent to providers, including the frequency with which providers will be able to access their progress.

Aetna works collaboratively with providers on an ongoing basis to help them improve health outcomes, reduce costs, and improve satisfaction. Provider Services liaisons can pull utilization data in real time to identify training and educational needs and work one-on-one with providers to help improve patient outcomes. Utilization data are also used to assist in developing provider incentive programs such as our value-based purchasing arrangements. Reports that identify needs for provider collaboration are based on clinical data that can be pulled from a number of internal and external sources, including our Utilization Management (UM) business application on a monthly, quarterly, or annual basis.

Aetna's UM business application provides the infrastructure for utilization management and claims. Our UM staff use this system for all physical and behavioral health care authorizations in real time to verify enrollment and eligibility, provider status for participating and non-participating providers, and to view claims activity. The system facilitates care coordination by allowing our interdisciplinary care team and other care supports to view the authorizations and claims for enrollees through complete care episodes in real time. The system streamlines care transitions and helps enrollees have positive health outcomes. The information entered by the provider into

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

the portal is seamlessly integrated into the UM business application for processing. Aetna's interdepartmental staff, including UM, Care Management, community health workers, Enrollee Services, delegated vendors, and the nurse help line staff all have varying levels of access to the same information, negating redundancies across departments that could contribute to delayed service authorizations. Care managers can view enrollee progress in the UM business application to identify and address gaps in care.

### **Provider Performance Profile**

Aetna's provider performance profile contains essential clinical and enrollee information that promotes quality efforts to maximize point-of-care delivery.

The provider performance profile reflects panel enrollee receipt and costs of defined clinical services or health care status for the profile measurement and/or reporting period. Aetna utilizes profiles for various programs and initiatives.

The provider performance profile is comprised of data such as:

- HEDIS measures
- Inpatient admissions
- Emergency department utilization trends
- Readmission rates
- Detailed utilization data
- Costs per enrollee
- Predictive modeling data
- Provider level detail on specific performance measures

### **Innovative Performance Programs**

Aetna is continuously pursuing innovative projects that increase quality, access, and availability, and efficiencies while reducing cost. For instance, our leadership worked with providers and the State on the Prematurity Symposium to educate providers on improving birth outcomes.

We are also evaluating a utilization management program that we are considering using in Florida to help educate and collaborate with providers on improving utilization trends and reducing costs. Leaders from both the Aetna Better Health of Florida program and the Aetna Medicaid organization's corporate team are involved with this educational initiative. The program develops and applies measures of clinical appropriateness to help providers identify and reduce unwarranted variation in the practice of medicine. The program was developed in collaboration with three pilot customers, including a prestigious hospital system in a major metropolitan area, one of the largest independent physician groups, and a large regional health plan as a response to reduce the more than \$200 billion that is spent each year on inappropriate care (translating to \$50+ on a PMPM basis).

Aetna will begin its Awesome Provider program in 2018, offering more transparency in the provider selection process and celebrating Medicaid Managed Medical Assistance (MMA) primary care providers that demonstrate high-quality clinical performance. The program is comprised of primary care providers with at least 100 assigned enrollees and a minimum of 5

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

enrollees in each quality measure denominator (if more than one sub-measure) who have scored within the 50th percentile rate in 75% of applicable program measures. The top three scoring practices in each category will receive the award of Aetna Awesome Provider, which will be communicated both in the provider online directory and to other providers to promote a competitive atmosphere. In choosing among Aetna's Awesome Providers, enrollees will know they are getting a provider that meets or exceeds standards.

The program provides reports on HEDIS quality measures for adult (an asterisk [\*] indicates the HEDIS measure is also one of the State's required measures):

- Access to preventive/ambulatory health services\*
- Cervical cancer screening
- Comprehensive diabetes care—eye exam\*
- Medication management for people with asthma\*

HEDIS reporting measures for children (pediatrics) include (an asterisk [\*] indicates the HEDIS measure is also one of the State's required measures):

- Children and adolescents' access to primary care providers between 12 to 24 months, 25 months to 6 years, 7 to 11 years, and 12 to 19 years\*
- Childhood immunization status (Combo 3)
- Lead screening in children
- Well-child visits in the third, fourth, fifth, and sixth years of life
- Immunizations for adolescents

**EXHIBIT A-4-b  
MMA SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA (10-2-17)**

**EXHIBIT A-4-b**  
**MMA SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**Evaluation Criteria:**

1. The adequacy of the respondent's methodology for identifying and resolving barriers and network gaps; including ongoing activities for network development based on identified gaps and future needs projection.
2. The adequacy of the respondent's plan to meet the needs of enrollees if it is unable to provide the service within its provider network; including immediate, short-term and long-term interventions.
3. The adequacy of the respondent's approach for measuring timely access for the specified provider types and the extent to which the respondent's approach includes clear methodology for determining the following:
  - (a) Average wait time for an urgent appointment; and
  - (b) Average wait time for a routine appointment.
4. The extent to which the recruitment efforts outline the frequency and specific measures to be used to track the need to deploy recruitment activities for the provider types listed.
5. The extent to which the retention efforts outline the approach to keeping providers satisfied and in good-standing with the respondent.
6. The extent to which the quality and/or performance metrics it will use to gauge progress toward the Agency goals are transparent to providers, including the frequency with which providers will be able to access their progress.

**Score:** This section is worth a maximum of 40 raw points with each of the above components being worth a maximum of 5 points each.

5 additional points will be awarded to respondents who demonstrate that providers shall have real-time access to their progress in achieving quality and/or performance metrics.

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**2017 "DRAFT" Network Development Management Plan**

**Trade secret as defined in Section 812.081, Florida Statutes**

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**EXHIBIT A-4-b  
MMA SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA (10-2-17)**

**MMA SRC# 6 – Provider Network Agreements/Contracts (Regional):**

The Agency has identified some of the key network service provider types that will be critical in order for the respondent to promote the Agency's goals.

The respondent shall demonstrate its progress with executing agreements or contracts it has with providers in the region by submitting **Exhibit A-4-b-1**, Provider Network Agreements/Contracts (Regional):

**Response:**

The completed Exhibit A-4-b-1 can be found on the following page.

**Evaluation Criteria:**

For each service provider type the respondent may receive up to 20 points as described below. Points for each service provider type will be awarded as outlined in the table below:

<b>Percentage of agreements/contracts for each service provider type</b>	<b>Points</b>
0.0%	0
1.0% - 25%	5
25.1%- 50%	10
50.1%- 75%	15
75.1% or greater	20

**Score:** This section is worth a maximum of 240 raw points based on the above point scale.

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**EXHIBIT A-4-b-1**  
**MMA SRC# 6 - PROVIDER NETWORK AGREEMENTS/CONTRACTS**  
**(REGIONAL) (10-2-2017)**

**Enter Respondent Name Below**

Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida

**EXHIBIT A-4-b-1**  
**MMA SRC# 6 - PROVIDER NETWORK AGREEMENTS/CONTRACTS**  
**(REGIONAL) (10-2-2017)**

<b>SRC SCORE</b>
<b>235</b>

<b>Service Provider Type</b>	<b>Agreements/Contracts</b>	<b>Total Population</b>	<b>% of Population</b>	<b>Recipient Count</b>	<b>Ratio</b>
Board Certified or Board Eligible Adult Psychiatrist	16	117,974	0.3	35392	1500
Board Certified or Board Eligible Child Psychiatrist	5	117,974	0.3	35392	7100
Cardiology	41	117,974	0.3	35392	3700
Cardiology (PEDS)	5	117,974	0.3	35392	16667
Cardiovascular Surgery	11	117,974	0.3	35392	10000
Endocrinology	5	117,974	0.3	35392	25000
Endocrinology (PEDS)	4	117,974	0.3	35392	20000
Internal Medicine	66	117,974	0.3	35392	3000
Obstetrics/Gynecology	60	117,974	0.3	35392	1500
Pulmonology	11	117,974	0.3	35392	7600

**EXHIBIT A-4-b-1**  
**MMA SRC# 6 - PROVIDER NETWORK AGREEMENTS/CONTRACTS**  
**(REGIONAL) (10-2-2017)**

Ratio Results	%	Score
23.00	69.6%	19
4.00	100.0%	24
9.00	100.0%	24
2.00	100.0%	24
4.00	100.0%	24
1.00	100.0%	24
2.00	100.0%	24
12.00	100.0%	24
23.00	100.0%	24
5.00	100.0%	24

Percentage of agreements/contracts for each service provider type	Points
0.0%	0
1.0%	9
25.1%	14
50.1%	19
75.1%	24

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**EXHIBIT A-4-b**  
**MMA SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**MMA SRC# 7 – MMA Physician Incentive Program (MPIP) (Statewide):**

The Agency has designed the MMA Physician Incentive Program with the expectation that Managed Care Plans should be able to increase compensation for physicians, using funds achieved through savings from effective care management, as specified by Section 409.967(2)(a), Florida Statutes. The respondent shall describe its plan for ensuring physician compensation rates are equal to or exceed Medicare rates for MMA covered services. Specifically, the response shall include detailed descriptions of quality initiatives the respondent intends to implement or maintain that produce savings by promoting the Agency's goals, as well as other areas where the respondent has evidence that a potential for savings and increased quality exists.

**Response:**

With our enrollees at the forefront of everything we do, Aetna's primary objective is to improve the health and well-being of every enrollee we serve. For many years, Aetna has collaborated with providers and communities to encourage the movement from a pay-for-volume model to a strategic plan wherein reimbursement is foremost a mechanism to promote positive health outcomes and efficient use of resources. This value-based focus forms the foundation of Aetna's Managed Medical Assistance (MMA) Physician Incentive Program (MPIP) and creates the environment in which we use value-based compensation to improve quality, increase access by paying high-quality providers at the Medicare rate, reduce preventable events, improve birth outcomes, and reduce emergency department (ED) visits—all of which directly align with the Agency's health care delivery system goals and objectives.

There has been a longstanding challenge in the State with adequate reimbursement to Medicaid providers, in addition to access challenges particularly with regard to specialists and sub-specialists. In response to this challenge, and in response to an April 2016 settlement between the Florida Pediatric Society, et al., and AHCA, the State implemented the MPIP program.

Under the MPIP program requirements, established by AHCA, a plan can either use the Agency-created qualification standards or create its own with AHCA approval. For Years 1 and 2 of the program, Aetna developed its own requirements using the State's requirements as a baseline.

Under the current MPIP program, the following physicians are eligible for the MPIP enhanced payment, which is 100% of Medicare.

**PEDIATRICS**

Qualified providers include board-certified pediatricians, family physicians, and general practitioners. To qualify for the MPIP program, pediatric providers must practice in a group with at least 100 paneled Medicaid enrollees over the measurement period and practice at a site recognized as a PCMH by one of the following organizations:

- Utilization Review Accreditation Commission (URAC)
- National Committee for Quality Assurance (NCQA), Level 2 or higher
- Accreditation Association for Ambulatory Health Care (AAAHC)

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- The Joint Commission (JC)

In addition, pediatric provider groups must achieve all of the following access and quality measures for the plan's Medicaid enrollees during the measurement period:

- Healthcare Effectiveness Data and Information Set (HEDIS) lead screening: Achieve the 50th percentile for the health plan's Medicaid enrollees using 2016 HEDIS specifications
- HEDIS child access for three out of four age bands: Achieve the 50th percentile for the health plan's Medicaid enrollees using 2016 HEDIS specifications
- ED utilization: ED utilization of assigned enrollees of less than 650 visits per 1,000 enrollees
- After-hours availability: Group must offer hours after 6:00 p.m. during the week or on weekends

All of the measures are designed to reduce potentially preventable events (PPEs) while improving quality and access. Specifically, meeting the child access and lead screening measures will improve our HEDIS scores and contribute to a decrease in utilization through disease prevention and health maintenance.

Our after-hours and ED utilization measures will also contribute to reducing PPEs, as well as over- and under-utilization, by providing early access to care and, in turn, an early intervention in dealing with acute illness. We expect these decreases in PPEs to translate to savings, which Aetna will then pass to pediatric providers in the form of payment at 100% of Medicare.

### **OB/GYNs**

Qualified providers are physicians who are board certified in obstetrics and gynecology by the American Board of Obstetrics and Gynecology or the American Osteopathic Board of Obstetrics and Gynecology, and who practice within a group with at least 10 deliveries for our Medicaid enrollees over the measurement period. In addition, they are required to meet the following standards: HEDIS-specific postpartum care above the national Medicaid mean as calculated by NCQA; HEDIS-specific prenatal visit rate greater than or equal to 81% at or above the Medicaid 75th percentile; and a Florida Medicaid C-section rate of less than 35%. These performance measures will also contribute toward meeting HEDIS performance targets and quality of care by helping to ensure postpartum follow-up and avoiding or reducing avoidable C-sections. In turn, these quality improvements will significantly improve maternal health and reduce maternal-fetal morbidity. By reducing avoidable C-sections, and physician and hospital costs associated with maternal-fetal health issues and morbidity, Aetna can realize savings that will be passed onto OB/GYNs in the form of payment at 100% of Medicare for qualifying providers.

### **PEDIATRIC SUB-SPECIALISTS**

In the approved 2017 MPIP program, the Agency added the following five categories of board-certified pediatric sub-specialists, which Aetna incorporated into its plan:

- Cardiology
- Endocrinology
- Nephrology

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Neurology
- Psychiatry

The program aims to recruit these sub-specialists into the Medicaid program, which has historically been difficult because of low reimbursement rates. For the first year of inclusion in the program, Aetna has accepted the AHCA criteria of board certification as the sole qualifying criteria to receive the increased reimbursement rate of 100% of Medicare. It did so because of the challenge involved in identifying specific quality criteria upon which to measure these types of subspecialists. To improve the program and tie the higher reimbursement rate to demonstrated or improved quality and savings, Aetna is developing a program (described later in this response) that will measure practice patterns for the most commonly performed services in specific specialties to determine whether individual providers' practice pattern fall into an established national standard. Individual provider claims data will be measured against the national standard, as developed by a nationally renowned medical institution. Only specialists whose practice falls within the national standard will receive the enhanced reimbursement. All specialists will be provided with information showing where they measure against the national practice standard and will be educated on how to improve their practice patterns and qualify for the bonus payment. In this way, the MPIP program will not only increase payment to qualified, high quality specialists, but should also improve the practice patterns of all sub-specialists, increase overall practice quality, and subsequently improve overall patient care.

### **IMPROVED QUALITY TIED TO PAYING HIGHER PHYSICIAN RATES**

**CRITERION 1:** The extent to which the respondent's proposal to improve quality can be tied to redirecting costs to pay higher physician rates

In determining quality criteria for years one and two of the program, Aetna is focused on indicators that demonstrate quality, while reducing PPEs and improving outcomes to generate the savings necessary to pay higher physician rates. Our process for creating our MPIP programs was an intense build, analysis, and review of the program design, criteria, and data outcomes. Thus, our individual MPIP proposal enhanced the Agency's Alternative Incentive program option in several ways.

In the case of pediatricians, Aetna did not believe that the patient-centered medical home (PCMH) distinction alone ensured a sufficient improvement in access and quality and reduction in cost to merit enhanced payment. To further tie enhanced payments to cost redirection we added quality requirements, ED utilization thresholds and after hours availability. Curtailing avoidable ED utilization is critical to managing costs since avoidable use of the ED is significantly more expensive than an office visit. Medicaid enrollees often utilize the ED whenever they are unable to access a PCP due to scheduling unavailability and/or enrollee inability to access a physician during normal business hours. For this reason, we encourage our PCPs to maintain hours in the evening or on weekends. This added after-hours availability measure to the pediatric MPIP will improve enrollee access to PCPs and decrease unnecessary ED visits. The resulting savings in ED usage will be passed to the PCPs in the form of the MPIP payment of 100% of Medicare.

The OB/GYN criteria developed by AHCA including the reduced C-section rate, and HEDIS prenatal and postpartum rates above the Medicaid 75% are also designed to improve quality

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

while reducing costs. Avoidable C-sections are tied to higher rates of NICU utilization, as well as to increased rates of maternal complications. Similarly, mother-and-baby health improvements will result from prenatal and postpartum visit adherence. Tying the enhanced payment to OB/GYNs to these three measures should decrease maternity and NICU costs. Cost savings as a result of these reductions will be redirected to paying qualifying OB/GYNs the higher rate of 100% of Medicare. We also added a 10-enrollee requirement to the OB/GYN incentive program, thus ensuring we are rewarding OB/GYNs with Aetna enrollee experience.

On October 1, 2016, AHCA approved the agreement for Year 1. Recently, we received approval from the Agency for our Year-2 agreement, which will commence on October 1, 2017. As with Year 1, our program included quality, access, and cost redirection requirements for both pediatric providers and OB/GYNs.

### **QUALITY INITIATIVES THAT REDIRECT COSTS BY REDUCING POTENTIALLY PREVENTABLE EVENTS AND IMPROVING PRENATAL CARE AND BIRTH OUTCOMES**

**CRITERION 2:** The extent to which the respondent incorporates quality initiatives that will result in redirecting costs by reducing potentially preventable events

**CRITERION 3:** The extent to which the respondent incorporates quality initiatives that will result in redirecting costs by improving prenatal care and birth outcomes

Aetna is aligned with AHCA's goals of reducing preventable events, improving prenatal care, and improving birth outcomes. We focus on improving outcomes, decreasing costs, and increasing efficiencies through our comprehensive approach, including:

- Person-centered, integrated care management
- Identifying risks among population groups, including trends by geography filtered by ZIP codes
- Using interdisciplinary care teams for a holistic approach within a collaborative model
- Provider support through training, tools, enhanced communication, and incentives
- Network development focused on identifying and maintaining providers delivering quality of care
- Technology for data sharing for an improved enrollee and provider experience
- Advanced data analytics capabilities for hospital utilization review and outcomes evaluation

Aetna continues to examine areas in which we can reduce PPEs and increase prenatal care and birth outcomes. We rely on the use of performance improvement projects (PIPs), which we maintain in accordance with the requirements defined in the SMMC contract. We submit required PIP reports to the Agency on a yearly basis.

Aetna implemented the MPIP program so that physicians can earn incentives for the following measurements, which reinforce care in an appropriate and cost-effective setting:

- Percentage of enrollees for three of four age bands (12 to 24 months, 25 months to 6 years, 7 to 11 years, 12 to 19 years) who had a visit with a PCP during the measurement period (benchmark is NCQA Medicaid 50th percentile)

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- ED utilization of all assigned enrollees (benchmark is fewer than 650 visits per 1,000 enrollees)
- Office hours after 6 p.m. or weekend hours
- Percentage of children with lead screening before their second birthday (benchmark is NCQA Medicaid 50th percentile)

Qualified obstetricians and gynecologists can earn incentives by achieving or exceeding benchmarks for the following metrics:

- Percentage of enrollees who had 81% or more of expected prenatal visits (benchmark is NCQA Medicaid 75th percentile)
- Percentage of enrollees who had a postpartum visit on or between 21 and 56 days after delivery (benchmark is NCQA national Medicaid mean)
- Percentage of single births that were delivered by C-section (benchmark is less than 35%)

Beyond the MPIP program, Aetna has developed value-based provider contract relationships that produce savings, reduce PPEs, and enable PCPs to benefit financially from improved patient care and effective care management. One of Aetna's key models for delivering care is through PCP risk contracts. In fact, approximately 40% of our current enrollees are tied to PCPs with some type of value-based risk contract arrangement. We are adding quality metrics to all of our PCP risk contracts that tie a portion of any surplus bonus payment to PCPs meeting the specified quality metrics including compliance with HEDIS requirements and maintaining after-hours availability. By tying provider payments to quality criteria, we directly incentivize PCPs to better manage patient care, ensure compliance with HEDIS requirements, reduce ED visits, and add after-hour physician availability.

In our experience, MPIP can produce savings when combined with our innovative and forward-thinking value-based purchasing model.

Aetna expects the MPIP program, together with our value-based purchasing model, to enhance the following quality initiatives:

- Reduction of PPEs, including:
  - Hospital readmissions
  - Avoidable ED visits
  - Avoidable inpatient admissions
  - Avoidable C-sections
- Increased enrollee engagement with PCPs and OB/GYNs to improve prenatal care and birth outcomes resulting in:
  - Improved HEDIS compliance
  - Improving HEDIS gaps in care closure rates
  - Managing and lowering total costs of care delivery

The value of our nationwide experience is evidenced in our ability to take success in one state plan and expand it to Florida. An example of such success is a measure from our plan in New Jersey, where VBP enrollees showed increased improvement over non-VBP enrollees: the HEDIS measure Rate of Prenatal and Postpartum Care (PPC) for enrollees in a VBP practice

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

was 71.0%, while the rate for enrollees in a non-VBS practice was 56.6%—marking a VBS improvement rate of 14.4%.

### **OTHER AREAS FOR POTENTIAL SAVINGS AND INCREASED QUALITY**

**CRITERION 4:** The extent to which the respondent identifies other areas for quality initiatives or efficiencies that will result in potential cost savings

Aetna continuously pursues innovative projects with a potential for cost saving and efficiencies while increasing quality. We are examining the MPIP program and contemplating the usefulness of the concept in other areas. In our search for new concepts and practices, we are exploring collaboration with physicians from a well-known teaching hospital. As previously noted, they have identified specific practice standards for procedures commonly performed by specialists such as cardiologists, orthopedic physicians, and dermatologists. We are considering the use of practice standards as a mechanism for measuring specialist quality. Specialists whose claims fall within normal practice standards will be eligible for an incentive bonus. This project will enable us to tie physician best practices, which are evidence of quality and produce efficiencies, to an increased rate of reimbursement in the form of incentives.

In the future, this program will allow us to expand the reach of the MPIP program into additional types of specialists and sub-specialists and base enhanced compensation on quality and efficient service utilization on the part of each type of specialist. In turn, quality outcomes will reduce avoidable medical costs, with Aetna able to redirect the resulting savings into increased physician compensation at 100% of Medicare.

Preliminary analysis indicates we can expect a 3% to 5% cost savings associated with a reduction in avoidable care that could lead to PPEs. For example:

- When a private academic medical center started posting each physician's opioid prescription practices at monthly meetings, the opioid prescription rate fell 34% in a single year and prevented many potential addictions
- When another academic medical center distributed reports comparing individual C-section rates to the hospital-wide average, the C-section rate fell from 35% to 27% in a single month

This pilot project has implications for quality and costs in the areas of cardiology, orthopedics, dermatology, and oncology, as well as the prevention of opioid addiction. It provides an opportunity to expand the reach of the MPIP program into additional specialties while ensuring enhanced payments for such specialists are tied to quality, efficient medical practice. As such, Aetna will be expanding this program into additional regions of the state upon award.

### **Evaluation Criteria:**

1. The extent to which the respondent's proposal to improve quality can be tied to redirecting costs to pay higher physician rates.
2. The extent to which the respondent incorporates quality initiatives that will result in redirecting costs by reducing potentially preventable events.

**EXHIBIT A-4-b**  
**MMA SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

3. The extent to which the respondent incorporates quality initiatives that will result in redirecting costs by improving prenatal care and birth outcomes.
4. The extent to which the respondent identifies other areas for quality initiatives or efficiencies that will result in potential cost savings.

**Score:** This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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**EXHIBIT A-4-b**  
**MMA SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**C. RECIPIENT EXPERIENCE**

**MMA SRC# 8 – Primary Care Providers (PCP) Assignment (Statewide):**

The respondent shall describe its overall process of assigning enrollees to primary care providers (PCPs), including its assignment algorithm. The response shall include the quality and/or performance metrics used to determine high quality PCPs, and the timeframes associated with processing an enrollee's request to change PCPs.

**Response:**

Aetna understands the importance of self-directed care—one component of which is an enrollee's ability to select his or her own primary care providers (PCPs) based on existing relationships. Our PCP assignment process is respectful of the enrollee's choice of physicians and is achieved by incorporating enrollment file data and information as a part of the assignment process.

Enrollees may request a change in PCP for any reason without restriction. Changes are processed in real time, exceeding the requirement of within three business days of the request. If an enrollee does not select a PCP during the enrollment process, we can assign one based on factors such as proximity and quality using the process described in this response.

**ASSIGNING ENROLLEES TO PRIMARY CARE PROVIDERS**

Upon enrollment, Aetna receives the assigned PCP for each enrollee as designated by the enrollment file; however, an enrollee can select his or her own PCP based on personal preference. Enrollee Services representatives assist enrollees in selecting a PCP if they do not have one or their PCP is out-of-network. Enrollees can select an obstetrician/gynecologist (OB/GYN) as their PCP if that practitioner is willing to provide primary care services and coordinate the care of other covered services, as defined in their respective field of training and experience.

Because the enrollee/PCP relationship is critical to successful treatment and coordination of care, we work with enrollees to make sure they are comfortable with their choices. Reinstated enrollees are assigned to their previous PCPs. If a PCP is no longer in our network, enrollees assigned to that PCP receive all of the necessary information and assistance to make a change. If an enrollee does not select a PCP, we automatically assign one to ensure continuity of care; however, the enrollee can choose to change his or her PCP designation at any time, if desired.

Our Enrollee Services representatives and care managers are available to assist enrollees in selecting or changing their PCP. Our enrollee packet, distributed upon enrollment, contains a list of network PCPs to help enrollees in the selection process or to find another provider at any time (e.g., specialty provider). This information is also available on our website and through the no-cost Aetna mobile application (app) for both iOS and Android smartphones.

**ASSIGNMENT ALGORITHM**

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

**CRITERION 2:** The extent to which the respondent's algorithm includes assignment of enrollees to high quality PCPs

Our auto-assignment logic uses a programmed hierarchy of factors and an algorithm to determine the best match for the enrollee in the following order: enrollee's current or past relationship with PCP, other family member's relationship with PCP, the PCP's geographic proximity to the enrollee, and the programmed preferred provider status (i.e., high quality). The preferred provider status is based on data accumulated under the Awesome Provider program, and full risk groups, as well as providers with value-based purchasing (VBP) contracts who meet quality measures as well as pediatricians who meet State Medicaid Physician Incentive Payment (MPIP) program requirements. Assignment is also dependent upon whether or not a provider is open to accepting new patients. In the event a provider is at or nearing capacity, we manually verify the panel status and re-assign the enrollee to next provider that meets their criteria. We also consider an enrollee's primary language at each level of the auto-assignment logic, making every effort to assign a PCP who speaks the same primary language.

### **QUALITY AND/OR PERFORMANCE METRICS USED TO DETERMINE HIGH-QUALITY PCPS**

**CRITERION 1:** The extent to which the respondent's description includes how quality and/or performance metrics are defined and utilized in the assignment process

Aetna remains committed to continuous quality improvement to fulfill the aim of improved health outcomes for all of our enrollees. Our proven results are evident in consistently high National Committee for Quality Assurance (NCQA) status ratings, as well as across our quality, medical management, and health equity programs. Recently, Aetna was ranked the leading NCQA Florida Medicaid plan for the second consecutive year. In addition, we are also ranked among the top 15 Medicaid plans in the United States. NCQA accreditation demonstrates a commitment to quality, outstanding clinical performance, and consumer experience. In Florida, Aetna has achieved an NCQA accreditation level of Commendable for three years in a row—awarded to those organizations with well-established programs for service and clinical quality that meet rigorous requirements for consumer protection and quality improvement. This demonstrates our in-depth understanding of quality, both in terms of the enrollee experience as well as clinical and operational excellence.

Aetna monitors provider performance on an ongoing basis to help ensure providers meet the standards required to remain a preferred provider in the auto-assignment logic and algorithm process. We take into consideration a full range of information, including quality of care concerns, complaints/grievances, medical record reviews, and ongoing monitoring (e.g., satisfaction survey results) as part of our assessment process. Year-round assessments, along with results from our Awesome Provider program, are necessary components for providers achieving preferred status in the auto assignment process based on full risk groups, as well as VBS contracts who meet quality measures and/or pediatricians who meet State MPIP program requirements.

**Performance Programs Using Quality Metrics:** In 2018, Aetna will begin our Awesome Provider program, which offers more transparency into the provider selection process and celebrates Florida's Managed Medical Assistance (MMA) PCPs who demonstrate high clinical quality

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

performance. This program includes PCPs with at least 100 assigned enrollees and a minimum of 5 enrollees in each quality measure denominator (if more than one sub-measure), who have scored within the 50th percentile rate in 75% of applicable program measures. The top three scoring practices in each category receive the award of Aetna Awesome Provider, which is communicated both in the provider online directory and among other providers to promote a competitive atmosphere. When choosing one of Aetna's Awesome Providers, enrollees have the satisfaction of knowing their provider meets and/or exceeds standards.

The Awesome Provider program provides reports on the following Healthcare Effectiveness Data and Information Set (HEDIS) quality measures for adults (an asterisk [\*] indicates a HEDIS measure that is also one of the State's required measures):

- Adults' Access to Preventive/Ambulatory Health Services (AAP)\*
- Cervical Cancer Screening (CCS)
- Comprehensive Diabetes Care – Eye Exam (CDC DRE)\*
- Medication Management for People with Asthma\*

HEDIS reporting measures for children (pediatrics) include the following (an asterisk [\*] indicates a HEDIS measure that is also one of the State's required measures):

- Children and Adolescents' Access to Primary Care Practitioners (CAP) between 12 to 24 months, 25 months to 6 years, 7 years to 11 years, and 12 years to 19 years\*
- Childhood Immunization Status (Combo 3) (CIS)
- Lead Screening in Children (LSC)
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
- Immunizations for Adolescents

Aetna also uses our MPIP, VBP, and PCP risk contracted providers as an evaluation point in the preferred assignment process. Under MPIP, designated physician types earn enhanced payments equivalent to the appropriate Medicare fee-for-service rate (as established by AHCA), based on achieving key access and quality measures. Aetna implemented the MPIP so that physicians can earn incentives for measurements, which reinforce care in an appropriate and cost-effective setting. Requirements for PCPs include:

- Percentage of enrollees for three of four age bands (12 to 24 months, 25 months to 6 years, 7 to 11 years, 12 to 19 years) who had a visit with a PCP during the measurement period (benchmark is NCQA Medicaid 50th percentile)
- Emergency department utilization of all assigned enrollees (benchmark is fewer than 650 visits per 1,000 enrollees)
- Office hours after 6:00 p.m. or weekend hours
- Percentage of children with lead screening before their second birthday (benchmark is NCQA Medicaid 50th percentile)
- Qualified obstetricians and gynecologists can earn incentives under the MPIP program by achieving or exceeding benchmarks for the following metrics:
  - Percentage of enrollees who had 81% or more of expected prenatal visits (benchmark is NCQA Medicaid 75th percentile)
  - Percentage of enrollees who had a postpartum visit on or between 21 and 56 days after delivery (benchmark is NCQA national Medicaid mean)

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- Percentage of single births that were delivered by C-section (benchmark is less than 35%)

In our experience, the MMA MPIP can produce savings when combined with an innovative and forward-thinking VBP model.

Aetna is involved in a number of PCP risk contracts that affect approximately 40% of our current enrollees. By tying provider payments to quality criteria, we directly incentivize PCPs to better manage patient care, ensure compliance with HEDIS requirements, reduce emergency department visits, and add after-hour physician appointments. We are adding language in Year 2 of these PCP agreements that ties a portion of the payment of any surplus to the PCP meeting their quality metrics.

Aetna's VBP participants have individually designed agreements that align financial incentives with improved quality, cost, utilization, and outcomes through shared financial accountability between the health plan and the provider. Our VBP incentive model not only includes primary care, specialty care, and hospital-based care, but also expands into other treatment venues such as:

- Behavioral health
- Community mental health centers (CMHCs)
- Federally qualified health centers (FQHCs)
- Rural health centers (RHCs)
- Non-traditional providers (i.e., housing, palliative care, etc.)

Despite the complex nature of VBP programming for some of these provider types, Aetna has extensive, proven experience with these models. While Aetna VBP models may vary as to the degree of financial risk assumed, each of the models include quality and outcome metrics that are directly tied to provider payment. It is important to us, as a member of each local community, to approach our VBP collaborative relationships with our providers in such a way as to maximize program participation. We do this by utilizing the following continuum of contractual agreements:

- Pay for Quality (P4Q): An annual bonus program related to quality metrics for providers who do not immediately qualify for our other VBP agreements. The program rewards providers for achieving better performance on a broad spectrum of HEDIS and utilization metrics for their Aetna enrollee panel; this can be used by primary care, specialty care, and hospital-based providers.
- Patient Centered Medical Home (PCMH): A program that utilizes a medical home because the enrollees are likely to have complex needs and require an integrated behavioral health/physical health home. PCMHs 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, behavioral health integration, and community services. Our local PCMHs are supported through a per-member-per-month payment model, and they deliver integrated care. Our agreements are collaborative and outline the expectations of both stakeholders so there is shared accountability for outcomes. This can be used by primary care, specialty care, and hospital-based providers.

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- **Shared Savings:** A program for those practices serving a larger portion of our Medicaid enrollees, and which possess the skills and infrastructure necessary to manage the population (includes both upside and downside options to accommodate provider desire to assume increased risk and may be delivered in an accountable care organization (ACO) or a clinically integrated network environment); can be used by primary care and specialty care.
- **Bundled or Global Payments:** This program provides an opportunity for specialists who would not ordinarily participate in primary care incentives to participate in programming directed toward their specialty—for example, case-rate payments for comprehensive obstetrical care for high-risk mothers or organ transplants; can be used by specialty care.
- **Full Risk:** A program that rewards providers for access, affordability, and quality of care in a gain-share, risk-share, or full-risk manner. We have a full-/partial-risk program in Florida. This program can be used for primary care, specialty care, and hospital-based providers.
- **Non-traditional Providers/Services:** A program modified to reach out to non-traditional providers who work with enrollees in transition and enrollees that have more unique needs. We join organizations where they are and support their unique contributions; this approach makes our programs increasingly enrollee-centric.

Information Provided to Assist in Selecting a PCP: Because Aetna strives to provide our enrollees with as much information as possible when selecting a provider, we offer several indicators, through our online directory, to help enrollees determine if a provider has the ability to fulfill their needs. These indicators include whether or not the provider is accepting new patients, access to after-hours care, board certifications, hospital affiliations, and languages spoken and/or available interpreter services. This information is available (as applicable) across all provider types, including specialty providers designated by this Invitation to Negotiate. For long-term care, home health, nursing care, and home- and community-based providers, we offer several additional category indicators: National Provider Identifier (NPI) number (if applicable), Florida license number, website (if available), handicap accessibility, special training, and geographic service area. These indicators help ensure enrollees select the right provider for the right service and in the right setting.

Rate this Provider capability is offered for all provider types. Using the online directory, enrollees can rate a provider based on their experience with the provider's performance. The enrollee is asked to rate the provider on a scale from one to five (with one as the lowest score and five as the highest). The response is calculated in the back end as part of the claims management system with all performance ratings averaged and displayed by the appropriate number of stars next to the provider's name. Users can also compare one provider to the other with the star rating displayed by each provider's name. Criteria will be added to our provider directory, such as criteria for CMS rankings or performance ratings similar to our Awesome Provider program.

### **TIMEFRAMES ASSOCIATED WITH PROCESSING REQUESTS TO CHANGE PCPS**

**CRITERION 3:** The extent to which the respondent can process requests for PCP changes within three (3) business days

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Enrollee Services representatives and care managers are available to assist enrollees in selecting or changing their PCP at any time. Any PCP changes are made real time, exceeding the contractual requirement of within three business days. PCP changes can also be made in real time by the enrollee at any time through our website or mobile app. Our enrollee packet, distributed upon enrollment, contains information on how to access the online provider director by computer, tablet, or smartphone. It also includes instructions on how to change PCP designation and how to download an ID card for immediate use. This information is also available on our website and through the no-cost Aetna mobile app for both iOS and Android smartphones. In addition, we conduct random sample audits as part of our quality process to confirm we are meeting all timeframe and PCP change requirements.

### **Evaluation Criteria:**

1. The extent to which the respondent's description includes how quality and/or performance metrics are defined and utilized in the assignment process.
2. The extent to which the respondent's algorithm includes assignment of enrollees to high quality PCPs.
3. The extent to which the respondent can process requests for PCP changes within three (3) business days.

**Score:** This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

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**EXHIBIT A-4-b**  
**MMA SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**MMA SRC# 9 – PCP Timely Access Standards (Statewide):**

The respondent shall describe the process and monitoring plan it uses to ensure compliance with the timely access standards as defined in **Exhibit B-1**, Managed Medical Assistance (MMA) Program, **Section VIII.**, Provider Services **Item A.**, Network Adequacy Standards, **Sub-Item 8.**, Timely Access Standards. The respondent shall also describe the process and methodology it uses for determining whether a PCP has the capacity to accept new patients.

**Response:**

With 30 years of experience managing Medicaid networks across the country, Aetna has an in-depth understanding of the challenges associated with providing access to providers for the Medicaid population. Traditionally, Medicaid enrollees have experienced limited access to certain providers, particularly specialists and subspecialists; however, our extensive experience with managed care and our innovative solutions such as value-based contracting and incentive programs enable us to increase provider participation and access to care for our enrollees.

Aetna is committed to continuous quality improvement to fulfill the aim of improved health outcomes for all of our enrollees. Our proven results are evident in consistently high National Committee for Quality Assurance (NCQA) status ratings across our quality, medical management, and health equity programs. Recently, Aetna was ranked the top NCQA Florida Medicaid plan for the second consecutive year. In addition, we are also ranked among the top 15 Medicaid plans in the United States.

NCQA accreditation demonstrates a commitment to quality, outstanding clinical performance, and consumer experience. In Florida, Aetna has achieved an NCQA accreditation level of Commendable for a full three years—awarded to those organizations with well-established programs for service and clinical quality that meet rigorous requirements for consumer protection and quality improvement. This demonstrates our in-depth understanding of quality in terms of the enrollee experience as well as clinical and operational excellence.

Aetna has ensured compliance with timely access standards (as defined in Exhibit B-1, Managed Medical Assistance (MMA) Program, Section VIII, Provider Services Item A, Network Adequacy Standards, Sub-Item 8, Timely Access Standards)—and will continue to do so in the new contract term—through our proven monitoring methods and processes. Additionally, these processes determine whether a practitioner has the capacity to accept new patients. Captured through our monitoring tools and processes, this information is updated in the online provider directory available on our website and Aetna mobile app. Our compliance to timely access standards supports enrollees and providers alike. We can assist providers in their goals of meeting the State's objectives to maintain and/or improve health outcomes for their patients.

Currently, we have [REDACTED] contracted primary care providers (PCPs) throughout the State, as well as many other community and safety net providers. We meet 100% adequacy for PCPs in all 11 regions. Additionally, we have contracted with the following key primary care providers:

Region 1 - [REDACTED]  
Region 2 - [REDACTED]  
Region 3 - [REDACTED]

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Region 4 -	
Region 5 -	
Region 6 -	
Region 7 -	
Region 8 -	
Region 9 -	
Region 10 -	
Region 11 -	

Ensuring Compliance with Timely Access Standards

Aetna's monitoring plan complies with timely access standards (as defined in Exhibit B-1) and we consistently exceed these standards in our existing contracts with the State. Standards are based upon appointments for:

- Urgent medical or behavioral health care services:
  - Within 48 hours of a request for services not requiring prior authorization
  - Within 96 hours for medical/behavioral services that require prior authorization
- For non-urgent care services, appointment standards are:
  - Follow-up appointments within seven days post discharge from an inpatient behavioral health admission
  - Within 14 days for initial outpatient behavioral health treatment
  - Within 14 days of a request for ancillary services for the diagnosis or treatment of an injury, illness, or other health issue
  - Within 30 days of a request for a primary care appointment
  - Within 60 days of a request for a specialist appointment (after the appropriate referral is received by the specialist)

Aetna's PCP appointment standards are:

- Urgent care within 24 hours, exceeding the contractual standard of 48 hours
- Routine sick care visits within seven days, exceeding the contractual standard of 14 days
- Well-care visits within 30 days, consistent with the contractual standard

To validate that our participating PCPs are in compliance with appointment standards, we conduct regular studies based on a sample quarterly audit. Based on our most recently completed quarterly audit of 207 participating PCPs in Region 11, 100% were compliant with the standard.

Reporting Tools to Evaluate Access to Timely Appointments

Timely access for enrollees and verification of compliance with appointment requirements occurs through a variety of monitoring tools, which can proactively identify and improve access to care. Monitoring activities include the following:

- Conduct annual enrollee surveys to evaluate appointment availability, wait times, and after-hours accessibility

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- Evaluate feedback received from Provider Services liaisons, Enrollee Services staff, Care Management, Utilization Management, advisory committees, and anyone who serves as a touchpoint for enrollees or providers noting issues or concerns with appointment access or wait times
- Review and resolve enrollee concerns related to access, appointment availability, and wait times
- Review enrollee complaints and feedback on a quarterly basis: trending enrollee grievances and identifying any potential availability or accessibility issues, performing root cause analysis, and developing corrective action plans
- Review Enrollee Advisory Committee input, findings, and enrollee survey results regarding access, appointment availability, wait times, non-participating prior authorizations, and out-of-network requests
- Review data from enrollee and provider satisfaction surveys to identify issues, concerns, and opportunities for improvement
- Conduct a random sample of providers to ensure they meet access and appointment availability standards. These phone surveys target specific provider groups, including PCPs, obstetricians, high-volume specialty care, and behavioral health providers.

#### **Relationship and Communication Methods to Monitor and Identify Issues with Timely Access to Appointments**

Reports based on the data collected through the monitoring methods described above are submitted to several committees to help ensure we meet timely access requirements based on both the existing health plan contract with the State and NCQA requirements. Data is collected on a regular basis by individuals who also sit on these various committees providing their expertise and knowledge of the processes, procedures, and ability to assess areas for improvement. Committees review recommendations, make suggestions, monitor status of corrective actions, and assist in prioritizing resources within the organization to achieve the State's goals. The monitoring processes are overseen by a multi-tiered committee structure that meets on a monthly or quarterly basis that includes the following:

- **Enrollee Advisory Committee:** Provides feedback on appointments and network providers (who are not meeting standards or who have issues or concerns) and provides input on additional network needs or opportunities for improvement. The committee meets on a monthly basis and is responsible for promoting collaborative efforts with providers, Aetna staff members, and leadership to enhance the service delivery system in local communities while maintaining a focus on enrollees and allowing input on policy and programs, similar to our efforts with the Community Action Forum.
- **Provider Engagement Committee:** Consists of enrollees and providers who participate on the Quality Management/Utilization Management (QM/UM) Committee. The committee meets on a quarterly basis to provide feedback on appointment availability standards, as Aetna's standards are more stringent than State requirements. The committee is also responsible for reviewing satisfaction survey results and providing feedback and input on policies and programs. These findings are submitted to Quality Oversight Committee for further review and integration into our existing programs/policies.
- **Service Improvement Committee:** Consists of various members of Aetna's leadership and operational teams. The committee meets on a monthly basis to reviews data and

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reports on monitoring activities, including timely access standards. The committee presents status and concerns on appointment availability survey results, trended complaint and survey data, and other findings from routine activities. The committee advises and makes recommendations to the Quality Management Oversight Committee (QMOC) on enrollee and provider issues and is supported by the Grievance and Appeals Committee.

- Long-Term Care Committee: Consists of service providers for long-term care, home- and community-based services, home health, hospice, and others. The committee meets on a quarterly basis to provide feedback on claims submissions, processes, satisfaction, issues, and concerns. The committee also provides feedback on policies, programs, and solutions to meet enrollee needs in their service areas. Their feedback is submitted to the Quality Oversight Committee for further review and integration into our existing programs/policies.
- Quality Management Oversight Committee (QMOC): Chaired by the chief medical officer with the ultimate authority and responsibility to validate that monitoring requirements are met.

Whenever we become aware of an issue involving access or wait times, our Provider Services liaisons, care managers, and Enrollee Services staff members assist enrollees with resolving issues by contacting the provider and working with the PCP or specialist to locate another provider who may be able to see the enrollee. Then, we work closely with the provider to resolve any future access issues. For example, in July, an enrollee called Enrollee Services for a referral to an orthopedic specialist who takes Florida Healthy Kids coverage. We referred the enrollee to the Physician's Regional Healthcare System and called the orthopedic provider's office to verify their acceptance of the coverage. We also verified eligibility for the provider so that the enrollee could schedule an appointment. We followed up to confirm the enrollee was able to see the provider. Whenever we are alerted to a potential problem, we immediately investigate and remediate the issue. We also work with providers to assist them in understanding and meeting these timely access requirements and better serving their enrollees.

According to our provider agreements, participating physicians and other providers are contractually obligated to adhere to Medicaid access and appointment standards. They are also required to provide services in the same manner as they would provide to commercial or other non-Medicaid enrollees. Standards are communicated through the provider manual, enrollee handbook, newsletters, and on-site visits. Provider training addresses wait times and appointment standards; disability access, competency, and expertise; cultural needs; and hours of operation.

#### **URGENT AND NON-URGENT SERVICES**

CRITERION 1: The extent to which the respondent's process and monitoring plan ensure that enrollees have access to urgent or non-urgent services within the timely access standards defined in Exhibit B-1, Managed Medical Assistance (MMA) Program, Section VIII., Provider Services, Item A., Network Adequacy Standards, Sub-Item 8., Timely Access Standards. Currently, Aetna meets and exceeds the State's requirements for timely access to urgent and non-urgent services for PCPs, including:

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Access to urgent care within 24 hours—exceeding the 48-hour requirement for services not requiring prior authorization and 96 hours for services requiring prior authorization
- Access to routine sick care visits within seven days—exceeding the 14-day requirement
- Access to well care visits within 30 days—meeting the 30-day requirement

We continually monitor these PCPs to ensure compliance with these standards using all of the following monitoring activities and reporting tools:

- Conduct annual enrollee surveys to evaluate appointment availability, wait times, and after-hours accessibility
- Review feedback received from Provider Services liaisons, Enrollee Services staff, Care Management, Utilization Management, advisory committees, and anyone who serves as a touchpoint for enrollees or providers noting issues or concerns with appointment access or urgent care services
- Review and resolve enrollee concerns related to access, appointment availability, and wait times
- Review enrollee complaints and feedback on a quarterly basis, which includes trending of enrollee grievances to identify any potential availability or accessibility issues, performing root cause analysis, and developing corrective action plans. We also receive review input from Enrollee Advisory Committee findings and enrollee survey results regarding access, appointment availability, and wait times, non-participating prior authorizations, and out-of-network requests for both urgent and non-urgent services.
- Review data from enrollee and provider satisfaction surveys to identify issues and concerns as well as opportunities for improvement for both urgent and non-urgent services
- Conduct a random sample of providers to ensure they meet access and appointment availability standards
- Evaluate quality of care concerns to determine if there are access issues or negative outcomes owing to access; if so, we include this information in provider re-credentialing reviews and decisions. Depending on the specific issues identified through our monitoring tools and processes, this information is reviewed through our committee structure to determine their continued network participation.

Whenever we are alerted to a potential problem, we immediately investigate and mitigate the issue. We also work with providers to develop processes or provide educational initiatives to help them comply with timely access requirements.

By monitoring and identifying enrollees using the emergency department (ED) for non-emergent conditions, we can identify individuals and providers who may benefit from care management and education on alternative urgent care and after-hours practice options. For providers falling outside of these standards, we will provide one-on-one education and care management opportunities with providers for enrollees demonstrating ED overuse according to the State's contract requirements of 3 to 10 visits depending on the region. Our Enrollee Services and Care Management staffs work with enrollees to provide education and support on the appropriate use of emergency services.

### **SPECIFIC MITIGATIONS**

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

**CRITERION 2:** The extent to which the respondent's monitoring plan includes specific mitigation steps it will take if there is a potential accessibility issue identified

If we determine there are any existing or potential accessibility issues, we perform outreach to locate additional providers within the geographic area to close any gaps in network access and, if necessary, issue single case agreements to guarantee enrollees have access to needed services. To mitigate any potential accessibility issues, we continually assess all providers in our service area that are not currently in our network. If we identify providers who would add value (specialists) or accessibility to our network, we perform outreach to educate them on Aetna, our services, and the value of serving our Medicaid enrollees, and then we begin efforts to contract them for our network. Aetna's team performs both telephonic and one-on-one site visits to introduce providers to our network and assist them in the contracting process. We provide orientation, education, and assistance through our Provider Services team, which is available at any time to answer questions, address concerns, and assist with billing questions, issues, or enrollee concerns.

Aetna's monitoring plan includes the specific mitigation steps for any potential accessibility issue. Our goal is to work collaboratively with the provider to bring the practice into compliance. However, continued failures resulting in a pattern of non-compliance may result in a formal corrective action plan, which can lead to termination. Whenever we are alerted to a problem or potential issue, we collaborate with the provider to help resolve the issue. Taking into consideration the provider's input on our findings, we work to find a process to mitigate the issue. If the provider is non-compliant, we take the following steps:

- Provider Services calls the provider to confirm the issue of non-compliance and attempts to resolve the issue; if we cannot confirm the issue, the call is forwarded to the Quality Management/Utilization Management (QM/UM) department for further outreach.
- QM/UM evaluates the issue to see if it involves a quality of care issue; if so, we work with the provider to resolve the issue and ensure enrollees receive the appropriate care in the right setting to meet their needs.
- Provider Services staff educates the provider and staff on appointment standards and guidelines, and collaborates with the provider to resolve the issue and develop processes and procedures to mitigate the potential for future issues. Education can be performed during site visits, through conference calls, email, webinars, or letters.
- Following education initiatives, the group is re-evaluated the next month to determine if they are in compliance. If not, the provider is notified in writing that subsequent failures could lead to closing or freezing the provider's panel status pending compliance with this issue. Network management is informed to direct contracting efforts, if needed. We also evaluate if non-compliance could mean there is a need for more PCPs in that specific area to ensure access and availability standards are met for all providers in the area.
- As a last resort, we retain the right to terminate a participating agreement to remove any provider from the network for failure to provide timely access to appointments. We also allow the provider to appeal this decision if they can demonstrate they have sufficiently mitigated the issue and show they can be effective partners in the network. In Florida, we have never had to terminate a provider because of failure to provide timely access to care.

**DETERMINING PCP CAPACITY TO ACCEPT NEW PATIENTS**

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

**CRITERION 3:** The extent to which the respondent's process and methodology for determining PCP capacity clearly outline the steps and data used for determining whether a PCP has the capacity to accept new patients

Aetna's Provider Services team runs quarterly panel reports to determine if any PCPs are at or nearing capacity. We review these reports to determine if the PCP is passing all audits and not currently at the State standard capacity rate of 2,500 patients. Providers with fewer than 2,500 patients are considered as open to accepting new patients. We also track whether a provider is accepting new patients and their open/closed panel status through our ongoing monitoring activities. In the event a provider is nearing capacity or closed to new patients, we conduct outreach to find providers in the same geographic area and/or specialty to add to our network. We also review the panel status of other similar providers in that area to ensure they are open to accepting new patients in the event a referral or provider change is needed.

PCPs maintain open panels and availability to our enrollees as outlined in the "Scheduling Appointments and Waiting Times" section of the Aetna provider manual and enrollee handbook. PCPs must provide care or direct access to care 24/7. We conduct audits to confirm that after-hours telephone lines direct callers to plan-specific alternatives, such as urgent care centers or the emergency department as needed, and refer non-compliant providers to our medical director when corrective action is required.

We review access to practitioners and providers, including primary care (pediatrics, internal medicine, family medicine, general practice, advanced practice nurses), FQHCs, and rural health centers (RHCs), key high-volume specialty practitioners, high-impact specialists, long-term services and supports providers (as applicable), and State-required quarterly filings on appointment availability. We are also willing to include OB/GYNs as primary care as long as they are willing to meet the requirements to serve as a PCP.

Aetna has developed several innovative strategies to encourage appointment timeliness and open panels for MMA enrollees:

- We encourage providers to modify their after-hours messaging to include specific instructions on what to do for after-hours care and reducing avoidable ED visits. For example, directing enrollees to visit an urgent care center or call an on-call provider.
- Adopting telehealth/telemedicine solutions by working in collaboration with agencies and telehealth providers to grow access to these services and capabilities that will improve timely access to primary care, especially for those in the State where distances might present a challenge to access to care. Aetna has been working with Teladoc and MDLive since 2010, finding innovative approaches for delivering quality care. In Florida, we will use telemedicine to support virtual connections to our integrated care teams for optimal care coordination and to promote service expansion for specialty care and peer-to-peer consultation.
- We have contracted with the Florida-based My Home Doctor program to provide in-home visits for our most medically fragile enrollees. The program ensures access to clinicians around the clock to address patient needs. It dramatically reduces the use of 911, emergency department visits, and costly preventable hospitalization admissions and readmissions. We can resolve significant gaps in care with 24/7/365 access through

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this physician-driven, registered nurse care management platform. This service provides complex, high-risk patients with a cost-effective and convenient alternative to visiting an emergency department or urgent care center. This innovative house call delivery model has demonstrated improved clinical outcomes and a sharp reduction in ED utilization, unnecessary hospitalizations, and avoidable readmissions over the last 10 years.

**Evaluation Criteria:**

1. The extent to which the respondent's process and monitoring plan ensure that enrollees have access to urgent or non-urgent services within the timely access standards defined in **Exhibit B-1**, Managed Medical Assistance (MMA) Program, **Section VIII.**, Provider Services, **Item A.**, Network Adequacy Standards, **Sub-Item 8.**, Timely Access Standards.
2. The extent to which the respondent's monitoring plan includes specific mitigation steps it will take if there is a potential accessibility issue identified.
3. The extent to which the respondent's process and methodology for determining PCP capacity clearly outline the steps and data used for determining whether a PCP has the capacity to accept new patients.

**Score:** This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

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**EXHIBIT A-4-b**  
**MMA SUBMISSION REQUIREMENTS**  
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**MMA SRC# 10 – Transitions of Care (Statewide):**

The respondent shall describe how it will address the transition of care between service settings, including transitions from hospital to nursing facility rehabilitation and from hospital or nursing facility rehabilitation to home. Identify specific methodologies for ensuring that transition planning ensures appropriate primary care and behavioral health follow up, where appropriate. Provide an example of an effective transition plan.

**Response:**

Transitioning from one setting to another can be unsettling and even frightening for vulnerable enrollees, as well as their family members or caregivers. Aetna understands that effective transitions of care are paramount to maintaining and improving enrollees' quality of care, quality of outcomes, and most importantly, quality of life. Our objective is to help ensure a seamless transition of care with the aim of improving enrollees' health and recovery, efficiently and effectively coordinating their care, and reducing future admissions.

Because enrollees are at significant risk when transitioning from one setting to another, effective care transitions are vital to decreasing potentially preventable events. Our integrated care management model uses a strengths-based approach that empowers enrollees 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 enrollee receives the highest level of service and oversight to address his or her unique clinical and care management needs. The enrollee, along with his or her family and circle of support, are the principal voices and decision-makers in the care process. We serve as their advocates in a system of care that incorporates evidence-based, community services and addresses social determinants of health.

We routinely monitor metrics to make certain our transition of care program is effective and to have the staff necessary to meet the specific needs of our enrollees in Florida. In Region 11, where we currently operate, transition-of-care clinicians are assigned to specific hospitals and facilities to manage our enrollees' transitions from one setting to another. Transition-of-care staff members complete face-to-face visits with enrollees in the institutional setting, so discharge orders and referrals are handled as seamlessly as possible. We will scale this offering with our expansion across the State, will expand our home telemonitoring services for at-risk enrollees and post-discharge nurse visits, and will incentivize physical health and behavioral health providers to collaborate when the enrollee's care requires it.

**TRANSITIONS OF CARE BETWEEN SERVICE SETTINGS**

Transition planning for all enrollees begins on admission. The transition-of-care clinician begins by including the enrollee and his or her family as full partners in the discharge planning process and identifies all needs. If the enrollee transition is pre-planned, the Aetna care manager works with the enrollee to identify changes in need and service planning. Needs might include medication, education, support system, release of information, transportation, integrated health, and social determinant resources and referrals to support the new level of care, such as residential treatment, in-home services, and community engagement.

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If the transition to a different level of care is unplanned because of, for example, sudden hospitalization, the concurrent review clinician obtains real-time notification of admission through our proprietary inpatient census and immediately begins discharge planning. The concurrent review clinician engages with the provider to learn about the transition, the current services, and newly identified needs. The concurrent review clinician links in the transition-of-care clinician who collaborates with the enrollee, his or her circle of support, and internal utilization management to complete an update of the enrollee's individual plan of care and works to coordinate services in preparation for discharge: durable medical equipment, new referrals, and post-discharge appointments. Transition-of-care clinicians possess experience in both physical health and behavioral health, qualifying them to work with our enrollees, plan staff, vendors, hospital providers, physicians, and behavioral health specialists. As our regional footprint grows, we will collaborate closely with various stakeholders to secure appropriate staffing for other regions.

The transition-of-care clinician attends daily rounds with the medical director and concurrent review staff, so he or she can identify enrollees pending discharge and requiring assistance with transition. As a part of our process, the transition-of-care clinician connects with enrollees who have chronic conditions such as asthma, congestive heart failure, diabetes, and COPD. They also assist enrollees with cancer, hepatitis, HIV/AIDS, respiratory failure, sickle cell anemia, stroke, transplants, behavioral health diagnoses, or trauma, including burns, motor vehicle accidents, gunshot wounds, and traumatic brain injury.

As needs are identified throughout the admission, the transition-of-care clinician works alongside the facility discharge planner and health plan concurrent review clinician to make sure any services requiring prior authorization are processed and equipment is delivered to the home as ordered by the attending physician. After the transition plan is formulated, the transition-of-care clinician completes a variety of tasks, including:

- Notifying and involving the enrollee's PCP, who may not be aware that the enrollee has been hospitalized
- Identifying the root cause of the current admission to better understand circumstance that led to admission
- Identifying enrollee triggers during an acute stay that indicate potential for readmission (medical, behavioral, and social determinants of health)
- Targeting interventions according to evidence-based guidelines to help the enrollee achieve a successful discharge
- Preparing for enrollees' post-discharge needs by engaging enrollees and families in managing their health care needs
- Bridging the information gap between inpatient and outpatient settings (e.g., making sure the PCP and other outpatient practitioners have a copy of the discharge summary and medication list before they see the enrollee in follow-up)
- Coordinating post-discharge care across settings, including timely post-discharge appointments, transportation, and post-discharge meals
- Facilitating medication reconciliation for high-risk enrollees to ensure that medications have been filled and without complication, especially for our elderly enrollees
- Utilizing predictive modeling to identify enrollees at high risk for readmission within 30 days

## **EXHIBIT A-4-b**

### **MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

After the enrollee transitions to home or an alternative setting, the transition-of-care clinician follows up within 48 hours or 2 business days to ensure that all required services and equipment are in place and to coach the enrollee on the management of his or her conditions and self-care. A post-discharge questionnaire is completed, which is used to determine whether the enrollee was receiving care prior to admission and whether there are access issues or concerns with behavioral health, health literacy, or adherence. We also assess whether enrollees receive and understand their discharge instructions, have new medications, understand why they are taking those medications, and fill their prescriptions. We review the services ordered and confirm that they are being provided while assisting the enrollee with scheduling his or her follow-up appointments.

The transition-of-care clinician also assesses environmental or social determinants, such as the enrollee's living situation, food availability, and ability to function in his or her home. Enrollees are linked with any community services and resources that are immediately necessary for their safety. Our enrollees are encouraged to communicate with their care and service providers and to stay educated on their disease process, self-management skills, and adherence to recommended treatment. The transition-of-care clinician also encourages enrollees to accept the services provided by our care managers for ongoing support and assistance.

Aetna employs peer-support and recovery specialists as part of our fully integrated system of care to motivate and model sustained success for enrollees in managing their own recovery. We recruit local peer support specialists to ease transitions of care and to affect positive behavioral health outcomes. The recovery specialists' lived experience offers an alternative perspective on recovery. Recovery specialists add to continuity of care for enrollees by participating with their integrated team (care managers and providers) during discharge planning. Recovery specialists support the voice and choices of our enrollees using evidence-based intervention that promotes recovery from a number of conditions.

#### **HOSPITAL TO NURSING FACILITY**

Aetna recognizes enrollees in transition are the most at risk. Therefore, we employ our integrated care model to meet the needs of the enrollees transitioning between levels of care and care settings. Our processes incorporate any services offered by State, federal, or community agencies, and our Concurrent Review, transition-of-care, care management, and Utilization Management staff facilitates and encourages community integration and self-direction by ensuring delivery of those services. We promote social interaction, engagement, and self-empowerment.

Skilled nursing is a covered benefit for enrollees under the age of 18; however, these enrollees often transition to the State's long-term care program for children. Although we do not have a skilled nursing benefit for enrollees 18 and older, skilled nursing can be authorized for services in lieu of a continued hospital stay. If these services are authorized for enrollees 18 and older, Aetna is prepared to deliver on Medicaid in Florida. Adults can be approved for these services in lieu of hospital services. This outcome is unusual; however, Aetna is prepared to deliver the same seamless quality of care for all of our enrollees, whether they are transitioning home or to skilled nursing facilities.

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

MCG (formerly Milliman Care Guidelines) are used as a reference for determining medical necessity, and the medical director reviews the request to determine medical necessity. A group of specialized clinicians reviews skilled-nursing facility admissions to determine whether the enrollee is being transitioned to the right level of care. The utilization management clinician works closely with other internal team enrollees such as discharge planners and care managers to meet the enrollee's behavioral and physical health needs. To support the interdisciplinary care team strategy, a clinical pharmacist is available to support medication reviews with the enrollee, care manager, and prescriber to identify and assess current medication therapy (prescription and over the counter) in the context of the enrollee's medical diagnosis. The goal is to promote adherence, identify and resolve potential medication compliance barriers (e.g., medication interactions), share best-practice recommendations with prescribers regarding medication therapy, and assess the impact of outreach and intervention.

Whenever an enrollee resides in a long-term care facility and goes back and forth to the hospital, our override process makes sure we are not denying changes in medication and that we are completing medication reconciliation when the enrollee returns. Our pharmacy team works with CVS Health's pharmacy help desk to allow for hospital discharge and level-of-care overrides for enrollees transitioning from a hospital to a long-term care facility. Long-term care pharmacies call for overrides in the event a prescription cannot be processed at the point of sale. Whenever an enrollee is discharged from a state mental health facility, we allow the enrollee to continue his or her medications for at least 90 days, regardless of the formulary status of the drug, and we will place an override if necessary so the enrollee has an adequate supply of medication until a psychiatrist can see him or her.

### **HOSPITAL OR NURSING FACILITY TO HOME**

Aetna's care management and utilization management teams work in tandem with our enrollees and the hospital discharge planning staff to establish post-discharge services. All services and supports—including follow-up appointments with the enrollee's PCP or appropriate specialist, prescriptions and medication reconciliation, home health care, durable medical equipment, community resources and supports—are scheduled prior to the enrollee's discharge and in place on the enrollee's first day at home. Our care management team gathers any available contact information for the enrollee and adds it to our electronic care management system to assist with coordination of care upon discharge. Where provider access is limited, we promote home health visits within 72 hours of discharge with a report to the PCP. If an enrollee requires transition to a secondary setting for continued follow-up, our utilization management team works closely with our care management team to resolve barriers and to facilitate a face-to-face meeting with the enrollee.

We work with the nursing facility and the enrollee's interdisciplinary care team to develop a comprehensive transition plan for the enrollee's transition home. Because we assign care management caseloads based on geography, each nursing facility has one or two primary points of contact to support the coordination, transition, and reintegration of enrollees into the community. When transition plan goals are complete and stable housing is in place, we hold a pre-discharge interdisciplinary team meeting and invite all service providers responsible for supporting the enrollee after successful discharge.

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### **MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Enrollees with home- and community-based services are encouraged to follow age-appropriate screenings and health-maintenance guidelines and to seek evidence-based care for chronic physical and behavioral illnesses. Every assessment and encounter includes attention to comorbidities and reducing unhealthy behaviors (e.g., tobacco use or substance use) in a person-centered manner. We identify the issues that affect all enrollees, including their physical and behavioral health concerns, as well as their caregiver issues and circle of support needs, community health support needs, transportation challenges, access-to-care challenges, and knowledge gaps that prevent them from achieving their personal health care goals.

#### **ASSESSMENT CRITERIA FOR DETERMINING ENROLLEE SAFETY IN COMMUNITY**

**CRITERION 1.a:** Assessment criteria for making sure the enrollee can be served safely in the community

The transition-of-care clinician contacts the hospital discharge planner to identify the enrollee's needs upon discharge to support their resiliency and recovery. Relying on the orders from the attending physician, the hospital discharge planner's assessment and the concurrent review nurse's clinical notes, the transition of care clinician assesses whether the enrollee can be safely discharged to home with or without support services or requires discharge to an alternative setting. Criteria for discharge include mobility/ambulation; home health needs; home support services from family; home environment; clinical needs (e.g., IV medications, treatments, wound care); durable medical supply needs; and enrollee/responsible party self-determination for discharge. We confirm that all supplies and services are in place prior to discharge so that the enrollee returns to a stable environment.

While our goal is to transition enrollees to lower-acuity care settings, doing so is not always possible. Sometimes our enrollees require higher-acuity care settings. For example, frequent trips to the emergency department or recurring inpatient admissions may highlight the need for a higher level of care. Enrollees with dementia may require a higher-acuity setting to receive 24-hour monitoring. In these instances, we recognize the safety risks and know when to intervene on behalf of the enrollee.

The attending physician determines the best level of care based on an evaluation of the enrollee's biopsychosocial state. The physician and our health plan also use MCG as one criterion for assessing an enrollee's potential safety in the community. The transition-of-care clinician interviews the enrollee and their family or caregivers to determine whether the home can accommodate the enrollee. If we have reason to believe that an enrollee will not be safe, we approve a continued hospital stay while we continue to work on a discharge plan that ensures enrollee safety. We have also helped enrollees to receive placement in assisted living facilities and shelters that provide medical services.

For example, we helped a new teen mother and her infant with special needs find safe placement at a homeless shelter with a unique, supervised environment and supportive services, such as mental health therapy and parenting education. The young woman's family had put her out of their home when they learned she was pregnant. Her newborn had multiple medical issues, including a cleft lip and palate, missing and webbed fingers, and kidney and gastrointestinal issues. Without a stable residence, our enrollee would have had significant additional challenges tending to the care and safety of her newborn. Once she was safe at the

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### **MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

shelter, we arranged for transportation for the infant's medical appointments and continued to provide guidance, support, and education to her mother.

When an enrollee is being discharged home and a home health agency is necessary to ensure their safety, our transition-of-care clinician authorizes and coordinates this service and facilitates the confidential transfer of information to the vendor. We contact enrollees 48 hours post-discharge to make certain that they have everything they need pertaining to appointment scheduling, non-emergency medical transportation, durable medical equipment, and home health services.

#### **COLLABORATION WITH PROVIDERS' DISCHARGE PLANNING STAFF**

**CRITERION 1.b:** Collaboration with providers' (e.g., hospitals, institutional settings, assisted living facilities, crisis stabilization unit, statewide inpatient psychiatric program) discharge planning staff

At Aetna, we understand the importance of developing and maintaining a true collaborative relationship with discharge planning staff and providers who serve our enrollees. Our efforts center on clear communication, well-defined roles, secure and confidential data exchange, and delivering timely care coordination so that our enrollees experience a smooth transition between care settings. Our concurrent review clinicians and transition-of-care clinicians collaborate with providers and hospital discharge staff to make sure the physician's discharge orders is followed completely and on time, minimizing risk to the enrollee. We also promote collaboration between providers by allowing our providers to make referrals to other specialty services outside our network. In those cases, we make single-case agreements with those providers. The physical and behavioral health backgrounds of our transition-of-care clinicians allow them to collaborate easily with hospital providers, physicians, and behavioral health specialists.

Our electronic care management system facilitates communication between stakeholders in the enrollee's discharge. That system is composed of two components:

- Our internal care management system drives internal care management workflows and tracks key enrollee engagement events and the longitudinal care management records for our care management team
- Our external population health management system, CareUnify, supports the enrollee's interdisciplinary care team with external data sharing around key clinical events, including real-time notifications and detailed enrollee and panel information

With the needs of the enrollee as our first priority, our concurrent review clinicians collaborate with hospital staff—physician, care manager, and discharge planning/social worker—upon admission. The concurrent review clinicians work with discharge planners to understand doctors' orders for transition, current services, and post-discharge needs. Our concurrent review clinicians are the link between our transition-of-care coordinator and physicians and hospital discharge planning staff to streamline communication on behalf of the enrollee. The concurrent review clinician contacts the transition-of-care clinician who collaborates with the enrollee, his or her circle of support, and internal utilization management. The transition-of-care clinician updates the enrollee's individual plan of care and works to coordinate services in preparation for discharge, such as durable medical equipment, new referrals, and post-discharge

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

appointments. Service authorization activities are documented in our utilization management business application and can be viewed in real time by our care management team in addition to our providers utilizing the provider portal.

We also collaborate with discharge planning staff in assisted living facilities and staff in institutional settings such as nursing homes. Our care managers communicate with discharge planning staff as they execute a discharge to home by arranging for all referrals, scheduling necessary transportation, and ensuring that all durable medical equipment is available prior to discharge.

Aetna's behavioral health subcontractor, Beacon Health Options, provides treatment and discharge planning for all enrollees for behavioral health admissions, which begins at the time of the initial assessment on the day of admission. For enrollees transitioning from a hospital or nursing facility rehabilitation setting and returning to a community setting, Beacon employs specific strategies for transition and discharge planning, incorporating assessment of appropriate supports in the home, provision of supplies, and home care/nursing services.

Beacon has a designated transition coordinator to help Aetna's Care Management staff and Beacon's Utilization Management staff work together effectively to manage the pathway between utilization management to care management and to manage discharges of enrollees from behavioral health inpatient stays. Beacon's discharge coordinator is available to assist with behavioral health discharges from inpatient and other higher levels of care such as residential, SIPP, and other services.

The role of the transition coordinator includes:

- Identifying enrollees receiving behavioral health service who are in need of care management
- Making complete referrals for care management, inclusive of case presentations, collection of relevant assessment and claims data, and provider information
- Ensuring enrollees are discharged from inpatient facilities with seven-day Follow-Up after Hospitalization appointments by helping with appointment set up and access

When there is a discharge, the transition coordinator introduces the enrollee to an interdisciplinary care team prior to assignment to Aetna's care manager. This ensures the enrollee is assigned expeditiously to an Aetna care manager based on the data obtained during the assessment process. While many of these transitions are routine (e.g., an enrollee with a clear history of SMI), some are more complex and require additional review by the interdisciplinary care teams to help ensure appropriate case assignment to the appropriate care manager. The transition coordinator continues to follow the case for 30 days post discharge as the enrollee transitions to health plan care management. The transition coordinator serves as a liaison to behavioral health providers during the 30-day period.

The transition coordinator facilitates weekly interdisciplinary care team calls with Aetna to share assessment information and to agree upon case assignment. Prior to this weekly call, Beacon provides all completed assessments as well as a list of cases to be discussed and assigned. The goal of these rounds is immediate case assignment and an opportunity for Beacon's

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transition coordinator to highlight any findings in the assessment or outreach process that warrants immediate action from Aetna's care management team.

Aetna's care managers work collaboratively with Beacon's utilization management clinicians and acute care facilities to ensure appropriate discharge plans are established with enrollees and family and caregivers, if applicable. To ensure continuity of care, prevent readmissions, and facilitate effective transitions of care, care managers conduct proactive outreach to enrollees and their providers and, if applicable, families and caregivers post-discharge from an acute facility. This outreach includes assessment of the enrollee's understanding of their discharge plan, an assessment of the enrollee's knowledge of discharge medications, reinforcement of the treatment plan, an evaluation of gaps in care, barriers to treatment adherence, crisis planning, and support of the enrollee's self-management skills. During transitions of care, care plans are reviewed with the enrollee and his or her treatment team to determine whether modifications are necessary to meet the enrollee's transitional needs, and with enrollee input, care plans are modified as necessary.

As part of Beacon's utilization management, active treatment and discharge planning is discussed regularly during pre-service and continued-stay reviews with providers and facilities. Our Care Management department participates in active aftercare planning, which includes enrollee participation, and whenever possible and with the enrollee's permission, input from the enrollee's family and other identified supports, including appropriate providers. Included and considered are issues related to discharge readiness, barriers to discharge, and specific individualized plans to support the enrollee after discharge, in addition to basic plans for aftercare. Beacon Utilization Management staff and Aetna's Care Management staff document all discussions and actions in the appropriate care management and Utilization Management business application system.

During an enrollee's course of treatment, Beacon's Utilization Management clinician reviews the status of the discharge plan at each review. When a request is contraindicated, benefits are exhausted, or enrollees withdraw from a program, the Utilization Management clinician conducts a review of the discharge plan to assure the safety of the enrollee and appropriateness of follow-up treatment. The discharge plan is reviewed by a care manager for appropriateness, based on the individual's needs and may include the following:

- The plan is realistic, comprehensive, timely and concrete
- The plan considers the Utilization Management clinician's recommendations and enrollees preferences as recorded in previous treatment review notes
- Transition from one level of care or program to another is coordinated
- The plan incorporates actions to assure continuity of existing therapeutic relationships, as appropriate
- The provider assists the enrollee, parent, or guardian to understand the status of the discharge plan and has a signed copy
- Transportation and other needs are addressed as needed
- The discharge plan is communicated to the aftercare provider(s) as applicable and with the enrollee's permission
- Psychopharmacological needs are addressed
- Collaboration with medical practitioners has occurred

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- The enrollee has timely access to the recommended aftercare services, including date of first appointment, with whom, where, and other treatment and community resources to be utilized
- Barriers to aftercare planning are addressed and need for outreach or treatment reminders are indicated
- Support systems are outlined
- Community services and/or self-help groups are recommended
- Linkages to EAP services are established, if appropriate and available
- Family/work/community preparation has occurred which supports reintegration, as appropriate
- Review of all ongoing and new in-network continuing care services (both covered and non-covered) to assist the provider/facility in identifying appropriate resources for discharge planning

Aetna promotes collaboration, communication, and data sharing between the health plan and statewide inpatient psychiatric program by our enrollees' behavioral health provider on the interdisciplinary care team. Complementing the internal component of our care management platform, CareUnify offers our provider partners and care managers access to near real-time data, including admission, discharge and transfer information when available, claims data, and outstanding gaps in care. Our care managers coordinate a call between the enrollees' primary care provider, attending physician, behavioral health practitioner, and our medical director to discuss diagnose, proposed treatment, and potential discharge. The interdisciplinary care team collaborates with the concurrent review clinician, transition-of-care clinician, and the hospital's discharge staff to develop a discharge plan.

### **REFERRAL AND SCHEDULING ASSISTANCE**

#### **CRITERION 1.c.: Referral and scheduling assistance**

Referrals are essential components of an enrollee's care plan. The referral process connects enrollees to needed physical health, behavioral health, and social services. To ensure that enrollees receive the services for which they are referred, our transition-of-care clinician can authorize referrals, expediting the process for the enrollee. The transition-of-care clinician coordinates referrals by scheduling necessary appointments and arranging for transportation prior to discharge.

Enrollees are contacted after scheduled appointments to make sure their needs were met and that they understand the provider's instructions. The enrollee's care plan is updated in our care management system to reflect services received and any change in condition.

Enrollees discharged from a behavioral health setting receive automated and/or direct calls from their care managers to remind them of their post-discharge 7- and 30-day aftercare behavioral health appointments and, if needed, assist in securing appointments or rescheduling appointments. If an enrollee's benefits end during treatment and program participation, his or her care manager outreaches to provide alternatives and resources for continuing care and guidance on how to access the services. Enrollees transitioning from child or adolescent (pediatric care) to adult care are assisted with referral and linkage to adult services, when needed, to make certain they receive age-appropriate behavioral health services.

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **METHODOLOGIES FOR COORDINATING FOLLOW-UP WITH PCP AND BEHAVIORAL HEALTH PROVIDERS**

**CRITERION 1.d: Coordination with PCP and behavioral health providers to ensure appropriate follow up has occurred**

Our evidence-based integrated care management model creates a one-stop shop for physical, behavioral, and social needs. Through the integrated care model, information pathways are created through which providers, with the permission of enrollees, can have collaborative conversations with one another to ensure proper follow-up with the enrollees' PCP, behavioral health, dental, vision, and other specialty providers. We collaborate with enrollees, their system of support, community-based care resources, PCPs, and other practitioners to enhance care outcomes. For the enrollee, there is no wrong door when attempting to access the care necessary for their behavioral and physical health conditions.

Aetna's care managers educate our enrollees about their available provider options, assist them in scheduling appointments, and arrange transportation if needed. We encourage all enrollees to establish a relationship with a PCP. In cases where certain specialties—such as psychiatry—are scarce, we introduce the integrated care model for extending those services through PCPs. The enrollee's plan of care is always shared with the PCP. The PCP can assess whether the enrollee has behavioral health needs that warrant treatment. Enrollees with higher needs are referred to a partnering behavioral health provider for evaluation, treatment, and follow-up, while enrollees with lower needs can be managed by their PCP in partnership with a behavioral health provider.

Our advanced, proprietary care management system provides a complete suite of functional, physical, and behavioral health assessments, care planning tools, and monitoring functions. With this secure system and its remote access capabilities, our care managers can take a laptop into an enrollee's home on face-to-face visits in the field and immediately answer questions, enter enrollee information in real time, access and verify information, update and upload comprehensive care and service plans, and confirm that follow-up visits with all providers are scheduled and kept. Similarly, care managers and enrollees can use the Internet to access Aetna's website for Medicaid and health care information and education through the enrollee portal and through MyActiveHealth. Using a secure login, enrollees can also use the enrollee Web-portal to view their care plan.

For level 3 (high risk, intensive care management) and some level 2 (moderate risk, supportive care management) enrollees we are unable to reach post-discharge, we work with community-based partners to ensure post discharge supports and services are arranged. Care managers work with providers to build rapport with enrollees who do not have established outpatient behavioral health services and continue support upon transition to the community. The provider ensures follow-up post-hospitalization is completed, as well as the connection back to Aetna for continued community support.

### **PROCESSES PREVENTING UNNECESSARY READMISSIONS**

**CRITERION 1.e: Processes to prevent unnecessary hospital or nursing facility readmissions**

## **EXHIBIT A-4-b**

### **MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

The health and safety of our enrollees drives our desire to help them achieve and maintain optimal health. We recognize that the transition from acute care to home or another care setting can be challenging for our enrollees left to navigate the transition alone. Aetna's readmission prevention program supports enrollees who are discharged from the medical or behavioral health inpatient setting by establishing to meet their needs. We employ several strategies that contribute to the prevention of unnecessary readmissions to the hospital or nursing facility:

- Timely, effective discharge planning
- Post-discharge education and outreach
- Integrated care management with transition of care clinical support
- Tracking utilization
- Predictive modeling
- 24-hour Informed Health Line and 24-hour behavioral health crisis line
- Evidence-based interventions for enrollees in long-term care
- Readmission risk reduction strategies for enrollees with behavioral health concerns
- Pharmacy Hospital Readmission Reduction Program (HRRP)

#### **DISCHARGE PLANNING**

Our standard model expands upon the traditional concurrent review function (medical necessity review) to include a range of traditional care management functions related to identifying the root cause of the current admission, shaping the treatment and the discharge plan to decrease the risk of readmission by assuring continuity of care, and by not referring people back to the same circumstances that failed prior to the current admission. We identify, in real time, any enrollees with an inpatient stay, observation, or emergency room visit; such enrollees are treated as high risk for readmission. From day one of an inpatient stay, our concurrent review clinicians, transition of care clinicians, and care managers review the admission medically and also identify behavioral, social, or other contributing factors or root causes of the admission which enables us to understand and prevent discharge planning failures that can lead to readmission (e.g., not repeating the same discharge plan if there is a readmission).

During the transition period, we coordinate with the enrollee's circle of support and with traditional and non-traditional providers with warm handoffs to ensure a successful discharge. Our concurrent review clinicians assist facility staff to ensure post-discharge care is available and to ensure the enrollee's discharge plan is implemented. Upon notification of an admission, concurrent review clinicians collaborate with our transition-of-care clinicians, discharge planning staff, enrollees or their caregivers, care managers, PCPs and other practitioners to facilitate discharge planning efforts. This highly effective team approach—particularly the implementation of a dedicated transition of care clinicians—results in improved continuity of care in the safest and most cost-effective setting, so hospitals, PCPs, and plan personnel can focus more closely on special social, economic, cultural, and language interventions that reinforce improved outcomes for the enrollee.

#### **POST-DISCHARGE EDUCATION AND OUTREACH**

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Within 24 to 72 hours of discharge from the hospital, we reach lower-risk enrollees by telephone. During these calls, our care managers confirm that supports in place are meeting the enrollee's needs, to reduce avoidable readmissions, and to address any newly identified needs. Aetna also uses community health workers for home visits and to assist recently discharged enrollees with nonmedical needs such as helping the enrollee access community services to address social determinants of health. For high-risk enrollees, care managers meet with them face-to-face to assess adherence to the discharge plan and necessary support. We reassess when there is any change in emotional, functional, or cognitive status at regularly scheduled intervals.

Because the enrollee's preferred support system is often the first to recognize a physical, cognitive, or emotional decline or a change in condition, we educate caregivers to identify red flags like changes in cognition, behavior, and activities for daily living. When the caregiver notifies Aetna of a change, we re-evaluate the enrollee so that there is no delay in care that could potentially prevent a readmission and negatively affect their quality of life.

In the event we cannot contact the enrollee after discharge, we reach out to the enrollee's hospital and PCP by telephone and verify demographic information as needed. We provide the PCP with the enrollee's discharge summary and medication list and verify that follow-up appointments are scheduled. Hard-to-reach enrollees are flagged in our care management system. An alert is activated whenever the enrollee has an emergency room visit or inpatient admission, uses an area pharmacy, or engages in any other utilization. The alert enables the care manager to obtain current enrollee information and contact the enrollee directly if they are in the hospital or to talk directly with the pharmacy or provider to determine whether they have a better contact phone number or address.

### **INTEGRATED CARE MANAGEMENT**

Using our integrated care management program, we identify the gaps in an enrollee's care, knowledge, or service that place them at risk for hospitalization. Care managers regularly educate enrollees and their caregivers on the specific physical and behavioral health disorders and the appropriate use of emergency services, including when and how to contact their PCP. For high utilizers, care managers help enrollees identify social supports such as stable housing, nutritional counseling, transportation assistance, peer support, and socialization. During care planning visits with enrollees and their circle of support, care managers provide educational materials including information on the locations of urgent care settings closest to enrollees' homes and on when to use an urgent care setting or PCP instead of an emergency room. Using comprehensive assessments, we identify each enrollee's strengths and challenges—offering condition-specific education and developing a person-centered, stage-based plan of care that empowers enrollee self-care and increases the likelihood of staying out of the hospital or being admitted or readmitted to a nursing facility.

### **TRACKING UTILIZATION**

Several methods are used to track utilization and identify enrollees who will benefit from intervention. These tracking mechanisms include our admission and readmission report (detailing 7- and 30-day readmissions by facility, provider, and diagnosis); daily inpatient census and discharge census (which provides information to both utilization management and care management staff and is discussed during daily multidisciplinary rounds); health care equity

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

dashboard (which reflects inpatient usage by gender, age, race, ethnicity, and county); and referrals (tracked for integrated care management from many sources, including providers, families, agencies, organizations, individuals involved with the enrollee's care, or enrollees themselves). CareUnify provides real-time admissions, discharges, and transfers information for the health plan, PCP, and specialty providers on emergency department, inpatient, and outpatient utilization at the individual enrollee level.

### **PREDICTIVE MODELING**

Aetna's Consolidated Outreach and Risk Evaluation (CORE™) predictive modeling tool enables us to identify at-risk enrollees in need of care and disease management services. Proprietary and evidence-based, this stratification tool uses analytic methods we have honed for over ten years. These methods identify individuals who are at risk of higher-cost care or high utilization in the future. Scores are generated from internally developed algorithms based on Medicaid population data and our clinical and informatics expertise. Inputs to the algorithms include demographics, medical, behavioral, and pharmacy claims data. The resulting inpatient and emergency room models provide enrollee-specific scores indicating the likelihood of the enrollee visiting the emergency room or experiencing an inpatient admission in the next 12 months. The model is run monthly for our entire population and the results are reviewed by the appropriate clinical teams for enrollee contact and intervention opportunities. We also share risk stratification information with our provider partners to establish care priorities and care coordination activities—the information is always well received as providers often struggle with knowing who their highest-risk patients are and prioritizing the care they need.

### **24-HOUR LIVE ACCESS TO HEALTH CARE PROFESSIONALS**

Aetna's 24-hour Informed Health line and 24-hour Behavioral Health Crisis line provide enrollees with toll-free access to a team of registered nurses and behavioral health clinicians so they and their families can get the information they need to make informed care decisions in urgent situations.

### **EVIDENCE-BASED INTERVENTIONS FOR ENROLLEES IN LONG-TERM CARE**

For enrollees under the age of 18 in long-term care facilities and adults approved for skilled nursing services in lieu of hospital services, we have adopted evidence-based interventions to improve health and reduce avoidable hospitalizations. Our care management staff collaborates with on-site nursing facility staff to support enrollees with chronic conditions, including a treat-in-place component to reduce avoidable emergency room use and inpatient hospitalizations. We support providers in managing the biopsychosocial complexities of our enrollees with an emphasis on the appropriate management of chronic conditions, medication optimization, prevention of falls and pressure ulcers, and the coordination of care.

When all staff and caregivers who encounter our enrollees are more knowledgeable, we proactively ensure that our enrollees are safe, comfortable, and are receiving individualized care that considers their voices and choices. Aetna conducts nursing facility staff trainings that incorporate dignity training, understanding the operation and expectations for facilities, dementia training, proper use of psychotropic drugs, transition training, behavioral health training, and MDS-specific training on person-centered care plans and motivational interviewing techniques.

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **Behavioral Health Intensive Care Management Readmission Risk Reduction Program**

Aetna provides intensive care management to enrollees with two readmissions to an acute behavioral health inpatient facility for treatment within 30 days of discharge from a current acute inpatient admission stay. A dedicated care manager contacts the enrollee daily, if needed, while he or she is still an inpatient and after discharge. The care manager works with the enrollee to coordinate follow-up appointments, review and reconcile medications, and promote home health care visits.

### **AFTERCARE PROGRAM**

Our aftercare program was designed to foster a smooth transition to post-hospitalization behavioral health care and improve the continuity of care for enrollees after a mental health hospitalization. As part of this program, aftercare coordinators offer timely telephonic communications, encouragement to sustain efforts towards recovery, and when needed, extra guidance in navigating the provider network. Our staff members place follow-up calls and mail appointment reminders to the enrollee after discharge from the facility. We also confirm with the facility that the enrollee kept an outpatient appointment. If the appointment was not kept, staff members reach out to the enrollee to help establish a follow-up appointment. Care management staff document all results of the aftercare program, including number of appointments kept as scheduled, number missed and rescheduled, and number never rescheduled.

### **HOME-BASED THERAPY PROGRAM**

The home-based therapy program is designed to assist enrollees who require immediate or additional support in transferring back home after an inpatient mental health hospitalization. The home-based therapy program addresses enrollee non-adherence with follow-up appointments after hospitalization and resultant recidivism. Beacon's Clinical and Network departments built a network of high-quality outpatient behavioral health practitioners with a wide range of specialty, such as dual diagnosis, eating disorders, and psychotic disorders. This program addresses identified barriers to successful aftercare for enrollees and their dependents, such as physical disability or the need for additional assistance for enrollees with serious emotional disturbance. The program focuses on bringing mental health hospitalization outpatient services to enrollees who otherwise would not keep follow-up appointments, reducing the risk of recidivism and improving HEDIS Follow-Up after Mental Health Hospitalization rates.

Specifically, home-based therapy provides services in the enrollee's home, medication management, and care coordination services to enrollees who are unable to access traditional outpatient services or who otherwise would not keep follow-up appointments after a hospitalization for mental or physical health treatment. For those who are recently discharged from inpatient settings, this program reduces the risk of recidivism and improves outcome measures such as the HEDIS Follow-Up after Mental Health Hospitalization rates. The program also addresses barriers to successful ambulatory treatment and/or aftercare. Beacon's network of outpatient and home-based behavioral health practitioners includes specialists in geriatrics, children, adolescents, dual diagnoses, eating disorders, psychotic disorders, and medication management. Care managers also coordinate with community nursing providers to ensure that home care is provided for medical issues, further contributing to integration of clinical pathways.

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **Pharmacy Hospital Readmission Reduction Program**

Aetna's pharmacy hospital readmission reduction program (HRRP) is a collaborative approach to care, serving enrollees who are likely to experience a hospital readmission. HRRP focuses on providing coordinated care with concurrent review nurses, care managers, clinical pharmacists, and the enrollee's primary health care provider to create a supportive transition as enrollees leave the hospital setting. Using risk stratification tools and a combination of medical and pharmacy data, HRRP provides an accurate and timely assessment of enrollees' needs that enables the care team to intervene proactively before a negative health outcome is experienced. The goals of the HRRP are to decrease hospital readmission rates by providing coordinated care when enrollees transition from a hospital setting, improving medication regimens, increasing medication adherence, and decreasing overall health care utilization.

### **PROTECTION OF THE ENROLLEE'S PRIVACY**

**CRITERION 2:** The extent to which the respondent's process and example ensures the protection of the enrollee's privacy consistent with confidentiality requirements

The privacy of our enrollees is one of our primary concerns. Aetna complies with all applicable State and local laws to ensure that the exchange of personal health information is conducted in a manner that is compliant with Health Insurance Portability and Accountability Act (HIPAA) and HITECH Act requirements and protected health information (PHI). Aetna has written confidentiality procedures in place that govern our compliance with all federal and written laws related to our interactions with enrollees and their family/caregivers, the electronic treatment of records, and facsimile and electronic mail. All new Aetna employees are trained and tested to confirm their understanding of HIPAA/HITECH, PHI, and data security during our onboarding process. Existing staff members receive ongoing training, and they are retested annually. Additionally, Aetna's corporate Medicaid Pharmacy team works with our Corporate Audit team to perform annual CVS Health audits for our Medicaid business, including HIPAA/HITECH compliance.

Requirements related to privacy are written into all of our contracts with providers and subcontractors. We educate our providers and subcontractors on PHI and HIPAA/HITECH requirements and allowable exchanges of information during program orientation, either onsite at the provider's location or by webinar within 30 days of a provider joining our network. Providers are also supplied with resources and reference materials in their welcome packets. Providers receive ongoing training and program updates during annual visits from network account managers and sign an attestation of completion. Additionally, we conduct ad hoc trainings where needed or requested when providers add new staff enrollees requiring training. Aetna tracks the number of providers who complete the training and report to the Agency. To determine the effectiveness of our training, we employ the Kirkpatrick model to evaluate reaction, learning, behavior, and results.

Before sharing any enrollee-related information, we obtain appropriate written permission from enrollees and their families/caregivers (when applicable) that specifies the type of information we can share and with whom. We also document permission to share data specific to behavioral health, substance use, or HIV/AIDS status. Completed release forms are stored in our database for easy access by care managers. Aetna staff completes verbal verification of

**EXHIBIT A-4-b**  
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**AND EVALUATION CRITERIA (10-2-17)**

telephone callers and reviews our database to ensure a documented release of information has been entered before providing enrollee PHI.

We do not share third-party information and redirect providers to contact inpatient facilities directly to obtain the records requested. When we receive a request for information such as individual plans of care, enrollee goals, and clinician notes from another health plan or the Agency for transition-of-care purposes, we electronically send them in PDF format via secure email or work to establish a secure data exchange.

**SAMPLE TRANSITION PLAN**

[REDACTED]

[REDACTED]

**ASSESSMENT CRITERIA FOR DETERMINING ENROLLEE SAFETY IN THE COMMUNITY**

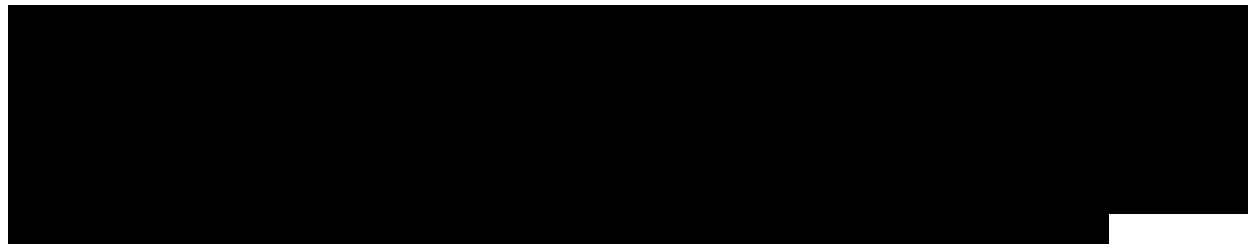
[REDACTED]

**COLLABORATOIN WITH PROVIDERS' DISCHARGE PLANNING STAFF**

[REDACTED]

**REFERRAL AND SCHEDULING ASSISTANCE**

**EXHIBIT A-4-b**  
**MMA SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**



METHODOLOGIES FOR COORDINATING FOLLOW-UP WITH PCP AND BEHAVIORAL HEALTH PROVIDERS



PROCESSES PREVENTING UNNECESSARY READMISSIONS



PROTECTION OF THE ENROLLEE'S PRIVACY



**Evaluation Criteria:**

1. The extent to which the respondent's process and example address the following transition of care requirements:
  - (a) Assessment criteria for making sure the enrollee can be served safely in the community;
  - (b) Collaboration with providers' (e.g., hospitals, institutional settings, assisted living facilities, crisis stabilization unit, statewide inpatient psychiatric program) discharge planning staff;
  - (c) Referral and scheduling assistance;

**EXHIBIT A-4-b  
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- (d)** Coordination with PCP and behavioral health providers to ensure appropriate follow up has occurred; and
  - (e)** Processes to prevent unnecessary hospital or nursing facility readmissions.
- 2.** The extent to which the respondent's process and example ensures the protection of the enrollee's privacy consistent with confidentiality requirements.

**Score:** This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

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**EXHIBIT A-4-b**  
**MMA SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**MMA SRC# 11 – Provider Network – Network Development Plan (Regional):**

The respondent shall submit a draft network development and management plan demonstrating how it will ensure timely access to the following services:

- Physical therapy (pediatric);
- Speech-language pathology services (pediatric);
- Occupational therapy (pediatric);
- Private duty nursing services (pediatric);
- Intermittent skilled nursing (pediatric and adult);
- Early intervention services;
- Compounding pharmacies; and
- Specialized therapeutic foster care.

The respondent's approach shall include at a minimum:

- a. Identification of network gaps (time/distance output reporting, after-hour clinic availability, open/closed panels, etc.);
- b. Strategies that will be deployed to increase provider capacity where network gaps have been identified;
- c. Strategies for ensuring timely access to services by measuring the time in-between when services are authorized and when they are received; and
- d. Strategies for updating the network development and management plan, including the data that will be used to inform improvements to increase access to services.

**Response:**

With 30 years of experience building networks across the country, the Aetna Medicaid organization follows a proven approach to network development for all provider types, including services for unique population needs. We have built effective network development plans for our health plans in Virginia, Arizona, Texas, Ohio, Illinois, Michigan, New York, Louisiana, and Kentucky serving Medicaid enrollees. Additionally, we have created plans for statewide expansion efforts in Louisiana and Virginia for the MLTSS populations, in New Jersey and Michigan, and in Texas for its STAR Kids program.

Aetna has conducted more than 20 successful implementations, meeting all State adequacy requirements over the past two years, including programs that meet the diverse and complex needs of the Medicare and Medicaid populations. Our network development and management plan addresses specific service needs such as pediatric physical, occupational, and speech language therapies; pediatric private duty nursing; pediatric and adult intermittent skilled nursing; early intervention services; compounding pharmacies; and specialized therapeutic foster care.

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Aetna has extensive experience working with complex populations with varied social determinants of health and physical and behavioral health care needs. Aetna's Medicaid organization currently serves both children and adults with complex needs across the country including Florida, Arizona, Illinois, Kentucky, Louisiana, Maryland, Michigan, New Jersey, New York, Ohio, Pennsylvania, Texas, Virginia, and West Virginia. With over 300,000 enrollees nationwide that are medically fragile or have complex conditions, we regularly work with government agencies, community organizations, universities, national provider associations, and others to inform our strategies to identify service providers that incorporate the entire system of care for complex biopsychosocial needs. Aetna's system of care incorporates the full spectrum of effective community-based services and supports for enrollees with or at risk for medical and behavioral health and related challenges. Through our collaboration of care model, we build meaningful relationships addressing the full continuum of physical and behavioral health care as well as social, functional, cultural and linguistic needs, to help our enrollees function better at home, in schools, in the community and throughout their lives.

### **NETWORK DEVELOPMENT AND MANAGEMENT PLAN APPROACH**

Aetna has extensive experience developing networks in the State of Florida, including our network serving the MMA population in Region 11 and the LTC populations in Regions 6, 7, 9 and 11. We have also served the Florida Healthy Kids contract in Regions 1-3, 5-9, and 11 for more than 20 years and Florida's commercial and Medicare populations over the past 30 years. Our network development and management plan is provided as Attachment MMA SRC 11.

Our network development plan and approach begins with understanding the needs of our enrollees. We host focus groups and meetings with advocacy groups and community organizations. These groups include Big Brothers Big Sisters, Boys and Girls Club, House of Healing, Indian River; Jessie Trice Community Health Center, Metropolitan Ministries, Sant LA Haitian Neighborhood Center, Suncoast Mental Health Center, The Embrace Girls Foundation, Tykes and Teens, USF Health, United Way of Indian River County, and Women's Breast and Heart Center. Our goal was to better understand the current service delivery environment and address access gaps to needed services.

We also met with provider associations such as the Florida Home Health Associations, and other participating providers such as Maxim Health Care, University Health Systems, and children's hospital organizations to gain a more in-depth understanding of the challenges they face in obtaining or finding services for enrollees with complex social and health care needs.

When developing a comprehensive network development and management plan, we take into consideration Aetna's basic values and beliefs. Everything we do at Aetna starts with our values—Integrity, Excellence, Caring and Inspiration. Our values and beliefs are built upon:

- Meeting enrollee needs: Our health plan leadership meets with enrollees, families, and providers on at least a quarterly basis through initiatives such as our Community Action Forum and Member Advisory Forum. Our discussions with these stakeholders enable us to identify unique needs and challenges. We deliver a clear, consistent message; for instance, if a provider network does not meet every individual's unique supportive and medical needs, the network is not adequate. We do not limit ourselves to meeting the required standards; instead, we develop our network to meet our enrollees' needs.

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- Delivering care in a culturally competent manner: Our network must deliver care in a culturally competent manner based on the prevalence of spoken languages and conditions within ethnic groups. All of our contracted providers receive cultural competency training at orientation and on an ongoing basis as needs are identified.
- Collaboration: We identify and collaborate with community-based organizations and providers to build a coordinated system of care based on a patient-centered model of care.
- Availability: We expand availability of patient-centered medical home (PCMH) practices, accountable care organizations (ACO), and utilize value-based purchasing (VBP) contracting strategies to transform care to improve the health of the populations we serve, enhance the enrollee experience and patient outcomes, and reduce cost of care for the benefit of the community.
- Reward: We collaborate with like-minded organizations to reward high-quality practices through recognition programs and by providing enrollees with performance or service ratings to assist in the selection process.
- Solicit advice: We regularly solicit advice and suggestions from State agencies, departments of health, community-based organizations, and provider associations to identify opportunities to strengthen and improve our provider network
- Data-driven monitoring: We provide quarterly and annual monitoring to evaluate network availability and access using various reports and data sources to meet and exceed compliance requirements and identify opportunities to improve the network on an ongoing basis. Monitoring tools include reviewing provider panel status, and GeoAccess reports to monitor access standards, network sufficiency, emergency department overuse, provider recruitment, and more. We also monitor quality performance metrics using satisfaction surveys, feedback from operations and enrollees, complaints and grievances, random access and appointment availability sampling, as well as performance ratings programs, such as Rate a Provider and Aetna's Awesome Provider program.
- Innovative strategies: We identify and deploy innovative Florida strategies to improve availability and access using solutions such as telemedicine, community collaboration, and value-based solutions. For example, we have contracted with the Florida-based My Home Doctor program to provide in-home visits for the most medically fragile. The program ensures access to clinicians around the clock to address patient needs. This service reduces the use of 911, emergency department visits, and costly preventable hospitalization admissions and readmissions. We can resolve significant gaps in care with 24/7/365 access through this physician-driven, registered nurse care management platform. Additionally, it offers complex, high-risk enrollees a cost-effective and convenient option to visiting an emergency department or urgent care center. This innovative house call delivery model has demonstrated improved clinical outcomes and a sharp reduction in ED utilization, unnecessary hospitalizations, and avoidable readmissions over the last 10 years.

Aetna has developed a strong pediatric therapy network statewide, [REDACTED]

[REDACTED]

**EXHIBIT A-4-b**  
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[REDACTED] we contract with statewide.

To meet the need for compounding pharmacies, we will utilize the extensive resources of our pharmacy providers who currently offer 12 compounding pharmacies throughout the State as indicated in the regions that follow. As needs are identified, we will conduct outreach to locate pharmacies that meet our enrollees' needs within their geographic areas where we do not currently have a compounding pharmacy contracted.

[REDACTED]

#### Behavioral Health Network Development

Aetna's subcontractor, Beacon, currently monitors all seven Medicaid-required behavioral health provider types, based on AHCA's specific time and distance standards, provider to enrollee ratios, # of beds per county, and # of specific facility types per region. The seven provider types are:

- 042 - Psychiatrists - Adult
- 043 - Psychiatrists - Child
- 907 - Licensed Practitioner Healing Arts
- 210 - Inpatient Psych Crisis Stabilization Unit (CSU) Adult Beds
- 211 - Inpatient Psych Crisis Stabilization Unit (CSU) Child Beds
- 901 - Inpatient Substance Abuse Detox Unit Beds
- 905 - Licensed Community Substance Abuse Treatment Centers

#### Identification of Network Gaps

CRITERION 1: The adequacy of the respondent's methodology for identifying and resolving barriers and network gaps; including ongoing activities or network development based on region-specific identified gaps and future needs projection

Our current network of participating providers for the required specialized services includes:

[REDACTED]

We measure minimum availability standards for these types of services as follows:

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Physical, occupational, and speech therapy: We try to offer and obtain participating contracts from all available providers who meet the required minimum/maximum access standards of 30 minutes/20 miles for urban and 60 minutes/45 miles for rural populations.
- Home health for private duty nursing and intermittent skilled nursing require two per county. It is understood that these agencies provide registered nurses (RNs) who visit enrollees' homes to provide these services. Having at least two per county assures our enrollees have a choice in selecting the service provider that best meets their needs.
- Compounding pharmacies: It is understood that compounding pharmacies are unique in nature, so our goal is to maintain a choice on a regional basis (or as these services are available).
- Specialized therapeutic foster care: We try to offer and obtain participating contracts from all available organizations providing this service.

Our network development plan assumes timely access to these unique and specialized services. Our care managers work closely with our high needs enrollees to make sure they receive timely services, whether for home health visits, appointments, and/or other service needs. If our care managers are unable to locate or obtain timely appointments for our enrollees, our care managers will reach out to our network development staff to assist in the identification of participating service providers or any provider within a reasonable distance. We will also assist with transportation to make sure the enrollee receives appropriate care in the proper setting.

### **Identifying Gaps or Barriers**

To help ensure network adequacy and identify any gaps or potential gaps, we will conduct a population analysis concentrating on the needed services and attempt to over-recruit for providers. Aetna works diligently with community resources and stakeholder groups to identify and respond to enrollee needs. We will monitor complaints and survey enrollees (especially on timely access) to determine and mitigate any issues and continually review GeoAccess reports to see if we can add any new providers to the network and make any future projections of network needs. Utilization data is reviewed to identify clusters where providers are needed (e.g., specialty services, areas where complaints have been made, etc.) and we will conduct outreach to begin contracting with these providers and close any gaps or potential gaps. Any barriers and potential barriers to access (i.e., transportation, language or cultural barriers, etc.) are identified and remedied. In the event there is a service gap and timely access is needed or a specialty is required not currently in the network, we will pay a differential to providers willing to accept Medicaid patients.

Aetna uses assessment and measurement programs as the primary means of determining network adequacy and our level of compliance with Florida access requirements. These assessments analyze compliance with travel distance standards, appointment availability, after-hours access, open panel status, and cultural competency for key provider types.

### **Ongoing Plan Monitoring to Identify Network Gaps**

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Across the health plans managed by Aetna's Medicaid organization, we use a variety of mechanisms to verify compliance with network standards and develop interventions to address gaps, as appropriate. Our suite of monitoring tools and reports are used to identify network gaps as follows:

- Provider-related enrollee complaints: Such complaints, including those identifying network gaps or barriers are reviewed weekly as part of our grievance process and are referred to the appropriate area for investigation and resolution. Our call center monitors trend reports that are shared with operations conducting weekly meetings to review phone center feedback as well as outreach by provider services staff to determine any network gaps or barriers.
- Conducting network panel studies using open/closed panel report: Panel studies demonstrate network access and availability needs.
- Conducting provider directory audits: Monthly audits confirm the accuracy of listings and make weekly updates to online directories for changes in demographics and panel status.
- Conducting provider phone surveys: We query providers on appointments and after-hours care including 24/7 availability.
- GeoAccess reports: We use monthly reports to measure against the State's access standard requirement at the ZIP code level.
- Interdisciplinary team collaboration: We identify any access or capacity concerns and addressing special needs.
- Network adequacy: We review utilization data for prevalent conditions, single case agreements, provider referral issues (availability of specialties), providers-gained-and-lost report, and unplanned network exits report to confirm sufficiency of the type and number of providers, including need for specialty providers.
- Reviewing provider to enrollee status: We review ratios by provider type and region to confirm availability of an adequate number of providers.
- Reviewing providers' panel status: We review open panel status to confirm where new enrollees can be assigned and identify providers who have reached their capacity and/or referral limits.
- Review grievances and feedback: We review quarterly analysis and trending of enrollee grievances to identify potential availability or accessibility issues, perform root-cause analysis, and develop corrective action plans, if necessary; we receive committee findings, and survey results on access, appointment availability and wait times, nonparticipating prior authorizations, and out-of-network requests.
- Leveraging Beacon for behavioral health gaps: If areas of deficiencies are detected, by either provider type, geographical area, or both, the Beacon Network team determines the barriers and creates interventions to cure the gap(s). Aetna is advised of Beacon's progress in forums, such as Joint Oversight Committee meetings and separate network discussions. Beacon also creates and runs an annual GeoAccess report for Aetna's existing service area, and generates a written network summary of the results, which is then submit to Aetna. Beacon's network development plan for the year is initiated by the network adequacy status verified by the GeoAccess report.

Identifying and Meeting the Need for Specialists

## **EXHIBIT A-4-b**

### **MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

We also review GeoAccess and provider data to determine the number of specialists in a geographic area to determine if we have an adequate number of these types of providers to meet enrollee needs. We look to provider associations, community organizations, hospitals and academic organizations to see if there are new providers entering the area or to develop partnerships to meet specific needs such as providing telehealth solutions or community solutions to increase access especially in rural markets or in hard to find specialty areas.

#### **Identifying and Meeting Future Needs**

We continually assess our need to grow our network to meet future projections and enrollee needs using the following methods by:

- Evaluating the current population demographics and consider the projected population demographic needs anticipating cultural and health disparities as an integral part of our annual network monitoring plan and Quality Management/Utilization Management (QM/UM) Committee meeting process.
- Inviting provider participation and input on future network needs through our Enrollee Advisory Committees, Provider Engagement Committee, LTC Advisory Committee, and QM/UM Committee to gather feedback on network needs or opportunities for improvement.
- Inviting participation and feedback in stakeholder meetings comprised of health care professionals, advocates, and enrollees to discuss issues of network adequacy, provider complaints, and recruitment priorities for growing the network.
- Obtaining stakeholder feedback on network composition, operations, and quality improvement initiatives to help ensure 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.
- Continually seek suggestions and innovative ideas from providers to help them become more successful, deliver better access, and offer more enrollee convenience.
- The local network team is crucial in identifying needs to expand the network to ensure timely access for enrollees. As they receive referrals from the integrated care team/medical management and other community agencies and organizations, they determine if additional recruitment efforts are needed. If so, they begin to conduct outreach to providers in that area or specialty to mitigate any potential gaps in care.
- Enrollee and provider referrals also trigger recruitment activity.
- Quarterly and annual monitoring plan reviews trigger recruitment action as we review GeoAccess reports.
- Evaluating the projected population needs against the current contracted provider network to identify any opportunities to recruit services and providers. Aetna maintains a recruitment database to help us track who is being recruited, and it shows our progress in obtaining signed agreements and applications. We offer providers an opportunity to sign an electronic contract using the Adobe e-sign capability to make it as convenient as possible for a provider to return and sign their document, increasing turnaround time from days to hours to receive a signed agreement.

Aetna's Florida network will be developed to meet all contract requirements: access standards; appointment times; type and number of facilities; ancillary, specialty, behavioral health, dental,

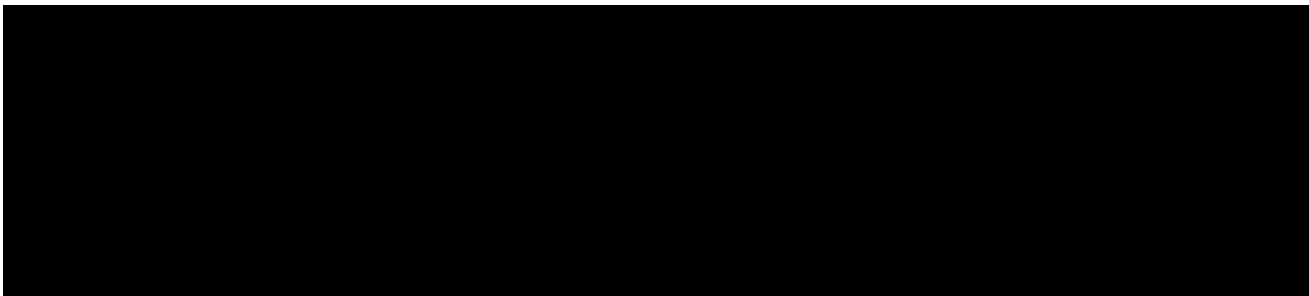
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vision providers, and pharmacies. We successfully manage our networks to ensure high-quality, culturally diverse, credentialed, and physically accessible provider groups to increase access and choice.

**INCREASING PROVIDER CAPACITY WHERE GAPS HAVE BEEN IDENTIFIED**

**CRITERION 2:** The adequacy of the respondent's plan to meet the needs of enrollees if it is unable to provide the service within its provider network; including immediate, short-term and long-term interventions

Besides recruiting or adding providers through the normal recruitment process and utilizing single case agreements to increase provider availability and access, we also use innovative strategies to improve access to these specialized services:

- 
- Collaborating with local community colleges to add educational programs and increase the number of people going into these types of provider services to increase access to pediatric home health services, including physical therapy, occupational therapy, speech therapy, private duty nursing, and intermittent skilled nursing services.
  - Collaborating with CVS to contract with additional compounding pharmacies. Our approach to contracting with compounding pharmacies is based on our long-term relationships with retail pharmacies across the State since we contract with all of them. Aetna ran a report of pharmacies registered with the NCPDP with a secondary provider type of compounding pharmacies resulting in 12 pharmacies in Florida. We will also proactively locate other compounding pharmacies throughout the State to ensure enrollees have convenient access to a pharmacy in their area that meets adequacy and access standards. Caremark recently introduced an additional credentialing process for those pharmacies that are primarily compounding providers to ensure they are meeting the required standards. We are evaluating the existing compounding pharmacies in our network to determine if they have completed this process.

Through Aetna's value-based purchasing (VBP) strategies, we identify both gaps in care through our population health specialists who are responsible for monitoring the full system of care for our highly complex enrollees and providing financial incentives to verify that appropriate care is delivered in the proper setting (whether in our outside of the home). Some of the VBP arrangements we are proposing for the noted service providers include:

- **Pay for Quality:** An annual bonus program related to quality metrics for providers who do not immediately qualify for our other VBP agreements. The program rewards providers for achieving better performance on a broad spectrum of HEDIS and utilization metrics

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

for their Aetna enrollee panel. It can be used by primary care, specialty care, and hospital-based providers.

- Patient Centered Medical Home (PCMH): This program is a medical home model whose premise is that enrollees may have complex needs and require an integrated behavioral health/physical health home. PCMHs address the complex health needs of the entire community through a highly coordinated system of care, including comprehensive primary care, specialty care, acute care, behavioral health, and community services. Our local PCMHs are supported through a per-member-per-month payment model, and they deliver integrated care. Our agreements are collaborative and outline the expectations of both stakeholders so there is shared accountability for outcomes.
- Shared Savings: A program for practices serving a larger portion of our Medicaid enrollees that possess the skills and infrastructure necessary to manage the population (includes both upside and downside options to accommodate provider desire to assume increased risk and may be delivered in an ACO or a clinically integrated network environment). It may be used with primary care, specialty care, and hospital-based providers.
- Full Risk: A program that rewards providers for access, affordability, and quality of care in a gain-share, risk-share, or full-risk manner; we have a full- or partial-risk program in Florida already in place with several PCPs such as Community Medical Group in Region 11.

Because we recognize that not every provider has experience with value-based arrangements, we assess provider needs on an individual basis for successful transition to a value-based arrangement. We meet providers where they are along the VBP continuum, and we support their unique capabilities and readiness, which in turn has the effect of helping these practices become more adept at effectively and efficiently managing the care of our enrollees.

Under our current suite of value-based arrangement offerings:

- PCPs can participate in pay for quality, PCMH, shared savings, and in full-risk capitation.
- Specialty care providers can participate in pay for quality, PCMH, shared savings, bundled payments, and full-risk capitation.
- Hospital-based providers can participate in pay for quality, shared savings, bundled payments, or full-risk capitation arrangement.

We also collaborate with other like-minded organizations to increase capacity through all of the methods previously noted. Our monitoring plan, committee structures, and participation in stakeholder meetings are used as a means to evaluate the current population demographics and consider the projected population demographic needs in anticipation of cultural and health disparities. Additionally, we:

- Invite provider participation and input on our Enrollee Advisory Committees, Provider Advisory Committee, Long Term Care Advisory Committee, and Quality Management/Utilization Management Committee to determine network needs and areas for improvement.
- Invite participation and feedback in stakeholder meetings composed of health care professionals, advocates, and enrollees to discuss issues, including network adequacy, provider complaints, and recruitment priorities for growing the network.

## **EXHIBIT A-4-b**

### **MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Solicitate feedback on network composition, operations, and quality improvement initiatives to make sure we meet the cultural needs of the community and assess any areas of concern.
- Invite provider participation in a variety of educational forums and webinars to share ideas, questions and concerns; we continuously look for innovative ways to help providers become more successful and offer better access and more enrollee convenience.
- Collaborate with Beacon for behavioral health needs.

#### **Solutions if Unable to Meet Enrollee Needs**

If a contracted network provider is unable to provide services in the timeframe needed, we use a number of metrics and internal resources to determine if availability and/or access to timely care are problematic:

- Our care managers, responsible for managing the day-to-day care needs for complex enrollees, are the first point of contact for determining if services are needed. Care managers send provider referrals to the Network Development department when a participating provider is not immediately available to serve an enrollee's needs.
- Aetna's provider services and contracting teams conduct research and outreach to both contracted providers as well as non-participating providers to identify a provider who is able and willing to meet the unique services needed. We arrange for transportation as appropriate and needed. We work closely with the provider and enrollee to make sure services are delivered as planned and expected. Then, through our regular monitoring plan activities, we track and measure availability and access.

When we identify that a participating provider is not available to meet an enrollee's immediate needs, we develop a solution such as:

- Immediate solution: Authorize the use of the closest qualified non-participating provider able to provide the service and determine if the provider is willing to accept Medicaid reimbursement and qualifies for Medicaid payment; if needed, we also provide transportation.
- Short-term solution: Offer and enter into a negotiated single case agreement with the service provider to meet the enrollee's current and recurrent needs until the time when the service can be transitioned to a participating provider or the provider becomes contracted with our network
- Long-term solution: Recruit all willing and qualified providers offering a short-form complaint agreement or long-form participating agreement to expand availability and access for needed services within the specific geographic area indicated

#### **TIME BETWEEN AUTHORIZATION AND RECEIPT OF SERVICES**

**CRITERION 3:** The extent to which the respondent's plan includes strategies for measuring the time in between when services are authorized and when they are received

To specifically track the time between authorization and receipt of services, we are adding a new report to our suite of regular monitoring tools. This report will gather data from the prior

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authorization process combined with actual claims data to evaluate the timely delivery of services. We will track the actual baseline data to provide an average of time between authorization and service delivery to recognize any behavior that falls outside of the standards that will be identified. We are proactively measuring the experience time and not waiting for phone calls or complaints from enrollees or providers that typically happen after the fact. This report will be reviewed on a monthly basis by our provider services liaisons, contracting, and management to evaluate any non-compliance issues or specific training needs. Because this is a new report, we will assess the process of gathering this data to ensure it fits the State's goals and objectives.

### **Measuring Timely Access**

The network monitoring plan provides regular reporting to evaluate and measure access to timely care for urgent and routine care appointments for each of the specified provider types (i.e., pediatric physical therapists, speech language pathology services, occupational therapists, private duty nursing, intermittent skilled nursing (both pediatric and adult), early intervention services, and specialized therapeutic foster care services) by:

- Conducting telephone surveys of enrollees and providers to determine access to timely care on a monthly basis, including provider counts by region and reporting on average wait times for both urgent and routine appointments
- Monitoring complaints from enrollee or provider services on an ongoing basis
- Using our suite of tools and reports to monitor ongoing timely access for the specified provider types
- Conducting outreach to referring providers on the integrated care team, medical management, and community agencies to determine if there are any access to care issues including average wait time for urgent and routine appointments
- Conducting community outreach to referring agencies and organizations to identify any access issues, concerns or needs throughout the year

Participating physicians and other providers are contractually obligated through provider agreements to adhere to access and appointment standards and are required to provide services in the same manner as all non-Medicaid enrollees. Standards are communicated through the provider manual, newsletters, during site visits, and in training documents providing education on wait times and appointment standards as well as disability access, competency, and expertise; cultural needs; and hours of operation.

### **Ongoing Monitoring Tools**

Aetna's full suite of monitoring tools can proactively identify and improve access to care and wait times on an ongoing basis:

- Provide and review appointment availability surveys that monitor appointment availability, wait time in the office, and after-hours accessibility
- Review general feedback from routine operations from provider services liaisons, enrollee services staff, care management, utilization management, advisory committees,

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and anyone who serves as a touchpoint for enrollees or providers noting issues or concerns with appointment access or wait times

- Conduct telephone provider surveys about their appointments, after-hours access, and 24/7 availability
- Review enrollee concerns conducting follow-up and resolving issues related to access, appointment availability, and wait times
- Review enrollee complaints and feedback on a quarterly basis, trend enrollee grievances to identify any potential availability or accessibility issues, perform root cause analysis, and develop corrective action plans, if necessary
- Evaluate input from Enrollee Advisory Committee findings and enrollee survey results regarding access, appointment availability and wait times, non-participating prior authorizations, and out-of-network requests
- Review enrollee and provider satisfaction survey data to identify issues and concerns as well as opportunities for improvement
- Review enrollee performance indicators obtained from the online provider directory functionality
- Perform random sampling of providers to ensure they meet access and appointment availability standards
- Gauge Enrollee Advisory Committee input and provider participation on our QM/UM Committee for feedback on issues, concerns, additional network needs or opportunities for improvement

We present status and concerns on appointment availability survey results, trended complaint and survey data, and other findings from routine activities to the Service Improvement Committee (SIC) and the QM/UM Committee. These committees review recommendations, make suggestions, monitor status of corrective actions, and assist in prioritizing resources within the organization to achieve goals.

#### **UPDATING THE NETWORK DEVELOPMENT AND MANAGEMENT PLAN**

**CRITERION 4:** The extent to which the respondent's update of its network development and management plan is informed by multiple data sources (including complaints, grievances, etc.)

**CRITERION 5:** The extent to which the respondent's draft network development and management plan addresses the delegation of provider network functions to subcontractors and the oversight of these operations

Aetna successfully manages our networks to ensure high-quality, culturally diverse, credentialed, and physically accessible provider groups to increase access and choice. We consider numerous factors that affect adequacy, availability, and accessibility. These include network composition, geographic distribution, provider and enrollee travel distances, types and numbers of providers available, access to timely appointments, access to urgent and emergent care, access to culturally and linguistically competent services, and disability access. By periodically assessing the network and ongoing monitoring, we ensure consistency with the contract, CMS standards, and other regulatory requirements. We are also experienced with establishing multiple payment strategies that tie open panel status to value-based incentive payment structures.

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### Updating Network Plan Based on Multiple Data Sources

The monthly reports used in the assessment process on an ongoing and continuous monitoring process are received from multiple data sources including:

- GeoAccess reports: We review reports on a monthly basis to measure patient-centered medical homes (PCMHs), specialists, hospital, behavioral health, dental, and vision against the State geographical access standard requirement.
- Conduct provider surveys: We survey providers by telephone about their appointments and after-hours access including 24/7 availability.
- Review providers' panel status: We review open panel status to confirm where new enrollees can be assigned and identify providers who have reached their capacity or referral limits.
- Review provider-to-enrollee ratios: We review ratios by provider type and region to confirm availability of an adequate number of providers.
- Network sufficiency: We review utilization data for prevalent conditions, single case agreements, provider referral issues (availability of specialties), providers gained and lost report, and unplanned network exits report to confirm sufficiency of the type and number of providers.
- Address provider-related enrollee concerns: We address enrollee concerns by following up and resolving issues related to access, appointment availability, and wait times.
- Review enrollee complaints and feedback: We review quarterly analysis and trending of enrollee grievances to identify any potential availability or accessibility issues, perform root cause analysis, and develop corrective action plans, if necessary. We also receive input from Enrollee Advisory Committee findings, enrollee survey results that include questions regarding access, appointment availability and wait times, non-participating prior authorizations, and out-of-network requests.
- Address emergency department overuse: We monitor and identify enrollees using the emergency room for non-emergent conditions who may benefit from care management and education on alternative urgent care and after-hours practice options.
- Compliance with practice guidelines: We measure and monitor providers to confirm they are within the scope of their license and following the plan's policies and procedures, including practice guidelines, and create provider utilization profiles and input from medical management identify practices struggling or not compliant.
- Conduct provider directory audits: We conduct monthly audits to confirm accuracy of provider listings and make weekly updates to online provider directories to reflect changes in demographics and panel status.
- Conduct provider network reviews: We review provider network and recruitment activities monthly.
- Conduct network panel studies with stakeholders: We conduct network access and availability studies for hospitals, primary, obstetrics/gynecology (pre- and postnatal care), high-volume specialty, emergent, urgent, and home health care, dental, and behavioral health.
- Interdisciplinary team collaboration: Aetna's Medical Management, Network Contracting, Provider Services, Enrollee Services, and Quality departments review and collaborate monthly to identify access or capacity concerns and address special needs such as vendors who specialize in complex pediatric home care, autism, and/or specialized needs.

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- Time between authorization and receipt of service (new): This report will track the time between authorization and receipt of services. We will gather data from the prior authorization process combined with actual claims data to evaluate the timely delivery of services. We will track the actual baseline data to provide an average of time between authorization and service delivery to recognize any behavior that falls outside of the standards that will be identified. This report will be reviewed on a monthly basis by our provider services liaisons, contracting, and management to evaluate any non-compliance issues or specific training needs. Because this is a new report, we will assess the process of gathering this data to ensure it fits the State's goals and objectives.
- Collaboration with Beacon for behavioral health network development plan

As an integral part of our annual network monitoring plan and QM/UM Committee meeting process, we evaluate the current population demographics and consider the projected population demographic needs in anticipation of cultural and health disparities. To gather feedback on network needs or opportunities for improvement, we invite provider participation and input on our Enrollee Advisory Committees, Provider Advisory Committee, LTC Advisory Committee, and QM/UM Committee. We also invite participation and feedback in stakeholder meetings composed of health care professionals, advocates, enrollees to discuss issues, including network adequacy, provider complaints, and recruitment priorities for growing the network. We obtain feedback on network composition, operations, and quality improvement initiatives to help ensure we meet the cultural needs of the community and assess any areas of concern. We also invite provider participation in a variety of educational forums and webinars to share ideas, questions and concerns. We constantly seek innovative ways to help providers become more successful by offering better access and more enrollee convenience.

The local network team is crucial in identifying needs to expand the network to ensure timely access for enrollees. As they receive referrals from the integrated care team/medical management and other community agencies and organizations, they determine if additional recruitment efforts are needed. If so, they begin to conduct outreach to providers in that area or specialty to mitigate any potential gaps in care. Enrollee and provider referrals also trigger recruitment activity. Additionally, the quarterly and annual monitoring plan review will trigger recruitment action as we review GeoAccess reports. We also evaluate the projected population needs against the current contracted provider network to identify any opportunities to recruit services and providers. Aetna maintains a recruitment database to help us track who is being recruited and show our progress in obtaining signed agreements and applications. We offer providers an opportunity to sign an electronic contract using the Adobe e-sign capability to make it as convenient as possible for a provider to return and sign their document, increasing turnaround time from days to hours to receive a signed agreement.

### **Delegation Oversight of Subcontractors**

Aetna's commitment to providing the best and most comprehensive health care for our enrollees may involve delegating certain services or functions to other organizations including physical, occupational, and speech therapy, behavioral health, and pharmacy services. For these entities, like Beacon, we enter into a formal agreement assigning delegated organizations or entities the authority to perform certain functions or services on Aetna's behalf. This may include credentialing, utilization management, claims payment or other applicable functions. Although

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we may delegate the authority to perform a particular function or service, we retain the overall responsibility for the services or function to be performed appropriately.

Aetna's delegation oversight program is comprised of three primary phases:

- General oversight for HIPAA, security, etc.
- Credentialing and re-credentialing; through the delegation oversight committee
- Operations oversight for overseeing day-to-day functions
- Network monitoring and reporting to verify compliance with all standards and requirements

Aetna evaluates the ability of potential delegates and monitors the delegated organizations for confirmation of care and/or service. Decisions made on the Aetna's behalf are also monitored for consistency throughout the network. Prior to implementing any delegation agreement, a systematic review of the potential delegated entity is conducted to verify the delegate's capacity to perform the delegated functions, and the organization's activities/files comply with Aetna and Florida's requirements. These reviews are conducted by individuals with expertise in the area being delegated.

Ongoing monitoring is performed as follows:

- Monitoring and evaluating delegated functions through regular reports, at least semi-annually
- Confirming (on an annual basis) that delegated functions/services are carried out consistently and in compliance with Aetna's and applicable standards, and the mutually agreed upon delegation agreement
- Performing an annual file review audit, if applicable, to confirm compliance with Aetna and applicable standards.
- Monitoring ongoing corrective actions taken to address identified deficiencies to promote progress, and take necessary action if improvements do not occur
- Reviewing the delegated organization's program that oversees the delegated function(s), and its quality program to verify it has appropriate quality improvement processes

The chief medical officer or a designated medical director is responsible for overseeing delegated medical management functions. The Quality Management, Provider Services, 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 enrollees' protected health information, as applicable. Should deficiencies be identified, Aetna will work with the delegated organization to set priorities and develop a corrective action plan. We retain the right to revoke the delegation agreement if serious problems are not corrected.

Delegation oversight activities are formally monitored as a component of the Quality Assessment and Performance Improvement (QAPI) program. Audit reports of delegated activities and corrective action plans, if applicable, are submitted to the appropriate oversight committee (e.g., QM/UM Committee, Delegation Subcommittee, Credentialing and Performance Review Committee) for review and approval and then to the Quality Management Oversight Committee.

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We regularly meet with our subcontractors to review network availability and access metrics for the specific provider types. If deficiencies or potential gaps are identified, we ask the subcontractor to recruit additional providers based on our network monitoring plan to mitigate any issues. If our care managers or population health specialists identify a need for additional pediatric therapists, we work with the specific vendor to add more capacity for those enrollees.

[REDACTED]

[REDACTED]

**Evaluation Criteria:**

1. The adequacy of the respondent's methodology for identifying and resolving barriers and network gaps; including ongoing activities or network development based on region-specific identified gaps and future needs projection.
2. The adequacy of the respondent's plan to meet the needs of enrollees if it is unable to provide the service within its provider network; including immediate, short-term and long-term interventions.
3. The extent to which the respondent's plan includes strategies for measuring the time in-between when services are authorized and when they are received.
4. The extent to which the respondent's update of its network development and management plan is informed by multiple data sources (including complaints, grievances, etc.).

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5. The extent to which the respondent's draft network development and management plan addresses the delegation of provider network functions to subcontractors and the oversight of these operations.

**Score:** This section is worth a maximum of 25 raw points with each of the above components being worth a maximum of 5 points each.

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**2017 "DRAFT" Network Development Management Plan**  
**Trade secret as defined in Section 812.081, Florida Statutes**

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**D. PROVIDER EXPERIENCE**

**MMA SRC# 12 – Provider Credentialing (Statewide):**

The respondent shall describe its proposed process to credential and recredential providers (including subcontractors' processes, if applicable), including credentialing timeframes, internal continuous quality improvement initiatives for recredentialing, transparency for providers on their application status and the steps the respondent or its subcontractors will take to ensure the respondent and the Agency have accurate provider demographic information in-between credentialing cycles.

**Response:**

Aetna's proven and rigorous credentialing and recredentialing process timeframes are more aggressive than the State's standard of 120 days. Aetna's credentialing turnaround time is 23.6 days for Florida from the date of the receipt of a completed application, through committee decision with a maximum of 45 days, far exceeding the industry standard and State requirement and is conducted in combination with both our local and national teams. Our processes adhere to State standards, as well as National Committee for Quality Assurance (NCQA) credentialing standards with policies and procedures that reflect all NCQA-established requirements. Additionally, our Credentialing unit is NCQA-certified. Aetna uses the Council for Affordable Quality Healthcare (CAQH) Universal Credentialing Data Source with our goal to provide an easy and convenient process for providers, while exceeding the State's requirements. Aetna's Credentialing Verification Organization (CVO) is also URAC-accredited.

For recredentialing, we proactively contact providers well ahead of the required deadlines, sending forms and instructions and reinforcing the timeframes to ensure the recredentialing process is completed well in advance of any deadlines—all the while, making it as seamless as possible for providers and mitigating any potential disruption to enrollees.

Aetna's commitment to quality processes begins with our senior leadership. In 2003, Dr. John Rowe, former chairman and chief executive officer (CEO) of Aetna Inc. was elected as the first chairman of the CAQH. Its mission is to make health care more affordable, share knowledge to improve quality of care, and make administration easier for providers nationwide. Dr. Rowe was instrumental in helping to install 27 member coalitions to CAQH, expanding its reach and commitment to quality throughout the health care industry. His efforts were formed by the belief that collaboration can lead to health care solutions not otherwise possible, including advancing CAQH efforts to streamline the business of health care for physicians and to identify new ways the industry can come together to help improve the system. To this end, Dr. Rowe was instrumental in advocating a universal standard credentialing form, which is still in use today across the industry. Dr. Rowe's extensive career also included serving as president and CEO of Mount Sinai New York University Health, one of the nation's largest academic health care organizations, as well as a widely recognized expert in gerontology, serving as Professor of Medicine and founding director of the Division on Aging at Harvard Medical School. He also authored over 200 scientific publications, most on the physiology of the aging process and a leading textbook on geriatric medicine.

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As a nationally recognized leader in the health care industry, Dr. Rowe was a firm believer in the positive role the industry could play to improve the health care system. Aetna's leaders following his example to continue to look for innovative solutions and ideas to move the industry forward to create better health outcomes, reduce costs, and administrative burdens for providers. Aetna was also at the forefront of innovation related to disparities in health care, one of the founding pillars of CAQH. Because we are one of the forward thinking leading health plans in credentialing processes, our leaders, management, and operational experts (including our credentialing team) are sought out to provide consultation and assistance to develop processes, look for innovative solutions and strategies, and continually look for ways to improve the future of health care delivery.

### **CREDENTIALING AND RECREDENTIALING PROVIDERS**

**CRITERION 1:** The adequacy of the respondent's description of its credentialing and Recredentialing criteria, certified credential verification organization processes, and utilization of a third party credentialing vendor

In 30 years of managing Medicaid networks across the country, Aetna has developed proven processes and procedures to help ensure we comply with all State and Centers for Medicare & Medicaid Services (CMS) requirements for credentialing and recredentialing providers. Our processes ensure we meet all standards for licensing and certification. Aetna maintains a network that is credentialed and re-credentialed and consistent with the accrediting bodies of NCQA, CMS, and Utilization Review Accreditation Committee (URAC), as well as State and federal requirements.

Aetna distinguishes itself from the competition through our robust turnaround times, team dedicated to non-traditional providers to expedite and streamline the credentialing process, expedited workflow for emergency situations (e.g., recent hurricanes and storms), and a commitment to dedicate staff/resources to process applications for much needed providers in specialty areas and regions to make sure we meet health care needs.

Aetna's NCQA-certified credentialing verification organization (CVO) turnaround time is on average 23.6 days for Florida from the date of the receipt of a completed application, through committee decision with a maximum of 45 days, far exceeding the industry standard and State requirement of 120 days. As a member of CAQH, Aetna uses CAQH ProView to obtain the necessary information to begin the primary source verification process. Aetna also adheres to NCQA credentialing standards with policies and procedures that reflect all NCQA-established requirements. Our process supports superior quality standards through extensive practitioner data collection, business criteria assessment, and primary source verification.

### **CREDENTIALING PROVIDERS**

For individual practitioners, we consider the following factors in our credentialing process and secure primary source verification as required, including:

- Licensure and/or certification that is verified through State licensing boards in geographical areas where network practitioners care for our enrollees
- Board certifications (when applicable)

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- Loss of/limitation of hospital admitting privileges (when applicable)
- Current professional liability coverage
- Drug Enforcement Agency (DEA) and State-controlled drug substance registration, when applicable, through verification by the U.S. Department of Commerce National Technical Information Service (when applicable)
- Disciplinary history or adverse actions related to licensure and Drug Enforcement Administration (DEA) registration queried through State licensing boards and the National Practitioner Databank (NPDB)
- Malpractice insurance claim history to examine any possible trends and look for evidence that might suggest any probable substandard professional performance in the future
- Mental and physical health to determine if the practitioner's history might suggest any probable substandard professional performance in the future
- Participation in government programs such as Medicare or Medicaid
- Professional education and training through verification by the American Medical Association (AMA) Masterfile, American Osteopathic Association (AOA) and specialty board or specific residency/training program (highest level of education, depending on practitioner type)
- Work history

In addition to the review of conduct and competency requirements previously noted, Aetna's review determines that the following contract requirements are met or the medical director or designee approves exceptions, as needed, to allow for appropriate network configuration:

- Board certification: Medical doctors/doctors of osteopathy (MD/DOs) must have current, in-force medical board certification using American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), Aetna recognized American Chiropractic Association (ACA Chiropractic Specialty Boards, Podiatric Specialty Boards, The Chiropractic Information Network/Board Action Databank (CIN-BAD), and the American Dental Association and as recognized by Aetna.
- Malpractice insurance: Limits meet Aetna requirements and the Sovereign Immunity Act 768.28 of the Florida Statute.
- Access and availability: Practitioners have office hours and wait times that meet Aetna and Florida contract standards.
- DEA certification and Controlled Drug Substance (CDS): As applicable, practitioners, as required, can appropriately prescribe medications.
- Participating hospital privileges: Practitioners, as required, must have active hospital privileges at an Aetna participating hospital.

Aetna's Credentialing and Performance Committee has the authority to make final determinations for those individual practitioners being considered for exceptions to Aetna's established requirements for professional competence and conduct as evidenced by Aetna's National Quality Management Policy 51 guidelines for provider types and requirements. Non-individual organization provider types (i.e., hospitals, facilities, and organizations) are reviewed to determine if they meet Aetna's policy requirements, including, but not limited to, the following:

- They are in good standing with State and federal regulatory bodies.

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- They are accredited by an Aetna-recognized accrediting entity for their various provider types.
- CMS/State survey or on-site quality assessment conducted if the provider is not accredited.

### **RECREREDENTIALING PROVIDERS**

Individual practitioners and non-individual providers, when applicable, are re-credentialed within 90 days using Aetna's standard credentialing process every three years. In between formal credentialing cycles, Aetna monitors the following as part of the ongoing quality review:

- For individual practitioners:
  - State board sanctions
  - Loss of license
  - Office of Personnel Management/Office of Inspector General reports
  - Medicare opt-out
  - Enrollee complaints that are tracked and monitored through our provider services' monitoring, grievance and appeals process, as well as received through our quality processes
  - Internally identified potential quality-of-care concerns tracked through Aetna's extensive monitoring and quality management tools and processes
- For non-individual providers:
  - Office of Personnel Management/Office of Inspector General reports
  - Internally identified potential quality of care concerns

We help to ensure that all network providers are screened against State and federal exclusion registries, and we comply with all contract requirements. During recredentialing, we review reports from the Department of Health and Human Services, recipient pre-appeals, complaints and appeals, utilization review outliers, claims history, internally identified potential quality-of care concerns, and identified non-standard procedures performed by Aetna's Medicaid Quality department.

### **STREAMLINED PROVIDER PROCESS**

**CRITERION 5:** The extent to which the respondent and its subcontractors incorporate the Agency's streamlined credentialing capability (via promotion of limited enrollment) in its credentialing and recredentialing processes

Aetna's thorough credentialing processes were developed to meet NCQA and state-specific requirements. Our CVO follows these guidelines to ensure our provider networks throughout the country meet the highest quality standards and the applicable primary source verification requirements to ensure we meet NCQA requirements. We will follow this same process for both limited and fully enrolled providers to ensure the Florida plan will meet all NCQA requirements; however, this will not affect any turnaround timeframes.

We encourage providers during the contracting outreach to initiate their limited-enrollment approval from the State while we begin the credentialing process for the managed care organization (MCO) to expedite the process. Our maximum standard timeframes to credential and re-credential providers is 45 days and currently exceeds the State requirements of 120

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days. On average, a new provider can be credentialed in approximately 23.6 with shorter timeframes for large groups and facilities/organizations. Our subcontractors will also follow their standard processes as outlined in the section that follows:

The process for Limited or Fully Enrolled providers will be the same as for any provider:

- The health plan submits a request to the CVO for credentialing the provider.
- The provider is added to the roster and loaded to CAQH for outreach to the provider to complete an application. The CAQH functions as a data warehouse for all data elements and information. For instance, many of these types of providers may not have an existing Medicaid ID number, but we initiate the credentialing process with final approval once a Medicaid ID number is received; however, this will not delay the credentialing process.
- When the application is completed, we download the information and begin the credentialing process that includes primary source verification of all required elements except for background screening which is performed as required at the State level.

As with all providers who undergo our credentialing process, we ensure timely and accurate credentialing processes to meet all requirements, while remaining responsive to provider concerns and questions.

To help ensure we meet the needs of our enrollees further, we are committed to providing timely access to the right provider in the right setting and at the right time. To do this, we provide the resources and staff (including committing to any overtime needed) to process applications for heavily needed providers or in sparse geographic areas to get providers into the network and accessible to our enrollees. We also proactively conduct outreach to help ensure we receive provider applications and keep the process moving. We remain sensitive to both enrollee and provider needs to meet this commitment, and we are flexible to work with providers and the health plan to meet their needs.

In emergencies, we understand that enrollees may need to see providers that might not be in our existing network, so we created a workflow to do what we can to make this happen. For instance, during Hurricane Katrina in Louisiana, because of the devastating flooding, it took the medical board in Louisiana a while to get up and running. We worked with providers to bring them onboard and handled some of the verification process after the fact to mitigate any disruption to needed medical care during this emergency. We were prepared to implement similar workflow processes during Hurricane Irma and other emergencies that arise.

### **CREDENTIALING PROCESS FOR DELEGATED SUBCONTRACTORS**

Aetna's commitment to providing the best and most comprehensive health care for our enrollees may involve delegating certain services or functions to other organizations, including other providers that may include but are not limited to:

- Ambient Healthcare for home infusion and injectable services
- American Therapy Administrators for outpatient rehabilitation
- Beacon Health Options for behavioral health services

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- Caring Associates, Inc. for home health care services
- eviCore for pain management services
- HearX for hearing evaluations and aides
- iCare for ophthalmology and optometry services
- iCore for home office drugs, drug replacement
- MCNA for dental services
- National Imaging Associates, Inc. for radiology services
- New Century Health for chemotherapy medication regimens
- South Florida Musculoskeletal Care for outpatient rehabilitation services
- SurfMed for durable medical equipment, power mobility devices
- United Health Systems for sleep studies

In this event, we enter into a formal agreement assigning delegated organizations or entities the authority to perform certain functions or services, on Aetna's behalf. Although we may delegate the authority to perform a particular function or service, we retain the overall responsibility for the services or function to be performed appropriately.

Aetna evaluates and monitors the ability of potential delegates and delegated organizations for confirmation of care and/or service. Decisions made on Aetna's behalf are also monitored for consistency throughout the network.

Before implementing any delegation agreement, a systematic review of the potential delegated entity is conducted to verify the delegate's capacity to perform the delegated functions and the organization's activities/files comply with Aetna's and Florida's requirements. These reviews are conducted by individuals with expertise in the area being delegated.

Monitoring is performed as follows:

- Monitoring and evaluating delegated functions through regular reports semi-annually
- Conducting pre-assessments prior to delegation; annual desk audits or Web conference reviews conducted with a random sampling of files thereafter
- Confirming (on an annual basis) 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 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

The chief medical officer or a designated medical director is responsible for overseeing delegated medical management functions. The Quality Management, Provider Services, 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 enrollees' protected health information, as applicable.

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Should deficiencies be identified, Aetna works with the delegated organization to set priorities and develop a corrective action plan. We retain the right to revoke the delegation agreement for non-compliance or if corrective action plans (CAPs) are not sustained.

Delegation oversight activities are formally monitored as a component of the Quality Assessment and Performance Improvement (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 Committee, Delegation Subcommittee, National Vendor Delegate Oversight Committee) for review and approval and then to the Quality Management Oversight Committee (QMOC).

### **TIMEFRAMES**

**CRITERION 2:** The extent to which the respondent's timeframes for processing credentialing applications is more expeditious than the industry standard processing timeline of one hundred twenty (120) days

All network providers undergo a rigorous credentialing and recredentialing process. Once a completed credentialing packet is received, Aetna's NCQA-certified credentialing verification organization (CVO) maximum turnaround time is approximately 45 days from the date of the receipt of a completed application, through committee decision, far exceeding the industry standard and State requirement of 120 days. Our state standards are typically less, such as an average of 23.6-day turnaround time in Florida. As a member of the CAQH, Aetna uses CAQH ProView to obtain the necessary information to begin the primary source verification process. Aetna also adheres to NCQA credentialing standards with policies and procedures that reflect all NCQA-established requirements. Our process supports superior quality standards through extensive practitioner data collection, business criteria assessment, and primary source verification.

Timeframes for credentialing and recredentialing are as follows:

- For individual providers, credentialing is completed within 23.6 days of the receipt of a completed application through committee review and decision in Florida.
- For non-individual credentialing, including facilities and organizations, credentialing is completed within 18 days of the receipt of a completed questionnaire. This expedited process allows us to credential hospitals and organizations as soon as possible to ensure enrollee access and no disruption of services.
- For large groups, Aetna provides an escalation process prioritizing the credentialing and/or recredentialing process for these providers. Because these applications are received in one group, it also allows us to reduce the turnaround time. Typically, we are able to process these large groups in 20 days or less, far exceeding the State and NCQA requirements.
- Recredentialing providers is completed within 90 days of the receipt of a completed application. To ensure timely completion, our team sends out the recredentialing application well in advance of the deadline. We also monitor these providers to ensure applications are received. If not, we send out reminders, make phone calls, and send

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emails to encourage their timely completion of the application to mitigate any potential disruption for our enrollees.

### **CONTINUOUS QUALITY IMPROVEMENT INITIATIVES**

**CRITERION 4:** The extent to which the respondent uses information from provider complaints, monitoring, and recommendations from its Quality Improvement Committee in its Recredentialing process

Aetna remains committed to continuous quality improvement to improve health outcomes for all of our enrollees. Our proven results are evident in consistently high NCQA status ratings, as well as across our quality, medical management, and health-equity programs. Recently, Aetna was ranked the top NCQA Florida Medicaid plan for the second consecutive year. In addition, we are also ranked among the top 15 Medicaid plans in the United States, an accomplishment of which we are very proud.

NCQA accreditation demonstrates a commitment to quality, outstanding clinical performance, and consumer experience. In Florida, Aetna has achieved an NCQA accreditation level of Commendable for a full three years—awarded to those organizations with well-established programs for service and clinical quality that meet rigorous requirements for consumer protection and quality improvement. This demonstrates our in-depth understanding of quality, both in terms of the enrollee experience, and clinical and operational excellence.

As part of Aetna's contracting and credentialing process, we screen, enroll, and revalidate all network providers in compliance with all State and CMS requirements to meet all licensing and certification standards, including those for psychiatric residential treatment facilities. All network providers also undergo a rigorous credentialing and recredentialing process using the State's application form and collaborating with the CAQH to collect provider credentials through the CAQH universal application and use the CAQH Universal Credentialing Data Source. Aetna adheres to NCQA credentialing standards with policies and procedures that reflect all NCQA-established requirements and our CVO is NCQA-certified. Aetna is also URAC accredited.

Our process supports superior quality standards through extensive practitioner data collection, business criteria assessment, and primary source verification. We monitor for State board sanctions, loss of license, and Office of Inspector General reporting as they are published by the organization providing the list, as each organization has a different timeframe for publication. We help ensure all network providers are screened against State and federal exclusion registries, and we comply with all criminal background checks and fingerprint requirements. During recredentialing, we review reports from the Department of Health and Human Services, recipient pre-appeals, complaints and appeals, utilization review outliers, claims history, internally identified potential quality-of-care concerns, and identified non-standard procedures.

Aetna credentials and re-credentials institutional providers prior to contracting and every three years thereafter (except where laws or regulations that require more frequency). We confirm 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 enrollees. We ensure providers are appropriately licensed by the State, have a National Provider Identification (NPI) number, Medicaid number (if

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available), and appropriate ongoing certification and training, as required and agreed upon by their contract. All applicants must be contracted under a facility agreement and satisfy applicable Aetna assessment standards.

Once the primary source verification process is completed, the application goes to Aetna's Credentialing and Performance Committee, which informs the health plan of the results of the credentialing process. This committee is chaired by an Aetna regional medical director, and it includes representatives from a range of providers in specialties that include primary care and high-volume specialists as well as other specialty providers as necessary for peer review. The committee is responsible for conducting professional review activities involving the providers whose professional competence or conduct adversely affects, or could adversely affect the health or welfare of enrollees.

Aetna conducts ongoing monitoring of sanctions for credentialed providers and the health plan conducts ongoing monitoring of quality of care. The health plan's Provider Services department and Aetna's Credentialing and Performance Committee share information, whenever it is received, concerning sanctions of providers by licensing bodies. Both at the corporate and plan levels, we review the Office of the Inspector General's List of Excluded Individuals/Entities, and terminate any providers who are no longer qualified to perform Medicaid services.

As part of our ongoing quality improvement processes, Aetna's Provider Advisory Committee solicits feedback on our credentialing and recredentialing 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.

The Aetna organization is currently working in partnership with several states using an innovative strategy to assist providers by using the same Credentialing Verification Organization (CVO) as a single source provider credentialing solution. Our Florida leadership team has shown an interest in extending this capability into their market to support their Medicaid operations. A single source CVO will:

- Streamlines processes
- Reduce the administrative burden and overhead costs for providers
- Offer practitioners the convenience of having one credentialing/recredentialing date
- Frees up providers to spend their time and focus on seeing and assisting their patients

Aetna has also developed a solution to streamline credentialing for atypical or non-traditional provider types. We have a dedicated department in our Medicaid division that credentials all atypical (non-medical) provider types. Because of their dedicated focus, they are able to credential these provider types within approximately 10 business days.

### **TRANSPARENCY**

**CRITERION 3:** The adequacy of the respondent's approach to providing transparency to providers throughout the credentialing and recredentialing processes, including how providers will be informed at each step of the application process

We are always available to answer any inquiries or concerns about a provider's credentialing

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

status. Provider Services serves as a single point-of-contact to answer any questions a practitioner may have about their application and can provide real-time updates on its status. Practitioners can also call the Florida customer service or Provider Services line or Credentialing department if they prefer to inquire about the status of their application and receive an update in real-time.

Typically, the Aetna's Credentialing department sends reports to the health plan to keep them up-to-date on the status of all credentialing applications. The provider services team uses these reports to update practitioners on the status of their application.

As part of their normal communication process, the credentialing team sends an acknowledgement of the receipt of the request for participation in the network by fax when the provider's request for credentialing is received from the Florida plan. If an application is deemed incomplete, the credentialing team makes three attempts (within a 15 business day timeframe, allowing 5 business days between requests) to contact the practitioner to advise him or her of the missing data element(s). Once the provider completes the peer review stage and is accepted, a notification of the acceptance is sent to the provider.

### **STEPS TO ENSURE ACCURATE INFORMATION**

**CRITERION 6:** The extent to which the respondent outlines steps the respondent and its subcontractors will take to ensure provider demographic or participation status changes are reported to the plan in-between credentialing cycles

Aetna follows standardized policies and procedures to update provider listings, rosters, and directories based on the contract requirements of the plan, and we have several methods to validate and update provider information on an ongoing basis. Approximately 70% of our provider updates are received through rosters with the additional 30% collected by various means such as phone calls, email, Web portal, on-site visits, logs, subcontractor update files, and any other interaction we have with providers.

We request current provider rosters quarterly as required by CMS (or monthly with value-based payment partners), and we load them in compliance with State law and standards. Large groups send monthly rosters to the plan to notify us of any demographic information updates, and these changes are uploaded to the system. Aetna conducts monthly reviews of an active provider report that lists any provider who does not have any Aetna enrollees to determine if they want to remain in the network; if not, we remove him or her from the directory.

### **ACCESS GAP LOGS**

Using our access gap log, we monitor provider issues and any access issues are logged and reviewed. We monitor the log to review any patterns or trends that may be occurring and to identify any areas of concern. We also audit our provider logs and database to verify the accuracy of directory information through our routine monitoring processes on a monthly basis.

### **DELEGATED SUBCONTRACTOR FILE UPDATES**

All of our delegated subcontractors provide weekly files with updates, revisions, deletions and

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

changes to the provider rosters that we upload to our system and add to our provider directory. The Provider Services department conducts periodic reviews of provider data of all providers (including subcontractors) to verify accuracy of the information provided.

### **ONSITE VISITS AND ROUTINE COMMUNICATION**

We also confirm the accuracy of our provider listings and directories during regular on-site visits and through routine communication with providers making note of any changes. During provider services liaison site visits, our standard process also includes the discussion of provider panels; and we request updates on a monthly basis or more often as needed. By reviewing open panel status to confirm where new enrollees can be assigned, we identify providers who have reached their capacity or referral limits so that our directories indicate which practitioners are accepting new patients. When a provider notifies the plan of any demographic changes (by letter or phone call), Provider Services staff takes the information and verifies it to be accurate, and then makes the necessary changes in the system. If an enrollee calls and advises us of an incorrect phone number or address, Provider Services staff contacts the provider, asks for the correct information in writing, and then updates the system accordingly. Once the information is updated in the system, the online directory is updated nightly so that the new information can be readily accessed. In addition, through regular provider communications (fax blast or the mailing of printed materials), any returned items are immediately addressed and updates are made in the system.

### **PHONE CALLS/CALL TRENDING**

Enrollee Services staff monitors phone calls for trend reporting and enrollee concerns about inaccuracies in the provider directory. Upon discovering a discrepancy, we take immediate action to correct it and help enrollees find a replacement provider.

### **NETWORK ACCESS AND AVAILABILITY STUDIES**

We conduct network access and availability studies for hospitals, providers of obstetrics/gynecology (pre- and postnatal care), high-volume specialty, emergent, urgent, home health, dental, and behavioral health services and make note of any status changes we need to update in provider listings. We also conduct audits to confirm that providers have either an after-hours service or offer a message directing callers to an emergency room or other options such as an urgent care center or other providers based on plan-specific information, as appropriate.

### **STREAMLINING PROCESS FOR INFORMATION ACCURACY**

Aetna has engaged Availity as an aggregator of provider data in Florida to improve and streamline our data collection processes, and to reduce the administrative burden of our providers. Through Availity's provider data management, our providers will have an easy, one-stop-shop to update, validate, and attest to the accuracy of their demographic information. This will not only expedite our verification process, but also improve the accuracy of the data we provide to enrollees, providers, and the State.

### **AVAILABILITY OF ACCURATE DIRECTORY LISTINGS**

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

To ensure the most accurate directory listings are readily available (by either print or online through the Web portal), we apply continuous process improvement strategies. Nightly updates to provider information are made in the system, pushed to the online directory, and published to the website. Aetna meets the requirement to provide Web content using accessibility guideline-compliant, machine-readable formats. Aetna currently exceeds the contractual requirements to submit updates to the hard copy provider directory no later than 30 business days after receipt of the updated provider information. A copy of the hard copy directory can be downloaded from the portal at any time.

Aetna's provider directories contain the following information, at a minimum: provider name, group affiliation (if applicable), type (e.g., physician, specialist, hospital, pharmacy), street address, telephone numbers, web address (as appropriate), specialty, gender, and whether the provider is accepting new enrollees. Additionally, the directory includes the provider's cultural and linguistic capabilities (languages spoken by provider or skilled medical interpreters at the practitioner's office), whether the provider has completed cultural competence training, whether Spanish language or other staff are available, and accessibility for persons with disabilities.

### **Evaluation Criteria:**

1. The adequacy of the respondent's description of its credentialing and recredentialing criteria, certified credential verification organization processes, and utilization of a third party credentialing vendor.
2. The extent to which the respondent's timeframes for processing credentialing applications is more expeditious than the industry standard processing timeline of one hundred twenty (120) days.
3. The adequacy of the respondent's approach to providing transparency to providers throughout the credentialing and recredentialing processes, including how providers will be informed at each step of the application process.
4. The extent to which the respondent uses information from provider complaints, monitoring, and recommendations from its Quality Improvement Committee in its recredentialing process.
5. The extent to which the respondent and its subcontractors incorporate the Agency's streamlined credentialing capability (via promotion of limited enrollment) in its credentialing and recredentialing processes.
6. The extent to which the respondent outlines steps the respondent and its subcontractors will take to ensure provider demographic or participation status changes are reported to the plan in-between credentialing cycles.

**Score:** This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

**EXHIBIT A-4-b**  
**MMA SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**MMA SRC# 13 – Value Based Purchasing (Regional):**

- a. The respondent shall describe the continuum of value-based purchasing (VBP) contractual arrangements available for providers, delineated by primary care, specialty care and hospital-based care.
- b. The respondent shall describe the volume of contracts it expects to implement or maintain through a VBP arrangement each year for each of the next five (5) Contract years, delineated by primary care, specialty care and hospital-based care.
- c. The respondent shall include specific outcomes it expects to see throughout the life cycle of the VBP continuum, delineated by primary care, specialty care and hospital-based care.
- d. The respondent shall describe specific VBP arrangements it intends to implement and/or maintain in an effort to promote the Agency's goals, delineated by primary care, specialty care and hospital-based care.

**Response:**

Physicians play a pivotal role in improving quality, reducing costs and potentially preventable events (PPEs), and ensuring efficient and effective use of health care resources. Aetna will help providers achieve these goals by developing financial models that awards physicians for quality and appropriate service utilization.

Aetna was an early adopter and leader in value-based purchasing (VBP), and Aetna Chief Executive Officer Mark Bertolini said, "Value-based contracting now represents approximately 50% of Aetna's spend with a goal to achieve 75% by the end of 2020."

The transition of health care payment from volume to value is a foundation for changing behavior, engagement, and outcomes at the provider, enrollee, and health plan levels. No one entity can accomplish these goals alone—it requires a solid relationship built upon trust and transparency and supported by data, reporting, and connectivity between all parties with the goal of achieving the State's mission.

With a record of executing successful VBP arrangements across the country—including over 500 VBP arrangements, and one million enrollees enrolled in some type of VBP arrangement Aetna is changing the behaviors of enrollees and providers. In 2012, we expanded our VBP programs into our Medicaid product lines with the development of Aetna Better Value, which offers providers an array of alternative payment methodologies designed to help ensure participation of large or small, traditional or non-traditional providers. From full-risk capitation to VBP arrangements with patient-centered medical homes (PCMHs) to shared risk and incentive payments, we work toward having the majority of our network providers in contracts that improve quality, reduce costs, and increase patient satisfaction and engagement.

To increase the number of VBP contract arrangements statewide for the Aetna Medicaid organization, Aetna Better Value will leverage relationships with a broad spectrum of eligible and willing providers who participate in VBP arrangements with our Aetna Medicare and

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

commercial lines of business. Aetna Better Value's VBP director will reside in the State of Florida and will foster the development of and monitor VBP relationships with providers.

### **CONTINUUM OF VBP CONTRACTUAL ARRANGEMENTS AVAILABLE**

**CRITERION 1:** The extent to which the respondent has provided the continuum of value-based purchasing arrangements available to network providers, delineated by primary care, specialty care and hospital-based care

Aetna Better Value's VBP participants have individually designed agreements that align financial incentives with improved quality, cost, utilization, and outcomes through shared financial accountability between the health plan and the provider. Our VBP incentive model not only includes primary care, specialty care, and hospital-based care, but also expands into other treatment venues, such as:

- Community mental health centers
- Federally qualified health centers (FQHCs)
- Rural health centers (RHCs)
- Non-traditional providers (i.e., housing, home health)

While Aetna VBP models may vary as to the degree of financial risk assumed, each of the models include quality and outcome metrics that are directly tied to provider payment. These metrics are customized to primary care, specialty care, and hospital-based services. It is important to us as members of local communities to approach VBP relationships collaboratively to maximize program participation. We do this by utilizing the following continuum of VBP arrangements, from least involvement of risk to most:

- **Pay for Quality:** An annual bonus program related to quality metrics for providers who do not immediately qualify for our other VBP agreements, this program rewards providers for achieving better performance on a broad spectrum of Healthcare Effectiveness Data and Information Set (HEDIS) and utilization metrics for their Aetna enrollee panel. It can be used by primary care (including FQHCs/RHCs), specialty care, and hospital-based providers. Primary care providers (PCPs) with smaller numbers of assigned enrollees may also participate in this program.
- **PCMH:** This program is a medical home model for enrollees with complex needs or requiring an integrated behavioral health/physical health home. PCMHs help address the complex health needs of the entire community through a highly coordinated system of care that includes comprehensive primary care, specialty care, acute care, behavioral health integration, and community services. Our local PCMHs are supported through a per-member-per-month payment (capitation payment) model, and they deliver integrated care. Our agreements are collaborative and outline the expectations of both stakeholders so there is shared accountability for outcomes. This model is primarily used with PCPs, but it can also be used with specialty providers.
- **Shared Savings:** A program for practices serving large panels of Medicaid enrollees and that possess the skills and infrastructure necessary to manage the population. This model includes both up- and downside options to accommodate provider desire to assume increased risk and is suitable in an Accountable Care Organization (ACO) or

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

clinically integrated network (CIN) environment. It may be used with primary care, specialty care, and hospital-based providers.

- **Bundled or Global Payments:** This program provides an opportunity for specialists who would not ordinarily participate in primary care incentives to receive a bundled rate for services rendered by condition and/or procedure. The payment and associated incentives are directly dependent on quality of care and patient outcomes. This is an option for specialty care or hospital-based providers.
- **Full Risk Capitation:** This program rewards providers for access, affordability, and quality of care in a gain-share, risk-share, or full-risk manner. We have full- and partial-risk programs in Florida already in place with several PCPs such as Access in Region 11. We expect to implement this program for specialty care providers and hospital-based providers statewide as providers reach the state of business maturity at which it becomes appropriate.

Because we recognize that not every provider has experience with value-based arrangements, we assess provider needs on an individual basis for successful transition to a value-based arrangement. We meet providers where they are along the VBP continuum, and we support their unique capabilities and readiness, which in turn has the effect of helping these practices become more adept at effectively and efficiently managing the care of our enrollees.

Under our current suite of value-based arrangement offerings:

- PCPs can participate in pay for quality, PCMH, shared savings, and in full-risk capitation.
- Specialty care providers can participate in pay for quality, PCMH, shared savings, bundled payments, and full-risk capitation.
- Hospital-based providers can participate in pay for quality, shared savings, bundled payments, or full-risk capitation arrangement.

In Florida, 40.5% of our enrollees have relationships with providers who are in some sort of value-based arrangement. The results of these arrangements are as follows:

- Medical loss ratio for these VBP providers is 80%
- Medical loss ratio for non-VBP providers is 86%
- For VBP PCP groups with more than 100 enrollees, emergency department (ED) visit/1,000 was 24% less than for non-VBP providers.

In Florida, across all Aetna product lines, over 40% of our claim payments currently go to providers who deliver value-based care.

To increase the number of VBP contract arrangements for the Aetna Medicaid organization, Aetna Better Value will leverage relationships with a broad spectrum of eligible and willing providers in addition to the following Aetna Medicare/commercial VBP providers already contracted across Florida:

- Baptist Health & St. Vincent's HealthCare in Jacksonville
- Baycare Health System in Clearwater
- Family Medical Specialists in Plant City
- Holy Cross Hospital in Fort Lauderdale

- ## VOLUME OF VBP CONTRACTS EXPECTED

### Region 1

Aetna's rationale for the percentages presented as follows:

[REDACTED]

Table MMA SRC 13: Percentages of VBP Arrangements (5 years) for Region 1 lists the volume of VBP agreements Aetna expects to implement over the next five years in Region 1.

## SPECIFIC OUTCOMES EXPECTED THROUGHOUT THE VBP LIFE CYCLE

CRITERION 3: The extent to which the respondent describes how its VBP arrangements incentivize quality improvement, including specific outcomes it expects at each stage on the continuum

Aetna Better Value's VBP arrangements incentivize quality improvements through the following:

- Total cost-of-care reduction (primary, specialty and hospital based care):
  - Improvement in specific HEDIS measures, as well as readmissions, ED visits, and after-hour availability
  - Gaps in care closure improvement
  - Improved transition of care and care hand-offs across entire continuum of care
  - Improved enrollee engagement with PCP, PCMH, and behavioral health care
  - Improved enrollee and provider experience

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**MMA SUBMISSION REQUIREMENTS**  
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- Reduction in potentially preventable events (primary, specialty and hospital based) care such as:
  - Hospital readmissions
  - Avoidable emergency department visits
  - Avoidable inpatient visits
  - Preventable complications
- Improvement in birth outcomes and prenatal care(primary, specialty and hospital based care)

The outcomes that we expect as a result of Aetna Better Value's VBP arrangements at each stage of the continuum include, but are not limited to, the following:

- Pay for Quality:
  - Greater coordination between primary care and specialists (delineated to PCPs and specialists)
  - More enrollee education through closer relationships between enrollees and physicians (delineated to PCPs and specialists)
  - Patient engagement (delineated to PCPs and specialists)
- Patient-Centered Medical Home (PCMH):
  - Greater coordination between primary care and specialists (delineated to PCPs and specialists)
  - Reliance by the enrollee on the PCP and ability to access care, thereby averting PPEs (delineated to PCPs)
  - Reduction in total cost of care as the PCP is more engaged, with referrals where appropriate (delineated to PCPs)
  - More enrollee education through closer relationships between enrollees and physicians (delineated to PCPs and specialists)
  - Reduction in PPE, improvements in quality of care rendered, and reduction in readmit rates (delineated to PCPs)
  - Patient engagement (delineated to PCPs and specialists)
  - Follow-through and communication between specialist and PCP (delineated to PCPs and specialists)
  - Less polypharmacy and redundancy in prescriptions (delineated to PCPs and specialists)
  - Fewer duplicative outpatient services such as radiology and labs (delineated to PCPs and specialists)
  - Fewer readmissions/potentially preventable admissions (delineated to PCPs and specialists)
  - More coordination between specialists, primary care, and hospital-based providers of care (delineated to PCPs and specialists)
- Shared Savings:
  - Greater coordination between primary care and specialists (delineated to PCPs and specialists)
  - Reliance by the enrollee on the PCP and ability to access care, thereby averting PPEs (delineated to PCPs)
  - Reduction in total cost of care as the PCP is more engaged, with referrals where appropriate (delineated to PCPs)

**EXHIBIT A-4-b**  
**MMA SUBMISSION REQUIREMENTS**  
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- More enrollee education through closer relationships between enrollees and physicians (delineated to PCPs and specialists)
- Reduction in PPE, improvements in quality of care rendered, and reduction in readmit rates (delineated to PCPs)
- Patient engagement (delineated to PCPs and specialists)
- Follow-through and communication between specialist and PCP (delineated to PCPs and specialists)
- Less polypharmacy and redundancy in prescriptions (delineated to PCPs and specialists)
- Fewer duplicative outpatient services such as radiology and labs (delineated to PCPs and specialists)
- Fewer readmissions/potentially preventable admissions (delineated to PCPs and specialists)
- More coordination between specialists, primary care, and hospital-based providers of care (delineated to PCPs and specialists)
- Opportunities to develop population health/risk-based agreements with specialty and hospital based physicians, (delineated to PCPs, specialists, and hospital-based care)
- Fewer duplicative inpatient services (delineated to PCPs, specialists, and hospital-based care)
- **Bundled or Global Payments:**
  - Greater coordination between primary care and specialists (delineated to PCPs and specialists)
  - Reduction in total cost of care as the PCP is more engaged, with referrals where appropriate (delineated to PCPs)
  - More enrollee education through closer relationships between enrollees and physicians (delineated to PCPs and specialists)
  - Reduction in PPE, improvements in quality of care rendered, and reduction in readmit rates (delineated to PCPs)
  - Patient engagement (delineated to PCPs and specialists)
  - Follow-through and communication between specialist and PCP (delineated to PCPs and specialists)
  - Less polypharmacy and redundancy in prescriptions (delineated to PCPs and specialists)
  - Fewer duplicative outpatient services, such as radiology and labs (delineated to PCPs and specialists)
  - Fewer readmissions/potentially preventable admissions (delineated to PCPs and specialists)
  - More coordination between specialists, primary care, and hospital-based providers of care (delineated to PCPs and specialists)
  - Opportunities to develop population health/risk-based agreements with specialty and hospital based physicians, (delineated to PCPs, specialists, and hospital-based care)
  - Fewer duplicative inpatient services (delineated to PCPs, specialists, and hospital-based care)
- **Full Risk Capitation:**
  - Greater coordination between primary care and specialists (delineated to PCPs and specialists)

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- Reliance by the enrollee on the PCP and ability to access care, thereby averting PPEs (delineated to PCPs)
- Reduction in total cost of care as the PCP is more engaged, with referrals where appropriate (delineated to PCPs)
- More enrollee education through closer relationships between enrollees and physicians (delineated to PCPs and specialists)
- Reduction in PPE, improvements in quality of care rendered, and reduction in readmit rates (delineated to PCPs)
- Patient engagement (delineated to PCPs and specialists)
- Follow-through and communication between specialist and PCP (delineated to PCPs and specialists)
- Less polypharmacy and redundancy in prescriptions (delineated to PCPs and specialists)
- Fewer duplicative outpatient services such as radiology and labs (delineated to PCPs and specialists)
- Fewer readmissions/potentially preventable admissions (delineated to PCPs and specialists)
- More coordination between specialists, primary care, and hospital-based providers of care (delineated to PCPs and specialists)
- Opportunities to develop population health/risk-based agreements with specialty and hospital based physicians, (delineated to PCPs, specialists, and hospital-based care)

**ARRANGEMENTS TO PROMOTE THE AGENCY'S GOALS**

**CRITERION 4:** The extent to which the respondent describes how its VBP arrangements incorporate goals or incentives for reduction of potentially preventable events

**Aetna Better Value – Incentivizing Quality Improvement**

The reduction of PPEs is addressed in each of our VBP arrangements; for example, we include the reduction of hospital admissions, the number of avoidable inpatient admissions, and the number of avoidable C-sections as metrics to follow. Additionally, in many arrangements, we include a total cost of care metric as another way to follow PPEs.

One way that Aetna's VBP arrangements build in goals and incentives for reducing potentially preventable events is our population health strategy, which is a true partnership with our provider network. We understand that to obtain the collective vision of achieving the triple aim, we have to be locally engaged and closer to our provider network, in close collaboration with a clinically integrated approach that supports and enhances the provider-patient relationship. As part of our effort to drive population health support for our providers, we have created a new and innovative role—the population health specialist. Our population health specialists are a multitiered team of experienced clinicians and specialists who understand the challenges for enrollees navigating the health care system, in a small community clinic setting or a large integrated delivery system. They know the business of health care and understand that data-driven decisions tied to tightly aligned and coordinated teams lead to the most effective care and successful value-based arrangements and incentive programs. Aetna's population health specialists bring their expertise and experience to select practices in our population health

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

initiative, focusing on providers with value-based arrangements. Specifically, our population health team provides the following practice support:

- Serves as the dedicated relationship manager and single point of contact for the health plan
- Provides CareUnify education and training and supports adoption with data analysis and workflow analysis and enhancements and dashboard and data integration into their current systems and workflows
- Performs regular data and metric reviews (daily or weekly as indicated by practice size) of performance on total cost of care, utilization trends, and quality outcomes
- Reviews and identifies high-risk enrollees needing care and services, aligns care and services in the right setting for their PCMH
- Supports regular care rounds, especially for complex enrollees, around clinical events such as a hospital discharge and confirm follow-up appointments are completed
- Coordinates with the health plan care management and quality teams on resource coordination
- Supports the provider, enrollee, and their circle of support with community service agencies where appropriate
- Supports providers' practice transformation with integration of our data and systems with their workflows, processes, and goals
- Aligns and drives additional resources and care coordination with a hospital system or behavioral health provider

As we move forward with our population health initiative, we are committed to providing proper resources, working closely with our provider partners to help our enrollees achieve better health. By assigning our population health specialists to our provider partners, we create a collaborative relationship that drives innovation and ultimately better health outcomes for our enrollees. Another link in our strategy to achieve a reduction in PPEs is our provider network, exemplified by one of our local providers in Miami-Dade (Region 11):

As a global risk provider, Access (one of Aetna's Region 11 PCP groups) assumes full responsibility for all the care of its patients, clinically and financially. Access has developed a true holistic model of care that helps its Aetna enrollees, with their basic life needs through their Destination Access Sites, Medicaid eligibility and recertification, food stamps, temporary cash assistance, and Section 8 housing, all while attending to clinical needs through its staff model primary care and specialty care medical centers. Particularly with its Medicaid population, Access finds that providing those basic life needs and clinical care makes for healthier enrollees.

Once an individual selects or is assigned to Access, Access deploys an aggressive and continuous model of care. Access recognizes the responsibilities it has to its partner health plans and enrollees. Access has made significant investment in a state-of-the-art outreach infrastructure through the Patient Services department. This includes leadership, systems, technology, staffing, training, and reporting.

The purpose of the Patient Services department is to engage the patient from the moment of enrollment throughout their tenure with Access and to decrease PPEs. The department's many functions include:

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Welcome call to patient immediately after becoming a Access enrollee with purpose of scheduling initial appointment and assessing and scheduling transportation needs
- Patient encounter follow-up call within 24 hours of their encounter
- Evaluating clinical need status
- Patient experience feedback
- Call after no encounter for 60 days
- Special needs calls/text

Access attempts to hear and address all the Aetna Medicaid enrollee's health concerns. Over the years, it has found that a significant number of patients forget to mention all their health needs to their doctor at the point of encounter. These health issues, if left unaddressed, may become a health crisis for the enrollee, prompting him or her to seek care at an emergency department for a problem that was avoidable.

When Access calls each enrollee within 24 hours of his or her appointment, its staff ask, "During your visit with your doctor, did you mention all your health needs, and did Access address them to your satisfaction?" If the patient mentions that Access did not, Access can schedule the enrollee for another visit, sometimes the very same day, often within 48 hours. Access can also schedule transportation with its fleet of vans or through a third-party relationship with Lyft.

In the first quarter of 2017, Access's Patient Services department made appointment follow-up calls, reaching 96% of its enrollees. Of those, 0.06% stated they still had an outstanding health need for which Access scheduled an immediate follow-up appointment.

In Access's analysis of its VBP, it assumes that a portion of enrollees (for purposes of this example, half) would eventually visit an ED for that need, at an average cost of \$1,000. Access estimates that it has reduced PPEs from what, in many cases, would have resulted in a hospital admission. Because of Access's engagement with enrollees after each encounter, Access enrollees receive best-in-class care that leads to improve outcomes and reduction of PPEs.

### **IMPROVEMENT OF BIRTH OUTCOMES**

**CRITERION 5:** The extent to which the respondent describes how its VBP arrangements incorporate goals or incentives for improvement of birth outcomes

As Aetna Better Value enters into VBP arrangements with providers, one of our key focus areas will be the improvement of birth outcomes. While the incentives will vary depending on the type of agreement used (i.e. shared savings, bundled payments, etc.) we include the following goals and incentives in our current VBP agreements with providers who can affect birth outcomes.

- Goals and incentives for improvements in prenatal care, including capture of the date of the first prenatal visit
- Goals and incentives for appropriate screening for substance abuse disorder during pregnancy
- Goals and incentives for appropriate reduction of C-section rates
- Goals and incentives for postpartum care
- Goals and incentives for improved NICU outcomes

**EXHIBIT A-4-b**  
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- Goals and incentives for the reduction of prematurity and improvement of inter-conception spacing

Aetna Better Value believes that the improvement of birth outcomes is a realistic goal through the development of VBP arrangements. For example, in New Jersey, Aetna VBP enrollees showed increased improvement over non-VBP enrollees: the HEDIS measure rate of prenatal and postpartum care for enrollees in a VBP practice was 71.0%, while the rate for enrollees in a non-VBP practice was 56.6%—a VBP improvement rate of 14.4%. As initiatives in other states such as New Jersey prove successful, Aetna will implement these strategies in Florida for the new contract.

**VBP STRATEGIES FOR CURRENT PRIMARY CARE PROVIDERS**

**CRITERION 6:** The extent to which the respondent provides a breakdown of specific VBP strategies employed with its current network of primary care providers

Within Florida's community of providers are various structures, differing capabilities, and many experience levels. We expect to collaborate and establish meaningful, bidirectional communications to understand truly the changing, inherent challenges faced by these providers in treating and supporting this population.

**Regions 1 – 10**

We currently have risk agreements in Region 11, and we expect to have risk agreements with PCPs in Region 1 meeting the following goals: for PCPs: [REDACTED]

We recognize the importance of creating a glide path for the provider and health plan to advance to VBP models that are more sophisticated. This is accomplished by doing the following:

- Systematically assessing provider readiness for VBP models
- Providing on-the-ground provider support for practice transformation
- Providing tools and data to support provider success
- Moving providers along the VBP continuum

Additionally, local health plan leadership 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 VBP 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 alternate payment methodology 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.

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

As the Aetna Better Value program matures, we continuously refine our approach to determine the optimal way to assess provider readiness.

Aetna employs multiple strategies with our PCP network. For PCPs, we utilize the following continuum of contractual agreements:

- **Pay for Quality:** An annual bonus program related to quality metrics for providers who do not immediately qualify for our other VBP agreements. The program rewards providers for achieving better performance on a broad spectrum of HEDIS and utilization metrics for their Aetna enrollee panel. It can be used by primary care, specialty care, and hospital-based providers.
- **Patient Centered Medical Home (PCMH):** This program is a medical home model whose premise is that enrollees may have complex needs and require an integrated behavioral health/physical health home. PCMHs address the complex health needs of the entire community through a highly coordinated system of care, including comprehensive primary care, specialty care, acute care, behavioral health, and community services. Our local PCMHs are supported through a per-member-per-month payment model, and they deliver integrated care. Our agreements are collaborative and outline the expectations of both stakeholders so there is shared accountability for outcomes.
- **Shared Savings:** A program for practices serving a larger portion of our Medicaid enrollees that possess the skills and infrastructure necessary to manage the population (includes both upside and downside options to accommodate provider desire to assume increased risk and may be delivered in an ACO or a clinically integrated network environment). It may be used with primary care, specialty care, and hospital-based providers.
- **Full Risk:** A program that rewards providers for access, affordability, and quality of care in a gain-share, risk-share, or full-risk manner; we have a full- or partial-risk program in Florida already in place with several PCPs such as Community Medical Group in Region 11.

### **Region 11**

We currently have the following quality and risk based agreements in place in Region 11. Each of these risk agreements includes quality metrics for potentially preventable events and access to primary care among many others:

- 154th Street Medical Plaza
- 54th Street Medical Plaza
- Access Medical Group
- Comprehensive Health Center
- Continucare
- Doctor's Medical Center
- Family Medical Specialists, LLC
- Heather Frater Williams, MD
- Interamerican Medical Center Group
- Med One Medical Management
- Medical Care Consortium

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Nostrum
- PAUCG
- Rozalyn H. Paschal, MD
- University Medical Health Center

We recognize the importance of creating a glide path for the provider and health plan to advance to VBP models that are more sophisticated. This is accomplished by doing the following:

- Systematically assessing provider readiness for VBP models
- Providing on-the-ground provider support for practice transformation
- Providing tools and data to support provider success
- Moving providers along the VBP continuum

Additionally, local health plan leadership 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 VBP 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 alternate payment methodology 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.

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## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Shared Savings: A program for practices serving a larger portion of our Medicaid enrollees that possess the skills and infrastructure necessary to manage the population (includes both upside and downside options to accommodate provider desire to assume increased risk and may be delivered in an ACO or a clinically integrated network environment). It may be used with primary care, specialty care, and hospital-based providers.
- Full Risk: A program that rewards providers for access, affordability, and quality of care in a gain-share, risk-share, or full-risk manner; we have a full- or partial-risk program in Florida already in place with several PCPs such as Community Medical Group in Region 11.

### **DATA SHARING WITH PROVIDERS AND SUPPORT FOR THEIR PROGRESSION**

**CRITERION 7:** The extent to which the respondent describes the approach in sharing specific data elements with providers under a VBP arrangement and the level of respondent support offered to providers to ensure progression along the continuum of VBP arrangements

Aetna is ultimately responsible for overseeing and assessing the success of our VBP program in Florida. The Florida VBP director, along with population health specialists and Provider Services, Network Contracting, and Quality department staff, closely watches medical spend across the market as well as by provider to ensure we are on track to meet goals and to identify providers who may need technical assistance. We understand the importance of providers' financial success to their continued participation in our VBP program, so we are prepared to help them when they require assistance in improving results.

We meet with our PCMHs and shared savings partners at least quarterly. Together, we review performance data, discuss challenges and barriers to improvement, and provide technical advice as applicable to improving population health capabilities. We look at evidence-based practices and share reports to illustrate comparisons of performance. This includes HEDIS and utilization metrics as well as total cost of care. We have found that providers participating in a thorough performance review were 6.36% higher on HEDIS quality measures than providers not participating in a VBP Medicaid program.

Aetna employs various information technology systems to support our VBP providers. Our electronic claims system identifies providers who are participating in VBP arrangements and verifies that they are being paid according to their contract. Furthermore, CareUnify empowers provider partners with near real-time access to complete patient profiles and data around hospital and emergency department admissions, readmissions, medication reconciliation, open care gaps, and transition of care. Together, these tools create a powerful integrated system that helps providers engage and manage their patients without having to pay for additional resources.

Reporting tools increase accountability and transparency while improving efficiencies. On-demand tools are available through the provider portal, or if a provider is using CareUnify, through that platform. If a provider is using CareUnify, his or her view of the data is refreshed daily; if providers choose not to use CareUnify, reporting is still available to them to identify

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

success and potential areas for improvement.

Aetna offers access to our CareUnify health information platform at no cost. CareUnify provides a single data-sharing platform that empowers providers with near real-time access to complete patient profiles, fostering collaboration and quality improvement.

### **Provider Performance Data**

Aetna uses HEDIS, a nationally recognized measurement tool developed by the National Committee for Quality Assurance (NCQA), to monitor, evaluate, and improve the quality of care, access to care, and utilization of services to our enrollees. We follow all data collection guidelines in accordance with the most recent NCQA technical specifications.

We receive data from a variety of sources for quality and performance reporting. All data sources and processes follow guidelines set forth by NCQA for HEDIS reporting. Data sources we use in performance measure reporting include claims and encounters, immunization and lead registries, lab results, vision, dental, electronic medical record, and provider medical record chart review. Data are received via secure file transfer protocol (FTP), secure email transmission, or by retrieving files from a secure Web application. We automate the processing of data sources during the calculation of performance metrics using our NCQA-certified software. Data validation checks are in place for every piece of the integration process to procure complete, timely, and accurate data collection.

Our CareUnify platform provides seamless transfer of near real-time data between Aetna and our providers. Aetna's electronic care management system aggregates and displays data from multiple sources that include all physical and behavioral health claims data as well as key social determinants of health to create an individualized and comprehensive profile and care record tailored to each enrollee. Our platform can also capture data from multiple sources such as electronic health records (EHRs), registries, and other data repositories to add to a single care record. Care managers or provider partners can access data to manage each enrollee's needs at point of care or for global population health management, such as matching diabetic enrollees with diabetes-specific care and services.

We also use HEDIS data as it relates to the provider agreement. While metrics are reported annually, we refresh the data monthly using claims data; that way, providers know their performance at any given time during the year. Aetna reports to providers monthly the information we collect from our claims data set. Should the provider feel any information is inaccurate or incomplete, he or she has the opportunity to supply or update the HEDIS information. We then add appropriate information to our data set until both parties agree there is an accurate view of performance on which to base incentive payments.

We understand that not all providers will choose to adopt our CareUnify solution because they may already be using a different tool or solution. In those cases, we customize our reporting capabilities based upon provider practice feedback and deliver the information in a manner that is acceptable to their practice. Examples of delivery and reporting customization include direct data connections and information through our provider portal or through an established health information exchange (HIE), all of which provide real-time data and information.

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Aetna provides various tools and reports designed to promote provider success, including enrollee assignment rosters, quality metrics, gap closure reporting, and more. Our Provider Services representatives meet monthly with provider practices who participate in Pay for Quality or with PCMHs to train providers on the use of these tools.

### **Evaluation Criteria:**

1. The extent to which the respondent has provided the continuum of value-based purchasing arrangements available to network providers, delineated by primary care, specialty care and hospital-based care.
2. The extent to which the respondent has provided specific percentages of overall contracts, delineated by primary care and specialty care and hospital-based care, that it intends to implement or maintain through some type of VBP arrangement for each of the five (5) Contract years, including a rationale for the intended percentages.
3. The extent to which the respondent describes how its VBP arrangements incentivize quality improvement, including specific outcomes it expects at each stage on the continuum.
4. The extent to which the respondent describes how its VBP arrangements incorporate goals or incentives for reduction of potentially preventable events.
5. The extent to which the respondent describes how its VBP arrangements incorporate goals or incentives for improvement of birth outcomes.
6. The extent to which the respondent provides a breakdown of specific VBP strategies employed with its current network of primary care providers.
7. The extent to which the respondent describes the approach in sharing specific data elements with providers under a VBP arrangement and the level of respondent support offered to providers to ensure progression along the continuum of VBP arrangements.

**Score:** This section is worth a maximum of 35 raw points with each of the above components being worth a maximum of 5 points each.

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COVENTRY HEALTH CARE OF FLORIDA, INC. DBA  
AETNA BETTER HEALTH® OF FLORIDA

## **Attachment MMA SRC# 13**



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Trade secret as defined in Section 812.081, Florida Statutes

COVENTRY HEALTH CARE OF FLORIDA, INC. DBA

AETNA BETTER HEALTH® OF FLORIDA

MMA SRC# 13: Table MMA SRC 13-1: Percentages of VBP Arrangements (5 years) for Region 1

Table MMA SRC 13-1: Percentages of VBP Arrangements (5 years) for Region 1

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**EXHIBIT A-4-b**  
**MMA SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**E. DELIVERY SYSTEM COORDINATION**

**MMA SRC# 14 – General HEDIS Performance Measures Experience (Statewide):**

The respondent shall describe its experience in achieving quality standards with populations similar to the target population described in this solicitation. Include in table format, the target population (TANF, ABD, dual eligibles), the respondent's results for the HEDIS measures specified below for each of the last two (2) years (CY 2015/ HEDIS 2016 and CY 2016/ HEDIS 2017) for the respondent's three (3) largest Medicaid Contracts (measured by number of enrollees). If the respondent does not have HEDIS results for at least three (3) Medicaid Contracts, the respondent shall provide commercial HEDIS measures for the respondent's largest Contracts. If the Respondent has Florida Medicaid HEDIS results, it shall include the Florida Medicaid experience as one of three (3) states for the last two (2) years.

The respondent shall provide the data requested in **Exhibit A-4-b-2**, MMA Performance Measurement Tool (10-2-2017) to provide results for the following HEDIS measures:

- Childhood Immunization Status (Combo 3);
- Well-Child Visits in the First 15 Months (6 or more);
- Immunizations for Adolescents (Combo 1);
- Well-Child Visits in the 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup>, and 6<sup>th</sup> Years of Life;
- Adolescent Well Care Visits;
- Frequency of Ongoing Prenatal Care (>= 81% of expected visits); and
- Timeliness of Prenatal Care.

**Response:**

Aetna's goal is to become the highest-ranking health plan among Medicaid enrollees, providers, and other stakeholders. With a mission to improve the health and well-being of every enrollee we are privileged to serve, we are committed to continuous quality improvement to fulfill the aim of improved health outcomes. Our proven results are evident in consistently high NCQA ratings and across quality, medical management, and health equity programs. Aetna was recently named the highest-ranking NCQA Florida Medicaid plan for the second consecutive year and ranks among the top 15 Medicaid plans in the nation. Our experience implementing, managing, and caring for Medicaid enrollees results in improved access to care, higher quality of care in appropriate settings, and a simplified consumer experience in a culturally competent manner.

**EXPERIENCE ACHIEVING QUALITY STANDARDS WITH SIMILAR POPULATIONS**

**CRITERION 1:** The extent of experience (e.g., number of contracts, enrollees, or years) in achieving quality standards with similar target populations for the HEDIS performance measures included in this submission requirement

The Aetna organization has over 160 years of experience operating in all 50 states and is among the nation's leading diversified health care benefits companies, serving an estimated

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

46.7 million individuals with information and resources necessary to help them make better-informed decisions about their health care. Through our affiliate, Aetna Life Insurance Company, Aetna has been licensed to do business in Florida since 1892. Aetna Inc. was recently named to Fortune's 2017 Most Admired Companies list, ranking second in the health insurance category. Aetna offers a broad range of traditional, voluntary, and consumer-directed health insurance products and related services, including Medicaid health care management services; government-sponsored plans; medical, pharmacy, dental, behavioral health, group life, and disability plans; medical management capabilities; workers' compensation administrative services; and health information technology products and services. Aetna's customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers, labor groups, and expatriates.

In 2007, Aetna Inc. acquired Schaller Anderson, Incorporated (Schaller Anderson), a company founded in 1986 and experienced in Medicaid. As a leader in Medicaid managed care, Schaller Anderson participated in the nation's first fully capitated statewide managed care programs, the Arizona Health Care Cost Containment System (AHCCCS), through its management of health plans serving that program. Schaller Anderson was at the forefront of innovation in Medicaid managed care as states across the nation emulated Arizona's success. Through a series of name changes, Schaller Anderson's subsidiary, Schaller Anderson of Arizona, LLC, became what is currently known as Aetna Medicaid Administrators LLC, which now manages health plans in 14 states: Arizona, Florida, Illinois, Kentucky, Louisiana, Maryland, Michigan, New York, New Jersey, Ohio, Pennsylvania, Texas, Virginia, and West Virginia. Through these contracts, Aetna serves more than three million TANF, CHIP, ABD, dually eligible, and LTSS enrollees. These Medicaid enrollees include high-needs children, pregnant women and families, individuals with disabilities, seniors eligible for Medicare and Medicaid, community-based services, and individuals living in long-term care facilities. We are extremely proud of our time-tested leadership and legacy with the Medicaid managed care population.

Our goal is to improve the functional status and quality of life for enrollees while providing budget predictability to our State partners. Our experience implementing, managing, and caring for high-acuity Medicaid beneficiaries results in improved access to care, higher quality care in appropriate settings, and a simplified, culturally competent enrollee experience. We take our responsibility as a steward of public programs seriously. In partnership with providers, community resources, and other key stakeholders, we offer an extensive suite of programs and services that work in concert to meet the individual needs of our enrollees.

### **EXPERIENCE ACHIEVING QUALITY STANDARDS FOR MEASURES INCLUDED IN REQUIREMENT**

Aetna meets or exceeds performance goals for all measures in this requirement. We have improved in all measures from the year prior to the SMMC contract and since the implementation of the SMMC contract in 2014. Through our disciplined approach, we met 100% of HEDIS 2017 hybrid measures at the 50th percentile rate; met 64% at the 75th percentile rate; and met 80% of our MMA performance measure goals—an increase over HEDIS 2016 for which we met 70% of goals; HEDIS 2015, for which we met 62% of goals; and HEDIS 2014, for which we met 48%.

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Aetna's attention to quality performance regarding well visits, immunizations, and prenatal visits, is evident in the following outcomes:

- Well-child visits in the first 15 months (6+ visit rate) have increased by 37 percentage points since the year prior to the SMMC implementation and 35 percentage points since our first year under the SMMC contract, now reaching the 90th percentile rate for HEDIS.
- Well visits in the third through sixth year of life have improved by 7 percentage points from prior to the SMMC contract and one percentage point over the first year of the SMMC contract, reaching the 75th percentile rate for HEDIS.
- Our adolescent well-child visit rate improved by approximately 11 percentage points since the year before SMMC implementation and 4 percentage points since the first year of the contract, now exceeding the 75th percentile rate.
- Childhood immunization status (combination 3 rate) has improved by almost 17 percentage points from before SMMC and 6 percentage points following, now reaching the 50th percentile rate for HEDIS for the first time.
- Immunizations for adolescents (combination 1 rate) has improved 17 percentage points from before the SMMC contract, and 4 points since the contract implementation, reaching the 50th percentile rate.
- Timeliness of prenatal care has improved by 20 percentage points since prior to the SMMC contract implementation, and 8 percentage points above our rate the first year of the SMMC contract, with current performance at the 95th percentile rate.
- The frequency of ongoing prenatal care increased by approximately 26 percentage points since the year prior to SMMC implementation and 2 percentage points since SMMC implementation, currently performing at the 75th percentile rate.

At Aetna, we never rest upon our successes. Instead, we review our performance monthly to identify areas where we can make improvements or where interventions are necessary. We engage enrollee, provider, and system interventions where appropriate. Regardless of whether goals are met, we work to improve and increase our performance year over year. For example, for well-child visits in the first 15 months, we fell below the 50th percentile goal for 2014, with a rate of 39.9%. In 2015, we met the 50th percentile goal with a rate of 61.1%. In 2016, we achieved the 90th percentile with a rate of 74.26%.

### **GENERAL PERFORMANCE MEASUREMENT TOOL**

**CRITERION 2:** The extent to which the respondent exceeded the national mean and applicable regional mean for each quality measure reported and showed improvement from the first year to the second year reported

We have completed Exhibit A-4-b-2 for our two largest contracts, Pennsylvania and Kentucky, which both serve populations similar to the Florida SMMC plan. In Pennsylvania, we serve 207,957 enrollees and have 24 years of experience achieving quality standards. We have six years of experience serving Medicaid enrollees in Kentucky and currently have 248,389 enrollees.

**EXHIBIT A-4-b**  
**MMA SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**Evaluation Criteria:**

1. The extent of experience (e.g., number of Contracts, enrollees or years) in achieving quality standards with similar target populations, for the HEDIS performance measures included in this submission requirement.
2. The extent to which the respondent exceeded the national mean and applicable regional mean for each quality measure reported and showed improvement from the first year to the second year reported.

**Score:** This section is worth a maximum of 70 raw points with component 1 worth a maximum of 10 points and component 2 worth a maximum of 60 points as described below:

**Exhibit A-4-b-2**, MMA Performance Measurement Tool (10-2-2017), provides for forty-two (42) opportunities for a respondent to report prior experience in meeting quality standards (seven (7) measure rates, three (3) states each, two (2) years each).

For each of the seven (7) measure rates, a total of 5 points is available per state reported (for a total of 105 points available). The respondent will be awarded 1 point if their reported plan rate exceeded the national Medicaid mean and 1 point if their reported plan rate exceeded the applicable regional Medicaid mean, for each available year, for each available state. The respondent will be awarded an additional 1 point for each measure rate where the second year's rate is an improvement over the first year's rate, for each available state.

An aggregate score will be calculated and respondents will receive a final score of 0 through 60 corresponding to the number and percentage of points received out of the total available points. For example, if a respondent receives 100% of the available 105 points, the final score will be 60 points (100%). If a respondent receives 95 (90%) of the available 105 points, the final score will be 54 points (90%). If a respondent receives 10 (10%) of the available 105 points, the final score will be 6 points (10%).

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EXHIBIT A-4-b-2  
MMA SRC# 14 - MMA PERFORMANCE MEASUREMENT TOOL (10-2-2017)

RESPONDENT NAME: Coventry Health Care of Florida, Inc. dba Aetna Better Health of Florida								
Group B								
	State #1:	Florida	State #2:	Kentucky	State #3:	Pennsylvania		
HEDIS Performance Measure	CY 2015 Rate	CY 2016 Rate	CY 2015 Rate	CY 2016 Rate	CY 2015 Rate	CY 2016 Rate		
Adolescent Well-Care Visits	56.51	59.33	38.92	48.38	50.69	49.31		
Childhood Immunization Status - Combination 3	67.88	71.70	67.69	70.14	74.54	71.53		
Frequency of Ongoing Prenatal Care - ≥ 81% of expected visits	72.32	74.73	61.61	76.98	61.92	71.46		
Immunizations for Adolescents - Combination 1	76.32	78.10	80.62	77.73	76.85	77.55		
Timeliness of Prenatal Care	93.02	94.95	79.86	84.65	81.07	84.94		
Well-Child Visits in the First 15 Months of Life - 6 or more visits	61.07	74.26	55.66	59.95	64.58	65.97		
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	82.62	77.91	58.17	66.44	69.44	72.22		

<b>Total Points</b>	<b>73</b>
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## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **MMA SRC# 15 – Failure to Meet HEDIS Measures (Statewide):**

In addition to providing HEDIS measure data, describe any instances of failure to meet HEDIS or Contract-required quality standards for the measures listed below and actions taken to improve performance. Describe actions taken to improve quality performance when HEDIS or Contract-required standards were met, but improvement was desirable.

- Childhood Immunization Status (Combo 3);
- Well-Child Visits in the First 15 Months (6 or more);
- Immunizations for Adolescents (Combo 1);
- Well-Child Visits in the 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup>, and 6<sup>th</sup> Years of Life;
- Adolescent Well Care Visits;
- Frequency of Ongoing Prenatal Care ( $\geq 81\%$  of expected visits); and
- Timeliness of Prenatal Care.

#### **Response:**

Aetna's passion for improving the individual lives and well-being of our enrollees drives all that we do each day. We join our enrollees where they are—and we partner with them along their journeys to optimal health. Aetna meets or exceeds performance goals for all measures in this submission requirement. We continue to improve in all measures from the year prior to the SMMC contract and since the implementation of the SMMC contract in 2014.

#### **IMPROVING QUALITY IN MEANINGFUL WAYS**

**CRITERION 1:** The extent to which the described experience demonstrates the ability to improve quality in a meaningful way and to successfully remediate all failures for the HEDIS performance measures included in this submission requirement

**CRITERION 2:** The extent to which the described experience demonstrates the ability to improve quality in a meaningful way even when HEDIS or Contract-required standards were met, but improvement was desirable, for the HEDIS performance measures included in this submission requirement

Aetna's attention to quality performance regarding well visits, immunizations, and prenatal visits is evidenced in our outcomes and supported by the improvement activities that include (but are not limited to) the following:

#### **WELL-CHILD VISITS IN THE FIRST 15 MONTHS**

Well-child visits in the first 15 months (6+ visit rate) have increased by 37 percentage points since the year prior to the SMMC implementation and 35 percentage points since our first year under the SMMC contract, now reaching the 90th percentile rate for HEDIS.

Many of our improvements are the result of collaborating with physicians and early interventions with enrollees. We work closely with our physicians to help them understand the well visit timing and coding requirements, and we offer gaps-in-care reports through our provider portal. We use tools such as our child growth chart to remind new parents regarding the timing of well visits,

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

along with associated care required such as immunizations. Our Text4Baby program provides text reminders to help ensure timely well visits. Our OB care managers partner with new mothers to help ensure they have a valued pediatrician and obtain any assistance required in completing well visits in a timely manner. With the My Home Doctor program, we can send a physician to the enrollee's home if the enrollee is unable to obtain in-office care. Our growth chart, a color-yourself height measurement wall chart that we send to new mothers and new enrollees who are due for service with children under 13, is an example of an innovative tool that reminds parents of immunization and well-visit timing.

### **WELL-CHILD VISITS IN THIRD THROUGH SIXTH YEAR**

Well visits in the third through sixth year of life have improved by 7 percentage points from prior to the SMMC contract and 1 percentage point since our first year under the SMMC contract, reaching the 75th percentile rate for HEDIS.

Similar to other well screening measures, we work with providers and enrollees to help ensure the provision of timely and complete care. Aetna reviews monthly data to identify gaps in care and any trends in gaps. We work with providers to mitigate any provider-specific issues and to close gaps. We have an extensive toolbox for enrollee outreach that includes enrollee reminders, education, resource tools, and live assistance, as needed. Our growth chart is one of those tools used for this age group; as a wall chart, it is a visible reminder of timing of well visits and immunizations.

### **ADOLESCENT WELL-CHILD VISITS**

Our adolescent well-child visit rate improved by approximately 11 percentage points since the year before SMMC implementation and 4 percentage points since the first year of the contract, exceeding the 75th percentile rate. One of our challenging measures has been adolescent well visits, as many of the routine interventions do not result in improvements (live outreach, mailers, and text messages). We have found that the challenge is not just with the parent, but child resistance to visits and their ability to sway their parents away from preventive care. Education alone has not been successful with this measure. One method that has proven successful is helping enrollees understand they have a choice with the type of provider they use and offering to facilitate a change. In talking with enrollees, we learned that some prefer a family medicine provider as they age and mature, having felt a stigma associated with using a pediatrician as a teenager. Another barrier we discovered through medical record reviews is that providers saw enrollees for sick visits, but did not use those opportunities for well screenings, where appropriate. We worked closely with the Agency for Healthcare Administration to remove the well/sick visit billing prohibition from the Medicaid handbook so that physicians can provide and receive reimbursement for both services on the same day.

### **CHILDHOOD IMMUNIZATION STATUS (COMBO 3)**

Our childhood immunization Combo 3 rate has improved by almost 17 percentage points from before SMMC and 6 percentage points following, now reaching the 50th percentile rate for HEDIS for the first time. We have been working with providers to leverage the Florida State Health Online Tracking System immunization registry through training and one-on-one technical assistance. We have worked closely with providers to educate them on the vaccine schedule,

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

but also distributed tools to help providers understand and manage better their office immunization programs. Our growth chart is one of our innovative tools, a favorite of parents, reminding them of immunization and well-visit timing. Gaps in care reports have also helped improve measure performance, and through enhanced gaps in care reporting through the provider portal ad hoc, additional improvement is expected and has been noted on interim reports in 2017.

### **IMMUNIZATIONS FOR ADOLESCENTS (COMBO 1)**

Immunizations for adolescents (Combo 1 rate) has improved 17 percentage points from before the SMMC contract, and four points since the contract implementation, reaching the 50th percentile rate. Similar to efforts on well visits for adolescents, ensuring the enrollee has the right provider is an initiative used to move teens to family medicine providers instead of pediatricians when they reach an appropriate age and when they prefer a different provider specialty. Working with all specialty primary care providers, we have educated physician offices on the ability to offer well services, including immunizations, to enrollees who have no contraindication. This has increased the number of well visits and immunizations for adolescents, and alleviated provider frustration with limits on sick/well visit provision and billing.

### **TIMELINESS OF PRENATAL CARE AND THE FREQUENCY OF ONGOING PRENATAL CARE**

Timeliness of prenatal care has improved by 20 percentage points since prior to the SMMC contract implementation, and 8 percentage points above our rate the first year of the SMMC contract, with current performance at the 95th percentile rate. The frequency of ongoing prenatal care increased by approximately 26 percentage points since the year prior to SMMC implementation and 2 percentage points since SMMC implementation, currently performing at the 75th percentile rate. Aetna works closely with obstetric providers to ensure they know which enrollees are due for care and can schedule timely visits. We leverage our obstetric care managers to coordinate care, educate enrollees and providers, and assist enrollees to eliminate any barriers to timely and complete care. Our prenatal care packet includes valuable information on pregnancy and accessing care and includes extensive resources for staying healthy, using benefits, and getting care. Text4Baby and other technology-based programs have proven popular and successful with our enrollees, and they supplement our live outreach and care management. Aetna has an extensive high-quality provider network for obstetric provider choice, but also has My Home Doctor whenever an enrollee is unable to visit a provider in the office.

We examine our performance monthly (including rates) to identify areas where we can make improvements or where interventions are necessary. To assure continuous improvement, we employ enrollee, provider, and system interventions where appropriate. Regardless of whether goals are met, improvement measures do not cease; instead, we work to improve and increase our performance year over year.

For example, for well-child visits in the first 15 months, we performed under the 50th percentile goal for 2014 with a rate of 39.9%. In 2015, we met the 50th percentile goal with a rate of 61.1%. In 2016, we achieved the 90th percentile with a rate of 74.26%.

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **ONGOING, CONTINUOUS QUALITY IMPROVEMENT**

Improving quality in meaningful ways requires attentive, ongoing monitoring, sophisticated analysis, real-time data, innovative approaches to managing enrollee needs and collaborating with providers. Aetna has the expertise and resources to positively impact the health care delivery system in a manner that benefits all stakeholders and improves overall quality.

Our quality strategy is founded on building competencies in enrollees and providers that extend well beyond initial interventions. The result is longevity in our membership, increased enrollee and provider engagement, high enrollee satisfaction as represented by the highest CAHPS score of all Florida Medicaid plans in 2016, and high provider satisfaction.

Through our disciplined approach, we met the 100% HEDIS 2017 hybrid measures at the 50th percentile rate, 64% at the 75th percentile rate, and 80% of our MMA performance measure goals. This was an increase over HEDIS 2016, for which we met 70% of goals; HEDIS 2015 for which we met 62%; and HEDIS 2014, with 48%.

Our improvement initiatives, which include remediating failures or continuing to improve upon high-performing measures, include the following:

- Increasing value-based purchasing relationships with quality outcomes included as a financial incentive and adding quality outcomes to existing risk relationships
- Monitoring rates monthly
- Using rapid-cycle improvement processes
- Rewarding high-quality providers with Aetna's Awesome Provider program
- Leveraging the State's MPIP incentive plan to drive quality behavior
- Collaborating with providers and offering tools to help manage enrollees better
- Working with community groups to create a strong community structure to support enrollee needs
- Embracing innovation to solve historic Medicaid enrollees issues such as lack of correct contact information
- Improving completeness and accuracy of data from providers and other sources to ensure accurate reflection of service

Our strategy for performance measure improvement also includes the following:

- Providers
  - Gaps-in-care reports
  - HEDIS coding tools
  - Claim analysis and customized provider-specific solutions
  - One-on-one assistance for staff and provider
  - Provider incentive programming and reports
  - EHR assistance to help providers leverage their systems to close gaps in care
  - CareUnify (our 360-degree population health management system)
- Enrollees

## **EXHIBIT A-4-b**

### **MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Live outreach (previously limited and expanded to behavioral health and other measures)
- Automated outreach
- Text messages
- Free cellphone
- Email (future state: waiting on emails from AHCA this year)
- Prescription bag tags, refill and preventive care reminders on prescription packaging
- Birthday cards with preventive care reminders
- Growth chart for kids with well-visit periodicity and immunization schedule
- Mailed reminders
- Education on service gaps and care management
- Provider right-sizing
- Unable-to-reach letters
- Unable-to-reach enrollee program
- My Home Doctor program/physician house call program for high-risk, complex enrollees
- Incentives
- ActiveHealth wellness coaching
- Coordination with care management for appropriate enrollees
- OB care coordination for pregnant enrollees

We experience year-over-year improvement by using the appropriate mix of interventions, oversight, data mining, and partnerships. Aetna continues to develop and deploy innovative solutions for ongoing improvement. Sophisticated population health management platforms such as CareUnify allow real-time, 360-degree views of enrollee care and services for the provider and the plan so that interventions and course corrections can be made before opportunities for care are missed. As performance measures indicate, we have the knowledge, skill sets, and infrastructure to improve care for enrollees.

Our use of technology improves quality by facilitating conversations that produce behavior changes among specialists, traditional and non-traditional providers, and most importantly, our enrollees. The result is decreased duplication of services and improved provider understanding of enrollee complexities such as the social issues that drive high utilization and prescribing practices that decrease polypharmacy, reduce opioid prescribing, and improve enrollee adherence. Our innovative technology drives behavior changes that result in higher quality and lower costs for the State's health care delivery system, along with improved enrollee and provider outcomes.

Aetna initiatives are communicated to every level of the organization through mandatory town hall meetings, email notifications, employee website articles, web-based learning modules, and demonstrations. Aetna views investments in technology as long-term improvement strategies, not as one-time projects. Our collaboration with some of the nation's leading technology and health companies—Apple, General Electric, and Intel, in addition to our own subsidiary Healthagen—drives new ideas and advances every innovation.

### **Evaluation Criteria:**

**EXHIBIT A-4-b**  
**MMA SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

1. The extent to which the described experience demonstrates the ability to improve quality in a meaningful way and to successfully remediate all failures for the HEDIS performance measures included in this submission requirement.
2. The extent to which the described experience demonstrates the ability to improve quality in a meaningful way even when HEDIS or Contract-required standards were met, but improvement was desirable, for the HEDIS performance measures included in this submission requirement.

**Score:** This section is worth a maximum of 10 raw points with each component worth a maximum of 5 points each.

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## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **MMA SRC# 16 – HEDIS (Data Sources) (Statewide):**

The respondent shall describe:

- a. The extent to which it has used the following standard supplemental data sources for its HEDIS and other performance measures:
  - Laboratory result files;
  - Immunization data in State or county registries;
  - Transactional data from behavioral healthcare vendors; and
  - Current or historic State transactional files in a standard electronic format.
- b. The extent to which it has used supplemental data from electronic health record vendor systems and data from certified eMeasure vendors for HEDIS and other performance measures.
- c. The extent to which it has experience reporting HEDIS measures collected using Electronic Clinical Data Systems.

#### **Response:**

As part of our commitment to quality, the Quality Management team monitors HEDIS rates throughout the year to assess the impact of our efforts to improve rates, identify disparities, and adjust strategies. Rates are tracked monthly and compared to the previous year's rates on a rolling 12-month and year-to-date basis. Aetna uses all sources of data within NCQA guidelines of supplemental data.

#### **USE OF SPECIFIC STANDARD SUPPLEMENTAL DATA SOURCES**

CRITERION 1: The extent to which the described experience demonstrates the ability to use standard supplemental data sources (lab result files; immunization data in State or county registries; transactional data from behavioral healthcare vendors; and current or historic State transactional files in a standard electronic format) for HEDIS and other performance measures

#### **LABORATORY RESULTS FILES**

Aetna has real-time access to LabCorp's database, so we can access records for individual enrollees or groups of enrollees to determine whether enrollees are meeting their health goals or to identify emerging risks. For example, we may access records of enrollees with diabetes to verify that they are receiving HbA1c testing. Weekly updates from Quest Lab are also uploaded to our system. We actively pursue data feeds from other provider groups and labs that might affect our HEDIS rates.

#### **IMMUNIZATION DATA IN STATE OR COUNTY REGISTRIES**

Aetna works closely with the Florida State Health Online Tracking System (SHOTS) immunization program and provides the State with monthly updates on our enrollees. We receive an annual update from the State that use to compare data and to ensure we are actively

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

closing and addressing gaps. We are actively working with the State's Department of Health to obtain these updates more frequently.

Additionally, we assist with training providers on the effective use of the State's immunization registry for vaccine management, affording enrollees access to their own or their children's health records, and more. Our provider training on Florida SHOTS includes written coding hints and a tip sheet, phone calls, face-to-face visits by our Provider Services team members, WebEx trainings, and a toolkit.

### **TRANSACTIONAL DATA FROM BEHAVIORAL HEALTH CARE VENDORS**

Aetna receives and uses all encounter data, including encounter data from behavioral health care vendors for HEDIS and other performance measures.

### **USE OF SUPPLEMENTAL DATA FROM ELECTRONIC HEALTH RECORD VENDOR SYSTEMS AND CERTIFIED EMEASURE VENDORS**

**CRITERION 2:** The extent to which the described experience demonstrates the ability to use supplemental data from electronic health record (EHR) vendor systems and data from certified eMeasure vendors for HEDIS and other performance measures

Aetna has engaged in direct data pulls with our provider partners to enhance our HEDIS quality and risk adjustment scoring since 2014. We are actively working with all major EHR, clinical data, and certified eMeasure vendors, including over 21 different organizations such as Epic and Cerner. As part of this effort, we devised several different methods to capture data to pull into our back-end data warehouse using secure file transfer protocol sites and continuity of care documents to process clinical information. These automated file transfers enable us to parse the specific information necessary to identify key service data and electronic charting that can then be used in a number of ways to close gaps and monitor in near real-time gaps in each provider's care. These data elements, including important supplemental data feeds, can then be passed to our quality and population health database systems (including QSI), to create immediate administrative review and closure.

We can pull in lab data, immunization records, demographic data, assessments, referral reports, and other electronic data to validate when and where specific services are delivered. Using data feedback loops, we can validate information so that all care is aligned to the right service and addresses HEDIS care gaps. Aetna is currently revising our supplemental data feed process to create real-time feedback loops using standard files wherever possible to make the process uniform and scalable.

Aetna will continue to work with clinical data vendors of all types, including all certified eMeasure vendors, to provide the most accurate and timely performance monitoring for our key stakeholders. Aetna continues to invest significant resources into HEDIS tracking and performance management with the goal of improving quality and reducing costs for the State. Free-flowing and secure data exchange between organizations is a central tenet of our population health initiative and a driving force behind our value-based solutions, where we continue to expand our pay-for-quality and alternative payment models and programs rapidly.

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **EXPERIENCE REPORTING HEDIS MEASURES COLLECTED FROM ELECTRONIC CLINICAL DATA SYSTEMS**

**CRITERION 3:** The extent to which the described experience demonstrates the ability to report HEDIS measures collected using Electronic Clinical Data Systems (ECDS)

While the Aetna Medicaid organization has not reported the new electronic clinical data systems measures, we are in the process of completing its development of the Medicaid ECDS system. The Aetna Medicaid ECDS is designed to integrate and consume clinical data for our enrollees from Electronic Medical Records and Health Information Exchanges (HIEs), as well as the claims system. The system can integrate and pull data on a daily basis from leading EMR systems such as Cerner, Athena Health, Allscripts, eClinicalWorks, and NexGen, as well as the State HIE. The data is pushed through a CCD engine that can identify, parse, and pass relevant information to Aetna's HEDIS engine. This structured and semi-structured clinical data, combined with claims data, is processed by the HEDIS engine where reports are generated and sent to providers for action.

Aetna's ECDS system is designed based on data integration best practices and includes a CCD engine that can parse and convert data streams into multiple formats. The target date for production is November 2017.

#### **CareUnify<sup>SM</sup>, A UNIQUE DATA SOURCE**

As part of our commitment to new and innovative data-sharing technologies, Aetna developed CareUnify, a proprietary population health management technology. The primary purpose of CareUnify is to create a provider-facing collaborative information platform to digitally share and aggregate actionable data across systems and organizations to promote effective and efficient care coordination—particularly for complex, high-risk individuals. Our CareUnify tool is a dynamic software application that in a single instance connects the entire community of health care providers for an individual enrollee or access to a provider's complete patient panel. CareUnify serves as a care-traffic control tool that aggregates information to provide a secure, single comprehensive patient record for providers.

CareUnify collects data around service and care plans, workflows, behavioral health notes, gaps in care, social determinants of health, total cost of care, and population health management in a timely manner for the integrated care team. It features a real-time HEDIS gaps dashboard that provides an open gaps and opportunities list that can be easily integrated into the provider's workflows and systems, giving specific details on each enrollee to identify quickly high-risk enrollees and opportunities to prevent hospital admissions or other avoidable expensive care. CareUnify will be live for our Florida provider network in October of this year.

Our CareUnify solution makes the best use of data from electronic health records and less sophisticated practice management systems, creating a seamless and unified data visualization experience. While CareUnify incorporates provider data, it also establishes a common gateway and foundation for bi-directional sharing of Aetna payer information with provider electronic health record systems. For example, CareUnify identifies all open gaps for the provider and his or her team to use within their native workflows and systems, whether they use the data at point of care or for larger population health management.

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

CareUnify has been audited and approved by NCQA as a valid source for obtaining and sharing supplemental data. As a result, providers can upload supplemental data directly into CareUnify, or as noted above, we can exchange continuity of care documents directly with the provider's electronic health record system so that supplemental data is captured at point of service. Our approach is to use CareUnify to create as much real-time closure as possible so providers can more efficiently address their larger-panel needs and not backtrack or duplicate efforts based on stale data. We offer CareUnify at no cost to select providers as part of the collective effort to address HEDIS gaps and deliver quality care in a timely manner.

### **EASY INTEGRATION WITH HEALTH INFORMATION EXCHANGES**

Aetna currently receives live ADT feeds through Florida's HIE, and that information will be sent through CareUnify for our Florida network beginning in October 2017. We have deep experience with the integration of CareUnify and state/private HIEs, now more than eight around the country already improving outcomes. Timely access to admission, discharge, transfer and other meaningful clinical data on enrollees in combination with our data-analytics engine and CareUnify clinical workflows can have a profound impact on reducing hospital readmissions, emergency department use, and inpatient utilizations as well as improving HEDIS measures. After the adoption of CareUnify, the Aetna Medicaid organization's Michigan health plan has seen an approximately 5% improvement in HEDIS scores. These improvements have been seen in post hospitalization follow-up for a high-risk, dually eligible population. Integration of CareUnify and Florida's HIE systems gives real-time notifications to care team members about admissions, discharges, and transfers or when acute events are detected, immediate intervention is indicated, or gaps in care need to be addressed. Aetna is confident that our Florida plan will also see a significant improvement in HEDIS scores as a result of implementation.

### **Evaluation Criteria:**

1. The extent to which the described experience demonstrates the ability to use standard supplemental data sources (lab result files; immunization data in State or county registries; transactional data from behavioral healthcare vendors; and current or historic State transactional files in a standard electronic format) for HEDIS and other performance measures.
2. The extent to which the described experience demonstrates the ability to use supplemental data from electronic health record (EHR) vendor systems and data from certified eMeasure vendors for HEDIS and other performance measures.
3. The extent to which the described experience demonstrates the ability to report HEDIS measures collected using Electronic Clinical Data Systems (ECDS).

**Score:** This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

**EXHIBIT A-4-b**  
**MMA SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**MMA SRC# 17 – Coordination of Carved Out Services (Statewide):**

The respondent shall describe its approach to coordinating services that are not covered by the respondent, but are covered by Florida Medicaid either through the FFS delivery system (e.g., behavior analysis services, prescribed pediatric extended care) or through a prepaid dental plan.

**Response:**

Aetna is committed to the Agency's overall objective for Medicaid enrollees to receive all medically necessary services in a timely manner and in the most appropriate setting, thereby achieving optimal quality outcomes while containing costs. Our approach to coordination of carve-out services will assist the Agency in reducing the duplication of treatments and services, thus minimizing waste in the system. Aetna always addresses the enrollee's needs, whether the services are carved in or carved out.

Aetna is prepared to and experienced in coordinating services currently carved out by the Agency or that the Agency plans to carve out. We have the experience, infrastructure, and processes necessary to coordinate seamlessly with the carved-out service system, including fee-for-service and prepaid dental plans.

Our Enrollee Services representatives and care managers are thoroughly trained regarding services covered by agencies outside of Aetna available through Florida Medicaid. They provide this information directly to our enrollees and their families; care managers assist with referrals or make referrals directly on behalf of enrollees. They help to ensure successful referrals, provide ongoing care coordination, and help to remove barriers for all enrollees.

**COORDINATION OF SERVICES NOT COVERED BY US BUT OTHERWISE COVERED BY FLORIDA MEDICAID**

We work with our enrollees and their families to develop a comprehensive service plan that includes covered and non-covered services. Through this process, we provide extensive education on the full service plan. Our care managers are trained on the specifics of carved out services and educate enrollees in a variety of culturally competent ways on how to access carved-out services they may require, e.g., Behavioral Analysis Services (BAS) education for the parents of a child with autism or who may benefit from this service. As part of that education, we provide enrollees with contact information for the organizations supplying the services in question, provide education materials, make warm transfers to the organization, and facilitate conference calls with the enrollee, the organization, and the enrollee's circle of support.

To increase access to care and services and improve health outcomes for enrollees, Aetna's seamless system of care immediately links enrollees to continuous and coordinated quality care whenever they require services that are not covered by the health plan but are covered by Florida Medicaid. We address our enrollee's needs in a holistic manner, whether the services are carved in or carved out. Our Enrollee Services team refers enrollees who require services not covered by our contract to the appropriate programs, and we continue to provide all required care coordination and care management services to our enrollees, regardless of where they receive services.

**EXHIBIT A-4-b**  
**MMA SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**INTEGRATED SYSTEM OF CARE APPROACH**

Aetna takes an integrated care management approach that includes a full spectrum of effective, community-based health care and psychosocial services and supports for individuals, their families, and circles of support. Our integrated care management:

- Is organized into a network to function as a virtual team
- Drives collaboration between agencies of state and local government and community-based organizations
- Builds meaningful partnerships with enrollees and their families/circle of support
- Addresses enrollees' cultural and linguistic needs

Our enrollees often need treatment and services not covered directly by the health plan but available from other agencies of state, county, or local government or from community-based organizations. Our integrated care managers identify the health care resources available within each region and familiarize themselves with the requirements and obligations of each provider so they can include those resources when it is appropriate for optimal outcomes.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

PPECs are medical day care centers dedicated to the care of medically fragile infants and children. The centers are designed to optimize the development of each child's independence, while helping them reach their full potential. Daily care at PPEC centers involves clinical interventions, therapy services (physical therapy, occupational therapy, and speech and language therapy) and educational activities.

**EXHIBIT A-4-b**  
**MMA SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**ORAL HEALTH**

When oral health is carved out in 2019, there will likely be several different dental vendors throughout the State that may be different from the dental vendor we will be contracting with to provide expanded dental services for adults. Aetna will offer as expanded benefits adult dental services not covered under the State contract including cleanings, x-rays, cavities and periodontal. To ensure enrollees understand how to access services we will perform the following:

- Develop relationships with all dental vendor care management departments to enable seamless referrals of enrollees in need of dental services
- Promote referral partnerships between our dental network providers and providers of dental vendors not managed by the health plan; optimally dental providers will participate in all dental plan networks
- Engage and educate enrollees on the difference in benefits covered by the health plan and those that are available through the statewide Medicaid dental vendors
- Confirm that health plan staff and subcontractors are aware of and effectively communicate the appropriate information on services available through Medicaid dental vendors
- Educate providers through our website, handbook and informational bulletins on services covered by the health plan and the dental vendors, ensuring that they are transmitting accurate information to enrollees
- Work with all dental vendors to provide educational materials to enrollees explaining which services are covered by dental vendors and the health plan

**BEHAVIORAL ANALYSIS SERVICES**

We strongly support the proven, evidenced-based practice of behavioral analysis services (BAS), a service carved out and provided by AHCA through Beacon Health Options, for enrollees dealing with issues related to the autism spectrum. Our Care Management staff members provide care coordination for these enrollees and their families to ensure that services covered by Aetna are provided to complement and supplement BAS services, including speech therapy and occupational therapy.

[REDACTED]

[REDACTED]

[REDACTED]

**EXHIBIT A-4-b**  
**MMA SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**RECIPROCAL REFERRAL PARTNERSHIPS**

**CRITERION 1:** The extent to which the respondent describes effective and efficient processes for reciprocal referral for needed services

Effective referral arrangements make it possible for care coordination and for enrollees to receive the array of services they need without disrupting continuity of care. There are two ways to promote effective and efficient coordination of referrals. One critical way is to promote and facilitate provider coordination; this involves ensuring that providers are aware of the resources, services and carved out services that are available to enrollees. The other is through direct collaboration with community agencies.

Provider engagement involves a multiple prong approach wherein provider outreach and education about carved out services is conducted broadly through provider education materials, newsletters and campaigns, and in a targeted and individual manner when it is enrollee-specific and when our care managers identify the need for services outside of the Medicaid covered benefits. Direct linkages with organizations offer our health services team the access necessary for us to coordinate services directly when appropriate.



The collaboration with community organizations and the linking of providers to these community organizations creates a virtual health care team to meet each enrollee's clinical needs in a coordinated manner. We will be reaching out to all the relevant entities in each region to foster mutual understanding of treatment availability and of how each can work with the others to serve the enrollees best.

We will coordinate our internal system of care with their oversight and management practices. In other words, we integrate our care plans with the covered services not managed by the health plan. This means we include their services in our care plan and make sure all services offered to the individual are aligned and coordinated. We minimize complexity for the enrollee, streamline services so the entire plan of care is enacted promptly, and minimize the risk of duplicate or conflicting services.

**ENGAGING AND EDUCATING ENROLLEES IN UNDERSTANDING THE DIFFERENCE IN BENEFITS COVERED BY THE HEALTH PLAN AND THOSE THAT ARE AVAILABLE THROUGH OTHER MEDICAID DELIVERY SYSTEMS**

## **EXHIBIT A-4-b**

### **MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

**CRITERION 2:** The adequacy of the respondent's approach to engage and educate enrollees in understanding the difference in benefits covered by the respondent and those that are available through other Medicaid delivery systems

Enrollees engaged in self-care are frequently confronted with a complicated health care system whose parts and pieces do not work well together. We are committed to reducing this burden by providing navigator services to guide each enrollee to his or her destination in the health care system through education, collaboration, engagement, identification of barriers and strengths, and by leveraging those strengths to enhance resiliency, improve condition management, and promote self-efficacy.

#### **EDUCATION FOR ENROLLEES**

The initial mechanism for providing information regarding services available through other Medicaid delivery systems will be through our enrollee handbook, the enrollee Web portal, periodic mailings, and inserts accompanying an explanation of benefits.

We designed our website to provide timely, accurate, and accessible information to educate enrollees. The website is available in English or Spanish and can be made audible with a WCAG 2.0 AA screen reader. Enrollees can review their benefits, review and download a copy of the enrollee handbook, and send secure communication requests and questions to Enrollee Services for a response within 24 hours. In addition, we provide information on how to access carved-out services such as adult, BAS, and PPEC services.

Our Enrollee Services team provides education on all covered services and treatments that might assist enrollees to maintain or improve their health via its dedicated hotline, our enrollee handbook, the enrollee Web portal, periodic mailings, and inserts accompanying an explanation of benefits. We feature information about specific carved-out services and about how to access them in our enrollee newsletter and through handouts at enrollee-specific care planning team meetings.

#### **CARE PLAN DEVELOPMENT PROCESS**

We also educate our enrollees on all services available to support them through our care plan development process. We determine and support our enrollees' unique service needs through our care plan development process, including identification of services from Aetna and from community providers. Our holistic, enrollee-centered care and utilization management approach is developed with consideration of the enrollees' medical, behavioral, psychosocial, cultural, and spiritual health needs identified by comprehensive screening and evaluation tools.

The care manager uses motivational interviewing techniques, in combination with the Patient Activation Measure tool (PAM), to establish trust and to engage the enrollee. Care managers use PAM to assess an enrollee's level of activation, motivation, and likelihood of establishing and achieving goals (e.g., personal, health-related, etc.). This evidence-based tool generates a score based on the enrollee's responses. Based on his or her activation score, PAM recommends specific approaches that align with the enrollee's activation level. The aggregate information is the basis for the initial individualized plan of care.

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

An individualized care plan may include specific interventions or tasks that foster the enrollee's ability to fulfill his or her care plan and self-management goals and might involve completing referrals, assisting an enrollee with access to a provider or a community resource, or making follow-up calls to verify the enrollee received the care or services needed. Community health workers can assist with these activities as members of the integrated care team.

Care managers assist the enrollee and the interdisciplinary care team in identifying root causes of the enrollee's health deficits or high utilization of health care resources and plans care to ameliorate those conditions. Services provided by all agencies are aligned and consistent with the care plan. We educate the enrollee on these services and treatment that will contribute to meeting their identified goals, and we request that enrollees sign the care plan indicating their agreement to participate in the services.

Our care management team assumes responsibility for arranging, coordinating, and referring enrollees to all of the identified programs that meet the enrollees' needs. If an enrollee has difficulty arranging an appointment for a carved-out service, our staff makes a three-way referral call with the enrollee to Florida Medicaid's recipient. They track the completion of the referral and receipt of the service, using established policies and processes. We will train our non-clinical community health workers to further educate and support enrollees in completing paper work, gathering required information/documents, and removing any barriers to attending appointments with carved-out service providers.

### **ENSURING HEALTH PLAN STAFF AND SUBCONTRACTORS ARE AWARE OF AND EFFECTIVELY COMMUNICATE THE APPROPRIATE INFORMATION ON SERVICES AVAILABLE THROUGH OTHER MEDICAID DELIVERY SYSTEMS**

**CRITERION 3:** The extent to which the respondent's description includes a process for ensuring respondent's staff and subcontractors are aware of and effectively communicate the appropriate information on services available through other Medicaid delivery systems

Aetna is committed to providing our staff members and subcontractors a full understanding of the scope of carved-out covered services; eligibility criteria; how to access services; when the enrollee can expect to begin receiving services; how, where, and by whom the services are delivered; and financial expectations of enrollees. Whenever we receive an update on a covered or carved-out service, we revise our systems and desk reference documents. We periodically review our systems and desk references to make sure they are accurate and complete.

### **TRAINING OF AETNA STAFF**

We teach each team and our subcontractors to communicate appropriate information on services available through other Medicaid delivery systems. Every individual who interacts with an enrollee or provider receives the training, education, and support to provide the best possible encounter, including our staff in Enrollee Services, Provider Services, Medical Management, Care Management, Quality, Claims, Grievances and Appeals, and IT support. All of these individuals are crucial to our enrollee and provider engagement strategy.

Our comprehensive training curriculum for staff covers a variety of topics, including service availability, contract requirements, program requirements, claims, billing, prior authorizations,

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

grievance and appeals, information on how to handle concerns effectively and on cultural competency. We maintain and disseminate internal policy and procedure documents and provide role-specific training to make sure that our staff understands the availability and accessing of carved-out services. We thoroughly train all our staff to identify potential gaps in care, and coordinate to get the enrollee the services they need using:

- Specific in-service trainings that might include representatives of the carved-out services
- Internal directories of all services and community resources available, including 2-1-1
- Enhanced staff skills related to person-centered referral process
- Enrollee Services and medical management scripts for each carved-out service

As programs and waivers change, we update call center, care coordination, care management, and disease management desk references and follow the process described to keep the training current.

Staff is required to take regular refresher trainings as well as targeted trainings when there are updates and changes to the service delivery array. We conduct department-wide ad hoc trainings as needed to disseminate information. We hold monthly staff meetings to discuss changes across disciplines with multiple departments. We regularly host subcontractors who provide overviews of their services through Lunch and Learn sessions, often with continuing education credits for our clinical staff.

Ongoing training helps staff members internalize the information, but we provide additional individualized remediation, coaching, and mentoring as needed. We conduct audits of staff performance, including observation and listening to live and recorded calls, to confirm that correct information is being disseminated and give feedback to the staff on the interaction. We audit files to determine whether referrals should have been made on behalf of an enrollee, if the referral was made, and what the disposition of the referral is. We conduct staff and clinical case rounds with our medical directors, utilization management staff, care managers, and others to brainstorm service solutions that will meet the needs of our enrollees.

### **ADDITIONAL AETNA STAFF TRAINING TO SUPPORT ENROLLEES**

Our Enrollee Services representatives receive additional training, coaching, and guidance on policies and procedures to support each enrollee in achieving the best possible outcome. They learn to provide accurate information, including available carved-out services, and thoroughly review issues with enrollees to achieve final resolution in the first call, if possible. They learn:

- Active listening to reflect that they understand the reason for the call and to communicate their intention to respond
- Empathy for the caller's situation demonstrated by a caring tone of voice
- Ownership of the issue within the scope of their responsibility and authority
- Accurate information for addressing the caller's issue
- Proper channels for resolving various types of problems

All staff members who facilitate referrals receive in-depth training and coaching on the process, including assessing need and identifying barriers with the enrollee. They must demonstrate an understanding of the availability of agencies and programs throughout the system, including the

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

services provided, eligibility requirements, hours of operation, and fees as well as the agency's capacity to provide services appropriate to the enrollees' cultural and linguistic background. We support them through the referral process, assistance with any paperwork, and follow-up to ensure that the referral was completed.

### **MENTAL HEALTH FIRST AID**

We are also committed to ensuring our community and stakeholders have the education and information to help anyone in need of assistance. Mental Health First Aid (MHFA) is an evidence-based community educational program that trains individuals to assist someone experiencing a mental health or substance use-related crisis. In the MHFA course, participants build their mental health literacy and learn a five-step strategy for helping someone in both crisis and non-crisis situations, including how to identify risk factors and warning signs for mental health and addiction concerns and where to turn for help. Topics covered include:

- Depression and mood disorders
- Anxiety disorders
- Trauma
- Psychosis
- Substance use disorders

MHFA teaches that individuals experiencing these challenges can and do get better, and how they can use their strengths to stay well.

Aetna is committed to MHFA, and we have approximately 35 certified MHFA instructors enterprise-wide who have trained more than 1,600 employees to date. We train all enrollee-facing health plan staff, including clinical and non-clinical staff, in MHFA. Aetna will work to develop an MHFA training program in Florida in an effort to expand the knowledge and skills to community members. Aetna has trained first responders, primary care physicians and other specialists, and members of worship communities.

### **TRAINING OF SUBCONTRACTORS**

**CRITERION 3:** The extent to which the respondent's description includes a process for ensuring respondent's staff and subcontractors are aware of and effectively communicate the appropriate information on services available through other Medicaid delivery systems

Aetna Better Health® of Florida has streamlined our approach to engaging, educating, and supporting subcontractors throughout our 30 years of administering Medicaid plans. We use a deliberate and thoughtful approach to working with provider communities. This level of outreach is technological and hands-on, a collaborative strategy structured to ensure that all types of providers fully understand their responsibilities in a managed-care environment, their requirements under the contract and how to collaboratively interact with other providers to best meet enrollee needs.

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We conduct initial training within 30 days for newly contracted providers regarding the system of care, including carved out services, coordination of care of all services, and compliance with all contractual requirements for meeting the needs of our enrollees. We conduct ongoing monthly training for the specified provider types identified through monitoring, QI processes, and claim submission and payment processes to ensure our subcontractors are accessing carved out services on behalf of our enrollees. Training includes information on how we can assist the provider with any questions, issues, or problems with this process and how to access our provider portal for immediate information.

All of our Florida subcontractors are well versed in the service delivery system and availability of services through other Medicaid delivery systems. Our provider services liaisons will be located throughout the State to ensure ready access to subcontractors. Our outreach team regularly attends joint operating committee meetings with large medical groups and hospitals and any providers that request support for their efforts. This includes a general overview of the available service delivery system, the Agency's goals, information on where to seek assistance, access to the provider portal, how to bill for services or seek answers on claims, how to request prior authorizations, criteria for Medicaid eligibility, and our integrated care management model.

Our provider services staff members provide information to our subcontractors via letter, telephone, and email and facsimile blasts. This communication focuses on limiting disruption in services to enrollees, and includes instructions for making information available to enrollees and downstream providers. Our network staff members also communicate with providers regarding continuity of care to enrollees and the implementation of agreements designed to enable us to work directly with them to provide services.

Whether Florida-based or as part of our national support team, we understand that every encounter matters and that providers are the backbone of our enrollee service.

### **Evaluation Criteria:**

1. The extent to which the respondent describes effective and efficient processes for reciprocal referral for needed services.
2. The adequacy of the respondent's approach to engage and educate enrollees in understanding the difference in benefits covered by the respondent and those that are available through other Medicaid delivery systems.
3. The extent to which the respondent's description includes a process for ensuring respondent's staff and subcontractors are aware of and effectively communicate the appropriate information on services available through other Medicaid delivery systems.

**Score:** This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

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**EXHIBIT A-4-b  
MMA SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA (10-2-17)**

**EXHIBIT A-4-b**  
**MMA SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**MMA SRC# 18 - Vignette (Statewide):**

The respondent shall review the below case vignette, which describes potential Florida Medicaid recipients. Note: The vignette included below is fictional.

*Jose is a 15-year old male. He is diagnosed with bipolar disorder and is currently hospitalized under the Baker Act; this is his third psychiatric admission under the Baker Act in the past year. Up until six (6) months ago, Jose lived with his mother and two younger siblings, but he moved in with his father after his behavior declined and his mother was unable to protect herself and his siblings from Jose's angry outbursts and verbal and physical aggression. His father is physically disabled from a work injury, and he is concerned about managing Jose upon release, as Jose's behavior at home and school has significantly declined. At school, Jose is currently failing and has a notable number of absences and office referrals for altercations. Jose was diagnosed two months ago, during his second psychiatric admission, with bipolar disorder. Jose has been prescribed a low dose of Seroquel daily, but he does not take it consistently because of the side effects. He experiences drowsiness, dry mouth, and nausea. In his current admission, his laboratory testing results showed evidence of thyroid dysfunction. The hospital social worker assisted the family in completing and submitting a referral for Statewide Inpatient Psychiatric Program (SIPP) services, but the SIPP provider informed the social worker that authorization was denied. Jose's father has called the plan's enrollee help line for assistance with completing an expedited appeal. Jose was involved in outpatient therapy for the past six weeks. There have not been any adjustments to his medications to date. Jose has been enrolled in Medicaid since he was 5-years old. He has been enrolled in his health plan since July 2014.*

The respondent shall describe its approach to coordinating care for an enrollee with Jose's profile, including a detailed description and workflow demonstrating notable points in the system where the respondent's processes are implemented:

- a. New Enrollee Identification;
- b. Health Risk Assessment;
- c. Care Coordination/Case Management;
- d. Service Planning;
- e. Discharge/Transition Planning;
- f. Disease Management;
- g. Utilization Management; and
- h. Grievance and Appeals.

Where applicable, the respondent should include specific experiences the respondent has had in addressing these same needs in Florida or other states.

**Response:**

Jose's life has suffered traumatic disruption over the past year—maybe longer. The vignette describes a pattern of repeated treatment failure marked by multiple inpatient hospitalizations, progressively worsening behavior, school failure, family instability, and diminishing opportunity. Neither parent feels safe bringing Jose into their home. In addition, what appears to be the last

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

remaining option—residential treatment through the Statewide Inpatient Psychiatric Program (SIPP)—may have been foreclosed.

Adding to the complexity of Jose's story is the recent discovery of possible thyroid dysfunction and concerns about medication management. After being diagnosed with bipolar disorder and started on low-dose Seroquel during his prior hospitalization two months ago, Jose has not tolerated the medication because of several adverse side effects, but his medications have not been adjusted since discharge.

Aetna is responding to this vignette based on the integrated partner model we have formed with Beacon Health Options (Beacon). Aetna has successfully subcontracted with Beacon for 12 years, delegating management of the behavioral health benefits and the specialty behavioral health network. Within our new integrated partner model, Aetna will provide care management services for Jose and Beacon will perform utilization management services. Beacon strongly supports the Aetna integrated care management model. Aetna and Beacon have an aligned clinical vision that enables Aetna and Beacon clinical staff, working seamlessly side-by-side, to integrate care management and utilization management for all enrollees.

In this instance, Aetna's goal is to ensure Jose receives optimal care and that he is given an opportunity to achieve his goals and improve his health outcomes. Aetna's person-centered approach supports Jose with stabilization, reunification with his family, and utilization of community-based treatment, services, and supports to make the reunification successful long term. This aligns with the Agency's goal of increasing the percentage of enrollees receiving services in the community instead of an institutional setting.

We recognize Jose requires an environment of stability and permanency that will enable him to address his significant behavioral and physical health needs, support his strained relationship with his family, and promote improved performance in school, among other issues. Aetna and Beacon will collaborate with Jose and his family, the inpatient treatment team and outpatient clinicians that had been treating Jose, as well as the managing entity of the Statewide Inpatient Psychiatric Program, Jose's school, and other State and community resources to support Jose and his family's recovery from the traumatic disruption of the past year.

### **APPROACH**

**CRITERION 6:** The extent to which the respondent demonstrates a holistic system of coordinated health care interventions designed to achieve cost savings through the organized and timely delivery of high quality services

**CRITERION 4:** The extent to which the respondent describes an approach that supports care delivery in the most appropriate and cost-effective setting and avoids unnecessary institutionalization (i.e., hospital or nursing facility care) or emergency department use

Highly sensitive situations such as Jose's are the inspiration and impetus for a new enrollee-support model developed by Aetna's Behavioral Health team, using the acronym SACRED, which stands for:

- Stabilize: increase the enrollee's safety and decrease suffering

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- Assess: biopsychosocial assessment, social determinants of health, history of trauma, resources, strengths, values, beliefs, and preferences
- Consult: family, circle of support, current and previous providers, and wraparound services
- Refer: behavioral health provider, physical health provider, wraparound services
- Engage: enrollee, family, circle of support
- Discharge: seamless continuity of treatment

The SACRED model encompasses the essential components required for Jose to improve his health. Our first priority is to stabilize his condition and assure safety and security for him and his family.

Jose's three psychiatric admissions are representative of a growing trend in Florida, where 32,000 children were subject to examinations under the Baker Act during the 2015-16 fiscal year according to an annual report prepared for the Florida Department of Children and Families. It marks a 50% increase over a five-year period.

Jose's current hospitalization marks a critical time. Jose, his family, and everyone supporting them—his providers, the hospital, Aetna's Care Management team, and Beacon's Utilization Management team—will have to work in partnership to develop a plan of care and determine short-term and long-term solutions for Jose.

While he is hospitalized, we will work with the hospital to ensure Jose begins a full thyroid axis workup. According to the British Thyroid Foundation, "Hyperthyroidism can cause anxiety, irritability[,] and mood swings, while hypothyroidism can cause mental slowing and memory problems as well as depression." It is important to determine whether, and the extent to which, his thyroid dysfunction may be contributing to his mood disturbance. Seroquel has been associated with the development of hypothyroidism in a small percentage of cases. The treatment team will need to determine the extent of the thyroid condition as well as the benefits and risks of continuing the Seroquel prior to Jose leaving the hospital. Some aspects of the work up may be completed following discharge. The care manager would coordinate a call among Jose's attending physician, outpatient behavioral health practitioner, and primary care provider to discuss Jose's diagnosis, best next steps for his treatment, and proposed follow-up after discharge.

We view our role as educating Jose and his parents about the best approaches for Jose's care. We recognize the Statewide Inpatient Psychiatric Program serves the needs of Florida's youth with a Diagnostic and Statistical Manual of Mental Disorders-5 diagnosis, for whom a "less restrictive setting is not available." The care manager will coordinate with Beacon to make sure Jose's parents have as much information as possible about SIPP to inform their expectations about appealing the current decision or applying for admission in the future. If Jose's father decides to pursue an appeal, Beacon will work closely with him to prepare the appeal.

Our experience informs us a short-term residential admission, supported by evidence-based practices such as functional family therapy (FFT) or multi-systemic therapy (MST), could help stabilize Jose and prepare the family for Jose's return home. Ideally, family therapy would begin while Jose is in the hospital. Both forms of therapy are available through providers in Florida: functional family therapy:

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- Camelot Community Care – Fort Lauderdale,
- Camelot Community Care – CW, Fort Lauderdale
- Chrysalis Health, Central Florida
- Southwest Key Central, Central Florida,
- Southwest Key North, Northern Florida
- Southwest Key South, Southern Florida

### **Multi-Systemic Therapy:**

- Henderson Mental Health Center, Inc, South Florida
- Jewish Adoption and Family Care Options, South Florida

The care manager will coordinate with Beacon to determine whether an FFT or MST provider is available for Jose and his family either as an alternative to SIPP or to provide continuity of treatment after discharge from a short-term admission to SIPP.

### **NEW ENROLLEE IDENTIFICATION**

**CRITERION 1.a:** Identification processes for enrollees with complex health conditions or who are in need of care coordination

The vignette description states Jose has been enrolled in Medicaid since he was 5 years old and has been enrolled with Aetna since July 2014.

When Jose is admitted to the inpatient psychiatric facility the first time, Beacon's Utilization Management clinician would perform a telephonic review with the inpatient provider to assess for medical necessity and to determine if the stay can be authorized under the Agency's guidelines. The Utilization Management clinician would record the information in Beacon's integrated FlexCare management information system (MIS). Beacon's Utilization Management staff would transmit data on Jose's admission to the Aetna Care Management staff. The FlexCare MIS automatically lists Jose's inpatient admission on Beacon's daily census report, which is transmitted to Aetna. Aetna's care manager assigned to Jose's inpatient facility would identify him on the census report and review Jose's medical treatment history. In the absence of additional information that would have identified Jose as a candidate for care management, his first psychiatric admission likely would have been managed by Beacon Utilization Management without Aetna engaging care management outreach.

This process would have occurred after each of Jose's inpatient admissions. Jose's second admission would have identified him as being at high risk for future admissions. Aetna would have identified him as a candidate for care management and conducted telephonic outreach to begin the outreach and assessment processes. Based on our interpretation of the vignette's timeline, we did not begin working with Jose after his second admission. There are several reasons this may have occurred. We may have been unable to reach either of Jose's parents, or they may have declined care management at that time.

Our presumption is that Jose's father's outreach to Aetna's Enrollee Services line for support on his appeal to the Statewide Inpatient Psychiatric program resulted in a referral for care management services. The Enrollee Services representative would have assisted the father and

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

then set up a three-way call with a Care Management staff member to complete the referral process.

Aetna has multiple ways to identify enrollees with high risk for utilization for care management support. They include:

- Daily Event Notification Service (ENS) reports—ENS provides real-time notice to subscribing organizations like Aetna of patient encounters, which enables our care managers to follow up with enrollees and their providers for appropriate support
- Hospital provider authorization notification
- New enrollee's file with serious emotional disturbance indicator (in Jose's case, he is diagnosed with bipolar disorder two months ago during his second psychiatric hospitalization)
- Referral from primary care physician (PCP) or specialist through defined protocols as part of the provider agreement
- Predictive modeling: We use a predictive model to identify enrollees who are not currently hospitalized but who are at medium to high risk for hospital admission, high risk for an emergency department visit, and high risk for high cost over the next 12 months. Our Consolidated Outreach and Risk Evaluation™ (CORE) tool identifies each enrollee's risk (including behavioral, social, and physical). Based on this data, our care managers proactively reach out to those enrollees at the highest risk to offer them care management, during which we gather information on triggers and stressors, engage them in disease management, offer community-based resources, and support enrollees in reaching out to their primary care physicians, medical specialists, or behavioral health providers for any needs by scheduling appointments, escorting enrollees to appointments, and making transportation arrangements as needed. The care manager would facilitate the development of a crisis stabilization/safety plan for Jose and his family, defining how to respond to crises through family interventions and support from outside resources such as his providers and the behavioral health crisis line.
- Transition of care clinician: Aetna's transition of care clinician collaborates with Beacon's concurrent review clinicians and Aetna's care managers, hospital discharge planners, and providers to offer assistance and connect with enrollees who have "trigger" diagnoses. The transition of care clinician can make referrals to care management based on his/her evaluation of an enrollee.
- Quarterly emergency department high utilizers report
- The inpatient census: The electronic care management system has triggers that notify the Care Management and Utilization Management departments of all inpatient admissions. This enables Jose's care manager and concurrent review clinician to begin working directly with Jose during hospitalization.
- Referral from Enrollee Services department through warm transfer and three-way call with Care Management
- Referral from Health Information Line (nurse line) through warm transfer and three-way call with Care Management
- Referral from the behavioral health after hours line through defined, integrated system protocols

### **HEALTH RISK ASSESSMENT**

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

**CRITERION 1.b:** Description of the sources of data/information that would be utilized in the assessment process, including timeframes for completion

Jose's referral to care management would result in a phone conversation between an Aetna Care Management team member and Jose's father based on his initial outreach. We can support Jose and his parents with Spanish-speaking team members to enhance communication, if needed, in accordance with the Agency's cultural competency plan requirements as described in Attachment B. One of Jose's parents would be asked to complete a proprietary health risk questionnaire (HRQ) and proprietary outreach questionnaire (ORQ) on Jose's behalf. When we developed our standardized health risk questionnaire, there was not an evidence-based Medicaid-specific health risk assessment tool in the public domain. As a result, we created our own tool using questions from various evidence-based tools, including the Patient Health Questionnaire-9, Behavioral Risk Factor Surveillance System, and Child and Adolescent Health Measurement Initiative. Aetna would complete a comprehensive assessment process within 30 days, including development of Jose's plan of care.

Self-reported data, such as that elicited in our health risk questionnaire, is a critical component of our integrated care model. Our model addresses physical, behavioral, and social health, which is necessary for managing our most vulnerable, highest-risk enrollees like Jose. Many of the most serious behavioral and social issues cannot be captured in claims data. We have a set of biopsychosocial questions that help us to identify high-risk enrollees either in the absence of or as a supplement to claims data. We support enrollees within the context of health care equity and social determinants of health and develop their plans of care based on their goals and needs.

Additionally, our health risk questionnaire includes several questions to identify the possibility of a mental health or a substance use disorder. A positive response to any question about mental health or substance use leads to several more focused screening tools. Our health risk questionnaire is brief and targeted, which enables us to complete a quick assessment of the enrollee to inform us of whether he has immediate needs or should be referred for a more in-depth assessment with a care manager.

### **CARE COORDINATION/CARE MANAGEMENT**

**CRITERION 1.c:** Application of the respondent's case management risk stratification protocol

Enrollees are assigned to the appropriate care management level through a combination of information from our secondary reports, proprietary CORE methodology, enrollee assessments, and root-cause analysis. Only through addressing the root cause issues can we help enrollees reach their goals and optimal health status.

#### **Care Management Risk Stratification Protocol**

Jose is identified for our intensive level of care management, which focuses on high-risk, vulnerable enrollees characterized by biopsychosocial complexities. CORE helps us to identify enrollees for whom intensive or complex care management will promote access to appropriate care for improved health and well-being, and prevent avoidable utilization of services. We developed Medicaid-specific, proprietary algorithms based on medical, behavioral, and

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

pharmacy claims; diagnoses; impact scores; and our clinical and informatics expertise. These algorithms allow us to rank all plan enrollees from highest to lowest risk.

We identify three overlapping groups of enrollees: those who are highest-cost and highest-risk overall, those most likely to utilize emergency department services in the next year, and those most likely to be admitted to an inpatient setting in the next year. We run the model for our entire population on a monthly basis. The results are reviewed by the appropriate care management and medical management teams for enrollee contact and intervention opportunities. In addition, CORE uses pharmacy claims to identify many risks related to non-adherence and other medication management issues that care coordination can influence. Approximately 40% of an enrollee's risk assessment comes from pharmacy utilization and claims.

CORE provides care managers baseline data prior to the comprehensive assessment process. The assessment process establishes a profile of Jose as part of our person-centered approach.

### **SYSTEM OF COORDINATED HEALTH CARE INTERVENTIONS**

**CRITERION 6:** The extent to which the respondent demonstrates a holistic system of coordinated health care interventions designed to achieve cost savings through the organized and timely delivery of high quality services

Jose's plan of care will be developed during a face-to-face visit between the care manager, Jose, and his parents. The visit will provide an opportunity for the care manager to meet Jose and his family, beginning relationships based on trust and compassion and focused on Jose achieving his health goals. The care manager will help Jose and his family understand that Jose's path to better health begins within himself and with the support of his family.

During the visit, Jose and his parents will complete a comprehensive, evidence-based assessment, which gives us a deep understanding of who Jose is, and what his needs are from a medical, behavioral, social, functional, and cognitive standpoint. The assessment provides us with the information necessary to create the framework for Jose's plan of care and for formation of his interdisciplinary care team. Our goal would be to complete the assessment as soon as possible after he is identified for care management services. However, if he is placed in a residential facility, development of his plan of care could be slightly delayed while his other needs are met. The care manager would use Jose's inpatient record, discharge plan, and residential treatment plan (if applicable) as the foundation for the initial phase of care management.

Jose's family life is an important component. It is essential for the care manager to understand the relationship between Jose's mother and father, their custodial arrangement for Jose and his siblings (if they are divorced), and background on the father's disability. We would also inquire if Jose has developed an Individualized Education Program (IEP) through his school.

The care manager conducts a comprehensive assessment of Jose, using an instrument that is based on best practices and clinical guidelines. The comprehensive assessment contains a biopsychosocial scope with elements of root-cause analysis and social determinants. The care manager will engage Jose and his parents in a collaborative conversation using Motivational

## **EXHIBIT A-4-b**

### **MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Interviewing to understand the goals that matter most to him and the discrepancies in his current lifestyle. This is a conversation of experts: Jose is an expert in his life—his values, preferences, and beliefs, the goals that are most important to him, and his readiness to make changes in his life. The care manager has clinical expertise in evidence-based practices that can help Jose achieve his goals. The care manager uses the Parent Patient Activation Measure (P-PAM) as an evidence-based assessment of Jose's parents' activation level, as well as their ability and motivation to change behavior. This helps guide the care manager through care planning, which matches Jose's parents' level of activation. In this manner, Jose, his family and the care manager create a plan of care that is realistic and actionable.

The care manager discusses Jose's story in terms that make sense to him and his family. We receive verification from the family members we are accurately reflecting their beliefs, preferences, and goals. This becomes the basis for identifying the root causes of Jose's current and recent challenges. Jose's preliminary plan of care addresses any immediate urgent needs Jose may have and describes how the care manager and other members of Jose's care team and circle of support will work with Jose to mitigate the impact of the most important root causes. This work is not complete until Jose and his parents agree that it makes sense and commit to the activities in the plan of care. The care manager works with Jose to define and prioritize both short- and long-term goals, translate those goals into achievable steps, and implement the plan of care in phases according to their activation level. This phased approach will enable Jose to meet short-term goals quickly and to increase his confidence level early. One of Jose's goals might be to stay out of the hospital and remain living with his father. Our role is to serve as an advocate, and to help Jose discover what is truly important to him. We are helping to shape Jose's life plan, not simply a care plan.

The goals of our holistic system of care interventions are to help ensure the plan of care agreed upon and implemented by Jose and his family meets Jose's short- and long-term goals. Keeping Jose out of the hospital and living with his father is a cost savings; more importantly, it focuses the care on Jose, thus enabling him to live in the least restrictive and most integrated setting compatible with his preferences.

It is common for individuals like Jose to have more than one care manager, thus creating a risk of having competing or conflicting care or treatment plans, making their treatment fragmented and ineffective. This includes not only the behavioral health provider but also the school and other providers. In addition, when there is a lack of supportive services, Jose and his family could feel hopeless and frustrated with the systems of care. The goal of the care manager is to coordinate and streamline these conflicting or competing priorities into a plan that will work best toward the treatment goal. Our external population health management system, CareUnify<sup>SM</sup>, would support Jose's interdisciplinary care team (including Beacon as a provider of delegated services) with external data sharing around key clinical events that includes real-time notifications in addition to detailed enrollee and panel information. CareUnify also enables Jose and his family to electronically communicate with the interdisciplinary team and provide a platform for his working plan of care and service plan.

As part of the initial process of getting to know Jose, we learn about the important people in his life, including the people he and his parents want on his interdisciplinary care team. At a minimum, Jose's interdisciplinary care team would include Jose and his parents, his primary care physician, attending physician, behavioral health practitioner, school social worker, Aetna's

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

pharmacy representative, and Aetna's care manager. The care manager would share Jose's plan of care with his primary care physician and behavioral health practitioner and schedule calls with them to ensure Jose's plan of care is aligned with his treatment plan. Again, CareUnify would be an invaluable communication tool to ensure that Jose's interdisciplinary care team are informed about his plan of care, changes to that plan, key clinical events, keeping the care team aligned in their efforts and minimizing confusion for Jose and his parents about who is coordinating specific components of care. It also promotes enrollee safety by ensuring key care actions like medication reconciliation are addressed.

### **APPLICATION OF COORDINATION PROTOCOLS**

CRITERION 1.g: Application of coordination protocols utilized with other insurers (when applicable), primary care providers, specialists, other services providers, and community partners particularly when referrals are needed for non-covered services

It is not unusual for our enrollees to receive services through the Statewide Medicaid Managed Care Program's comprehensive benefit package, along with non-covered services from a variety of programs and community resources. We coordinate care regardless of the source. The services Jose receives are included in his plan of care. Our care manager facilitates communication, consultation, and information sharing among the service providers.

If Jose is in need of non-covered services, we have experience coordinating the financial and medical management responsibilities for specific carved-out benefits for enrollees, such as Intermediate Care Facilities for Individuals with Intellectual Disabilities, prescribed pediatric extended care, or Early Intervention services.

To facilitate effective coordination of care with providers of non-covered services, our programming includes activities such as:

- Connecting Jose to physical and behavioral health providers and resources that support his ability to stabilize his conditions and reach his health care goals—leveraging the resources of Aetna's and Beacon's provider networks and, for out-of-network providers, facilitating letters of agreement or single-case agreements
- Securing urgent or emergency care if Jose is experiencing a crisis, including notification of any behavioral health or specialty provider who may be involved— a crisis stabilization/safety plan is included in the development of Jose's plan of care
- Coordinating benefits by collaborating with contracted and non-contracted partners and providers to determine benefit eligibility and coordination of covered benefits
- Involving community or provider-based care managers who may offer unique or specific services that Jose may need such as Florida 2-1-1 which provides crisis centers, suicide prevention, youth wellness programs, programs for trauma/violence prevention and intervention and on-line referral services for Jose and his family that include housing, transportation, employment, and comprehensive family services
- Making referrals for health-related services, which are outside the benefit package, through external programs or community resources and organizations
- Reporting (internal and external), including monitoring and reporting referrals, authorizations, and outcomes according to internal health plan requirements and external

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agreements; reporting is available in real-time dashboards, daily census and Event Notification Service reports, and various monthly utilization and quality reports.

- Coordinating care with the primary care physician and patient-centered medical home or health home team and other interdisciplinary care team participants to facilitate referrals for needed services that may not be covered under the Statewide Medicaid Managed Care Program
- Developing relationships with community partners to learn about non-covered benefits to assist them with their needs and to make referrals to those services. Community partners such as the Family and Communities Empowered for Success program in Miami-Dade County, which provides youth and their parents with mental health and substance abuse services; National Alliance on Mental Illness Miami-Dade County, which hosts support groups twice monthly for family and friends of individuals with mental illness or mental illness co-occurring with substance abuse; and Depression and Bipolar Support Group of Miami, which meets twice monthly.

### **COMMUNICATION AMONG PROVIDERS AND INTEGRATION OF INFORMATION**

CRITERION 1.k: Evaluation criteria 1k. Application of strategies to integrate enrollee information across the plan and various subcontractors when the respondent has delegated functions

CRITERION 3: The extent to which the respondent demonstrates innovative processes that it has in place to enhance communication among all service providers and subcontractors (for delegated functions)

CRITERION 7: The extent to which the respondent describes innovative and evidence-based strategies to integrate information across all systems/processes into its workflows

In advance of the initial interdisciplinary care team meeting, the care manager would share Jose's plan of care with the entire team; the plan of care will be a focal point of discussions throughout the course of support for Jose. The interdisciplinary care team meetings provide an opportunity to review Jose's plan of care and his current clinical status to make sure all of his biopsychosocial needs are being met. The care manager takes the lead on the assignment and follow-up of all action items that result from the meetings.

Aetna's technology system protocols enable Jose's care manager to have access to all of Jose's records within our systems so he/she can stay updated on key care management components such as Jose's medications, prior authorization requests, utilization management processes, and results of P-PAM assessments. Aetna is able to better support Jose through our systems that provide essential departments access to our primary enrollee support system (i.e., enrollment, claims processing, service authorization) and care management system.

Aetna accomplishes exceptional levels of care collaboration by using our electronic care management system, which is composed of two components:

- Our internal care management system drives internal care management workflows and tracks key enrollee engagement events and the longitudinal care management record for our care management team.

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- Our external population health management system, CareUnify, which would support Jose's interdisciplinary care team (including Beacon as a provider of delegated services) with external data sharing around key clinical events that includes real-time notifications, detailed enrollee and panel information. CareUnify also enables Jose and his family to electronically communicate with the interdisciplinary team and provide a platform for his working plan of care and service plan. If Jose's parents or his providers do not have the ability to access CareUnify, the care manager will maintain communication and deliver information through face-to-face visits, phone, email, and fax.

CareUnify features industry-leading and proprietary features like care paths that take information and convert it into meaningful and actionable steps for the entire care team, regardless of their affiliation or the four walls within which they sit. These features can be applied to any condition we support.

Care paths are specialized workflows designed to create simple, predefined steps shared by a team of providers around a common clinical event tied to best practices. While a care path can be created for any number of clinical events that require team coordination, a very common care path successfully used in CareUnify is related to managing a transition of care after an enrollee is discharged from a hospital stay.

The power of the care path function is to ensure accountability for providing quality care and to prevent duplication of services. More importantly, setting a care path, tied to key clinical events, helps keep the care team aligned in their efforts and minimizes confusion for the enrollee about who is coordinating specific components of care. It also promotes enrollee safety by ensuring key care actions like medication reconciliation are addressed.

### **ASSESSMENT OF PROVIDER CAPACITY**

**CRITERION 1.h:** Description of the assessment of provider capacity to meet the specific needs of enrollees

Our aim will be to include all of Jose's providers in our network. For example, if Jose is diagnosed with a thyroid disorder, he may require the services of an endocrinologist. If that were to be the case, we'd ensure access to this specialist. Jose's providers that are not currently in our network would be encouraged to join by our Provider Services department. For providers unable or unwilling to join, the care manager will coordinate with the Provider Services department to facilitate letters of agreement or single-case agreements.

It is critical that Jose's medications be closely managed by a behavioral health specialist until his condition is stabilized and he tolerates his medication(s) well. An additional consideration is the possibility of modifying his psychotropic medications in light of possible treatment of a thyroid disorder as Seroquel has a potential impact to cause hypothyroidism. Medication management should be performed by a psychiatrist or a Psychiatric ARNP, or within an integrated primary care/behavioral practice that includes access to specialized behavioral health expertise.

An enrollee who has had several inpatient admissions in short succession and is not tolerating his or her medications well needs to be seen frequently, ideally within a week of discharge from inpatient hospitalization and weekly thereafter until his condition is stabilized. This often is

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beyond the capacity of many community mental health centers. That no adjustment was made to Jose's Seroquel dosage since he received his diagnosis and started the medication, despite his adverse effects, suggests his treatment may not have been closely managed. In this situation, Aetna will arrange for prompt follow-up care.

Aetna and Beacon will evaluate the adequacy Jose's outpatient treatment and work with Jose's behavioral health providers to address any treatment gaps. We will also identify integrated primary care practices with the requisite behavioral health expertise as potential alternatives if the behavioral health providers lack the capacity for more frequent medication management visits. Improving network capacity is one of the reasons Aetna and beacon are working closely to promote development of these integrated practices.

Of course, the other critical participants in Jose's medication management are Jose himself and his parents. The better informed they are about the medications themselves and the goals of treatment, the more effectively they'll be able to participate in managing the treatment along with the clinical team. The care manager will make sure Jose has all the information he needs, answer questions he and his parents might have, and offer Jose access to peer support to learn how other teens have learned to manage these challenges.

A second important aspect of provider capacity to meet the specific needs of enrollees is availability of evidence-based intensive in-home and community-based family therapies. These have been shown to have better outcomes and fewer risks than psychiatric residential treatment for most children and youth being considered for residential treatment. They can serve as alternatives to admission, and as step-down resources that can appreciably shorten length of stay.

There are several providers across Florida that offer one of these therapies. Earlier in this response, we listed providers that offer two of the best-known: functional family therapy and multi-systemic therapy. Aetna and Beacon will collaborate to encourage these providers to expand their capacity and to encourage other providers serving children and youth to include these evidence-based practices in their array of services.

### **SERVICE PLANNING**

**CRITERION 1.d:** Identification of service needs (covered and non-covered) and a description for service referral processes that the plan has in place

**CRITERION 1.g:** Application of coordination protocols utilized with other insurers (when applicable), primary care providers, specialists, other services providers, and community partners particularly when referrals are needed for non-covered services

The care manager works closely with Jose and his parents to educate them on Jose's enrollee benefits and to help facilitate provision of services to meet his needs. A primary focus is the clinical management of Jose's acute treatment episode. Jose's providers will discuss and collaborate on medication and clinical intervention (including adjustment of the dosage of Seroquel and other medication under his current regimen) to manage the acute episode, with a goal of helping Jose safely return to the community. His mother and father can ask questions of

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Jose's treatment providers, inclusive of options for community-based management of his condition.

The care manager works closely with Beacon's Utilization Management staff and the interdisciplinary care team to identify behavioral health services to support Jose. We would help Jose to establish the services and follow up on their outcomes. We would monitor services such as therapy and peer support to help ensure they are supporting Jose's plan of care goals and improving health outcomes. Our care managers, in collaboration with Beacon's Utilization Management clinicians, will consult with behavioral health providers if expected outcomes are not being achieved, to identify whether the current care plan needs to be revised.

Because Seroquel is an atypical antipsychotic, the prescribing clinician will monitor Jose's metabolic profile. This will be coordinated with Jose's primary care provider to share clinical findings timely, to consider alternative causes of any metabolic changes and to eliminate duplication of lab tests. The care manager will educate Jose and his parents about metabolic effects they might notice, such as unexpected weight gain.

A major barrier to implementing integrated care is how difficult it can be for an enrollee to get the treatments, services, and supports he or she needs because health care providers are often fragmented from one another. Aetna has implemented standard operating protocols throughout our system of care (care management, utilization management, provider network, and enrollee services) to mitigate the risks to individual enrollees. We help match enrollees with complex co-occurring conditions with integrated clinical practices in either of our networks (Aetna and Beacon) that would be a "best fit" with their needs, and educate the enrollee about the benefits of getting their health care from an integrated provider.

Jose will benefit from Aetna's integrated care model, which includes (but is not limited to) all the services enrollees in a particular vulnerable population might need. This includes covered services managed by Aetna; physical and behavioral health services not managed by Aetna and/or not covered by the contract; school-based services and clinics; wraparound treatments, services, and supports available from government agencies or offered by community-based organizations; and waivers such as the Model Waiver. Referrals to community services are based on social determinants of health.

We have developed a social determinants questionnaire to assess an enrollee's need for additional resources. If services are needed, a notification through CareUnify will be sent to the care manager. For service referrals, our care managers utilize Florida 2-1-1, which is a free, confidential service that connects enrollees with local, community-based organizations across the state. Florida 2-1-1 provides assistance with food, housing, employment, health care, counseling, and more.

If Jose is interested, we can also seek opportunities for him to release energy through physical activities that align with his interests, such as sports, cycling, skateboarding, etc.

Within Aetna's and Beacon's integrated partner model, service providers, agencies, and organizations are working together to construct a system of care that benefits Jose and his family. As a result, our integrated care model ensures the right resources are available, organized, and coordinated to enable Jose to achieve goals that matter most to him. The model

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also allows enrollees like Jose to live in the least restrictive and most integrated setting compatible with their preferences, treatment efficacy, and safety, which helps to minimize preventable use of high-intensity, high-cost health services such as inpatient hospitalization, long-term residential/institutional care, and emergency department visits.

### **DISCHARGE/TRANSITION PLANNING**

**CRITERION 1.f:** Application of discharge and aftercare planning protocols that facilitate a successful transition

For purposes of this exercise, we will focus on the discharge/transition planning process for Jose following his third psychiatric admission.

From day one of Jose's third admission, the Beacon concurrent review clinician reviews the admission for medical necessity, and works collaboratively with Aetna's care manager to identify behavioral, social, or other contributing factors or root causes of the admission. This enables us to shape the plan for continuity of care after discharge and prevent discharge planning failures that can lead to readmission.

Additionally, Aetna's transition of care clinician collaborates with Beacon's after-care coordinators to foster a smooth transition and timely follow-up care to post-hospitalization behavioral health care and improve the continuity of care for enrollees after a mental health hospitalization. Aetna's transition of care clinician collaborates with the concurrent review clinician and care manager, hospital discharge planners, and Jose's outpatient providers to coordinate services leading up to and during transition out of the hospital and supporting continuity of treatment at the next level of care. Beacon's aftercare coordinators offer timely telephonic communications, encouragement to sustain efforts toward recovery, and when needed, extra guidance in navigating the provider network.

Earlier in this response, we described our preference for evidence-based practices such as functional family therapy (FFT) or multi-systemic therapy (MST) that could help stabilize Jose and prepare the family for Jose's return home. The list of current providers suggests that Jose and his family might not live in proximity to one of their offices. If that were to be the case, Beacon would also create a home-based therapy program, which is designed to assist enrollees who require immediate or additional support in transferring back home after an inpatient mental health hospitalization. Therapeutic services in the home (TBOS) may be an effective way to provide the support that Jose's father needs to help Jose remain in the community. The care manager and Jose's TBOS provider engage in ongoing motivational interviewing techniques and psycho-education to educate Jose's father, mother, and Jose on the importance of taking his medication.

Upon discharge, several agencies could provide intensive services for Jose and his family. Specifically, there are community agencies that employ teams of behavioral health professionals including a targeted care manager, individual therapist, family therapist, a family coach (who works solely with the parents on parenting skills), psychiatrist (who address and reconcile medication for stabilization of the youth), and are in the home daily to ensure monitoring and support for the youth and his family. These agencies also provide pediatric care that can address Jose's chronic illness or his thyroid issue. The Aetna medical and behavioral health care managers work closely to ensure follow-up medical appointments are made for Jose

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regarding his thyroid issue and behavioral health symptoms. The care manager outreaches to Jose's outpatient provider regularly about continued medication monitoring for adherence, side effects, and the potential for metabolic syndrome.

After the initial meeting and after discharge from acute care, the care manager engages in regular contact with Jose, his family, and his treatment team to ensure appropriate follow-up. Treatment planning for Jose and his family will be an ongoing and holistic process defined by the trajectory of Jose's care. The care manager interfaces with his school staff, family, and outpatient provider with the goal to close treatment gaps (especially around clinical care and therapy) and family-based supportive services. Longer term goals include helping Jose be successful in school, with a behavioral intervention plan supported by the treatment team, for both school and home.

If Jose continues to be a safety risk in the home, the care manager would collaborate with Beacon's Utilization Management team to consider the possibility of residential treatment or placement in a therapeutic group home. They would work with Jose's mother and father together with the targeted care manager to pursue such placement.

### **STRATEGIES FOR SELF-MANAGEMENT AND TREATMENT ADHERENCE**

**CRITERION 1.i:** Identification of strategies that promote enrollee self-management and treatment adherence

Jose's individualized support from his care manager will include education on the importance of self-management and treatment adherence to improving his health outcomes. The care manager also will work with Jose's parents to educate them on their role in Jose managing his conditions. Jose will be supported by the MyActiveHealth enrollee portal and mobile application, which offers digital coaching, videos, audio files, and social communities that will help Jose manage his conditions, including both his bipolar disorder and his thyroid dysfunction.

Additionally, Jose would receive mailings of Krames patient education materials that are aligned with his conditions. The care manager will use these tools for discussion points when meeting with Jose and his parents. Our materials are in an easily understood language and format at or near fourth-grade comprehension, in compliance with Attachment B of the Invitation to Negotiate. All written material is available in multiple languages, as prescribed by the Agency.

Our educational information for Jose and his parents could include:

- Signs and symptoms, self- management, and collaboration with provider and behavioral health practitioner
- Importance of enrollee supports
- Medication management and adherence
- Wellness Recovery Action Plan
- Suicide risk signs
- Substance abuse treatment
- Additional educational information on co-morbid conditions
- Diet and nutrition
- Importance of physical activity and wellness activities

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### **STRATEGIES TO FACILITATE COMPLIANCE WITH THE PLAN OF CARE**

CRITERION 1.e: Description of the interventions and strategies that would be used to facilitate compliance with the plan of care, including use of incentives, healthy behavior programs, etc.

The care manager would provide support for Jose's interest in joining a peer support group. We would work with organizations like the National Alliance of Mental Illness (NAMI) Florida help identify support groups and arrange for Jose to participate.

Beacon has significant experience serving diverse enrollee populations across the country with innovative program designs emphasizing peer-to-peer supports and individual-driven care. Each Beacon contract using peers employs one or more of the following peer models, based on the specific requirements of the contract:

- Peer and family support: Peers provide a wide-range of guiding, advocacy, and connecting services to enrollees and their families; typically working as adjuncts to clinical services
- Peer warm lines: Warm lines staffed by peers provide a direct communication link and emotional support for enrollees and families
- Prevention, education, and outreach: Peers organize and participate in community meetings, training, events, and educational forums
- Peer-run programs: Through peer-run programs, peers build support and capacity building for other community advocacy and peer services (e.g., NAMI)

Beacon works with community mental health center providers throughout Florida to acknowledge the importance and impact of peer services within the community. Beacon engages with providers to increase the utilization of peer supports to drive improved health outcomes.

### **DISEASE MANAGEMENT**

Aetna's disease management program is delivered within the framework of our integrated care management program. The goal of the disease management program is to improve our enrollees' health status and their ability to self-manage their chronic condition so that they can minimize the extent to which it interferes with their lives, as well as to identify and manage co-morbid conditions as needed. It aims to reduce longer-term premature morbidity (complications) and mortality of the condition. Aetna has designed our disease management program to support enrollees like Jose most likely to have high utilization of inpatient admissions and emergency department visits related to their diagnosis and severity of illness.

We will screen Jose for co-occurring disorders (i.e., substance abuse) and provide education on Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements. Our care managers are experts in EPSDT guidelines and closing gaps in care. The care manager's outreach to Jose will be individualized based on his unique needs and social determinants. The care manager will educate Jose and his parents on his gaps in care, identify barriers, and assist them with accessing the resources and benefits they need to overcome those barriers and complete needed care.

The care manager also will work with Jose and his behavioral health provider to promote the

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development of an evidence-based wellness recovery action plan (WRAP), a self-designed prevention and wellness process. We would encourage Jose to work with a peer to create his personalized WRAP plan.

### **UTILIZATION MANAGEMENT**

**CRITERION 1.j:** Application of utilization management protocols (i.e., identification of the criteria that will be utilized, processes to ensure continuity of care, etc.)

Beacon's utilization management strategy begins with service authorization for all care and combines review criteria with data-driven management of facilities and providers to improve quality and control costs. Our shared focus is on increasing access to the most clinically appropriate levels of care for individuals while minimizing the administrative burden on providers. Beacon is also attentive to identifying and addressing clinical practices that are not supported by published guidelines or evidence-based practices. Like Aetna, Beacon's approach is focused on promoting the best, most cost-effective interventions, treatments, setting, and approaches. It is about being aware of and attentive to the individual's total life situation, including illness, social needs, strengths, and resources available for promoting recovery.

Beacon's utilization management program encompasses management of care from the point of entry through discharge for all enrollees. Using its Florida Medicaid Level of Care Criteria (LOCC) for mental illnesses and American Society of Addiction Medicine (ASAM) criteria for substance use disorders, Beacon manages behavioral health care utilization management with objective, scientifically based clinical criteria and treatment guidelines in its service authorization process. Intensive utilization management is reserved for high-cost, highly restrictive levels of care and cases that represent potential clinical complexity and risk. Licensed behavioral health clinicians base their reviews on clear and concise criteria developed specifically to guide level of care, treatment, and length of stay determinations.

In Jose's case, Beacon's Utilization Management clinicians and program are important components of the services and support we provide to Jose. The care manager and Jose's interdisciplinary care team would work closely with the Utilization Management clinicians and closely align to help ensure continuity of care for Jose. As a common practice in behavioral health, we would adopt a step-down approach for Jose aimed at sustaining and improving his health outcomes. Our focus would be on preparing Jose for his return home. Previously, we described the possibility of Jose being admitted to a residential facility, supported by family therapy, following discharge from his third admission. If Jose does have a short-term residential stay, we would collaborate with Beacon to determine his next step, such as intensive outpatient care.

If Jose is admitted to short-term residential treatment through SIPP, our care manager would follow his care closely, meeting with clinical representatives of the residential treatment team every two to three weeks. Some of the issues we would track include:

- Results of the completed thyroid work-up, subsequent treatment and any implications for the diagnosis and/or treatment of bipolar disorder
- Medication management related to the bipolar disorder
- Participation and progression of family therapy

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Jose's care might require tests and/or other services that fall outside SIPP covered services and might require prior authorization. For example, completing his thyroid work-up might require Aetna's Utilization Management department to gather appropriate information from the ordering practitioner for medical necessity review and authorization within the contractual timeframes for standard or urgent requests. If the test or service is not authorized, the medical director making the decision is available to discuss the determination and alternatives with the requesting provider. A notice of adverse benefit determination would then be provided to the enrollee and requesting provider, including appeals and fair hearing information.

The scope of utilization management activities covers all clinical aspects of preventive, diagnostic, and treatment services in both the inpatient and outpatient settings, which include physical health, behavioral health, and pharmacy. Our programs are all inter-related and integrate all physical and behavioral health components to assure Jose receives consistent access to care and services across the service network, as well as quality cost-effective care in a timely manner.

The utilization management program delivers innovation on three important fronts: informatics, measuring provider performance on specific utilization metrics, and developing diversionary and alternative services:

- Beacon uses informatics to help drive threshold-based authorizations and performance-based metrics. Threshold-based authorizations, for instance, make sure the right care proceeds because it flags potential conditions, which are used to help design the best treatment plan to meet an individual's needs.
- Measuring provider performance improves the network—from both a quality and operational perspective.
- System of diversionary services is essential to prevent avoidable readmissions, execute an effective discharge, and avoid unnecessary costs. To provide the most appropriate care in the least restrictive settings, Beacon collaborates with community-based providers to either expand or create a continuum of rehabilitative services to address enrollees' unique needs.

Beacon develops and adopts clinical practice guidelines that have undergone significant re-evaluation by national professional organizations including the American Medical Association (AMA) and the Institute of Medicine. With an eye toward increasing rigor and improving transparency, these organizations have articulated principles that form the foundation for new standards of guideline development. The American Psychiatric Association (APA) and the American Academy of Child and Adolescent Psychiatry (AACAP) have both published statements on their websites in support of these new standards. Related to the continued evolution of clinical practice guideline development calling for higher standards of evidence, the industry currently has maintained or produced a limited number of guidelines that meet the new standards for guideline rigor and transparency. Beacon has reviewed and adopted the following guidelines that meet those standards:

- The APA Practice Guideline on the Use of Antipsychotics to Treat Agitation or Psychosis in Patients with Dementia
- The APA Practice Guidelines for the Psychiatric Evaluation of Adults
- The ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use

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- The CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016 (adopted by Beacon as treatment recommendation for primary care or pain specialty practitioners)

Beacon abides by the Medicaid contract and Federal law that ensures that any mental health services for children under the age of 21 cannot be denied due to a non-covered benefit. Beacon has developed a process for authorization of any medically necessary service to enrollees under 21, in accordance with Section 1905(a) of the Social Security Act, when the service is not listed in the service-specific Medicaid Coverage and Limitations Handbook, Florida Medicaid Coverage Policy, or the associated Florida Medicaid fee schedule, or is not a covered service of the plan; or the amount, frequency, or duration of the service exceeds the limitations specified in the service-specific handbook or the corresponding fee schedule.

Uncovered Services require a prior authorization. To obtain prior authorization for any uncovered mental health services, the facility/provider calls Beacon's Utilization Management team to request prior authorization.

### **INTEGRATION OF INFORMATION ACROSS ALL SYSTEMS**

**CRITERION 7:** The extent to which the respondent describes innovative and evidence-based strategies to integrate information across all systems/processes into its workflows

In addition to telephonic authorization for inpatient and higher levels of care, behavioral health providers may also request online authorization, for outpatient services only, using Beacon's eServices online portal. This provider website serves contracted provider organizations. Once registered, providers receive confidential login and password information to perform various business transactions via Beacon's secure website, improving efficiency, minimizing administrative burden, and increasing providers' time available to enrollees. The eServices tool is accessible 24/7 through Beacon's website. By utilizing eServices, providers are able to do the following:

- Submit claims and outpatient services requests (when needed)
- Verify enrollee eligibility
- Confirm outpatient services status
- Check claim status
- View claims performance information
- Access to provider manuals, forms, bulletins, and mailings
- View or print frequently asked questions (FAQs)

Aetna has two pharmacy programs that could benefit Jose. The Drug Utilization Review (DUR) program is designed to analyze enrollee and practitioner drug utilization patterns to identify educational and/or intervention opportunities that promote enrollee safety and appropriate utilization, monitor quality outcomes, and to drive cost-effective drug therapy.

Additionally, Aetna's pharmacy benefit manager, CVS, proactively communicates with providers when enrollees stop using prescribed therapies so that providers can contact those enrollees, encouraging them to keep taking their medications and explaining why it is important to do so. Improved adherence with medication regimens can help slow disease progression and reduce

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medical costs. Through retrospective claims review, we will also use Pharmacy Advisor® Support to identify gaps in medication therapy, turning the prescription benefits plan into a powerful early-warning system for enrollee care. CVS will identify enrollees who may need additional medication or are taking an inappropriate or ineffective therapy. Within 72 hours of claims adjudication, CVS assesses drug profiles for potential issues or complications. CVS communicates in writing the identified opportunities, clinical recommendations, and associated clinical references to the provider.

### **GRIEVANCE AND APPEALS**

The events that brought into care management with Aetna was his father's request for help with an appeal related to the managing Entity not authorizing an admission to SIPP short-term residential treatment. While this is outside both Aetna's and Beacon's decision-making authority, Beacon will support Jose's father manage the appeal process. At the same time we will work with everyone involved to make it possible for Jose to receive treatment at home safely and at the appropriate intensity of care.

Aetna helps to make sure enrollees like Jose and his family are appropriately educated on their health care and their rights as enrollees. The care manager would work closely with Jose's parents to provide thorough and accurate information regarding complaint, grievance, and appeal processes and procedures. Our goal is to make enrollees' lives easier and not burden them with undue administrative challenges.

Beacon's enrollee complaint and grievance processes comply with Florida Managed Medical Assistance requirements and with all applicable federal and State laws, rules, and regulations. Beacon's Medicaid network providers who treat Aetna enrollees are notified about the enrollee grievance system in the provider handbook when they enter into a contract.

A grievance is an expression of dissatisfaction about any matter other than an action issued as part of a medical necessity utilization management denial determination. Possible subjects for grievances include, but are not limited to, the quality of care, the quality of services provided and aspects of interpersonal relationships such as rudeness of a provider or a managed care plan employee or failure to respect the enrollee's rights.

A grievance may be filed orally or in writing within one year of the occurrence. Beacon refers all enrollees and/or providers on behalf of the enrollees (whether a participating or non-participating provider) who are dissatisfied with Beacon or its activities to the Beacon ombudsperson for processing and documenting the grievance. Beacon's ombudsperson provides any reasonable help to the enrollee in completing forms and following the procedures for filing a grievance or requesting a Medicaid Fair Hearing.

Grievances are resolved by the ombudsperson within 30 calendar days of receipt of the grievance. The timeframe for a grievance may be extended up to 14 days when the enrollee asks for an extension, or when Beacon documents that additional information is needed and the delay is in the enrollee's interest. If the timeframe is extended by Beacon, the enrollee is notified within five business days of the determination, in writing, of the reason for the delay.

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Managed by the Clinical department, enrollees, authorized appeal representatives, or providers have the opportunity to appeal an adverse action/determination during the utilization review process and in compliance with Agency-mandated timeframes. Beacon will provide a timely response and resolution to appeals that are submitted by enrollees or their representatives.

Timeframes for standard appeals are based on the following guidelines:

- Pre-service appeal: The decision and notification of a pre-service appeal will occur within 30 days of receipt of the request
- Post-service appeal: The decision and notification of a post-service appeal will occur within 60 days of receipt of the request

### **SPECIFIC EXPERIENCE**

**CRITERION 5:** The extent to which the respondent demonstrates experience in providing services to enrollees with complex medical needs and provide evidence of strategies utilized that resulted in improved health outcomes

Aetna and Beacon are closely aligned in their shared approach to promoting integrated behavioral health and primary care models. Aetna's experience demonstrates the importance of managing behavioral health conditions when caring for enrollees with physical health conditions. Beacon has a strong record of promoting integrated behavioral health and primary care models in many locations across the State. Today, the Beacon family of companies serves more than 14 million Medicaid managed care lives nationally, including more than 900,000 Aged Blind and Disabled and Supplemental Security Income lives with full behavioral health benefits. Combining our mutual strengths and resources, Aetna and Beacon have formed an integrated partner model that is fully capable of meeting and exceeding the State's goals.

Beacon brings the strongest network of Medicaid behavioral health providers in the State, many of whom are already progressing toward full integration of physical and behavioral health. Tighter integration of physical and behavioral health resources within the plan will enable us to accelerate the growth of integrated behavioral health and primary care models throughout all regions of the State.

Beacon highlights clinical complexity using the Four-Quadrant Model as a way to stratify enrollees and their unique needs, providing the care most relevant to the individual based on his/her entry into the health care delivery system. For example:

- Quadrant 1: Enrollees with low severity mental health and/or substance use disorders are best served in the primary care setting with behavioral health resources integrated within the primary care practice
- Quadrant 2: Enrollees with serious mental health conditions without clinically significant substance use disorders or physical health conditions are best served in the specialized mental health continuum of care
- Quadrant 3: Enrollees with severe substance use disorders without clinically significant mental or physical health conditions are best served in the specialized addictions medicine continuum of care, well-described by the American Society of Addiction Medicine

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Quadrant 4: Enrollees with severe co-occurring mental health and substance use disorders, often complicated by multiple physical health conditions, require the highest level of integration and coordination of services

Aetna and Beacon agree that to serve the diverse and wide-ranging needs of our enrollees across the State of Florida, we must promote a range of integrated behavioral health and primary care models. We have identified a set of models to promote that are evidence-based and have been shown to improve patient outcomes, patient satisfaction, and cost-effectiveness in various practice settings. Our preferred models include Collaborative Care. This model was originally developed to enhance behavioral health care in the primary care setting. The American Psychiatric Association has identified Collaborative Care as a critical strategic response to the growing workforce shortage among behavioral health clinicians across the nation. The standard model requires the primary care practice to include a licensed behavioral health clinician as a member of the primary care treatment team in the office. This behavioral health clinician becomes a member of the primary care treatment team within the culture of the primary care practice; it is not an embedded psychotherapist role. Brief visits in examination rooms, hallway consultations, and networking with other resources within the larger system of care are all part of the role. The second requirement is easy access to an external consulting psychiatrist who supports the behavioral health clinician directly, consults with the primary care practitioners as needed, and may work with selected patients using telepsychiatry technology. Beacon has already deployed this model in Florida, and will collaborate with Aetna's network of primary care practitioners to make this more broadly available. We have found that larger primary care practices and FQHCs seem to accommodate this model more easily because they have the capacity to add full-time behavioral health clinicians to the primary care treatment team.

### **MODEL PROGRAM**

Mercy Maricopa Integrated Care (MMIC), a health plan Aetna manages in Arizona, has coordinated physical and behavioral health services as well as housing, employment, and court services to Medicaid enrollees around the Phoenix metropolitan area since 2014. This is a model program for Aetna's Medicaid organization. MMIC was the first regional behavioral health authority (RBHA) in Arizona to integrate physical health, behavioral health, and substance abuse services for Medicaid-eligible individuals with a serious mental illness (SMI). The integrated model serves approximately 20,000 people in Maricopa County.

### **WORKFLOW**

**CRITERION 2:** The extent to which the respondent's workflows/narrative descriptions include timeframes for completion of each step in the care planning process

Our narrative includes a detailed description and time frames for key steps supporting Jose's care planning and care coordination process. Jose's situation is complex and requires empathetic and expert support to help him address his biopsychosocial needs, as well as his family's. Aetna will provide care management support until Jose is able to demonstrate self-management of his condition. We will track progress toward his plan of care goals through regular visits, and address any barriers he is facing. Our support for Jose includes the following assumptions:

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- At the least, his second psychiatric admission via the Baker Act would have identified him as a candidate for care management services
- Aetna and Beacon would support Jose's father's appeal for SIPP admission
- If Jose is admitted for short-term residential treatment we would monitor Jose's stay with frequent check-in
- We would advocate for a full thyroid axis workup and medication management and reconciliation during Jose's third hospitalization
- Beacon's post-discharge aftercare program provides telephonic support and additional services
- An Aetna care manager would schedule a face-to-face visit with Jose and his parents to complete a comprehensive assessment and begin developing Jose's plan of care
- The care manager, Jose, and his parents will finalize his plan of care within five days after completion of the comprehensive assessment
- Beacon, our behavioral health subcontractor, will authorize and initiate services identified on Jose's plan of care within 14 days of plan of care development, or sooner if necessary
- Beacon will provide standard authorization decisions within seven days following receipt of the request for service. We will provide expedited authorization decisions within 48 hours after receipt of the request for service.

Figure MMA SRC 18-1: Continuum for Care for Jose in Attachment MMA SRC 18 provides an illustration of a detailed workflow demonstrating notable points in the care management and care coordination processes for Jose. Our support begins with identification of Jose. We learn about Jose through a comprehensive assessment process in which we partner with him and his parents to develop a plan of care. We support Jose with an integrated care management approach focused on achieving personal goals as determined by Jose and his parents.

**EXHIBIT A-4-b**  
**MMA SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**Evaluation Criteria:**

1. The adequacy of the respondent's approach in addressing the following:
  - a. Identification processes for enrollees with complex health conditions or who are in need of care coordination;
  - b. Description of the sources of data/information that would be utilized in the assessment process, including timeframes for completion;
  - c. Application of the respondent's case management risk stratification protocol;
  - d. Identification of service needs (covered and non-covered) and a description for service referral processes that the plan has in place;
  - e. Description of the interventions and strategies that would be used to facilitate compliance with the plan of care, including use of incentives, healthy behavior programs, etc.;
  - f. Application of discharge and aftercare planning protocols that facilitate a successful transition;
  - g. Application of coordination protocols utilized with other insurers (when applicable), primary care providers, specialists, other services providers, and community partners particularly when referrals are needed for non-covered services;
  - h. Description of the assessment of provider capacity to meet the specific needs of enrollees;
  - i. Identification of strategies that promote enrollee self-management and treatment adherence;
  - j. Application of utilization management protocols (i.e., identification of the criteria that will be utilized, processes to ensure continuity of care, etc.); and
  - k. Application of strategies to integrate information about the enrollee across the plan and various subcontractors when the respondent has delegated functions.
2. The extent to which the respondent's workflows/narrative descriptions include timeframes for completion of each step in the care planning process.
3. The extent to which the respondent demonstrates innovative processes that it has in place to enhance communication among all service providers and subcontractors (for delegated functions).
4. The extent to which the respondent describes an approach that supports care delivery in the most appropriate and cost-effective setting and avoids unnecessary institutionalization (i.e., hospital or nursing facility care) or emergency department use.
5. The extent to which the respondent demonstrates experience in providing services to enrollees with complex medical needs and provide evidence of strategies utilized that resulted in improved health outcomes.
6. The extent to which the respondent demonstrates a holistic system of coordinated health care interventions designed to achieve cost savings through the organized and timely delivery of high quality services.

**EXHIBIT A-4-b**  
**MMA SUBMISSION REQUIREMENTS**  
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7. The extent to which the respondent describes innovative strategies to integrate information across all systems/processes (e.g., prior authorization data synching up with the claims system) into its workflows.

**Score:** This section is worth a maximum of 85 raw points with each of the above components being worth a maximum of 5 points each.

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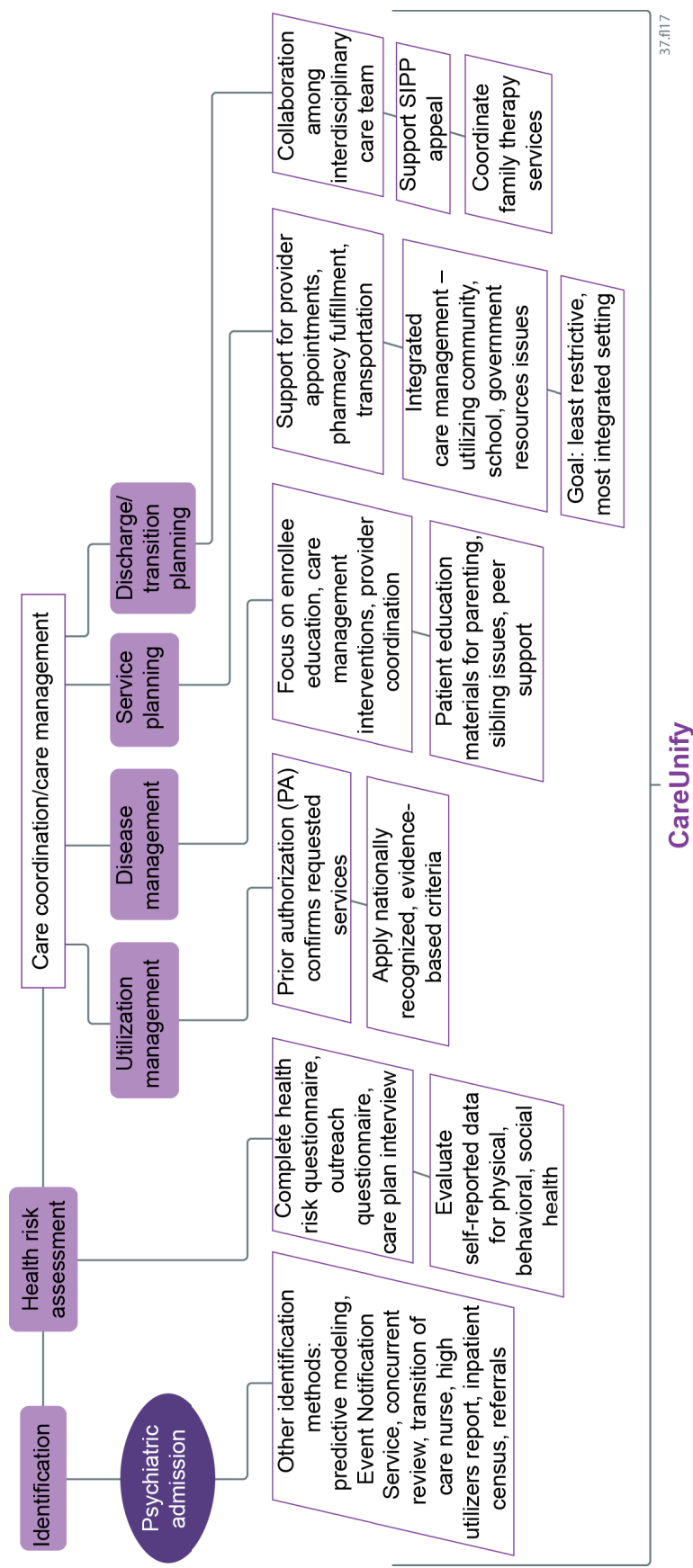
## **Attachment MMA SRC# 18**



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MMA SRC# 18: Figure MMA SRC 18-1: Continuum for Care for Jose



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Figure MMA SRC 18-1: Continuum of Care for Jose

*Jose is supported by our integrated care management model encompassing enrollee assessment, care coordination, utilization management (through Beacon), disease management, and discharge planning, as well as Jose's other needs. CareUnify technology enhances data integration and communication among Jose's providers and supports.*

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**EXHIBIT A-4-b**  
**MMA SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**MMA SRC# 19 - Vignette (Statewide):**

The respondent shall review the below case vignette, which describes potential Florida Medicaid recipients. Note: The vignette included below is fictional.

*Jane is a 57-year old female with Type II diabetes mellitus and hypertension. Jane is compliant with her treatment plan, which consists of the following prescribed drugs: Insulin and Lisinopril. She is also compliant with her follow-up appointments with her specialists. She lives alone, but receives support from her eldest daughter who lives nearby. Jane thought she timed her follow-up visit with her endocrinologist adequately to allow sufficient time to receive a new prescription for all drugs; however, Jane realizes she only has enough insulin to last through the doses for tomorrow. Her appointment with Dr. Seem, her endocrinologist, is in two weeks. Jane calls her doctor's office who informs her that they have no availability to see her today or tomorrow and Dr. Seem will not write a new prescription without examining Jane since it has been four months since her last appointment. Jane decides to call her health plan's member hotline for assistance.*

The respondent shall describe the approach for handling Jane's call and how the respondent would help Jane obtain her medication.

**Response:**

Jane appears to have made an honest mistake with a misjudgment of her insulin supply. Aetna understands these things happen, and while they cause undue stress and can result in a serious health risk for an enrollee, they are correctable with appropriate support and coordination of care. As the trusted source Jane reaches out to in this urgent situation, Aetna's primary goal is to identify a short-term solution before her insulin runs out the next day. At the same time, we would take a long-term view and make sure Jane is capable of self-managing her condition so she can prevent putting herself at risk again.

Aetna offers enrollee support 24/7 through our toll-free phone number, providing maximum coverage for all urgent and emergent needs. Jane could refer to the enrollee handbook for information on Aetna's Enrollee Services "hotline" as well as instructions on how to obtain renewals on prescriptions.

For the 2016 calendar year, Aetna achieved the top ranking among Florida's Medicaid health plans by the National Committee for Quality Assurance for customer experience. Aetna's Enrollee Services goal is to provide resolution in a single call to our service line. In July 2017, we achieved 94.9% "first call without repeat" for the Managed Medical Assistance program.

In Jane's case, we coordinated care and services between the Enrollee Services, Pharmacy, and Care Management departments, as well as our transportation vendor to meet Jane's short-term and long-term needs. Our integrated approach aligns with the Agency's goal of utilizing streamlined processes to enhance the enrollee experience.

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Our response to this vignette describes how our process is designed to prevent an emergency department or urgent care center visit in Jane's case to receive a prescription for insulin, as well as the follow-up support we can provide through integrated care management services.

### **INTERVENTIONS, STRATEGIES TO PREVENT URGENT CARE OR EMERGENCY DEPARTMENT VISIT**

**CRITERION 1.b.:** Description of the interventions and strategies that would assist Jane in avoiding a visit to urgent care or the emergency department to receive a new prescription

Jane was assisted by an Enrollee Services representative when she called our toll-free number. Our representative asked open-ended questions to gather all the information needed to help Jane, using workflows and desktop reference tools as needed. The representative assured Jane that help was available and that we would do everything possible to assist her. The representative affirmed that she would stay on the line with Jane until her issue is resolved.

Our Enrollee Services representatives have access to Aetna's real-time pharmacy data/information system. The representative was able to check if Jane had any refills left on her insulin prescription. The system also informed the Enrollee Services representative Jane has a prescription for Lisinopril. The representative would ask Jane about her Lisinopril supply, which she reported was current.

Because Jane was out of insulin, the representative completed a three-way call with Jane's endocrinologist, Dr. Seem, to schedule an emergency appointment or request that he call in a two-week prescription, covering Jane until her next scheduled appointment. Even with health plan outreach, Dr. Seem did not agree to the representative's request. While keeping Jane on the phone, our representative called the primary care physician (PCP) to see if he or she could see Jane the next day. We understand PCPs commonly have flexibility in their daily schedules to accommodate urgent care needs. Our objective was for the PCP to examine Jane and write a prescription. Jane's PCP agreed to see her the next day and we made sure she had transportation by scheduling with our transportation vendor. We also scheduled a ride with our transportation vendor to the pharmacy for Jane. Our transportation vendor provides same-day service to support our enrollees' needs.

In emergencies, an Aetna medical director can authorize a 72-hour supply of medication while we support an enrollee scheduling an appointment with his/her PCP or specialist to facilitate receipt of a new prescription.

### **TRAINING AND INTERNAL ESCALATION PROCESSES**

**CRITERION 1.a.:** Training for call center staff that illustrates the ability to triage cases of this nature, including the internal escalation process available to call center staff

Our Enrollee Services representatives are trained to help ensure that enrollees receive services in a timely manner, particularly in emergencies or cases like Jane's with 24-hour urgency. Our goal is for enrollees to see their personal providers because they can best support an enrollee's continuum of care and prevent an urgent care or emergency department visit.

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Aetna's multifaceted training program prepares Enrollee Services representatives to understand the full scope of available benefits for an enrollee, appropriately triage calls, identify and support access to care issues, and respond to and escalate crises.

Aetna's three-week training program for Enrollee Services representatives includes the following:

- Instruction in the classroom
- Self-directed technology
- Job shadowing with experienced Enrollee Services representatives
- Role playing
- Call calibration to listen to and learn from experienced and capable Enrollee Services representatives

After representatives begin taking live calls, they receive weekly feedback from their supervisor, who listens to their calls to ensure quality and accuracy. The standard is 95% or better on all call quality scores. Each representative is monitored and evaluated on six calls each month to help ensure continuous quality.

We dedicate time during our initial training to work with the representatives on their listening skills, on empathy, and on how to handle challenging calls. This training prepares them for handling crisis calls. Our training stresses that a representative's goal is to keep the enrollee talking and engaged while the representative connects with a clinician for support in a three-way call. The Enrollee Services representative can then assist in case 911 needs to be called or to facilitate an appointment while a clinician talks to the enrollee. Aetna's training modules include Call Escalation; Crisis, Emergent, and Urgent Care; and Guide to Identifying When an Enrollee is Suicidal.

Our training program and operations model are designed so an Enrollee Services representative seldom needs to hand off a call to another staff member. If necessary, the Enrollee Services representative stays on the line with the enrollee at every step.

Aetna has an enrollee hotline process to escalate an issue if the representative helping our enrollee cannot immediately address the problem. For example, we can facilitate a real-time three-way call with a nurse or clinician to support an enrollee if needed. If the situation is not urgent and/or the enrollee prefers, we can arrange for a care manager associate to call back to review the health risk assessment and assign the enrollee an appropriate level of care management and schedule a visit at the enrollee's request.

### **SERVICE INTEGRATION TO FACILITATE A SEAMLESS RESOLUTION**

**CRITERION 1.c.:** Evidence of the integration between and among all relevant departments, including subcontractors if applicable, to facilitate a seamless resolution

The Enrollee Services department coordinates continuity of care efforts with the Provider Services, Network Services, Utilization Management, and Care Management departments, to reach timely and responsive solutions. For example, the Enrollee Services department can coordinate with the Provider Services department to develop a single-case agreement for a

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

difficult to arrange for medication or service. Aetna's processes are well documented in our workflows and desktop reference tools, inter-departmental trainings, and protocols for handoffs. They are reinforced through joint meetings with other Aetna departments. In addition, Aetna's Service Committee addresses global issues that could affect enrollee access to medications or required services.

In Jane's case, the Enrollee Services representative identified that Jane will clearly benefit from our integrated care management services. Therefore, Jane would be informed that Aetna's diabetes disease management program is available to her as a standard part of our care management and that we could help her manage her insulin today and work with her to manage all her medications and help with exercise and diet. Jane was very interested and accepted our offer to warm transfer her to a care manager for further discussion.

Our care management staff educated Jane on how we work with program enrollees to improve their functional status and self-management and reduce or delay complications associated with diabetes. Jane was asked to complete a health risk questionnaire, outreach questionnaire and screened for depression since approximately 30% of people with diabetes have depression. The health risk questionnaire helps stratify enrollees for one of three levels of care management support: population health, supportive care management, or intensive care management. Self-reported data, such as that elicited in our health risk questionnaire, is a critical component of our integrated care model. Our model addresses physical, behavioral, and social health. The outreach questionnaire focuses on an enrollee's specific diagnoses.

Given the information obtained from Jane, it was determined that she would benefit from our supportive care management services. Enrollees stratified for supportive care management have short-term clinical needs such as HEDIS gaps in care, connections to community services, or disease management education. Jane was assigned a care manager, who would work with Jane, and her daughter if desired, to formulate a plan of care that reflects Jane's goals.

Jane is the principal voice on her preferences and goals for the best way to live her life. The role of the care manager is to serve as an advocate and to help Jane discover what is truly important to her. In supporting Jane, we help to shape a life plan, as opposed to simply a care plan. Through a trusting partnership, the care manager would identify and verify Jane's individual values; medical, behavioral, social, and functional needs; preferences; and objectives. The care manager would use motivational interviewing techniques in combination with the Patient Activation Measure tool (PAM). Our care managers use the PAM tool to assess an enrollee's level of activation, motivation, and likelihood of establishing and achieving goals (e.g., personal, health-related, etc.). This evidence-based tool generates a score based on the enrollee's responses. Based on his or her activation score, the PAM tool recommends specific approaches that align with the enrollee's activation level.

Aetna provides comprehensive care management support that addresses underlying root causes that are either driving adverse outcomes or creating barriers to improvement. Jane's plan of care would include methods for monitoring her medication to help prevent running out of medication again. Jane will share her plan of care with her daughter, primary care physician, and endocrinologist to help ensure alignment among Jane's circle of support and providers.

Jane and her care manager would meet by phone at least monthly, or more often based on Jane's needs. Jane and her care manager would monitor Jane's progress toward her plan of

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

care goals, and address any issues or concerns. Jane would have an opportunity to sign a consent form that enables Aetna to speak with Jane's daughter on Jane's behalf. This is a common Aetna practice, allowing family members to provide additional support for the enrollee.

The care manager would help ensure Jane has appointments scheduled with her PCP and endocrinologist and remains adherent to her comprehensive diabetes care measures, including hemoglobin HbA1c testing, dilated retinal exam, and LDL-C screening. We would provide educational information to Jane through care manager interventions, Krames education materials at or near fourth-grade comprehension, the MyActiveHealth enrollee portal and mobile application, and our biannual diabetes-focused newsletter.

### **CONCLUSION**

Jane called the Aetna hotline when she was unable to make an appointment with Dr. Seem on her own and realized that she was going to run out of insulin. Aetna's Enrollee Services staff is trained to identify the urgent nature of Jane's call and they reacted accordingly. After reaching out to the specialist to no avail, an urgent appointment was scheduled for the next day with Jane's PCP. Transportation was arranged for the PCP appointment and for transport to the pharmacy to pick up the two-week supply. The enrollee services representative called Jane the next day to ensure that Jane went to her PCP appointment and obtained the needed medication. Jane was very grateful for the assistance she received from Enrollee Services. In addition, Jane was referred to care management and after speaking with a care management team member she agreed to enroll in integrated care management at a supportive level and the diabetes disease management program.

### **Evaluation Criteria:**

1. The adequacy of the respondent's approach in addressing the following:
  - (a) Training for call center staff that illustrates the ability to triage cases of this nature, including the internal escalation process available to call center staff.
  - (b) Description of the interventions and strategies that would assist Jane in avoiding a visit to urgent care or the emergency department to receive a new prescription.
  - (c) Evidence of the integration between and among all relevant departments, including subcontractors if applicable, to facilitate a seamless resolution.

**Score:** This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

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**EXHIBIT A-4-b**  
**MMA SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**MMA SRC# 20 – Vignette (Statewide):**

The respondent shall review the below case vignette, which describes potential Florida Medicaid recipients. Note: The vignette included below is fictional.

*Emma is four-years old. She currently lives in a pediatric nursing facility. At the age of two she was admitted to PICU following a respiratory arrest during an acute illness. A further complication of her condition led to her requiring a tracheostomy to support her breathing. Following an acute exacerbation of her condition, she is now unable to breathe without the support of her ventilator when she is tired, asleep, or unwell. She is fully ventilated overnight. Her difficulties are compounded by complex seizures. Emma's doctor says Emma needs to have nurses or health care assistants with her at all times to monitor her ventilation. Emma's most recent developmental screening indicates the presence of an intellectual disability. Emma's condition has stabilized, but her mother is concerned about agreeing to bring her home permanently. Her mother is the sole income for their home, which includes three older siblings and Emma's maternal grandmother. Emma's grandmother is retired, and her ability to help the family is limited by severe rheumatoid arthritis.*

*To be discharged to her home, Emma's physician has ordered a custom wheelchair that must be individually fabricated and assembled. Her physician also ordered an electronic tablet to provide cognition exercises for Emma. The tablet has a cognition exercise application that reduces the likelihood for any seizure activity that may occur with other similar tablets. Florida Medicaid does not cover the tablet nor the wheelchair, which includes a part that will make it easier for Emma to hold the tablet. Her mother is unable to bear the costs for these special service items. Further orders for Emma's transition to home care are:*

- *Continuous pulse oximetry monitoring.*
- *Apnea monitor when she is not on the ventilator.*
- *A backup generator for the ventilator if the power goes out in the home.*

*Emma is a new enrollee. Prior to her enrollment, all services were provided through the Medicaid FFS delivery system.*

The respondent shall describe its approach to coordinating care for an enrollee with Emma's profile, including a detailed description and workflow demonstrating notable points in the system where the respondent's processes are implemented:

- a. New Enrollee Identification;
- b. Health Risk Assessment;
- c. Care Coordination/Case Management;
- d. Service Planning;
- e. Discharge/Transition Planning;
- f. Disease Management;
- g. Utilization Management; and
- h. Grievance and Appeals.

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Where applicable, the respondent should include specific experiences the respondent has had in addressing these same needs in Florida or other states.

### **Response:**

The opportunity for Emma to return to her home after living two years in a pediatric nursing facility represents an unimagined breakthrough and opportunity for the four-year-old girl and her family. It is presumed Emma's mother felt an emotional void not having all of her children at home, while feeling reassured by the professional care Emma was receiving at the nursing facility.

In reality, Emma's return home presents extraordinary challenges for Emma and her family. The coordination of care to set up the move and maintain safe living conditions is an ongoing, massive effort. The amount of responsibility that lies with her mother is immeasurable. The impact on her family will be great. The changes in Emma's life will be profound.

We have broad and deep pediatric experience at Aetna. Our current chief medical officer has 25 years of experience as a board-certified pediatrician, working with the developmentally disabled population for 20 of those years. His expertise, compassion, and bilingual capabilities enable him to effectively communicate and make personal connections with families during uncertain times. In addition, Aetna Medicaid has pediatric resources available to our clinical staff for consultation and support, including a pediatric pulmonologist.

### **CARE DELIVERY IN THE MOST APPROPRIATE AND COST-EFFECTIVE SETTING**

**CRITERION 4:** The extent to which the respondent describes an approach that supports care delivery in the most appropriate and cost-effective setting and avoids unnecessary institutionalization (i.e., hospital or nursing facility care) or emergency department use

Emma's story aligns with the Agency for Health Care Administration's goal of increasing the percentage of enrollees receiving services in the community instead of an institution.

Among our primary obligations is ensuring Emma's mother is educated on all of the benefits available to support both her and Emma as well as coordination to get all of the resources necessary for her care. Based on the information in this vignette, Emma would appear to qualify for the Children's Medical Services Managed Care Plan (CMS Plan) as a medically complex child. The CMS Plan fulfills an essential role with the provision of health services to the State's youth and children under age 21 with special health care needs. The CMS Plan served nearly 75,000 children in 2016 through enrollment in Florida's Medicaid State Plan and the Children's Health Insurance Program and funding from the Title V Maternal and Child Health Block Grant Program, according to the Florida Department of Health. These children have complex and intensive needs that are not easily met by existing models of care. We would support Emma's mother in educating her about the CMS Plan and determining Emma's eligibility if she was interested.

Aetna also is highly qualified to support Emma through our Enhanced Care Coordination program for medically complex and medically fragile enrollees under the age of 21 who are receiving services in a skilled nursing facility or are receiving private-duty nursing services in

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

their family home or other community based setting. We would designate a pediatric-certified nurse care manager to serve as the care coordinator for Emma and describe the care coordination activities performed by this designated care manager in the sections that follow.

In transitioning home, Emma will require a broad scope of services and support, including:

- 24-hour private-duty nursing
- Durable medical equipment and backup power for the ventilator
- Access to her primary care physician (PCP) and specialists—Aetna's lodging benefit supports families that require overnight stays for specialist visits (e.g., developmental pediatrician)
- Coordination of care between specialists and PCP through a multidisciplinary team
- Family counseling to provide psychological and emotional support
- Transportation services—stretcher-equipped
- Registration with a special-needs shelter if home evacuation is required during an emergency

Emma's transition will provide the benefit of dedicated, one-to-one nursing in which her caregivers will know her on a personal level and be able to observe changes in her health status. Being reunited with her family should provide emotional strength for everyone as well. Our goals would be for Emma to be medically stabilized and to have less utilization of institutional services.

We would collaborate with an organization such as the Agency for Persons with Disabilities (APD) to ensure we are providing appropriate care and support and addressing all the needs of Emma, her mother, and her family. The APD works in partnership with local communities and private providers to assist people who have developmental disabilities and their families. APD provides assistance in identifying the needs of people with developmental disabilities for supports and services.

We will educate Emma's mother on the resources available outside Medicaid as well as Title V benefits. Further, we believe it is important for Emma's mother to be peer-supported by a parent with similar experiences, and we will make those arrangements. We can coordinate with Family Network on Disabilities or Parent to Parent of Miami.

### **NEW ENROLLEE IDENTIFICATION**

**CRITERION 1.a:** Identification processes for enrollees with complex health conditions or who are in need of care coordination

**CRITERION 7:** The extent to which the respondent describes innovative strategies to integrate information across all systems/processes (e.g., prior authorization data synching up with the claims system) into its workflows

Aetna's medical director team is exceptionally diverse, with a range of medical and surgical specialists. Our medical directors work collaboratively and provide support to treating providers. For Emma, ongoing evaluation to determine the reasons for persistent ventilator requirements would be addressed.

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Emma's name would appear on a new-enrollee file in Aetna's system, as well as the inpatient census with a skilled nursing facility indicator and would immediately trigger an outreach. Aetna has multiple ways to identify new enrollees like Emma who likely would benefit from care management:

- Special needs enrollees identified from State enrollment files
- Referral from primary care physician or specialist
- Facility notification of admission to prior authorization staff
- Welcome call outreach
- Predictive modeling: To target enrollees 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 supports care management risk stratification by helping us to identify enrollees for whom intensive or complex care management will promote access to appropriate care for improved health and well-being, and prevent avoidable utilization of services. We developed Medicaid-specific, proprietary algorithms based on ICD-10 codes from medical, behavioral, and pharmacy claims, diagnoses, impact scores, and our clinical and informatics expertise, ranking all plan enrollees from highest to lowest risk. We produce our inpatient and emergency department risk scores using logistical regression models to predict the probability of an occurrence in the next 12 months. CORE predicts both financial and clinical performance. Indicators include prior year emergency department, inpatient, and specialist utilization, comorbidities, and pharmacy complexity. Specific behavioral health risk indicators include behavioral health admissions and readmissions, presence of serious emotional disturbance, poly-prescriber and poly-pharmacy activity for behavioral health medications, and concurrent use of multiple medications from one behavioral health therapy class.
- Event Notification Service: Aetna would receive a real-time notification Emma was admitted to the hospital each time she was there from the State's HIE. Aetna currently receives admission, discharge, and transfer (ADT) data that is being incorporated into our discharge planning process. The ADT information will be used in CareUnify for our care management team and our provider partners to begin discharge planning upon day one of admission or immediately following an ED visit to stay proactive to help ensure all needed care is quickly aligned to enrollees like Emma. Additionally, our team or assigned population health specialist to the provider will contact the enrollee's primary care physician, or the PCP would receive an electronic notification directly into the EHR from CareUnify, after an enrollee's emergency department visit. Following notification, we recommend a follow-up call to the enrollee with notice of any open HEDIS gaps or medication reconciliation to be completed. This information would be updated in the enrollee's CareUnify profile.
- Concurrent review: Our concurrent review clinicians review all enrollee admissions medically and identify behavioral, social, or other contributing factors or root causes of the admission, which enables us to understand and prevent discharge planning failures and delays that can lead to readmission. The concurrent review clinician makes a referral to care management if it is determined the enrollee would benefit from integrated care management and disease management support.
- Health Risk Assessments

## **EXHIBIT A-4-b**

### **MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

CRITERION 1.b: Description of the sources of data/information that would be utilized in the assessment process, including timeframes for completion

After notification of Emma's enrollment, we would make an outbound call to Emma's mother to schedule a face-to-face visit with our Enhanced Care Coordination care coordinator in the pediatric nursing facility. Our goal would be to make contact with Emma's mother within three days of notification to expedite the provision of services. The designated care coordinator is well qualified to support Emma and her mother. The care coordinator would have the following credentials: state-licensed registered nurse with at least two years of pediatric experience, or licensed practical nurse with four years of pediatric experience, or a professional with a Master's in social work and at least one year of related professional experience. Emma would be assigned a nurse care coordinator who is qualified to manage a ventilator and train caregivers on the equipment. Their first visit will provide an opportunity for the care coordinator to meet Emma's mother and Emma for the first time, beginning relationships based on trust and compassion and focused on Emma achieving her health goals.

During the visit, time permitting, Emma's mother would complete a health risk questionnaire (HRQ), outreach questionnaire (ORQ), SF 10™ Health Survey for Children, condition-specific assessments, and a comprehensive assessment on Emma's behalf. We will conduct follow-up phone calls and face-to-face visits to complete the enrollee assessment process within the mandated 30-day timeframe.

The health risk questionnaire includes specific questions about health conditions. Self-reported data, such as that elicited in our health risk questionnaire, is a critical component of our integrated care model. Our model addresses physical, behavioral, and social health, which is necessary for managing our most vulnerable, highest-risk enrollees like Emma. Many of the most serious behavioral and social issues cannot be captured in claims data. We developed a standardized set of biopsychosocial questions that help us to identify high-risk enrollees either in the absence of or as a supplement to claims data. For example, one question asks about the number of "different addresses" an enrollee has had in the past 12 months, which would relate to home environment stability for Emma's mother.

When we developed our standardized health risk questionnaire, there was not an evidence-based Medicaid-specific health risk assessment tool in the public domain. As a result, we created our own tool using questions from various evidence-based tools, including the Patient Health Questionnaire-9, Behavioral Risk Factor Surveillance System, and Child and Adolescent Health Measurement Initiative.

The HRQ covers the enrollee's demographic information; language preference; providers; recent or pending medical services; medicines and adherence; emergency room and hospital utilization; dental health; physical and mental health self-assessments; drug, alcohol, and tobacco use; diagnosed conditions; mobility; cognitive and communication ability; home stability; home and community-based services; and activities of daily living.

The SF-10 Health Survey for Children is a parent-completed short survey designed to measure health-related quality of life (HRQoL). HRQoL is defined by the Centers for Disease Control and Prevention as an individual or group's perceived physical and mental health over time.

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The evidence-based, comprehensive assessment gives us a deep understanding of who Emma is and what her needs are from a medical, behavioral, social, functional, and cognitive standpoint. The assessment provides us with the information necessary to create the framework for Emma's care and service plans and for formation of the interdisciplinary care team. Aetna's comprehensive assessment is based on best practices and clinical guidelines and it contains a biopsychosocial scope with elements of root-cause analysis and social determinants. We meet Emma where she is physically, mentally, emotionally, and socially, we listen to what her mother is saying, and we use all of our resources and training to help ensure our approach is individualized.

The designated care coordinator engages Emma's mother in conversation about the goals that are most important to her and Emma, Emma's strengths, and available resources. We compile it all into a case formulation that tells a story in terms that make sense to Emma's mother and are verifiable by her. The assessment process for Emma will be completed within 30 days. The care coordinator and Emma's mother will finalize a care plan for Emma within five days of the initial home visit, in accordance with Attachment B of the Invitation to Negotiate.

### **CARE MANAGEMENT RISK STRATIFICATION PROTOCOL**

CRITERION 1.c: Application of the respondent's case management risk stratification protocol

We developed Medicaid-specific, proprietary algorithms based on medical, behavioral, and pharmacy claims; diagnoses; impact scores; and our clinical and informatics expertise. These algorithms allow us to rank all plan enrollees from highest to lowest risk.

We identify three risk scores for each enrollee:

- (1) high risk of high overall cost during the next 12 months;
- (2) high risk of an emergency department visit over the next 12 months; and
- (3) medium to high risk of an inpatient admission over the next 12 months.

We run the model for our entire population monthly; the results are reviewed by the appropriate care management and medical management teams for enrollee contact and intervention opportunities. In addition, CORE uses pharmacy claims to identify many risks related to non-adherence and other medication management issues that care coordination can influence. Approximately 40% of an enrollee's risk assessment comes from pharmacy utilization and claims.

Within the framework of the Enhanced Care Coordination program, Emma is assigned to our intensive level of care management. Intensive care management focuses on high-risk, vulnerable enrollees characterized by biopsychosocial complexity. Intensive care management enrollees are reviewed in our clinical rounds with a clinical pharmacist and our medical director at least monthly and they receive either telephonic or face-to-face visits consistent with their individual needs and level of complexity. We flag our intensive level of care management enrollees so that our care coordinator is notified if the enrollee is admitted to a hospital. When this occurs, the care coordinator works closely with our transition of care nurse to schedule a pre-discharge planning meeting to ensure that all pre-discharge planning needs are met in a

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

timely manner and arranges to meet face-to-face with the enrollee and/or caregiver after discharge from the hospital.

The care coordinator confirms that Emma's mother has completed and signed the Agency for Health Care Administration-approved Freedom of Choice Certification Form within five business days of Emma's effective date of authorization for private-duty nursing services. The care coordinator maintains monthly (or more frequently if needed), face-to-face or telephonic contact with Emma and her mother.

We convene a multidisciplinary team comprised of Emma's mother, the care coordinator, her primary care physician, neurologist, pulmonologist and other pediatric specialists, and staff from the pediatric nursing facility no later than 60 days after Emma's enrollment into the plan. We also convene this team every six months thereafter, or when Emma has a change in status to provide a comprehensive review of the services and supports that Emma needs and to authorize any Medicaid reimbursable services prescribed for Emma. The care coordinator serves as the primary point-of-contact and communications liaison for the multidisciplinary team on Emma's behalf. The care coordinator uses electronic and telephonic protocols to ensure all members of the multidisciplinary team receive updates to any changes to Emma's status.

### **ASSESSMENT OF PROVIDER CAPACITY**

CRITERION 1.h: Description of the assessment of provider capacity to meet the specific needs of enrollees

Due to the complexity of Emma's care, it will be necessary to engage providers that have experience with pediatric enrollees with special needs. We anticipate the following is needed for a successful transition:

- Private Duty Nursing: We would engage an agency that is pediatric certified and has nurses available around the clock with experience in managing children who are ventilator dependent with tracheostomies and multiple co-morbidities. Our expectation would be to staff Emma's case with competent nurses with current knowledge of and experience with the latest medical technology and the ability to work with children and their families who are experiencing the challenges associated with life with a ventilator. Depending upon where Emma lives, this could be challenging. We would identify pediatric-certified nurses in the area; and once in place, we would review their plans of care, talk with Emma's family and physicians and continue to evaluate them on an ongoing basis to ensure that the nurses in place provide high quality and appropriate care. If Aetna does not have a network provider that meets these criteria, it may be necessary to seek an out-of-network provider by working with network and provider relations staff to complete a single case agreement.
- Respiratory Therapy: For enrollees who are ventilator dependent, we would require respiratory therapy services to assess the home environment initially to ensure that it can accommodate the equipment and make recommendations regarding home adaptations. Prior to discharge the respiratory therapist would need to complete an assessment of Emma's needs and then prepare the home environment for the transition. Working in conjunction with the ordering physician, Emma and her mother, they would

## **EXHIBIT A-4-b**

### **MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

need to identify the best ventilator for Emma and teach her mother and the nursing staff on how to clean and protect the airway and maintain the efficiency of the ventilator. Respiratory therapy services will be needed long term and the therapist would need to visit regularly to check on Emma's status, address any concerns the caregivers might have, and provide reports to the PCP and specialists. As in the case of private duty nursing, we would continuously evaluate the respiratory therapist. If the ventilator company were not available in Emma's area, a single case agreement would be completed with a non-network provider.

- Durable Medical Equipment: Emma's attending physician ordered DME that included a custom wheelchair, continuous pulse oximetry monitoring, apnea monitor, and electronic tablet to provide cognition exercises. In conjunction with the DME, Emma will require supplies for suctioning and possible consumable medical supplies. Aetna has statewide relationships with DME companies that would be able to fulfill the equipment requests under the MMA program.
- EPSDT Special Services: Emma's custom wheelchair would be provided as an EPSDT special service. Aetna is fortunate to have access to a clinical reviewer with extensive expertise in the fabrication of custom wheelchairs. Our clinical reviewer is also a wheelchair user, so his expertise in wheelchairs comes from a first-hand understanding as well as his professional training. A written description of the customization order, in addition to clinical documentation would be submitted for review by this clinical reviewer to ensure that the customization requested are appropriate and would meet Emma's needs.
- Physician Services: After a prolonged stay in the nursing facility, it may be necessary to assist Emma and her mother with re-establishing provider relationships in the community. This would include PCP and specialist services, such as pulmonology. We will help ensure Emma is supported by providers whose facilities are accessible and can accommodate Emma's equipment. It will be necessary to evaluate Emma's capability to be transported safely to and from appointments. Additionally, we will explore the opportunity for Emma to be seen through provider home visits.
- Transportation Services: In light of Emma's ventilator dependency, we would anticipate that her transportation needs would require ambulance with advance life support capability. Aetna has statewide ambulance providers in our network.

If feasible, Aetna's goal would be to maintain continuity of care with Emma's providers from her fee-for-service providers. We can facilitate letters of agreement or single-case agreements with Emma's providers who are not currently in our network. Our aim will be to include Emma's providers in our network. Aetna's ongoing evaluation of provider network will help identify providers to ensure Emma is being treated by the most qualified providers. We consider the following factors in our credentialing process and secure primary source verification as required including:

- Licensure and/or certification that is verified through State licensing boards in geographical areas where network practitioners care for our enrollees
- Board certifications (when applicable)
- Loss of/limitation of hospital admitting privileges (when applicable)
- Current professional liability coverage

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Drug Enforcement Agency (DEA) and State-controlled drug substance registration, when applicable, through verification by the U.S. Department of Commerce National Technical Information Service (when applicable)
- Disciplinary history or adverse actions related to licensure and DEA registration queried through State licensing boards and the National Practitioner Databank (NPDB)
- Malpractice insurance claim history to examine any possible trends and look for evidence that might suggest any probable substandard professional performance in the future
- Mental and physical health to determine if the practitioner's history might suggest any probable substandard professional performance in the future
- Participation in government programs such as Medicare or Medicaid
- Professional education and training through verification by the American Medical Association (AMA) Masterfile, American Osteopathic Association (AOA) and specialty board or specific residency/training program (highest level of education, depending on practitioner type)
- Work history

Emma's preliminary care plan addresses any immediate needs Emma may have and describes how the care coordinator and other enrollees of the multidisciplinary team will work with Emma's mother to mitigate the impact of the most important root causes and help ensure that an adequate support structure is in place to ensure all of Emma's needs are met. This work is not complete until Emma's mother –makes an informed decision that it makes sense and commits to the activities in the care plan. Emma's care coordinator will educate the family on Medicaid waivers that provide community-based services. For example, the Model Waiver's purpose is to provide services to eligible children under 21 who are medically complex/medically fragile or diagnosed with degenerative spinocerebellar disease. The Model Waiver is designed to delay or prevent institutionalization and allow waiver recipients to maintain stable health while living at home in their community.

These services can be accessed following a referral to the Agency for Persons with Disabilities and/or the Department of Elder Affairs Comprehensive Assessment and Review for Long-Term Care Services unit, which will perform an assessment to identify long-term care needs. The care coordinator would support Emma's mother in the application process and share information with the agencies upon request in adherence with Health Insurance Portability and Accountability Act regulations.

The care coordinator works with Emma's mother to define and prioritize both short- and long-term goals, translate those goals into achievable steps, and implement the care plan in phases according to her activation level. This phased approach will enable Emma's mother to meet short-term goals quickly, build trust with the care coordinator, and to increase her confidence level early. A long-range goal for Emma would be less dependency on the ventilator.

We will finalize a care plan for Emma within five business days of our initial visit with Emma's mother, in compliance with Attachment B of the Invitation to Negotiate. As applicable, we would authorize and initiate services identified on Emma's care plan within 14 days of the care plan development, or sooner if necessary, to ensure services are implemented with reasonable promptness, consistent with Emma's needs and as medically necessary.

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

The care coordinator would share Emma's care plan with the multidisciplinary team in advance of its initial meeting and be a focal point of its discussions throughout the course of its support for Emma. The multidisciplinary team meetings provide an opportunity to review Emma's care plan and her current clinical status to make sure all of her and her family's biopsychosocial needs are being met. The care coordinator takes the lead on the assignment and follow-up of all action items that result from the meetings.

### **APPLICATION OF COORDINATION PROTOCOLS**

CRITERION 1.g: Application of coordination protocols utilized with other insurers (when applicable), primary care providers, specialists, other services providers, and community partners particularly when referrals are needed for non-covered services

If Emma is in need of non-covered services, we have experience coordinating the financial and medical management responsibilities for specific carved-out benefits for enrollees, such as prescribed pediatric extended care. It is not unusual for enrollees to receive services through the Statewide Medicaid Managed Care Program's comprehensive benefit package, as well as non-covered services from a variety of programs and community resources. We coordinate care regardless of the source. The services Emma receives are included in her plan of care and our care manager facilitates communication, consultation, and information sharing among the service providers.

To facilitate effective coordination of care with providers of non-covered services, our programming includes activities such as:

- Connecting Emma to physical and behavioral health providers and resources that support her ability to reach her health care goals, especially living at home
- Securing urgent or emergency care if Emma is experiencing a crisis, including notification of any behavioral health or specialty provider who may be involved
- Coordinating benefits by collaborating with contracted and non-contracted partners and providers to determine benefit eligibility and coordination of covered benefits
- Involving community or provider-based care managers who offer unique or specific services or insight Emma may need including support groups specific to Emma's condition or illness.
- Making referrals for services, which are outside the benefit package, through external programs or community resources and organizations, such as Agency for Persons with Disabilities, Parent to Parent of Miami, and Florida 2-1-1
- Reporting (internal and external), including monitoring and reporting referrals, authorizations, and outcomes according to internal health plan requirements and external agreements
- Coordinating care with the primary care physician and patient-centered medical home or health home team and other interdisciplinary care team participants to facilitate referrals for needed services that may not be covered under the Statewide Medicaid Managed Care Program
- Emma's care manager and other Aetna staff members will network and develop relationships with community partners to learn about non-covered benefits to assist them with their needs and to make referrals to those services

### **COMMUNICATION AMONG PROVIDERS AND INTEGRATION OF INFORMATION**

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

CRITERION 3: The extent to which the respondent demonstrates innovative and evidence-based processes that it has in place to enhance communication among all service providers and subcontractors (for delegated functions)

CRITERION 1.k: Application of strategies to integrate enrollee information across the plan and various subcontractors when the respondent has delegated functions.

Aetna accomplishes exceptional levels of care collaboration by using our electronic care management system, which is composed of two components:

- Our internal care management system, which drives internal care management workflows and tracks key enrollee engagement events and the longitudinal care management record for our care management team
- Our external population health management system, CareUnify, which would support Emma's multidisciplinary team with external data sharing around key clinical events that includes real-time notifications and detailed enrollee and panel information

Aetna's technology system protocols enable Emma's care coordinator to have access to all of Emma's records within our systems so she can stay updated on key care management components such as Emma's medications, prior authorization requests, and utilization management processes. Aetna is able to better support Emma through our systems that provide essential departments access to our primary enrollee support system (i.e., enrollment, claims processing, service authorization) and care management system.

### **SERVICE PLANNING**

CRITERION 1.d: Identification of service needs (covered and non-covered) and a description for service referral processes

The care coordinator works closely with Emma's mother to educate her on enrollee benefits and to help coordinate provision of services to meet Emma's needs. Emma's transition to her home setting requires expert coordination of care, clear communication among all parties, unwavering support for Emma's mother and family, and a shared vision for improving Emma's health outcomes.

Aetna has extensive experience coordinating services for private-duty nursing in the State. Vulnerable children like Emma require continuous, skillful observation and ongoing medical treatment. The home health agency, which would be pediatric-certified, notifies the primary care physician and our care coordinator if there is a change in health status. We notify the Agency of all changes to an enrollee's service level. Emma's mother, Emma, the primary care physician, the home health agency, and other individuals involved in Emma's care (e.g., therapists, equipment, and supplies providers) must collaborate actively and cohesively to plan for the at-home care Emma receives. Our team approach improves continuity of care and allows hospital and health plan staff to address the Emma's specific social, economic, cultural, and language needs. The care coordinator consults with the Agency on a monthly call and submits a monthly written report.

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Emma's care coordinator serves as the single point-of-contact and liaison between the attending physician overseeing the case, the home health agency, Emma's mother, and other identified support systems or community resources. The care coordinator supports Emma across all care settings to ensure that appropriate care and services are rendered. The care coordinator facilitates the prior authorization of services through our Utilization Management and Pharmacy departments and takes an active role in discharge planning. The care coordinator is knowledgeable of Emma's circle of support, supports in the community, and sources of readmission risk, and he or she acts as an advocate for the enrollee when communicating with Emma's providers, medical assistance transportation services, waiver programs, and State government agencies. Our focus is on maintaining a continuum of care for Emma regardless of the payer source.

The care manager makes face-to-face visits and remains actively involved in Emma's care. The care manager supports Utilization Management staff members with all relevant clinical information in these cases prior to final review by the Utilization Management department. The care manager also provides the biopsychosocial information related to the family unit, resources, safety concerns, and formal and informal supports that impact Emma's care needs to help ensure individualized and appropriate services are in place. For example, the care manager makes sure Emma is receiving recommended Early and Period Screening, Diagnostic and Treatment services, and arranges for transportation as needed. The care coordinator regularly updates our medical directors on Emma's developments and works directly with the interdisciplinary team to coordinate the following services and durable medical equipment for Emma:

- Arranges ventilator equipment with ventilator management company
- Arranges and schedules transportation services with appropriate equipment (e.g., stretchers and advanced life support functionality) for Emma's appointments
- Coordinates with vendor SurfMed for pulse oximetry and apnea monitoring equipment
- Arranges for customized wheelchair (inspected by a specialist for fit as Emma grows) and accessories through durable medical equipment vendor, SurfMed; to ensure legal compliance, Aetna will cover the cost of the wheelchair through a special-approval prior authorization process of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) regulations.
- Arranges for tablet through The Children's Trust (utilizing prior authorization process for EPSDT)
- Arranges for backup power for ventilator (Florida Power & Light Company)
- Researches financial support for utilities payments if needed
- Supports Emma's mother registering for special needs shelter if emergency evacuation needed (e.g., Emergency and Evacuation Assistance Program of Miami-Dade County)
- Arranges services available to Emma's mother and the family that may or may not be covered benefits, such as respite services through a referral to The Children's Trust
- Researches Prescribed Pediatric Extended Care options for Emma and shares them with her mother
- Researches home school services (e.g., Miami-Dade County Public Schools) if necessary and shares learnings with her mother
- Arranges home therapies for Emma through contracted home health agency
- Arranges smartphone for Emma's mother at no cost through the Medicaid Lifeline Access Program (Wellpass, Inc.)

## **EXHIBIT A-4-b**

### **MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Reviews Emma's dental care benefit—delegated through MCNA Dental—with Emma's mother and makes arrangements as appropriate

#### **COORDINATED HEALTH CARE INTERVENTIONS**

**CRITERION 6:** The extent to which the respondent demonstrates a holistic system of coordinated health care interventions designed to achieve cost savings through the organized and timely delivery of high quality services

Emma will benefit from the Aetna's integrated care management model, which includes, but is not limited to, all the services enrollees in a particular vulnerable population might need, including covered services managed by Aetna; physical and behavioral health services not managed by Aetna and/or not covered by the contract; school-based services and clinics; and wraparound treatments, services, and supports available from government agencies or offered by community-based organizations. Additionally, within our care model, service providers, agencies, and organizations work together based on a mutual understanding of and commitment to each other's roles and responsibilities ensuring a whole person approach to care. As a result, Aetna's integrated care management model ensures the right resources are available, organized, and coordinated to enable Emma and her mother to achieve goals that matter to them. Through CareUnify, the care coordinator helps all the traditional and non-traditional providers in Emma's care access the single care plan for Emma. The CareUnify application enables Emma's providers to stay connected, which includes the private duty pediatric nurses, the respiratory therapists, the family caregivers, specialist, primary care providers, and others. CareUnify allows one conversation between and among these care providers and our care management team. This provides a single source of data and information supporting Emma's care.

Our system of care model surrounds Emma with all the necessary support and services and allows enrollees like Emma to live in the least restrictive and most integrated setting compatible with their preferences. Through CareUnify and our constant monitoring of home providers, we ensure that the treatments are effective and safe, which minimizes the use of avoidable inpatient hospitalization, long-term residential/institutional care, and emergency department visits. Our system of care accounts for all of the support, services, and safeguards required by Emma and her mother, enabling Emma to live in her home environment with her family and attend school if she is capable.

#### **DISCHARGE/TRANSITION PLANNING**

**CRITERION 1.f:** Application of discharge and aftercare planning protocols that facilitate a successful transition

Our goal is to execute a strategy that will prevent a lapse of services from being provided in the home. Based on our experience, there should be no reason for a lapse if all services are appropriate and in place at the time of discharge. Timing to complete the process is based on the unique needs of every enrollee. We will take however long is necessary to help ensure Emma is transitioning to a safe and healthy environment.

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First, and foremost, the care coordinator works closely with our transition of care (TOC) clinician to make sure all services are in place before Emma is discharged. The goal of our TOC program is to ensure that all post-acute care needs are met, including provide a smooth care transition, help prevent readmissions, and provides a better experience for our enrollees.

In compliance with the General Provisions of Attachment B of the Invitation to Negotiate, Aetna will:

- Ensure the Florida Department of Children and Families (DCF) is notified when Emma is discharged from the pediatric nursing facility
- Submit to DCF a properly completed DCF form CF-ES 2506 (Client Discharge/Change Notice) within 10 business days of Emma's discharge from the pediatric nursing facility. Additionally, Aetna will develop a final written transition plan within 30 days prior to discharge that includes all of the services and supports that Emma needs to successfully reside in the community.

Emma's care coordinator will work closely with the pediatric nursing facility's discharge planner to obtain all orders for Emma's needs including, but not limited to, home health, DME, and therapy. During this time, the care coordinator will assist Emma's mother with finding providers within the community and scheduling appointments as needed. Once providers have been established and a peer-to-peer consultation has been completed, the care coordinator will confirm all DME has been approved and delivered to Emma's home and the home health agency can safely begin providing services for Emma. Prior to discharge, Emma's mother will receive basic life support instruction, caregiving education, and documentation of all Emma's needs and upcoming appointments. The care coordinator will arrange for transportation with a stretcher and advanced life support functionality, from the facility to Emma's home.

A safe discharge for Emma involves the following components:

- Home health agency: Aetna will identify a home health agency that supports pediatric clients and has trained staff available to cover all shifts. Assuming the agency has trained and available staff, this could take less than one week to complete. This process begins when the interdisciplinary care team, including Emma's mother, comes to a consensus about the plan of care with transition home as one of the goals. The actual timing of discharge will depend on all services being in place, including every agency having hired and/or trained all staff required for Emma's care.
- Durable medical equipment: We will coordinate with our DME provider, SurfMed, to supply Emma's equipment and consumable supply needs. In addition, a ventilator respiratory provider would be contracted to manage the ventilator and train the caregivers and family members. Prior authorization of Emma's equipment typically would take less than one week with the appropriate supporting documentation. Emma's custom wheelchair requires authorization. Assembly of the chair could take three to four weeks. Emma will also need a pediatric hospital bed, which may be available in one week or less.
- Home assessment from the ventilator provider in conjunction with Florida Power & Light: Due to Emma's ventilation needs, Florida Power & Light will assess Emma's home to see if it can support her ventilation and supply backup power in the event of an outage. Depending on the electrical assessment, this could be completed in one day or up to two weeks (based on scheduling availability and/or home modifications).

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Home visit from the health plan: We will visit the home at minimum twice during the discharge planning process. The first visit would be to ensure Emma has a safe environment to return to, clear of any excessive clutter, wheelchair accessible, and the size of the home is able to accommodate Emma's DME. The final visit would occur with the transition of care manager to confirm visually that all DME has been delivered to the home. Following discharge, the care coordinator will conduct a home visit with Emma's mother. While Emma is being supported by our program, the care coordinator will meet with Emma's mother monthly—or more frequently as required— through face-to-face or telephonic visits to help ensure Emma's needs are being met, as well as her mother's and the family's. The care coordinator will review the progress of Emma's goals, check on the performance and reliability of the private-duty nursing agency, and Emma's DME.
- Parent education: Throughout the discharge planning process, the family will receive hands-on instruction from the care coordinator, pediatric nursing facility, and home respiratory vendor on how to care for Emma at home (including infection control and basic life support). This teaching will begin as soon as the family requests for the transfer home. This will allow the family to become comfortable with her care and train alternate caregivers. The care coordinator and transition of care manager will support this training by providing additional condition-specific education, review medications, pharmacy providers, DME providers, where to call in case of emergencies, how to reorder supplies, home health contact information, transportation assistance, community resources, and health plan information.
- Communication: Our primary communication throughout the discharge will be with Emma's mother and the pediatric nursing facility's discharge planner. The transition of care manager will communicate with the discharge planner every couple of days to facilitate pending authorizations and communications between the discharge planner and community providers. The transition of care manager can do this via phone or weekly visits to the facility.

### **STRATEGIES TO FACILITATE COMPLIANCE WITH THE PLAN OF CARE**

CRITERION 1.e: Description of the interventions and strategies that would be used to facilitate compliance with the plan of care, including use of incentives, healthy behavior programs, etc.

Our care coordinator is responsible to monitor that all services and equipment are in place and being utilized as ordered by the physician and scheduled with the various vendors. The care coordinator maintains the plan of care and ensures compliance with the plan through regular enrollee contacts and face-to-face visits. One of our tools for monitoring compliance is the Electronic Visit Verification (EVV) system, which electronically verifies that home health visits have taken place. Our care manager works with Emma's mom to increase her health literacy and understanding of Emma's plan of care. Moreover, the care manager helps Emma's family with their own self-care by providing education and resources specific to caregivers and carefully monitoring the family for any signs of caregiver burnout.

### **DISEASE MANAGEMENT**

CRITERION 1.i: Identification of strategies that promote enrollee self-management and treatment adherence

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Aetna's disease management program is delivered within the framework of our integrated care management program. The goal of the disease management program is to improve our enrollees' functional status and to reduce longer-term premature morbidity (complications) and mortality of the condition. Aetna has designed our disease management program to address those enrollees like Emma most likely to be high utilizers of inpatient admissions related to their diagnosis and severity of illness.

In addition to individualized support from the care coordinator, Emma's mother would receive mailings of Krames patient education materials specific to tracheostomy tube care and ventilator operation and maintenance, among many educational material options. Our materials are in an easily understood language and format at or near fourth-grade comprehension, in compliance with Attachment B of the Invitation to Negotiate.

### **UTILIZATION MANAGEMENT**

Our utilization management program is designed to ensure Emma receives the most medically appropriate, cost-effective health care to improve her physical and behavioral health outcomes and to improve access to comprehensive services. Our Utilization Management staff collaborates with the Care Management team under the direction of a medical director upon identification of enrollees with complex issues in a facility setting. Using an inter-departmental approach, our Utilization Management and Care Management team members work in concert to educate providers regarding covered services and to help ensure Emma receives the services she needs, when and where she needs them. Our Utilization Management staff also collaborates and consults with Emma's multidisciplinary team, including peer-to-peer calls, so that we reach consensus rapidly on the most appropriate course of Emma's care.

Our goals for Emma include:

- Assuring she receives continuing care through her established, current providers within the first 90 days, allowing for further assessment of needed services
- Practicing fully integrated utilization processes with care management and pharmacy to provide seamless access for Emma and through these rounds facilitating authorizations for appropriate medications
- Providing real-time authorizations directly in our care management platform to enhance the process for some services, including home therapies, private duty nursing services, respiratory therapy and specific DME

Aetna will provide standard authorization decisions within seven days following receipt of the request for service, in compliance with Attachment B of the Invitation to Negotiate. We will provide expedited authorization decisions within 48 hours after receipt of the request for service.

Our utilization management program incorporates utilization management decision-making criteria using appropriate evidenced-based clinical settings and services to treat co-occurring behavioral and physical disorders. Integrated with our quality management program, Aetna's utilization management program pursues the common principle of providing optimal clinical practices in all settings by balancing behavioral/physical health management, operations, and finance components.

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

If prior authorization is necessary, the following criteria and guidelines are utilized:

- Florida Medicaid contractual requirements and limitations
- MCG (formerly Milliman Care Guidelines)
- Aetna Clinical Policy Bulletins (CPB)
- Other (e.g. specialty society guidelines)

Our qualified and trained staff members are guided by established medical necessity criteria, but ultimately make determinations based on clinical judgement in the best interest of the enrollee, including consideration to specific and unique characteristics such as the local delivery system and the enrollees' age, comorbidity, complications, progress in treatment, psychosocial situation, and home environment.

### **INTEGRATION OF INFORMATION ACROSS ALL SYSTEMS**

**CRITERION 7:** The extent to which the respondent describes innovative and evidence-based strategies to integrate information across all systems/processes into its workflows

Our program integrates systems for managing, monitoring, evaluating, and improving the utilization of the care and services enrollees receive, including automated synchronization of prior authorization decisions with claims processing. Aetna fully facilitates the integration of the physical and behavioral health care services contracted providers render.

For example, Emma's information would be entered into CareUnify, our web-based population health management platform that integrates data from multiple internal sources such as claims, CORE risk stratification, and assessments data, and external resources such as the State's health information exchange (HIE) and providers' electronic health records (EHR) to create a comprehensive, tailored profile and dashboard. This information can be used to create a single source of truth that all members of the interdisciplinary care team can use to coordinate care around a common plan of care.

Aetna's Utilization Management prior authorization staff manages prior authorization services for all the home health services and durable medical equipment Emma requires, including the ventilator, specialized bed, customized wheelchair, monitoring equipment, and more. Prior authorization confirms requested services are for eligible enrollees; provided at an appropriate level of care and place of service; appropriate, timely, and cost-effective; coordinated with medical management and communicated to applicable operations areas (e.g., Finance, Enrollee Services, Provider Services) or per contractual requirement with external vendors; and documented accurately to facilitate timely reimbursement and reporting.

To support prior-authorization decisions, Aetna uses nationally recognized, evidence-based criteria, which are applied based on the needs of individual enrollees and characteristics of the local delivery system. Aetna utilizes national policies and processes for adopting and updating evidence-based clinical practice guidelines and preventative services guidelines from recognized sources that follow National Committee for Quality Assurance standards.

### **GRIEVANCE AND APPEALS**

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Although grievance and appeals is not directly addressed in this vignette, Aetna places high value on helping to make sure caregivers like Emma's mother are appropriately educated on their health care and their rights as enrollees. The care coordinator would work closely with Emma's mother to provide thorough and accurate information regarding complaint, grievance, and appeal processes and procedures. For example, the care coordinator and appeals coordinator would provide full support for Emma's mother during the course of an appeals process. Our goal is to make enrollees' lives easier and not burden them with undue administrative challenges.

Enrollee education includes availability of assistance in the filing process, the procedure for filing a grievance or appeal, the right to representation (self, legal counsel, relative, friend, provider); procedures for exercising the rights to request a State Fair Hearing within a specified time frame; the requirement that internal appeals must be exhausted before requesting a State Fair Hearing; the right to continue benefits at the current level if the appeal or State Fair Hearing is requested within the specified timeframe; and that the enrollee may be required to pay the cost of services furnished if the final decision is adverse to the enrollee.

Aetna will resolve complaints by close of business on the business day following receipt, in compliance with Attachment B. We will review grievances and provide written notice of results to the enrollee within 90 calendar days from the receipt date of the grievance.

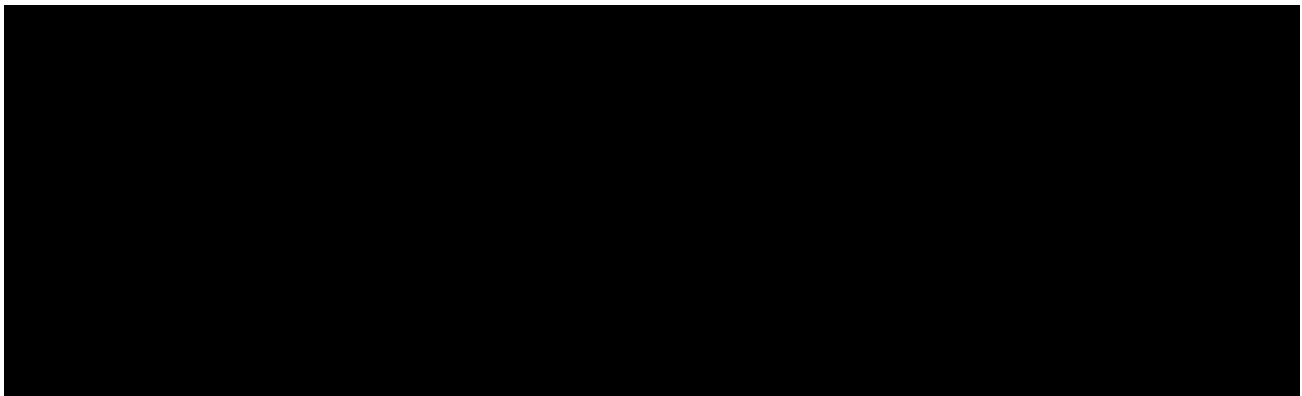
State Fair Hearings must be requested in writing. Grievances may be requested at any time, appeals must be requested within 60 calendar days of the initial denial, and State Fair Hearings must be requested within 120 calendar days of the appeal decision letter.

Enrollees may continue to receive services during an appeal or State Fair Hearing process whenever they meet required conditions.

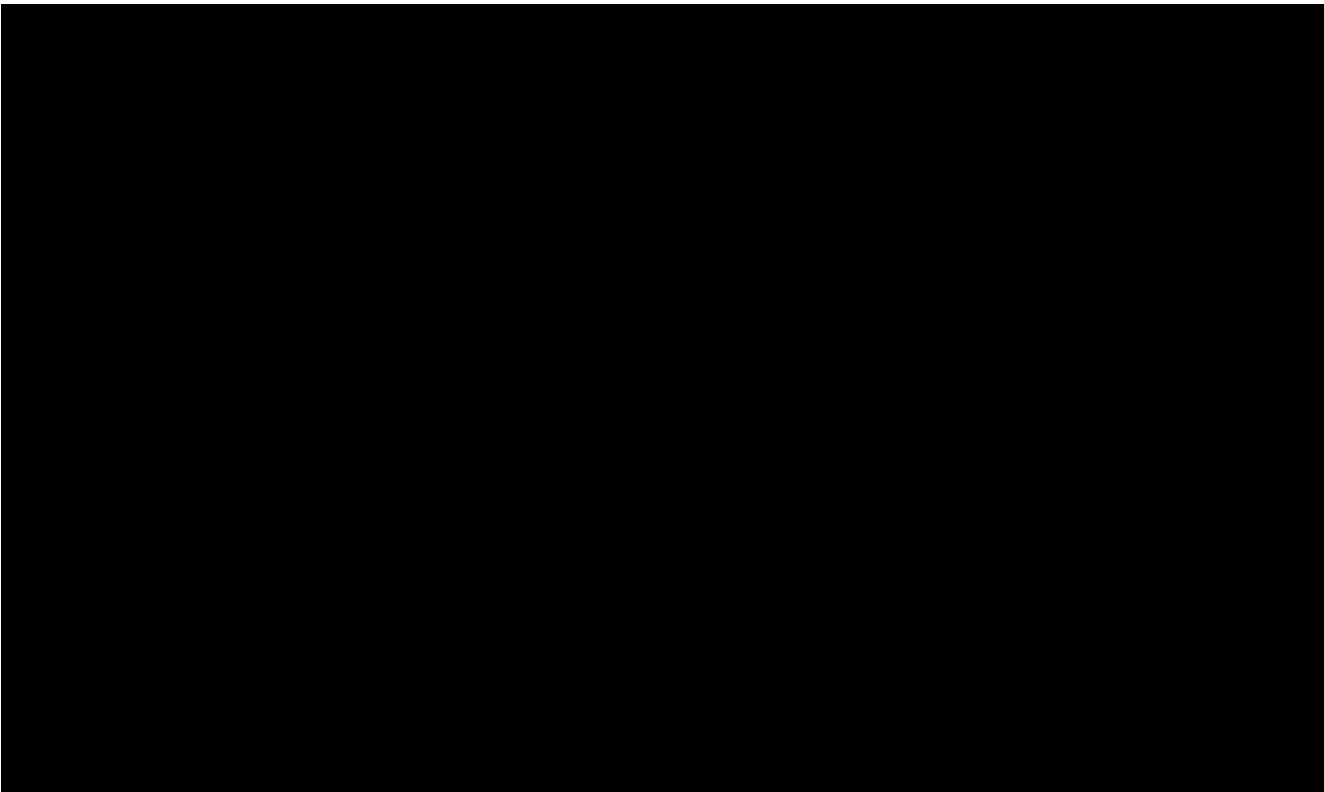
**SPECIFIC EXPERIENCE**

**CRITERION 5:** The extent to which the respondent demonstrates experience in providing services to enrollees with complex medical needs and provide evidence of strategies utilized that resulted in improved health outcomes

The comprehensive support and care provided by Aetna in Emma's story has similarities to the following real-life examples in Aetna's experience across our enterprise:



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Each week, our care manager contacted Valerie's aunt to monitor the progress of her home modifications, which included the construction of a room for Valerie with an electrical system that could handle the ventilator and any emergency power outage.

Valerie's intensive discharge planning process included everyone involved in Valerie's care. The care manager worked in consultation with the primary care physician to arrange for a home evaluation by the home health agency and worked with the treatment team in developing a plan of care for Valerie's safe transition to home. When Valerie was discharged from the pediatric SNF everything was in place to support a smooth transition and safe discharge to home.

Valerie received all of the medically necessary home health shift care services that she required in order to remain in the home with her family. Valerie has been able to remain independent and in the community because of strong family and care management support, collaboration, and planning.

**WORKFLOW**

**CRITERION 2:** The extent to which the respondent's workflows/narrative descriptions include timeframes for completion of each step in the care planning process

Our narrative includes a detailed description and timeframes for each step supporting Emma's care planning and care coordination process as she transitions home from the pediatric nursing facility. Emma, her mother, and her family require empathetic and expert support to complete a

## **EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

seamless transition and maintain a safe and stable environment with Emma at home. Our support for Emma includes the following:

- Emma's name would appear on a new-enrollee file in Aetna's system, as well as the inpatient census with a skilled nursing facility indicator
- One of our primary obligations is ensuring Emma's mother is educated on all of the benefits available to support Emma. Based on the information in this vignette, Emma would appear to qualify for the Children's Medical Services Managed Care Plan as a medically complex child.
- Assure she receives continuing care through her established, current providers within the first 90 days, allowing for further assessment of needed services
- After notification of Emma's enrollment, we would make an outbound call to Emma's mother to schedule a face-to-face visit with our care coordinator in the pediatric nursing facility. Our goal would be to make contact with Emma's mother within three days of enrollment notification to expedite the assessment process.
- We will conduct follow-up phone calls and face-to-face visits to complete the enrollee assessment process within the mandated 30-day time frame
- We will finalize a care plan for Emma within five business days of our initial visit with Emma's mother. As applicable, we would authorize and initiate services identified on Emma's plan of care within 14 days of the care plan development, or sooner if necessary, to ensure services are implemented with reasonable promptness, consistent with Emma's needs and as medically necessary.
- Aetna will provide standard authorization decisions within seven days following receipt of the request for service. We will provide expedited authorization decisions within 48 hours after receipt of the request for service.
- We will develop a final written transition plan within 30 days prior to discharge that includes all of the services and supports that Emma needs to successfully reside in the community

Figure MMA SRC 20-1: Continuum of Care for Emma in Attachment MMA SRC 20 provides an illustration of a detailed workflow demonstrating notable points in the care management and care coordination processes for Emma. Our support begins with identification of Emma, whose file would include a skilled nursing facility indicator. We learn about Emma through a comprehensive assessment process with her mother in which we partner to develop a plan of care. We support Emma with an integrated care management approach focused on achieving goals for Emma and her family as determined by Emma's mother.

### **Evaluation Criteria:**

1. The adequacy of the respondent's approach in addressing the following:
  - a. Identification processes for enrollees with complex health conditions or who are in need of care coordination;
  - b. Description of the sources of data/information that would be utilized in the assessment process, including timeframes for completion;
  - c. Application of the respondent's case management risk stratification protocol;
  - d. Identification of service needs (covered and non-covered) and a description for service referral processes that the respondent has in place;

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- e. Description of the interventions and strategies that would be used to facilitate compliance with the plan of care, including use of incentives, healthy behavior programs, etc.;
  - f. Application of discharge and aftercare planning protocols that facilitate a successful transition;
  - g. Application of coordination protocols utilized with other insurers (when applicable), primary care providers, specialists, other services providers, and community partners particularly when referrals are needed for non-covered services;
  - h. Description of the assessment of provider capacity to meet the specific needs of enrollees;
  - i. Identification of strategies that promote enrollee self-management and treatment adherence;
  - j. Application of utilization management protocols (i.e., identification of the criteria that will be utilized, processes to ensure continuity of care, etc.); and
  - k. Application of strategies to integrate information about the enrollee across the plan and various subcontractors when the respondent has delegated functions.
- 2. The extent to which the respondents' workflows/narrative descriptions include timeframes for completion of each step in the care planning process.
  - 3. The extent to which the respondent demonstrates innovative processes that it has in place to enhance communication among all service providers and subcontractors (for delegated functions).
  - 4. The extent to which the respondent describes an approach that supports care delivery in the most appropriate and cost-effective setting and avoid unnecessary institutionalization (i.e., hospital or nursing facility care) or emergency department use.
  - 5. The extent to which the respondent demonstrates experience in providing services to enrollees with complex medical needs and provide evidence of strategies utilized that resulted in improved health outcomes.
  - 6. The extent to which the respondent demonstrates a holistic system of coordinated health care interventions designed to achieve cost savings through the organized and timely delivery of high quality services.
  - 7. The extent to which the respondent describes innovative strategies to integrate information across all systems/processes (e.g., prior authorization data synching up with the claims system) into its workflows.

**Score:** This section is worth a maximum of 85 raw points with each of the above components being worth a maximum of 5 points each.

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**EXHIBIT A-4-b  
MMA SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA (10-2-17)**



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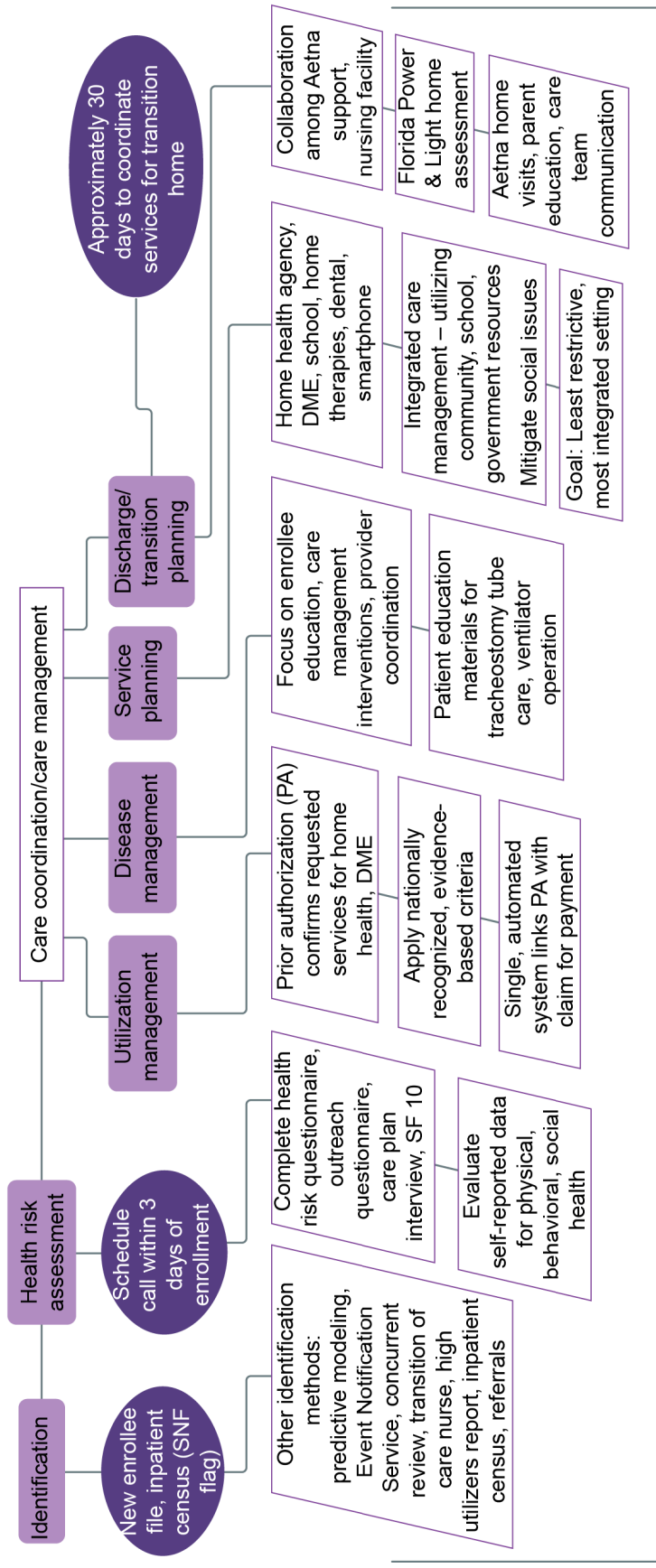
## **Attachment MMA SRC# 20**



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MMA SRC# 20: Figure MMA SRC 20-1: Continuum of Care for Emma



### CareUnify

Population health application integrates data and connects providers and support resources

Figure MMA SRC 20-1: Continuum of Care for Emma

Emma is supported by our integrated care management model encompassing enrollee assessment, care coordination, utilization management, disease management, service planning, and discharge planning, among other services. CareUnify technology enhances data integration and communication among Emma's multidisciplinary team and supports.

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**EXHIBIT A-4-b  
MMA SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA (10-2-17)**

**F. OVERSIGHT AND ACCOUNTABILITY**

**No SRCs in this Category for MMA.**

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**EXHIBIT A-4-b  
MMA SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA (10-2-17)**

**G. STATUTORY REQUIREMENTS**

**MMA SRC #21 – Provider Network Agreements/Contracts Statewide Essential Providers (Statewide)**

The respondent shall submit **Exhibit A-4-b-3**, Provider Network Agreements/Contracts Statewide Essential Providers, to demonstrate its progress with executing agreements or contracts with Statewide Essential Providers by submitting **Exhibit A-4-b-3**:

**Response:**

The completed Exhibit A-4-b-3 follows this page.

**Evaluation Criteria:**

<b>Percentage of agreements/contracts for each service provider type</b>	<b>Points</b>
0.0%	0
1.0% - 25%	10
25.1%- 50%	20
50.1%- 75%	30
75.1% or greater	40

**Score:** This section is worth a maximum of 40 raw points based on the above point scale.

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**EXHIBIT A-4-b-3**  
**MMA SRC# 21 - PROVIDER NETWORK/CONTRACTS STATEWIDE**  
**ESSENTIAL PROVIDERS (STATEWIDE) (10-2-2017)**

<b>Enter Respondent Name Below</b>
Coventry Health Care of Florida, Inc. dba Aetna Better Health of Florida

**EXHIBIT A-4-b-3**  
**MMA SRC# 21 - PROVIDER NETWORK/CONTRACTS STATEWIDE**  
**ESSENTIAL PROVIDERS (STATEWIDE) (10-2-2017)**

<b>SRC Score</b>
<b>40</b>

<b>Service Provider Type</b>	<b>Agreements/Contracts</b>	<b>Statewide Essential Count</b>	<b>%</b>	<b>Score</b>
Statewide Essential	18	23	78.3%	40

**EXHIBIT A-4-b-3**  
**MMA SRC# 21 - PROVIDER NETWORK/CONTRACTS STATEWIDE**  
**ESSENTIAL PROVIDERS (STATEWIDE) (10-2-2017)**

Percentage of Agreements/Contracts	Points
0.0%	0
1.0%	10
25.1%	20
50.1%	30
75.1%	40

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## Exhibit A-4-c: LTC Submission Requirements and Evaluation Criteria and Applicable Attachments/Exhibits



Young residents participate eagerly in a healthy eating demonstration sponsored by Aetna Better Health® of Florida, at which they are taught to prepare healthy snacks by FLIPANY.

FLIPANY serves youth and families, including seniors, through collaboration with community centers, parks, and social services agencies in low-income communities.

*All photos herein are presented with the express and written consent of the individuals in them.*

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**EXHIBIT A-4-c**  
**LTC SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**RESPONDENT NAME:** Coventry Health Care of Florida, Inc. dba Aetna Better Health of Florida

**A. RESPONDENT BACKGROUND / EXPERIENCE**

**LTC SRC# 1 – Participant Direction of Services (Statewide):**

The respondent shall describe its experience with participant direction of services (also referred to as self-directed or consumer-directed) by specifying the model(s) of participant direction used in the states in which the respondent currently operates and previously operated (e.g., agency with choice or fiscal employer agent). The respondent shall include a flowchart depicting how services are authorized and delivered through the participant direction programs referenced in the response. The description shall include:

- Whether the model(s) includes the use of employer authority, budget authority, or both;
- The target population (ABD, DD, general aging population, etc.);
- The number of participants in each participant direction program;
- The services provided through its participant direction programs;
- The monitoring approach used to prevent and detect waste and abuse, specifically over-utilization of services;
- The lessons learned from implementing participant direction programs; and
- The innovations it has deployed to enhance the delivery of services through the participant direction program.

**Response:**

Participant-directed options are a vital component of Aetna's integrated system of care in Florida—a coordinated model of health care and related services working in concert for each enrollee and his or her circle of support. Participant direction of services empowers our enrollees and their authorized representatives to control their services and supports by allowing them to hire, train, supervise, and dismiss the direct service worker(s) who are providing selected home and community-based services (HCBS). By building upon enrollees' strengths and removing barriers to care, each enrollee is afforded the opportunity to pursue those goals that he or she perceives as most important.

Aetna's integrated care management model uses person-centered case management to enable our aging and disabled enrollees to receive long-term care in the most integrated and least restrictive environment possible. Our integrated care management approach recognizes the complex biopsychosocial issues that must be addressed for our enrollees, and we help coordinate meeting their needs and desires.

In our view, enrollees are the sole authority to voice their personal preferences and quality of life goals. Our role is to serve as advocates and to help enrollees discover what is truly important to them. In supporting enrollees, we help to shape a life plan, as opposed to simply a care plan—a collaborative voice that results in real transformation.

Each enrollee's individual plan of care is tailored to meet his or her specific goals, needs, and preferences. Aetna provides comprehensive care management support and individual plans of

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

care with a primary focus on enrollees' goals and preferences, while addressing the underlying root causes that are either driving adverse outcomes or creating barriers to improvement.

During care planning, we work with the enrollee to develop a plan of care that supports the reduction of potentially preventable inpatient and outpatient hospital events and unnecessary ancillary services. We use motivational interviewing during transition discussions with enrollees and caregivers. Participant direction of services is available to all long-term care enrollees who have any participant-directed service on their authorized care plan and who live in their own home or family home. In accordance with State and federal regulations, participant-directed services must be medically necessary and cost-effective. They contribute to the Agency's goal of transitioning long-term services and supports systems by increasing the percentage of enrollees receiving services in the community instead of an institution.

We believe that enrollees who self-direct their services have a deeper, more personal investment in their care and are more satisfied with the care they receive. Evaluation results from the National Resource Center for Participant-Directed Services show that:

- Participant direction significantly reduced the unmet needs of Medicaid consumers who require personal assistance services
- Participants experienced positive health outcomes
- Quality of life for participants and their caregivers improved
- The program did not result in misuse of Medicaid funds or abuse of consumers
- It proved to be a cost effective option per enrollee

Participant direction also provides consistency and familiarity as the enrollee has chosen his or her caregivers over an Agency-supplied aide. Aetna encourages enrollees and their representatives to use participant-directed service delivery whenever appropriate.

### **EXPERIENCE WITH PARTICIPANT DIRECTION OF SERVICES**

**CRITERION 1:** The extent to which the respondent's description includes experience with managing a participant direction of service delivery model

Aetna is currently managing health plans involved in participant direction of services in nine states, including Florida, Arizona, Illinois, Michigan, New Jersey, New York, Ohio, Texas, and Virginia. In addition, Aetna operated a participant-directed option in Delaware from 2012 to 2014. Aetna's experience with participant direction of services dates back to 2008, through its management of the Mercy Care Arizona Long Term Care System (ALTCS) plan, which participated in Arizona's newly implemented participant direction of services program. Our programs are primarily employer-authority models with one state also allowing the enrollee to direct their budget (budget authority). Electronic visit verification systems are in place in Illinois and Texas.

Throughout the states in which Aetna's enrollees have access to participant directed services, our goal is to ensure the enrollees are educated and have the necessary supports to initiate this important option when appropriate. Michigan serves as an example of the success of our approach in implementing and managing participant direction of services. Nearly 17% of the Michigan enrollees in our duals demonstration plan elected to self-direct their care. The population served in Michigan is individuals ages 21 and over who meet institutional level of

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

care criteria and individuals with intellectual/developmental disabilities. This percentage exceeds both the Michigan average of 15% and the national average of 10% (based on national core indicators). In our prior Delaware program, approximately 40% of the long-term care community-based population used the participant direction of services option. Additionally, 98% of the participants surveyed indicated they would recommend our program to others. Aetna draws upon our lessons learned to expand participant direction of services in Florida and other states.

### **Aetna's Model of Participant Direction**

Aetna's participant direction services are part of the enrollee's care plan development process for long-term care enrollees. Our care managers educate and offer participant-directed services to enrollees who live in their own home or in a family home once their eligibility to participate in the participant direction option is determined. We also include information about participant direction of services in our enrollee handbook and on our website.

We collaborate with enrollees to develop a service plan that adequately meets their individual needs. Our care managers use our home- and community-based services tool to identify each enrollee's specific service needs and ensure enrollees have the willingness and ability to manage participant direction responsibilities. Once it is determined that enrollees or enrollee-selected representatives have this ability, they are supported and coached on how to be an employer, using Aetna and State tools by both the care manager and the fiscal employer/agent (FE/A).

Our processes are developed in a manner that considers the dynamic nature of our enrollees' lives and are modified to meet their evolving needs.

### **Participant Direction of Services Experience in Florida**

Participant direction of services affords enrollees the ability to make critical decisions regarding some of the most important activities of their lives: what kind of care they need to stay at home, who should provide that care, and how it should be managed. Aetna implemented the participant direction of services program in Florida in 2013.

Type of authority: The model for Aetna's Florida participant direction of services program is employer authority with approved units of service from the plan.

Target population: The target population includes those who meet the following criteria:

- 65 years of age or older and need nursing facility level of care
- 18 years of age or older and are eligible for Medicaid by reason of disability and need nursing facility level of care
- In hospice
- In institutional care
- Individuals who age out of Children's Medical Services and meet the following criteria:
  - Received care from Children's Medical Services prior to turning age 21
  - Age 21 years and older
  - Cognitively intact
  - Medically complex

**EXHIBIT A-4-c**  
**LTC SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

- Technologically dependent
- Medicaid Pending for Long-Term Care Managed Care HCBS waiver services

Enrollees served: As of October 2017, Aetna's Florida participant direction of services program serves 212 active enrollees, with 14 disenrollments (all related to death of enrollee) during the preceding quarter.

Services provided: Services that are mandated under Aetna's participant direction of services program are adult companion care, attendant care, homemaker services, personal care services, and intermittent skilled nursing.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Regional variation and cultural competency

Participant direction of services contributes to Aetna's commitment to providing culturally competent services to all enrollees. The participant direction of services program increases the likelihood that enrollees receive their services from someone who shares their cultural values and speaks their preferred language. Aetna has instituted Section 1557, the non-discrimination provision of the Patient Protection and Affordable Care Act and provides detail on its multi-language interpreter services in the long-term care enrollee handbook. All Aetna care managers are tested to verify fluency in languages they speak other than English. In Aetna's four participating long-term care regions (Regions 6, 7, 9, and 11), Spanish is commonly spoken by

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

our enrollees, while French Creole is often common in Region 11. The 701B Assessment tool, as well as Aetna's case management system, contains a preferred language section.

### **PARTICIPANT DIRECTION OF SERVICE EXPERIENCE IN OTHER STATES**

Aetna's Medicaid organization manages health plans that have experience with participant direction of services in nine states outside of Florida. The following details the types of authority, target populations, number of participants, and services offered in each of those states:

- Arizona, since 2008:
  - Types of Authority: Employer authority
  - Target Population: Individuals who meet institutional level of care criteria; excludes individuals with intellectual/developmental disabilities
  - Number of Participants: 60
  - Services Provided:
    - o Agency with Choice: attendant care, personal care, homemaker, habilitation (in-home/day),
    - o Participant direction attendant services (homemaking, personal care, general supervision)
- Delaware, 2012 to 2014:
  - Types of Authority: Employer authority
  - Target Population: Individuals ages 18 and older with disabilities who meet specific financial and functional criteria
  - Services Provided: Attendant services (homemaking, personal care, general supervision)
- Illinois, since 2013:
  - Types of Authority: Employer authority
  - Target Population: Individuals who meet institutional level of care criteria; excludes individuals with intellectual/developmental disabilities
  - Number of Participants: 1,019
  - Services Provided: Personal care, case management, temporary assistance, nursing (adults only), emergency home response services (adults only), non-medical transportation (adults only), training and counseling for unpaid caregivers, day programs (adults only), behavior services, therapies (adults only), adaptive equipment, assistive technology, home accessibility modifications, and vehicle modifications
- Michigan, since 2015:
  - Types of Authority: Employer authority and budget authority
  - Target Population: Individuals ages 21 and over who meet institutional level of care criteria; includes individuals with intellectual/developmental disabilities
  - Number of Participants: 941
  - Services Provided: Personal care, attendant care
- New Jersey, since 2015:
  - Types of Authority: Employer authority
  - Target Population: Individuals ages 65 and older and under the age of 65 and determined to be blind or disabled by the Social Security Administration or the State of New Jersey; excludes individuals with intellectual/developmental disabilities
  - Number of Participants: 64

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- Services Provided: Supported employment, habilitation, respite care, PERS
- New York, since 2013:
  - Types of Authority: Employer authority
  - Target Population: Individuals ages 18 and over who meet institutional level of care criteria and need community based long-term care services for more than 120 days; excludes individuals with intellectual/developmental disabilities
  - Number of Participants: 708
  - Services Provided: Personal care services
- Ohio, since 2014:
  - Types of Authority: Employer authority and budget authority
  - Target Population: Individuals who are age 18 and over and meet institutional level of care criteria; excludes individuals with intellectual/developmental disabilities
  - Number of Participants: 54
  - Services Provided: home care attendant service, alternative meals, pest control, minor home modification, maintenance, and repair; home medical equipment and supplemental adaptive assisted devices
- Texas, since 2016:
  - Types of Authority: Employer authority
  - Target Population: Individuals up to age 20 who meet the level of care provided in a hospital or nursing facility, intermediate care facility for individuals with an intellectual disability or a related conditions (ICF/IID), or an institution providing psychiatric services and have an assessed functional need for CFC services
  - Number of Participants: 32
  - Services Provided:
    - o Texas STAR Kids: Community First Choice (CFC) habilitation, personal care assistance
    - o MDCP: In-home respite, flexible family support services, supported employment, employment services
- Virginia, since 2017:
  - Types of Authority: Employer authority
  - Target Population: Individuals who meet institutional level of care criteria; excludes individuals with intellectual/developmental disabilities
  - Number of Participants: 1,329
  - Services Provided: Personal care, respite care

**PARTICIPANT DIRECTION OF SERVICES MODEL IN FLORIDA**

CRITERION 2: The extent to which the respondent's flowchart provides a description that addresses the following components:

- (a) Care planning;
- (b) Service authorization;
- (c) Involvement of the Fiscal Employer Agent;
- (d) Electronic Visit Verification;
- (e) Claims processing;
- (f) Claims payment; and
- (g) Encounter data submission

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All enrollees who reside in their home or a family home are eligible for participant direction of services. Our care managers provide them with an orientation to Aetna's integrated care management program and collaborate on the development of an individualized plan of care. The care manager completes the AHCA pre-screening tool; if the enrollee passes pre-screening, the care manager refers him or her to an enrollment specialist with the FE/A. The care manager undergoes extensive training on our participant direction of services program, as well as training on the ways our FE/A, monitors, and compensates caregivers. Aetna's care manager:

- Assists the enrollee with the participant direction of services program enrollment packet
- Interviews potential direct service workers (selected by enrollee)
- Reviews the participant direction of services manual and guidelines
- Completes the AHCA participant direction of services consent form and representative agreement
- Faxes the application and forms packet to FE/A Public Partnerships, LLC (PPL) for background check and sets up the caregiver in PPL's system
- Assists the enrollee with developing a contingency plan
- Completes the Caregiver Assessment
- Provides ongoing monitoring of the delivery of services by the caregiver to the enrollee

A workflow of Aetna's participant direction of services is illustrated in Attachment LTC SRC 1.

### **Care Planning**

Aetna uses a person-centered care planning process in which the plan of care is developed with the enrollee, who signs off on it upon implementation. The individual plan of care is a dynamic, living document driven by each enrollee and his or her care team. Aetna's involvement with participant direction of services begins at the enrollee's orientation visit with his or her care manager, which includes assessment that identifies the appropriateness of participant direction of services for the enrollee. As we conduct the Florida Department of Elder Affairs 701B Comprehensive Assessment and the Comprehensive Assessment and Review for Long Term Care Services (CARES), we begin to develop enrollee-identified and prioritized goals, activities, cultural preferences, and information to foster the enrollee's ability to make informed decisions and navigate the delivery system. We foster resiliency by working with the enrollee to identify his or her strengths. Additionally, our process assists enrollees in identifying, reducing, and removing barriers that may inhibit their ability to reach their goals. Following the orientation, the care manager develops the individual plan of care, completing the initial care planning and case formulation documents and developing a letter that introduces the preliminary plan of care to the enrollee. The enrollee or authorized representative completes and signs the Freedom of Choice Certification, receives an initial orientation, and is presented with the enrollee handbook and provider directory. A copy of the plan of care is provided to the enrollee and his or her representative (if applicable) and PCP within 10 days of development.

Enrollees are reassessed annually or after significant changes in their situation (e.g. an inpatient admission) and are presented with the option to utilize the participant direction of services program if they meet program criteria and are interested.

If the care plan lists at least one of the five eligible participant direction of services, the care manager provides additional documentation that the enrollee will find helpful as he or she

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chooses participant direction of services. All signed documentation of participant direction of services choices is maintained in the enrollee's case file. Enrollees who opt to receive eligible services via participant direction of services complete the pre-screening tool with their care manager to determine whether they are willing and able to manage their participant direction of services responsibilities. Enrollees choosing participant direction of services also receive the AHCA My Choices Participant Direction of Services Guidelines that details useful information about participant direction of services, the responsibilities of the care manager, enrollee and FE/A, and information on finding and hiring a direct service worker.

As part of the care-planning process, the care manager educates the enrollee on contingency planning and a plan is developed with enrollee or enrollee's representative. The contingency plan serves as the backup plan for gaps in services. The plan is utilized when the direct service worker is unable to provide the scheduled services authorized in the plan of care. The contingency plan includes information about action the enrollee and/or authorized representative should take to report gaps and what resources are available to the enrollee, including on-call backup providers and informal supports, to resolve unforeseeable gaps such as provider illness or resignation without notice or transportation failure. The informal support system shall not be considered the primary source of assistance in the event of a gap, unless this is the enrollee/family's choice. Enrollees often select other friends or family members to act as backup service providers. In these cases, enrollees are advised of the background screening requirements for backup direct service workers and the requirement that they be cleared prior to being utilized. If an enrollee wishes to use a non-participant direction of services direct service worker as the backup provider, the care manager reviews the care plan with the enrollee to assist with the selection and ensures phone numbers and contact information for the selected providers are included on the plan. The enrollee is notified that the plan is to be reviewed and discussed at least quarterly and a copy of the contingency plan shall be given to the enrollee when developed and as updated.

### **Service Authorization**

Notification of "good to go" for the direct service worker comes from the participant who is the employer of record. Once a direct service worker has completed the necessary paperwork to be hired (listed below), the participant receives notification of worker being approved from their care manager who is notified via email by PPL:

- DSW Information/Application and Attestation Form
- IRS Form W-4
- USCIS Form I-9 Employment Eligibility Verification
- Passed Level 2 state background check
  - Criminal background check results must be passed for a direct service to be approved

The schedule is set by the participant based on the care plan that was received and reviewed with the care manager.

Prior authorization is required for intermittent skilled nursing services. Prior authorization is reviewed and approved by the Prior Authorization team based on medical necessity. Authorization approval is documented in Aetna's electronic care management system. A

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

notification of the approval is generated to the enrollee's care manager who updates the plan of care and care summary to reflect the authorized service and its frequency and duration.

If the contingency plan must be implemented, the enrollee must advise the care manager and PPL to ensure the service provider authorization is amended and timesheets are processed for only the time worked. If a formal provider is providing the services, the care manager issues an authorization to the provider. Informal support services are documented in the enrollee case file. When the enrollee's contingency plan includes contacting a contracted home health agency to deliver services in the event the direct support worker is unavailable, the care manager authorizes the necessary type and amount of services and the span date. This service authorization is sent directly to the home health agency.

Our care manager completes the authorization, PPL implements the services, and we validate that the services are in place, provide ongoing monitoring, and confirm enrollee satisfaction with their services.

### **Involvement of the Fiscal Employer Agent**

The care manager facilitates the initiation of required fiscal employee/agent (FE/A) services documentation for enrollees who meet all criteria for participant direction of services. The enrollee and care manager identify potential community-based direct service workers, and this information is communicated to PPL and the enrollment form is emailed to PPL's enrollment specialist.

Aetna's participant direction of services enrollees and the caregivers who serve them benefit from PPL's well-established systems and processes for providing the FE/A. Aetna uses PPL's capabilities to assist with timesheet submission, processing payroll, and filing all state and federal taxes on behalf of participants and their direct service workers. These services ease the burden on our enrollees or their representatives who are employers of record and for direct service workers.

Aetna provides valuable service to its enrollees in PDO through its partnership with PPL, based on our extensive body of operational knowledge and national best practices on all aspects of participant direction of services. These best practices include:

- Call center agents who are specifically trained and assigned to meet the unique needs of the programs served; they are supported by comprehensive policy and procedure documents as well as specific scripting where appropriate.
- Interactive voice response (IVR) technology that allows the fiscal management services provider's computer to interact with the person calling to streamline the calls
- An interactive Web-based system that provides guidance and real-time validation of timesheet data against program rules
- Caregiver credentialing: PPL confirms caregivers' qualifications and credentials and documents them electronically
- Electronic data interchange (EDI) standards for program eligibility, billing, and provider payments
- A disaster recovery plan in place providing documented results of an annual disaster recovery test

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- Annual application vulnerability tests conducted based on the Open Web Application Security Project (OWASP) standard
- A certified security officer on staff to enforce all information technology security requirements and to assess the privacy and security of participant information

### **Electronic Visit Verification**

Aetna is in the process of implementing its electronic visit verification (EVV) system (in compliance with Section 409.9132, Florida Statutes [F.S.] and 59G-4.132, "Home Health Electronic Visit Verification Program" of the Florida Administrative Code) in collaboration with Tellus, a nationally recognized vendor. Our EVV system offers interoperability and compatibility with the Agency's current EVV system, also subcontracted through Tellus. The Tellus EVV system is interoperable and compatible with PPL's Time4Care™ state-of-the-art, Fair Labor Standards Act-compliant EVV system.

Key elements of the Time4Care system include:

- Mobile access: Providers and participants can download the Time4Care application on iOS, Android, or Windows smartphones and tablets
- Clock-in/clock-out time capture: Providers submit hours and minutes worked in real time using the Time4Care application; time submissions are validated against approved service authorizations
- Onsite approvals: Our EVV system gives participants or authorized representatives the ability to approve or deny their provider's hours and verify service delivery immediately after the provider's visit
- Geolocation: Time4Care captures the location in which a provider clocks in and clocks out to verify the provider is at the expected location
- Real-time alerts: Real-time notifications offer total transparency to in-home care, providing early warning of suspicious behavior
- Off-line mode: Providers can clock in and clock out even with a loss of Internet connection

EVV helps reduce home care delivery fraud related to improper recordkeeping, including paper time of service data by capturing time, attendance, and service plan information entered by the direct service worker at the point of care. This technology enables us to monitor service use and real-time receipt of authorized services. Aetna will use EVV for participant-directed services and will work in collaboration with providers in the community who may already be using electronic visit verification to develop a solution that effectively protects our enrollees from fraud, waste, and abuse.

### **Claims Processing and Payment**

As described above, PPL, Aetna's FE/A partner for participant direction of services, sets up payroll for enrollees' direct service workers. Direct service workers submit timesheets or report their hours and minutes worked using PPL's BetterOnline™ portal. PPL processes all timesheets, and they generate and deliver payroll checks to direct service workers. PPL generates and sends an invoice to Aetna for its payroll expenses. Aetna processes the invoice and pays PPL on a fee-for-service or per-enrollee-per-month basis, depending on the participant-directed services provided. We keep a collaborative relationship with PPL relative to

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

developing processes to conduct general claims oversight, perform reconciliation, and maintain appropriate controls.

The timesheet system does not allow for mathematical errors, regardless of whether they are submitted electronically or via fax. The system automatically calculates in and out times on direct service workers' timesheets and checks against the participant's authorization to ensure there are sufficient units remaining. Any issues with electronic timesheets are outlined in an error message at the point of submission. In many cases, direct service workers can make corrections to mistakes on the electronic timesheet to submit the timesheet for approval. In cases where they are unable to do so without assistance, PPL's dedicated customer service team can assist with submission by reviewing the saved timesheet with the direct service worker over the phone. Paper timesheets with issues trigger notification to the direct service worker from the customer service team. Customer Service reviews the corrections needed with the direct service worker and their employer and provides next steps as to resolution, including resubmission of timesheets with corrections needed.

PPL's payroll systems rules ensure that any timesheets submitted and approved that are older than 90 days are designated as pending and are reviewed by their dedicated payroll team. Any timesheets that are pending for being more than 90 days are sent to Aetna for approval prior to payment. Once written approval has been received, PPL pays the timesheet to the direct service worker. If approval is not provided, PPL denies the timesheets.

In the event of a disagreement between hours reporting by the direct service worker and the participant, PPL contacts the participant or his or her representative to explain the issue. A PPL customer service representative requests that the timesheet be corrected and resubmitted for processing. Once the participant/direct service worker returns the call to Customer Service, the representative works collaboratively to resolve the concern. If there is no agreement, the caller is referred to Program Management. The program manager reviews the program rules and makes corrections within Aetna's guidelines. When there is no amicable resolution, the issue is referred to the care manager for resolution.

### **Encounter Data Submission**

As PPL processes payroll for direct service workers, it also generates an encounter data file that is submitted to Aetna alongside an invoice. Aetna then submits encounter data to the Agency in a manner consistent with encounter data submission for all other services. To achieve accurate and timely submission, Aetna transmits all encounter data utilizing HIPAA-compliant 837 (I, P, and D) electronic formats. Our provider contracts require providers to submit claims within six months from the date of service on the approved electronic or paper claim form, and each claim must contain the necessary data. Following adjudication and payment, we export claims data into the encounter management system (EMS) system twice a week after each check run.

Aetna utilizes the EMS application that imports claims data from the health plan claim processing system. This data are formatted to Florida-specific encounter data requirements. The EMS also imports encounter data from subcontracted vendors, in this case PPL, and formats it for submission to AHCA. We use our EMS to monitor that the data is accurate, timely, and complete in our encounter submissions to the Agency. Our EMS processes long-term care claims utilizing the most current coding protocols (e.g., standard Centers for Medicare & Medicaid Services procedure or service codes such as ICD-10, CPT-4, HCPCS-I, II).

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Aetna processes the encounter data file and submits it to the Agency. When Aetna receives the Agency response of receipt of the submission and its acceptance or rejection of the encounter data, Aetna forwards it to PPL.

Aetna's company-wide subcontractor monitoring processes maintain accountability and oversight for all functions and responsibilities that we delegate to PPL. We meet monthly with PPL representatives to review encounter reports. If repeated rejections from the Agency occur, we initiate corrective action to remediate issues identified.



**LESSONS LEARNED**

**CRITERION 3:** The extent to which lessons learned have been utilized to improve the respondent's participant direction of service delivery model

Aetna's experience with participant direction of services dates back to 2008 through its management of Mercy Care Plan, which participates in the Arizona Long Term Care System Enrollee-Directed Options. In the past nine years, we have learned many lessons from our management of health plans involved in participant-directed programs. The following summarizes lessons we have learned in operating the Florida participant-directed option program.

**Eligibility**

In Florida, during the initial implementation of the participant direction of services program in 2013, our care managers were in consistent need of clarifying information related to enrollee eligibility and who could benefit most from participant direction of services. In response, Aetna and PPL collaborated to develop a care manager toolkit to assist care managers in vetting individuals. Aetna care managers now use PPL's care manager toolkit whenever they need to discuss participant direction with an enrollee or a family. It contains a packet in which the care

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manager can supply the enrollee with all documents that further support his or her participation in the participant direction of services program. Care managers keep this tool in their briefcase or car so they can access the training information with which PPL provided them. Armed with the right talking points, the care managers have gained confidence in their ability to introduce the participant direction of services program to their enrollees. The introduction of this kit has led to fewer calls for basic information as well as increased enrollment in the program.

Care manager training is key to growing the participant direction of services program in Florida. PPL conducts annual training for all care managers to educate them on how to have a conversation about participant direction of services during pre-screening with enrollee. The care manager training includes:

- Introduction to PPL (Aetna's FE/A)
- Overview of participant direction and services included
- Criteria for enrollee eligibility
- Overview of roles and responsibilities of enrollees, representatives, care managers, and direct service workers
- Roles of the enrollment specialist and the enrollment process
- The care manager toolkit
- Program policies and service authorizations
- Enrollment packets
- Electronic timesheet and timesheets submissions
- Service authorizations
- PPL's BetterOnline Portal

The training is conducted in person by PPL representatives in each of the regional offices.

### **Enrollment and enrollee education**

Aetna has enhanced the participant direction of services enrollment process by incorporating an enrollment specialist at PPL. During the enrollment process, the PPL enrollment specialist will review the process with the enrollee or a designated representative. This includes explaining the roles and responsibilities of enrollees, their representatives, and PPL as the FE/A. Enrollment specialists provide guidance in recruiting and hiring direct service workers and help enrollees and representatives to understand and provide training to direct service workers before they are paid for services. Once a direct service worker is identified, the enrollment specialist reviews and assists enrollees and representatives to complete several forms: the employer of record forms packet; the direct service worker enrollment packet containing employment information; the direct service worker agreement form; and federal IRS Form W-4 and USCIS form I-9.

### **Timesheets**

The program began with the use of paper timesheets that were read into a teleform system and required four to eight hours before feedback could be given. Aetna and PPL have introduced enrollees not only to the BetterOnline version of the timesheet but to a mobile application for recording timesheet information as well. The electronic version provides real-time data regarding available hours.

### **Data exchange**

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To provide accurate information to PPL, Aetna and PPL have developed an automated file exchange process. Enrollee eligibility is confirmed prior to the daily file that is sent to the fiscal management system, reducing manual entries that can lead to errors.

Electronic visit verification: We have learned that appropriate training to enrollees is essential for efficient use of EVV. Therefore, we have enhanced our training in the states where EVV is used to provide it in Spanish as well as English.

### **INNOVATIONS IN PARTICIPANT DIRECTION OF SERVICES**

CRITERION 4: The extent to which the described experience demonstrates past innovations or planned innovations in participant direction of services (e.g., mobile telephone applications, implementation of electronic access/training to complete required forms, and electronic visit verification)

Aetna, in collaboration with PPL, has implemented several innovations while operating the Florida participant direction of services program.

#### **Aetna mobile application**

Having a simple and easy-to-use application can help our enrollees and their families navigate the health care system, giving them instant knowledge and information that empowers them and facilitates participant direction. We developed the mobile application with simplicity in mind. The application enables enrollees to easily access relevant information and navigate different screens with minimal effort.

#### **BetterOnline Web-portal**

PPL developed BetterOnline as a Web-based solution for participant direction of services. BetterOnline provides an intuitive and user-friendly experience that is fully integrated with PPL's financial management system. User access and privileges are tailored to the needs of each stakeholder. Care managers have real-time access to enrollee demographic information, service authorizations, and timesheet activity that detail usage.

The BetterOnline platform also provides a single repository for enrollees and direct service worker demographic information and eligibility data. It is fully integrated with PPL's payroll system.

Utilization of the BetterOnline Portal by Aetna's participant direction of services enrollees is primarily to submit timesheets. There is an average of 330 electronic timesheets processed per month, which represents over half of all timesheets submitted. Online timesheet submission has doubled in the past 12 months.

#### **Customer service**

We have upgraded our call center capabilities in the past year. PPL's capabilities now include Hold My Place, an automated call-back feature that allows callers to receive a return call from PPL rather than remaining on hold; an interactive voice recognition system that allows service

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

workers to determine the status of their timesheets; and automated outbound calling and messaging that allows PPL and our State partners to disseminate important program announcements to stakeholders statewide. PPL also records calls for internal and external monitoring purposes.

### **Disaster recovery plan**

Aetna's FE/A for the participant direction of services program maintains and shares with Aetna large amounts of sensitive information, including protected health information and protected payment information for our enrollee and their direct service workers. Aetna has collaborated with PPL to develop its robust Disaster Recovery Plan to protect the programs we serve for mitigating and reacting to an emergency event and resuming normal operations. PPL's Disaster Recovery Plan addresses restoring software, master and electronic files, hard copy files, and hardware backup in the event management information systems are disabled, to minimize payroll and payment system interruptions. The Disaster Recovery Plan is part of PPL's overall Continuity of Operations Plan and complies with industry best practice guidelines.

### **Enrollment process**

The enrollment process now includes having both the employer of record and a direct service worker at the enrollment. During the enrollment, the worker and/or representative is registered for the criminal background check. This has reduced the number of days from enrollment to the start of services.

## **MONITORING AND FRAUD, WASTE, AND ABUSE PREVENTION**

**CRITERION 5:** The extent to which the respondent's monitoring approach ensures that fraud, waste and abuse is monitored and prevented, including over utilization of services

Fraud, waste, and abuse (FWA) prevention is one of Aetna's strengths. Participant-directed services are especially vulnerable to fraud, waste, and abuse, including an increased risk of collusion between enrollees and direct service workers they have hired. Aetna's FWA program for participant direction of services includes several interrelated processes.

We authorize participant direction of services so that caregivers cannot bill for more hours or services than have been authorized, as noted below. Aetna's long-term care managers for PDO audit direct service workers' timesheets to confirm they are consistent with service plans and assessments, have been signed, and do not contain edits. Care managers monitor enrollee needs to see that they are adequately met based on the authorized care plan.

We ensure that direct service workers meet state certification and program requirements. For example, direct service workers must meet and have completed training in universal precautions and HIPAA privacy standards, and they must be certified in CPR and first aid. For attendant care or intermittent/skilled nursing services, the direct service worker must be either an RN or LPN licensed in accordance with Chapter 464, F.S. We also identify specific findings that result in an automatic disqualification of a caregiver under participant direction of services and verify that caregivers are not on the care managers' exclusion list. If a background check reveals that our enrollee may be at risk, we immediately inform our enrollee and ensure that the enrollee is competent to make an informed choice about their direct service worker.

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Aetna provides formalized annual training and ongoing education to care managers and direct service workers on how to detect or identify and report fraud, waste, and abuse, including risks and penalties for FWA. Our care managers are trained to recognize non-verbal cues and are sensitive to the enrollee's environment. Aetna educates participant-direction enrollees on the basics of fraud, including how to recognize fraud and what to do if they believe that fraud may be occurring.

Through the PDO enrollment process, which includes an informational packet that conforms to a fifth grade literacy level, participants are educated on the basics of fraud, including how to recognize fraud and what to do if fraud is occurring. Participants are instructed not to sign blank timesheets and not to approve payment for a day they did not receive services. If participants suspect fraud, they are to contact PPL immediately. In addition, the enrollees are trained on the business rules around the behavior of timesheets that is built into the PPL system to prevent unauthorized workers from entering time. All timesheets and enrollment documents inform the enrollees and caregivers of consequences for falsifying records.

Aetna and its subcontractor staff members follow the best practices outlined by the Office of Inspector General for identifying potential fraud. This includes verifying conflicting timesheet submissions (i.e., date of services recorded on the timesheet submitted by the worker matches dates where the employer was receiving inpatient hospital care), confirming workers' qualifications and credentials, and resolving timesheet discrepancies. For example, the direct service worker can only submit time with the authorized codes that are connected to the individual they are working for. Workers cannot submit more time than they were approved for on the authorization. Workers cannot submit duplicative time, meaning the system rejects workers who attempt to submit time for two separate enrollees, and workers cannot submit time that overlaps with another worker's time. If an enrollee is unable to submit time electronically and instead submits a paper timesheet, both the participant and direct service worker must sign the timesheet. Once the timesheet is entered into its system, the rules previously noted apply. Aetna also ensures payments are made to appropriate parties through verifying that deposits are not made to participant accounts or mailed to participant addresses and that out-of-state provider addresses are legitimate.

Additionally, to protect our enrollees adequately, Aetna:

- Conducts annual quality audits of providers and utilizes its internal Special Investigations Units to review suspected cases of fraud or abuse and suspend payments when evidence of fraud is substantiated; all identified cases of fraud, waste, or abuse are referred to the AHCA Office of the Inspector General for potential further investigation
- Holds direct service workers accountable through contracting language
- Conducts and reviews participant direction of services enrollee satisfaction survey results
- Conducts regular unannounced home visits to confirm that quality services are being provided in a timely manner
- Conducts monthly enrollee outreach for the first 90 days of participation
- Completes and reviews quarterly provider services surveys
- Regularly monitors the enrollee and claims to ensure they are receiving appropriate and adequate services and provides any necessary support to continue in their role as an employer

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- Determines whether or not multiple enrollees are supported by the same caregiver via claims and systems edits

Using our nationwide experience as our guide, we believe that above proposed approach improves the quality of service facilitation and simplifies the process for the Agency by eliminating duplication of services and minimizing unnecessary expenses. An example may help illustrate this.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

**Subcontractor Monitoring to Prevent and Detect Fraud, Waste, and Abuse**

We use defined company-wide subcontractor monitoring processes to maintain accountability and oversight for all functions and responsibilities that we delegate to PPL as subcontractor for participant-directed services, in accordance with 42 CFR 438.230, including the updates that have recently gone into effect and NCQA standards, as well as all other state and federal requirements. Aetna assumes full responsibility for active, ongoing monitoring and continuous evaluation of subcontractor performance and compliance. Our team members in every department know that they play a key role in promoting program integrity and monitoring for fraud, waste, and abuse.

Aetna promotes program integrity and prevention of fraud by requiring that PPL staff members complete our compliance and fraud, waste, and abuse training at the time of initial contracting and annually thereafter. We review PPL's fraud, waste, and abuse programs annually to verify that they provide fraud, waste, and abuse training to their employees. Annual, AHCA-approved provider training is conducted electronically by way of online training modules and webinars. PPL has a well-established fraud and abuse policy and procedure that Aetna would be happy to share with the AHCA.

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Our senior project manager assumes oversight of PPL, which is audited annually by Aetna to review whether PDO-specific policies and procedures reflect current contractual requirements (set forth in Attachment II, Exhibit II-B, Section V.A.2) and was updated within the last year. The audit also reviews PPL's training requirements, PDO care management and monitoring functions, reporting practices, and compliance with all federal and state requirements and operation in accordance with Section 3504 of the Internal Revenue Service Code.

The annual audit includes a case file audit that incorporates the following questions:

- Does the direct service worker satisfy the minimum qualifications set forth in Section VI, Provider Network, Table 2? (Yes or No)
- Is there a signed Participant/Direct Service Worker Agreement Form in the case file? (Yes or No)
- Does the Participant/Direct Service Worker Agreement Form include services to be provided; hourly rate; direct service worker's work schedule; relationship to the enrollee; job description; agreement statement; dated signatures of case manager, enrollee, and direct service worker? (Yes or No)
- If yes, provide signed Participant/Direct Service Worker Agreement Form.
- If there is a rate change for any PDO service, is there evidence of written notice to the applicable enrollees or direct service workers at least 30 days prior to the change? (Yes/No/Not Applicable)
- If yes, is there an updated Participant/Direct Service Worker Agreement in the enrollee's case file? (Yes or No)
- Are the results and determination of clearance of a background screening for the direct service worker and/or representative located in the enrollee's case file? (Yes or No)
- Is there a direct service-worker hiring packet located in the enrollee's case file?

Aetna conducts joint operational calls (JOC) with PPL monthly or more frequently as needed, during which we review metrics, reports, complaints, trends, encounter timeliness, denials, and any potential FWA issues. In the JOC, we review PPL's overall performance and future innovations in their service delivery model. When additional information is needed, we require the vendor to submit ad hoc reports and we review them together in the JOC. All of this oversight provides us with information to improve service, develop processes, and identify trends and innovations to improve service to our enrollees.

Both Aetna and PPL are committed to complying with all laws and regulations related to fraud and abuse in federal health care programs. PPL acts as a mandatory reporter to state agencies regarding situations of suspected fraud, abuse, or neglect in all of its programs. If PPL suspects fraud, abuse, or neglect has taken place, PPL will immediately report the situation to the appropriate state and federal agencies. PPL adheres to the Federal False Claims Act, the Federal Program Fraud Civil Remedies Act, §6032 of the Deficit Reduction Act (DRA) of 2005, and applicable state laws pertaining to false claims and the prevention, detection, and reporting of Medicaid fraud, waste, and abuse.

Aetna care managers encourage enrollees in participant direction of services and direct service workers to utilize PPL's BetterOnline Web-portal. BetterOnline decreases the opportunity for fraudulent timesheet submission (e.g., forged signature or time) as enrollees and direct service workers log into the system using their personal username and password to submit and approve timesheets. Aetna's financial management system integrates with the BetterOnline Web portal

**EXHIBIT A-4-c**  
**LTC SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

to ensure validation in real time to check for common timesheet errors and fraudulent submissions.

**Evaluation Criteria:**

1. The extent to which the respondent's description includes experience with managing a participant direction of service delivery model.
2. The extent to which the respondent's flowchart provides a description that addresses the following components:
  - (a) Care planning;
  - (b) Service authorization;
  - (c) Involvement of the Fiscal Employer Agent;
  - (d) Electronic Visit Verification;
  - (e) Claims processing;
  - (f) Claims payment; and
  - (g) Encounter data submission.
3. The extent to which lessons learned have been utilized to improve the respondent's participant direction of service delivery model.
4. The extent to which the described experience demonstrates past innovations or planned innovations in participant direction of services (e.g., mobile telephone applications, implementation of electronic access/training to complete required forms, and electronic visit verification).
5. The extent to which the respondent's monitoring approach ensures that fraud, waste and abuse is monitored and prevented, including over utilization of services.

**Score:** This section is worth a maximum of 55 raw points with each of the above components being worth a maximum of 5 points each.

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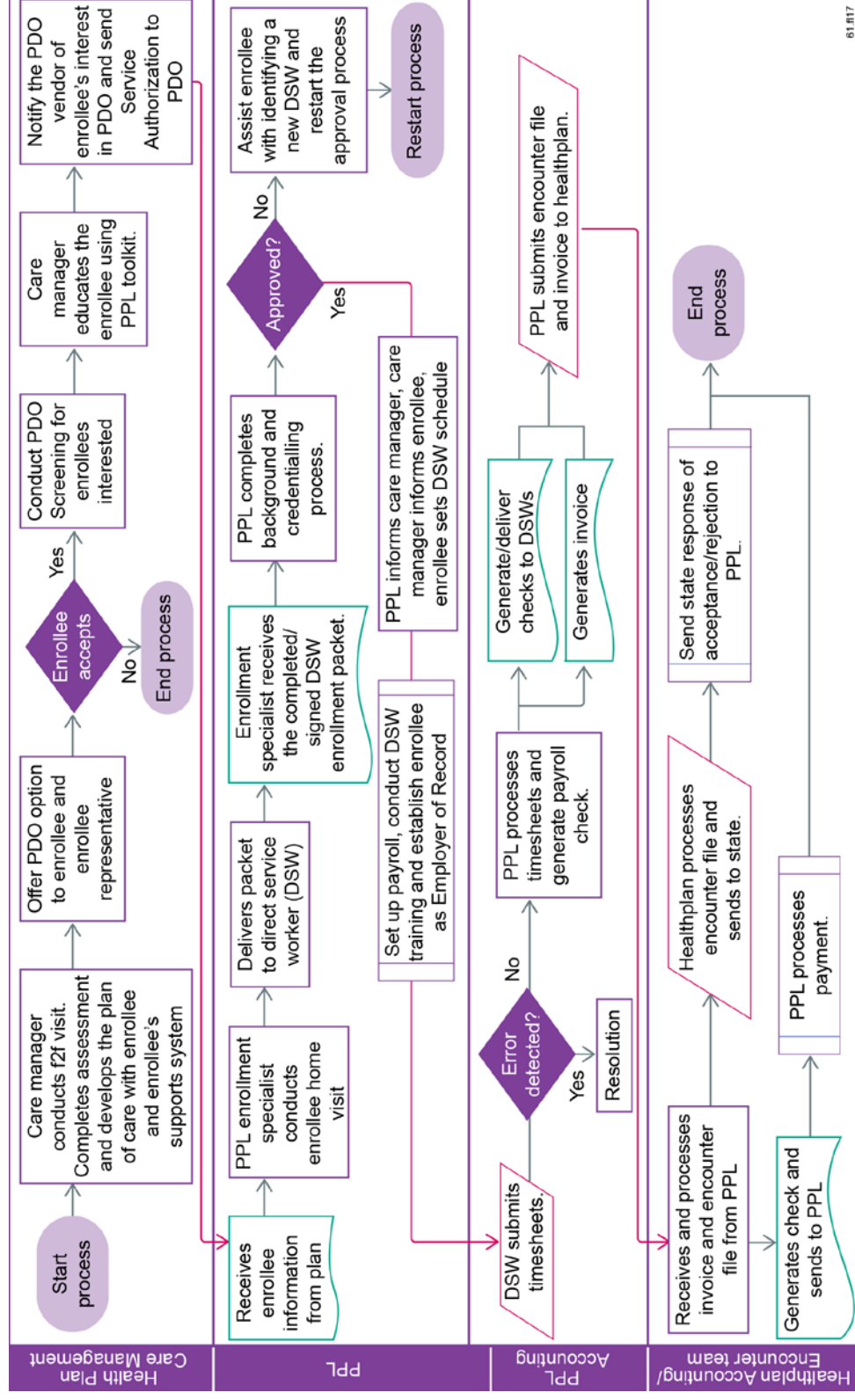
## **Attachment LTC SRC# 1**



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## LTC SRC# 1: The Participant Direction of Services Process



**Figure LTC SRC 1-1: The Participant Direction of Services Process**

*Services are authorized and delivered through Aetna's participant direction programs to eligible long-term care enrollees in Florida.*

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## **Consumer Directed Care PDO Desktop**



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## **Consumer Directed Care/Personal Directed Options**

### **Integrated Long Term Care Management**

- [Identifying Members that are Candidates for Consumer Directed Care](#)
- [Spouse Attendant Care Guidelines](#)
- [Spouse Attendant Care Details](#)

This procedure details the steps to be taken to ensure the unique processes of the Consumer Directed Care/Personal Directed Options (PDO) program are followed.

Apply this desktop after the hours needed for PDO qualifying services (adult companion care, Attendant Care, Personal Care, Homemaker Services, and intermittent and skilled nursing) have been calculated.

### **General Restrictions & Limitations:**

- The member must be competent, able and willing to self-direct his/her care. If not able to self-direct the care, the member may authorize a representative to fill this role.
- Individuals of the member's choosing may provide PDO services so long as the meet the minimum provider qualifications for the service and are age eighteen (18) or older and obtain a satisfactory Level II background screening
  - No additional qualifications are required for adult companion, homemaker or personal care services
  - Attendant care and intermittent / skilled nursing services require RN or LPN FL state licensure
- A CM with extensive training in PDO (as describe in the AHCA Contract) will be assigned to the member within two (2) business days of the member's decision to participate in the PDO program.
- Refer to the Respite Care Desktop for guidelines on the use of respite in PDO situations.

### **Identifying Members that are Candidates for Consumer Directed Care**

Note: Only complete this process if the member/family is receiving PDO qualifying service per their Plan of Care AND the member lives in his/her own home or a family home. .

<b>Players:</b>	Case Manager (CM), Case Management Coordinator (CMC)
<b>Process Initiation:</b>	CM has completed all modules of the <b>701B/interRAI Tool</b> and the HCBS Needs Tool and member qualifies for a PDO service as stated above.

Step	Action						
1	<p>Inform the member / representative of the option to participate in the PDO</p> <p><b>NOTE:</b> Use the Dynamo Consumer Directed Care Event to document the PDO process.</p>						
2	<p>Determine if the member is able to participate in Consumer Directed Care.</p> <table> <tr> <th>If the member...</th><th>then...</th></tr> <tr> <td>Is able to participate in consumer directed care OR has a designated representative that can managed the care AND meets the state specific requirements for consumer directed care</td><td>Proceed to Step 3</td></tr> <tr> <td>is not able to participate or does not meet the state specific requirements for consumer directed care,</td><td> <p>write clear note with a reason justifying not offering consumer directed care to the member</p> <p><b>Sample note:</b></p> <p>"Member is not oriented enough to understand or meaningfully participate, guide their own care, or be an employer due to dementia. Consumer directed care not offered to member."</p> </td></tr> </table>	If the member...	then...	Is able to participate in consumer directed care OR has a designated representative that can managed the care AND meets the state specific requirements for consumer directed care	Proceed to Step 3	is not able to participate or does not meet the state specific requirements for consumer directed care,	<p>write clear note with a reason justifying not offering consumer directed care to the member</p> <p><b>Sample note:</b></p> <p>"Member is not oriented enough to understand or meaningfully participate, guide their own care, or be an employer due to dementia. Consumer directed care not offered to member."</p>
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3	<p>Review basic Consumer Directed Care program elements with the member / family, including</p> <ol style="list-style-type: none"> <li>1. Program requirements</li> <li>2. Since the health plan is government funded and the member will be managing his/her care, it is important to report health care needs accurately to prevent Fraud, Waste, and Abuse.</li> <li>3. Inform Member/Family that intentional misrepresentation of the member's needs will be reported per Fraud, Waste, and Abuse Compliance requirements.</li> </ol>						
4	<p>Review functional deficits and HCBS Needs tool findings with the member/family-</p> <ol style="list-style-type: none"> <li>1. Go back to the Functional Module within the comprehensive assessment tool (701B / interRAI) and review the ADL/IADL sections in the module.</li> <li>2. Go through each task on the HCBS Needs Tool that corresponds to the Assessment</li> <li>3. Match up the IADL/ADL responses from the Functional Module to the HCBS Needs Tool</li> <li>4. Clarify with member/family activity/time for each section to be able to</li> </ol>						

	<p>estimate time for each task.</p> <p>5. Clarify with member/family when informal supports are still available to provide assistance to address the need. If available - Document Informal Supports available per task on the HCBS Needs Tool and or the case record.</p> <p>6. The HCBS Needs tool will calculate hours at the end of the review. Refer to the HCBS Needs Tool Guide used in training for detailed explanation on any task or General Supervision. Below are short examples  Example 1: Assessment identified member is independent in <i>Bathing</i>-  <ul style="list-style-type: none"> <li>Bathing on the HCBS Needs Tool should be filled in "0".</li> </ul> Example 2: Assessment identified member needs assistance with <i>Feeding/Meal Preparation</i>  <ul style="list-style-type: none"> <li>Enter that the member needs assistance with preparing and/or serving/setting up meals.</li> </ul> </p> <p>7. Seek clarification from the member/family for any discrepancies in functional ability reported and make note of this. Example: Family reports member is maximum assist for <i>Toileting</i> yet during the assessment member gets up and uses restroom independently.</p> <p>8. When the entire HCBS Needs Tool is complete, the tool will automatically add up the minutes for each task and each page.</p> <p>9. Continue to Step 4 below...</p>						
<b>5</b>	<p>Check the time at the end of each task line for accuracy-</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 35%;">If...</th><th>Then...</th></tr> </thead> <tbody> <tr> <td>Accurate</td><td>Continue with Step 5 below</td></tr> <tr> <td>Time does not appear correct</td><td> <ul style="list-style-type: none"> <li>Double check how you filled in each cell with the time</li> <li>Make Corrections</li> <li>Continue to Step 3 below</li> </ul> <p><i>Common errors include:</i>  Putting in time by hours rather than by minutes. Only enter minutes in the cells, the tool will tally up all the minutes and translate to hours at the end.  Leaving the "tasks per day" cell blank in the <i>Toileting</i>, <i>Eating</i>, and <i>Transfer</i> sections of the tool. This will prevent the formula from calculating correctly.  Enter the expected number of tasks per day in the appropriate cells.</p> </td></tr> </tbody> </table>	If...	Then...	Accurate	Continue with Step 5 below	Time does not appear correct	<ul style="list-style-type: none"> <li>Double check how you filled in each cell with the time</li> <li>Make Corrections</li> <li>Continue to Step 3 below</li> </ul> <p><i>Common errors include:</i>  Putting in time by hours rather than by minutes. Only enter minutes in the cells, the tool will tally up all the minutes and translate to hours at the end.  Leaving the "tasks per day" cell blank in the <i>Toileting</i>, <i>Eating</i>, and <i>Transfer</i> sections of the tool. This will prevent the formula from calculating correctly.  Enter the expected number of tasks per day in the appropriate cells.</p>
If...	Then...						
Accurate	Continue with Step 5 below						
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<b>6</b>	<p>Discuss time identified and service options with the member/ family-</p>						

	<ol style="list-style-type: none"> <li>1. Inform member/ family that based on the discussion, assessment, and cost effectiveness X hours of X service can be authorized to meet the member's needs in the home.</li> <li>2. Follow the Plan of Care-Service Plan Guidelines Desktop for details on getting the members agreement /disagreement with the Service options and for creating the Service Plan.</li> <li>3. Follow the QNXT HCBS Authorization resources for creating authorizations in QNXT.</li> <li>4. Follow the authorization desktops for creating authorizations in Dynamo.</li> </ol>
<b>7</b>	<p>At each member assessment visit-</p> <ul style="list-style-type: none"> <li>• Pull out the existing HCBS Needs Tool</li> <li>• Review the current tool with the Member/Family to confirm if service needs stayed the same or have change.</li> <li>• If service needs are the same – CM will sign and date the last page of the Tool.</li> <li>• If service needs have changed – CM will need to repeat steps 1-4 above to create a new HCBS Needs Tool.</li> </ul>
<b>8</b>	Members are advised of appeal rights any time there is a change in the scope, duration, or amount of services authorized.
<b>9</b>	Create authorizations and referrals based on your state's process [Health Plans to insert authorization and referral process here]

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**EXHIBIT A-4-c**  
**LTC SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**LTC SRC# 2 – Performance Measures (Statewide):**

- a. The respondent shall describe its experience in measuring performance and achieving quality standards with populations similar to the target population for the long-term care (LTC) component of the SMMC program. Describe experience with and performance on measures of the following elements of LTC:
- (1) Comprehensive LTC assessment and update (the percentage of LTC plan enrollees who have documentation of a comprehensive assessment within the appropriate time frame);
  - (2) Comprehensive LTC Care Plan (the percentage of LTC enrollees who have documentation of a Comprehensive LTC Care Plan within the appropriate time frame);
  - (3) Shared Care Plan (the percentage of LTC plan enrollees with a care plan for whom all or part of the care plan was transmitted to key LTC providers and the primary care provider within the appropriate time frame);
  - (4) Re-Assessment and Care Plan Update after Discharge (the percentage of discharges from inpatient facilities in the measurement year for LTC plan enrollees resulting in a re-assessment and care plan update within 30 days of discharge);
  - (5) Admission to an Institution from the Community among LTC enrollees (the percentage of LTC enrollee admissions to an institution (nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID)) from the community that result in a short-term or long-term stay during the measurement year);
  - (6) Successful Transition after Short-Term Institutional Stay among LTC enrollees (the percentage of LTC enrollee institutional admissions that result in successful discharge to the community (community residence for 30 or more days) within 100 days of admission); and
  - (7) Successful Transition after Long-Term Institutional Stay among LTC enrollees (the percentage of LTC enrollees who are long-term residents (101 days or more) of institutions who are successfully discharged to the community (community residence for 30 or more days)).
- b. The respondent shall describe any instances of failure to meet Contract-required quality standards for these types of measures, actions taken to improve performance, and how improvement was measured. (See Section 409.966(3)(a)2., Florida Statutes)
- c. The respondent shall describe its experience with and performance on other LTC performance measures, any instances of failure to meet Contract-required quality standards for these measures, actions taken to improve performance, and how improvement was measured.
- d. The respondent shall describe the data sources used for collecting and reporting LTC performance measures.
- e. The respondent shall describe how the respondent has obtained data needed to track measures related to care plan updates after hospital admissions and discharges, and emergency department visits.

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **Response:**

As part of our continuous quality improvement process, Aetna uses performance measurements to monitor important aspects of our long-term care (LTC) program, systems, and care processes. We collect data and analyze performance to determine how our current programs are working and how our resources can be allocated to optimize our LTC program's efficiencies and effectiveness.

Aetna has collected, analyzed, and reported to the Agency on LTC performance measures since January 2014 in Regions 6, 7, 9, and 11. With 30 years of experience managing Medicaid health plans, including those serving vulnerable LTC populations through 10 long-term care programs in 7 states (Florida, Arizona, Illinois, Ohio, New York, New Jersey, and Michigan), Aetna is a recognized leader in measuring performance and achieving quality standards. We currently serve approximately 5,000 LTC enrollees in Florida and more than 245,000 LTC enrollees across the nation.

### **ACHIEVING QUALITY STANDARD FOR MEASURING ELEMENTS OF LONG-TERM CARE (LTC)**

**CRITERION 1:** The extent of experience (e.g., number of Contracts, enrollees or years) in achieving quality standards with similar target populations, for measures related to the elements of LTC identified as number a.(1) through a.(7)

Aetna's commitment to continuous quality improvement has led to improved health outcomes for our enrollees. Our performance measurement and quality program has been reviewed and awarded consistently high accreditation standards by the National Committee for Quality Assurance (NCQA). Our Statewide Medicaid managed care program received an NCQA accreditation status of Commendable, with Aetna ranked the leading NCQA Florida MMA plan for the second consecutive year. In addition, we ranked among the top 15 Medicaid plans in the United States—a significant achievement.

Aetna's strategy for achieving the highest quality, most efficient and effective LTC program focuses on managing our coordinated, integrated care system. We seek to minimize stress and health risk for enrollees in institutional and non-institutional settings whenever possible and appropriate. Our strategy includes:

- Robust data and care management systems with sophisticated data analytics
- Real-time data for monitoring quality and other program components
- Benchmarking performance, quality, and outcome measures throughout the organization and in comparison to national standards
- Commitment to quality throughout the organization
- Hiring and maintaining staff who are knowledgeable and work to improve the system
- Ensuring use of appropriate technologies and creating incentives among stakeholders, (e.g., value-based purchasing (VBP))
- Well-defined systems and processes to anticipate needs and deliver timely customer services
- Measurement, monitoring, and transparent reporting of results

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Using these strategies, Aetna strives to measure performance objectively and accurately to maintain processes that are working and improving quality of care and access, while allowing for correction and redirection when measurements indicate problems or unexpected outcomes. The Agency contract requires Aetna to measure the Florida LTC-identified elements. We already measure some elements, and we are building data retrieval sources to measure other elements in the upcoming plan years. These identified elements include:

### **(1) Comprehensive LTC Assessment and Update**

We currently measure the percentage of LTC plan enrollees who have documentation of a comprehensive assessment within the appropriate timeframe:

- 2015 – 87.8%
- 2016 – 90.7%
- 2017 – 91.7%

### **(2) Comprehensive LTC Care Plan**

The percentage of LTC plan enrollees who have documentation of a comprehensive LTC care plan within the appropriate timeframe is also currently measured:

- 2015 – 89.6%
- 2016 – 74.7%
- 2017 – 97.5%

### **(3) Shared Care Plan – Care Plan shared with key LTC providers and PCPs**

Current measure of the percentage of LTC plan enrollees with a care plan submitted to the primary care provider within the appropriate timeframe:

- 2015 – 89.7%
- 2016 – 70.2%
- 2017 – 84.7%

Aetna shared 100% of care plans with the enrollee and often encourages copies to be shared across the remaining interdisciplinary care team.

### **(4) Re-Assessment and Care Plan Update after Discharge**

The percentage of discharges from inpatient facilities in the measurement year for LTC plan enrollees resulting in a re-assessment and care plan update within 30 days of discharge:

- Aetna will obtain this information from our electronic care management system, which tracks changes in the residential setting type (RST) to trigger a discharge notification. We will apply specific timespans appropriate to the requested measure to produce all contractually required performance measures to measure compliance that the re-assessment and care plan are updated within 30 days of discharge.

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **(5) Admission to an Institution from the Community**

The percentage of admissions to an institution (nursing facility or intermediate care facility for individuals with intellectual disabilities [ICF/IID]) from the community that result in a short-term or long-term stay during the measurement year):

- We will rely upon the residential setting type (RST) to detect category changes for institutional placement and apply specific timespans appropriate to the requested measure. Our inpatient census provides us with daily status reports of all enrollees who are in any institutional setting, including skilled nursing, intermediate care, or inpatient hospital settings. In addition, Aetna has elected to participate in the Agency's recommended Event Notification Service (ENS), which provides real-time notice of enrollee encounters from participating hospitals. With ENS in place, we have a consistent source of data for short-term inpatient stays, thus enabling us to cross-reference that data with all associated plans of care updates.

### **(6) Successful Transition after Short-term Institutional Stay**

The percentage of LTC enrollee institutional admissions that result in successful discharge to the community (community residence for 30 or more days) within 100 days of admission decreased:

- Data points have already been identified which identify enrollees who have been discharged (RST), identifying length of stay in short-term setting, dates of discharge, and auto-calculate community residence.

### **(7) Successful Transition after Long-term Institutional Stay**

The percentage of LTC enrollees who are long-term residents (101 days or more) of institutions who are successfully discharged to the community (community residence for 30 or more days) decreased from:

- Data points have already been identified that will include identifying enrollees who have been discharged (RST), identifying length of stay in long-term setting, dates of discharge, and auto-calculate community residence.

In compliance with Aetna's current Florida contract, we have collected and reported on other equally important LTC performance measures. Our data is collected from more than 5,000 enrollees in the four regions we are currently contracted to serve. This data we collect includes:

- Call answer timeliness
- Required record documentation:
  - 701B assessment
  - Freedom of Choice form
  - Plan of care/enrollee participation
  - Plan of care/PCP notification
- Face-to-face encounters
- Case manager training
- Timeliness of services

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- AHCA care management, Case Management File Audit Reports, and Case Management Monitoring and Evaluation Reports
- Monthly Supervisor case file audits
- 1:1 supervisor: care manager training
- Supervisor shadow visits with care manager
- Telephone follow up by supervisor to enrollees to ensure timeliness and satisfaction of services including care management
- Timeliness assessments

Additionally, LTC measurement lessons learned by our all Aetna plans, coupled with our experience in Florida, guides our approach to measuring performance and achieving quality standards, such as those promulgated by NCQA and HEDIS.

We examine results on both an enrollee and population basis. If we identify an opportunity for improving services for an enrollee, our care manager and other team members work directly with that enrollee and the integrated care team to make changes that will align services with the enrollee's goals and needs. For systemic issues, we work to analyze the results and develop initiatives and plans to address the issues, working through our Quality Management (QM)/Utilization Management (UM) Committee, Quality Management Oversight Committee, and the chief medical officer.

### **EXPERIENCE ACHIEVING QUALITY STANDARDS AND MEASURING QUALITY IMPROVEMENT**

**CRITERION 2:** The extent of experience (e.g. number of Contracts, enrollees, or years) in achieving quality standards with similar target populations for other LTC performance measures

**CRITERION 3:** The extent to which the described experience demonstrates the ability to effectively measure quality improvement

Aetna actively participates in helping the LTC community standardize quality measures. We reviewed the LTSS standards recently issued by NCQA and identified that our programs, in Florida and nationally, meet all such standards as currently designed. Aetna's Quality Improvement (QI) team monitors and measures quality using various metric sets, such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) family of surveys including enrollee satisfaction, care coordinator satisfaction survey, timely completion of assessments, interdisciplinary care team participation, individualized care plan completion, care coordination, and State performance measures. Additionally, we support and act on various quality improvement initiatives through our Value Based Purchasing (VBP) program.

As a current member of the National Association of Managed Long Term Services and Support (MLTSS) Health Plans, Aetna supports the association's commitment to a set of model MLTSS performance measures standards that align with the new Medicaid Managed Care regulations. These regulations require standard performance measures for MLTSS plans related to quality of life, quality and appropriateness of care provided, transitions, community integration activities, transitional care, and whether the consumer received the services and supports set forth in the person-centered care plan. We illustrate these proposed standards in the following Table LTC SRC-2-1: Proposed Performance Measures Standards in Attachment LTC SRC 2.

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

In addition to leading the development of measureable standards, Aetna conducts an annual CAHPS survey for a period specified by the Agency, using the HCBS CAHPS Survey 1.0 or other survey as required.

Another way in which Aetna measures and achieves quality standards is through implementation of enhanced processes to address HEDIS measures using care management staff liaisons for our enrollees. As an example, our LTC populations are included in the Care for Older Adults (COA) measures, which include advanced care planning, a functional status assessment, and pain assessment. Aetna recognized that by not addressing these sub-measures, there was an opportunity for intervention and improvement for our enrollees. By retraining the care management staff, including LTC care managers, updating our electronic care management system, and validating the completion of these indicators, we increased the overall COA rates. Aetna in Michigan increased advanced care planning from 5.32% HY 2016 to 27.91% HY 2017, and pain assessment from 25.93% HY 2016 to 62.79% HY 2017, respectively. Ohio completed 90.42% for functional status assessments.

Aetna's remains committed to measuring, evaluating, and executing on quality improvement standards.

### **MEETING QUALITY MEASURES OR SUCCESSFULLY REMEDIATING FAILURES**

**CRITERION 5:** The extent to which the respondent met all quality measures or successfully remediated all failures

In 2015, Aetna made the decision to update its software systems for the LTC program to help ensure we are better able to capture achievement percentages. This was performed in response to migrating data from a third-party vendor that demonstrated incompatibilities with our systems.

Through investigation, adjustment, and diligent work, Aetna's software has evolved since insourcing this program; the program has become more efficient and functional as we move away from the initial date of the migration. We have improved our ability to extract data from ECMS. Today, our ECMS allows our team to monitor compliance and quality metrics by extracting the data that measures our degree of compliance, while also providing quality measurements to track our performance over time. For example, for plan of care, data was manually entered into non-standardized field (e.g., not using a standardized field for dates such as dd/mm/20yy); now elements of the POC are directly entered in the system to pull by data fields. The fields are then used to pull specific information such as authorizations, next face-to-face visit, and complete POC, 701B, and Freedom of Choice form.

Additionally, Aetna worked to correct existing problems by taking the following steps:

- We acknowledged that we had a problem with our data and reporting to the State.
- We established a line of communication between Aetna and AHCA to resolve the problems.
- We formed a task force consisting of Quality/LTC/IT staff to collect and verify some of the missing pieces of data.
- Every time we found missing data, we performed a manual review of the data to compile reports.

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- We hired a new LTC program director skilled in data analysis and reporting, as well as LTC processes and procedures.
- Our new LTC director instituted a training program to handle the LTC documents differently, which included:
  - Stressing the importance of ongoing accountability
  - Changes in training materials that focused on Florida requirements
  - Enabling staff to recognize that by adapting to the situation they were able to collect and report on data with system modifications

We have modified the system to be significantly more functional for the care management staff and supervisors. Currently, we are measuring improvement in the system by crosschecking missing data. We are fortunate to have the knowledge and insight of other Aetna Medicaid LTC programs from which to draw solutions and innovations.

As an example, Aetna Better Health of Illinois recognized that the participant-directed option (PDO) workers in the State submit timesheets for rendered services in excess of authorized amounts, as defined by an enrollee's individualized service plan. The estimated cost of excess spend during fiscal year 2018 resulting from PDOs overbilling amounted to \$1.1 million dollars. Enrollees identified to have PDO workers that have potentially overbilled are reviewed by their LTC care managers individually to rule-out any systematic errors. When those errors are ruled-out or amended, these LTC care managers contact their enrollees to educate them about their authorized service hours and the possible ramifications of continued overbilling. Occurrences of overbilling are tracked as part of the process and LTC care managers document each contact with their enrollees in our electronic care management system.

LTC leadership meets monthly to discuss individual enrollees with frequent overbilling occurrences, as identified in the monthly reporting. Prior to these meetings, LTC care managers are tasked with providing their supervisors with a brief case history of their enrollee, the number of times they have overbilled, the number of times the LTC care managers have intervened, the number of times the PPL has intervened, and any other pertinent information that may have resulted in the excess cost. As a group, LTC leadership determines if the enrollee cannot manage personal care attendant service and should receive his or her home care services through Homemaker service. Once a determination is made to change the service provider, the LTC care manager is tasked with informing the enrollee and offering him or her appeal rights if the enrollee disagrees with the decision. Aetna Better Health of Illinois anticipates this process will address approximately 50% of the overbilling by PDO workers and help ensure all enrollees receive the appropriate services on their individualized service plans.

### **HOW OUR EXPERIENCE DEMONSTRATES THE ABILITY TO IMPROVE QUALITY IN A MEANINGFUL WAY**

**CRITERION 4:** The extent to which the described experience demonstrates the ability to improve quality in a meaningful way

Aetna uses the Plan-Do-Study-Act (PDSA) method to improve performance against the model of care goals and quality objectives; this includes gathering and analyzing data from claims or encounters, supplemental data sources, case records, surveys, and utilization management for baseline measurements and later re-measurements. This analysis enables us to evaluate

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

performance. We measure against goal and if we miss a target, we conduct root cause analysis to develop and implement appropriate quality improvement initiatives.

For example, as a result of documentation audits, we gained increased understanding of the care management platform capabilities and limitations. Following analysis, the following actions were taken and improvements implemented:

- Improved processes for documentation consistency
- Creating a process for ongoing auditing
- Making recommendations that improved the care management application
- Understanding the strengths and weaknesses of individual care managers which identified who had additional training and development needs
- Implementing new processes to engage enrollees (for example, enrollees can sign their own plan of care even though they have a legal guardian who will also sign)
- Finding mechanisms to quickly identify gaps in documentation for our population
- Identifying needs of enrollees before they resulted in gaps in care
- Enhancing our staff education, training and retraining

Improving our care management system allowed us to improve performance measure compliance and reporting requirements. These improvements included:

- Dropdown added to advance directive event to report on enrollee discussion on advance directives
- Document-type dropdowns added for reporting compliance, such as plan of care, plan of care summary, freedom of choice, and others
- Visit-type dropdowns and templates for initial/annual and 90-day review face to face added to ensure documentation compliance
- Dropdowns added for contractual requirements: ID plan, ID care, enrollee handbook, provider directory received and discussed
- Caseload case weight added to ensure compliance with care manager/caseload ratio
- Medicaid redetermination log integrated in the system
- Buckets for Medicaid redetermination and SIXT status added to monitor and prevent loss of Medicaid eligibility
- Level of care date from the State populates in enrollee records
- Resident-type dropdown added accurate placement reports
- Provider name look-up added to ensure accuracy of reports
- 701T assessment naming convention dropdown added for reporting compliance
- Dropdowns added for initial and annual orientation contract requirements (e.g., discussion of grievance and appeals, Medicaid fair hearing, etc.)
- Included built-ins, such as Medicaid redetermination letter, unable to locate or reach letters, contingency plan, and home-like characteristics checklist
- PASRR event additional dropdowns to comply with reporting requirements
- Buckets added for Unable to Locate, Refused Services, and Out of Service to identify and report enrollees to the State

Our LTC experience across the nation enables us to identify best practices and implement them as needed to help ensure the health, safety, and welfare of our enrollees is addressed at all times. As an example, our Illinois LTC team identified that reporting abuse, neglect, or exploitation of our enrollees to the identified agencies was insufficient to address our enrollees'

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

safety. Our LTC team developed several interventions and policies to review and remediate critical incidents in an effort to improve enrollee health outcomes and increase compliance with State reporting requirements. The critical incidents process has been improved by integrating critical incidents rounds to discuss appropriate interventions. Attendees to critical incident rounds include care management staff, clinical health services supervisors, and quality management nurses. Additionally, the health plan has implemented a process to help ensure appropriate follow-up to substantiated and unsubstantiated abuse, neglect, and exploitation reports.

In addition, Aetna provides ongoing education and support to staff through critical incident training by our Quality Management (QM) team and through distribution of a critical incidents companion guide. Using these tools and the support provided by QM and supervisors, staff can conceptualize critical incidents, respond appropriately, complete all reports within the required timeframes, and provide ongoing follow-up and feedback. The processes developed and implemented by Aetna have resulted in improved health outcomes of our enrollees as it relates to addressing and remediating critical incidents.

### **MULTIPLE DATA SOURCES, LTC PERFORMANCE MEASURE REPORTING AND CARE PLAN UPDATES**

**CRITERION 6:** The extent to which the respondent has used multiple data sources and has obtained data needed to collect and report on LTC performance measures, including those that require information related to care plan updates after hospital admissions and discharges, and emergency department visits

Today, Aetna's electronic care management system aggregates and exposes data from multiple sources that include all physical and behavioral health claims data as well as key social determinants of health to create an individualized and comprehensive profile and care record tailored to each enrollee. Our platform also captures data from multiple sources such as electronic health records, registries, and other data repositories tied back to a single care record that can be used by our care managers or our provider partners to manage each enrollee's needs at point of care or for global population health management, such as helping to ensure LTC enrollees receive specific care and services.

By capturing and sharing LTC enrollees' individualized plans of care through our fully integrated technology platform, information can be used to quickly address an LTC enrollee's needs and communicate changes, updates, and critical next steps with the extended integrated care team, the enrollee, and his or her circle of support. This simplified access to information allows our providers to deliver the right care at the right time and in the right setting.

By the end of 2017, we will begin to offer selected LTC providers an external provider tool through our integrated CareUnify platform, which encourages easier communication with organizations outside the health plan that are part of the larger integrated care team (e.g., psychiatrists, housing specialists, and the criminal justice system) with relevant enrollee-driven information that can be incorporated into the enrollee's shared care plan. We also capture critical social determinants such as housing, transportation, and employment needs to address the holistic needs of our enrollees and empower our care managers to quickly prioritize care needs or address the root causes of poor health outcomes. In addition, our technology platform

## **EXHIBIT A-4-c**

### **LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

provides secure remote access for our care managers while they are working out in the communities to coordinate the following services:

- Face-to-face visits with enrollees in their homes or community setting
- Access to information to coordinate care with other providers
- Real-time enrollee information that can be updated and shared with the entire care team
- Information verification, such as new assessments or reassessments
- Comprehensive care plans and case notes developed with the enrollee

Because of the high level of integration within our electronic care management system, all these components from disparate systems join, thus enabling the creation of a single, comprehensive care plan. Once data is collected, Aetna's LTC reporting/reconciliation process begins and the data is separated into the following two components: compliance/performance reports and continuous improvement/associated version control.

#### **COMPLIANCE/PERFORMANCE REPORTS**

LTC reports handled at the plan level, including many State compliance reports and the LTC performance measures, are transitioned to an automated reconciliation process. We added columns to the reports that point out whether each row has the expected information based on available report guides, validation tools, contract amendments, etc. These reconciliation reports are run automatically using SQL Server Reporting Services (SSRS) and are made available to management. SSRS is a server-based report generating software system. This ensures elements can be populated in ECMS prior to the final run and subsequent submission wherever possible. Once a report is designed and programed (fully coded), logic is applied to the data proactively from the report guides as well as any available State validation tools. This immediately highlights action items essential to maintain plan compliance, improve enrollee service, or populate information for ad hoc reporting. These action items are then made available through internally hosted reports and automated email subscriptions, allowing managers to keep a constant finger on the pulse of compliance and quality of service. Employees are also better able to focus on improving enrollee care and how to get there as opposed to all the nuances associated with a particular measure. All information for plan-level reports is developed in SQL Server Management Studio and pulled from our electronic care management system. The report-hosting tool utilized by the plan is SQL Server Reporting Services.

Aetna's Informatics team and plan-level leadership team work collaboratively to help ensure all compliance reporting is completed timely and accurately. Prior to a deliverable date, the Informatics lead and plan-level lead ensure all data validation points are reviewed and addressed as needed. This process is documented by the Informatics lead in the SQL service management studio to make certain past and present interactions of compliance reports are accurate and valid. Through this combined data validation process, the Informatics lead and plan-level lead assure system enhancements, staff training and additional interventions occur to address opportunities for improvement identified through the ongoing compliance reporting process.

#### **CONTINUOUS IMPROVEMENT AND ASSOCIATED VERSION CONTROL**

When report changes are needed because of contract amendments, feedback from the State, or feedback from plan employees, the information is communicated to our Informatics

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

department. Informatics is responsible to help ensure the reporting requirements/changes are implemented and that revisions are saved and housed in a repository for version tracking. Pending changes are tested until ready for production. This allows for version control and auditing to ensure that modifications are completed and recorded, and enhancing agility in the event of a regression. Once the new report is distributed, feedback is used to identify any edge cases which is an unexpected exception to the rule and where supplementary information is required to pull the data effectively. These exceptions are communicated to Informatics and management, and may be escalated to the Agency. If further revisions are required, the cycle begins again. This process has resulted in the near elimination of negative determinations from the Agency, resulting from data connectivity issues and code errors despite data migration from a contracted vendor in October 2015.

Aetna remains at the forefront of helping the LTC community standardize quality measures. Aetna's Quality Improvement (QI) team monitors and measures quality using various metric sets, such as HEDIS, CAHPS for enrollee satisfaction, care coordinator satisfaction surveys, timely completion of assessments, individualized care plan completion, care coordination, and Florida State performance measures. We support and act on quality improvement initiatives through our value-based services programs.

Data shows that Aetna's Medicaid LTC programs have been highly successful in keeping vulnerable enrollees in the least restrictive environment. For example, over a 2-year period in Florida, we increased the HCBS ratio by nearly 8% through nursing facility diversion and transitions. This was measured over a 2-year timeframe where the ratio of HCBS enrollees to the entire SMMC LTC enrollee population increased from 48% to 56%.

### **Obtaining Data Needed to Track Measures Related to Care Plan Updates**

The care planning process and assessment process are ongoing for all LTC enrollees. Goals that have been identified are entered into our electronic care management system and CareUnify to coordinate service delivery between all stop points on the continuum of care. Aetna's smart alert system informs a care manager when an enrollee has been admitted to the hospital or had an emergency department visit through our population health management system, CareUnify. CareUnify is Aetna's Medicaid population health management platform, which we provide to health care organization partners at no cost. It enables health care providers to gain access to 360-degree view of patient data and to allow for collaboration on managing care for patients through the continuum of care. Once the care manager is notified of the enrollee movement, the care plan update process is implemented and the information is stored for measurement by time and date.

In an ever-changing landscape of health care transformation, providers can no longer rely on paper-based charting and care delivery models built on outdated, fragmented data systems that cannot talk to one another. Aetna leads the way in designing the next-generation approach to information exchange and population health management software, which is CareUnify. The primary purpose of CareUnify is to create a collaborative information platform to digitally share and aggregate actionable data across systems and organizations with the purpose to promote effective and efficient care coordination, particularly for complex, high-risk individuals. CareUnify serves as a care traffic control solution providing a 360-degree view of all captured information to provide a common and secure data source for providers to access a single comprehensive patient record.

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Aetna understands the criticality of aligning our enrollees with care managers, providers, and community-based partners to encourage data sharing that creates an enhanced enrollee experience. Aetna has worked with community-based partners in numerous states to conduct activities that lead to enhancement in care planning upon initial enrollment with the plan, post-discharge, or emergency department visits as needed. As an example, our Illinois care management team collaborates with the Aids Foundation of Chicago (AFC) to complete reach and engage activities to help support the location and engagement of high-risk enrollees who are difficult to locate. Often, these enrollees are experiencing homelessness, multiple admissions, and/or have incurred difficult experiences with the health care system. AFC currently locates 50% of the referred enrollees each month and assists Aetna with completing health risk assessments and engaging enrollees in ongoing care management, thus leading to care planning and often resolution of health-related goals. Partnerships such as this are reviewed and implemented at the local plan level, as well as nationally to help ensure we are supporting the best interventions to address the needs of our enrollees.

Additionally, Aetna participates in the Agency's recommended Event Notification Service (ENS), which provides real-time notice of enrollee encounters from participating hospitals, is in development to be expanded for Medicaid, including LTC enrollees. With ENS in place, we will have a consistent source of data for short-term inpatient stays, which allows us to cross-reference that data with all associated plan-of-care updates.

### **Evaluation Criteria:**

1. The extent of experience (e.g., number of Contracts, enrollees or years) in achieving quality standards with similar target populations, for measures related to the elements of LTC identified as number a.(1) through a.(7).
2. The extent of experience (e.g., number of Contracts, enrollees, or years) in achieving quality standards with similar target populations for other LTC performance measures.
3. The extent to which the described experience demonstrates the ability to effectively measure quality improvement.
4. The extent to which the described experience demonstrates the ability to improve quality in a meaningful way.
5. The extent to which the respondent met all quality measures or successfully remediated all failures.
6. The extent to which the respondent has used multiple data sources and has obtained data needed to collect and report on LTC performance measures, including those that require information related to care plan updates after hospital admissions and discharges, and emergency department visits.

**Score:** This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

**EXHIBIT A-4-c  
LTC SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA (10-2-17)**

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## **Attachment LTC SRC# 2**



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**LTC SRC# 2: Table LTC SRC 2-1: Proposed Performance Measures Standards**

**Table LTC SRC 2-1: Proposed Performance Measures Standards**

Tier 1A: Initial Reporting on Entire MLTSS Population		
Domain	Indicator	Measure
Transition to Most-Integrated Setting	Successful transitions from long-stay institution to community setting	Proposed Mathematica measure
	Admission to an institution from the community	Proposed Mathematica measure
	HCBS vs. institutional services	DE MLTSS contract
Person-Centered Planning and Coordination	Timely comprehensive assessment and update	Proposed Mathematica measure
	Timely comprehensive care plan and update	Proposed Mathematica measure
Tier 1B: Initial Reporting Only on the MLTSS Populations for Which the Plan Also Holds the Medical Risk		
Domain	Indicator	Measure
Transition to Most-Integrated Setting	Successful transitions from short-stay institution to community setting	Proposed Mathematica measure
	Readmission within 30 days of hospitalization	HEDIS



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**EXHIBIT A-4-c**  
**LTC SUBMISSION REQUIREMENTS**  
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**B. AGENCY GOALS**

**LTC SRC# 3 – Transitions of Care (Statewide):**

The respondent shall describe how it will address transition and discharge planning for an enrollee going from a hospital or nursing facility rehabilitation setting and returning to a community setting. The respondent should identify specific strategies for ensuring that transition and discharge planning incorporates assessment of appropriate supports in the home, provision of supplies and home care/nursing services. The respondent shall include an example of an effective transition plan with appropriate timeframes for each step of the process.

**Response:**

Enrollees receiving long-term care services are most vulnerable when transitioning between hospital and nursing facility settings to a community setting, and from hospitals to nursing homes. Ineffective care transition processes can lead to poor community setting tenure and adverse events that may result in higher readmission rates. Using our person-centered transition service delivery process, we employ numerous techniques, procedures, and initiatives to optimize transition of care and care coordination.

A key role of Aetna's integrated care management model is to help enrollees have all of the supports and services necessary to facilitate a successful discharge, including home- and community-based services (HCBS) and Medicaid-covered services such as home care, durable medical equipment, and home rehabilitative services. In coordinating transitions to the community, our long-term care staff members serve as advocates to help enrollees discover what is truly important to them. In supporting enrollees, we help shape a life plan, as opposed to simply a care plan—a collaborative voice that results in real transformation.

Our long-term care staff is led by our medical director of long-term care, Dr. Darwin Caraballo, who has over 17 years of experience working to promote best practices for elders and adults needing long-term care (LTC) in both institutional and community-based settings. Along with a team of over 100 care managers, he currently provides oversight, coordination of care, and services for over 5,000 enrollees residing in the community, assisted-living facilities, and nursing homes. Dr. Caraballo conducts weekly rounds with the LTC Care Management (CM) and Utilization Management (UM) teams and completes daily medical reviews and authorizations for all LTC enrollee requests, including transitions of care, and provides daily assistance to all LTC care managers with newly assigned enrollee cases and/or new fluctuations on chronic health conditions. He also attends and conducts LTC transition meetings, staffing meetings, Fair Hearings, Interdisciplinary Care team meetings; attends and co-chairs UM/CM committee, National UM Steering committee, National Quality of Care committee, Credentialing committee, Medical Cost, and Joint Operating Committee (JOC) meetings with contracted providers and subcontractors. Dr. Caraballo leads Aetna's efforts to increase the percentage of enrollees receiving services in the community instead of in an institution, in alignment with the Agency's objectives.

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **TRANSITION AND DISCHARGE PLANNING PROCESS**

**CRITERION 1:** The extent to which the respondent's process and example address the following components of transition and discharge planning:

- (a) Assessment criteria for ensuring the enrollee can be served safely in the community;
- (b) Collaboration with providers' discharge planning staff (e.g., hospitals, institutional settings, assisted living facilities, ancillary providers);
- (c) Referral and scheduling assistance;
- (d) Coordination with home and community-based providers, including DME and home health providers as appropriate to meet the enrollee's needs; and
- (e) Processes to prevent unnecessary hospital or nursing facility readmissions

**CRITERION 3:** The extent to which the respondent's example provides appropriate timeframes for each step of the transition and discharge planning process

Aetna defines transition of care as the coordination and continuity of health care that must occur during movement from one health care setting to another (including home) as an enrollee's condition and care needs change during or following an illness. Whenever we transition an enrollee, we focus on a successful and safe transition between institutions or from institutional to community settings. Aetna includes a comprehensive staffing structure to support transition. Our care management staff works closely with our Utilization Management (UM) team. When collaborating with hospital or facility discharge planners, the goals of our transition staff are 1) facilitating the enrollee's transition to the least restrictive level of care possible post-discharge; 2) enabling enrollee safety and optimal functioning through the provision of appropriate services and supports; and 3) improving quality of life and health care outcomes; and, 4) ensuring the enrollee's setting of choice.

We continuously work toward improving programs and processes. In identifying opportunities for improvement, we recognize the need for dedicated transition clinicians to support transitions of care for enrollees residing in nursing rehabilitation facilities to community settings. Therefore, we developed and recently implemented our new transition of care program that incorporates the entire care team, and as noted in the bullets that follow, includes the assignment of a transition clinician to each region.

Aetna's long-term care (LTC) transition of care staff include:

- Care managers: LPNs, RNs (BSNs or ASNs) per AHCA regulations; Aetna has three levels of care managers, all of whom live in the communities we serve and who work from home offices
- Care management coordinator (CMC): A social work-prepared care manager usually assigned to enrollees at a supportive level of care as the primary care manager, but can be assigned to enrollees at an intensive level of care based on regional needs
- Clinical care manager (CCM): A licensed clinical social worker, licensed practical nurse, or registered nurse assigned as the primary care manager to enrollees at a supportive or intensive level of care that are clinically complex
- Transition clinician: A registered clinician assigned as the secondary care manager to enrollees in nursing homes; supporting identification and evaluation of enrollees for nursing home transitions, and enrollees who are at risk for being designated with custodial needs during an admission for nursing facility rehabilitation

## **EXHIBIT A-4-c**

### **LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Utilization management regional clinician (UMRN): A UM regional clinician is a Florida-licensed RN who is responsible for the clinical review of services requested and/or utilized by Aetna's enrollees. The UM regional clinician also assists with transition of care by working collaboratively with care managers and the medical director to identify and facilitate discharge needs during an acute hospital or nursing facility admission

#### **Interdisciplinary Approach**

Aetna maintains an interdisciplinary approach to discharge planning and transition of care for our long-term care enrollees. The interdisciplinary care team includes the following:

- Enrollee
- Enrollee's circle of support
- Caregiver
- Care manager and/or clinical care manager
- UM regional clinician
- Transition clinician
- PCP
- Behavioral health
- Pharmacy
- Medical and DME suppliers, where appropriate
- Medical director

Our care managers/UM regional clinicians are responsible for monitoring the enrollee's progress in the acute care setting and the transition clinician is responsible for monitoring the enrollee's progress in a nursing rehabilitation facility. The interdisciplinary team is charged with coordinating the enrollee's transition of care from the admitting facility to home or alternative settings.

#### **Inter-Departmental Communication**

Formal inter-departmental communication has been successful in facilitating a seamless transition to the community. Aetna's discharge planning process begins upon notification from the admitting facility. Activities include identifying enrollees' needs, determining post-discharge placement setting, and establishing the post-discharge services necessary after an acute hospital, nursing home, or rehabilitation facility admission. The following details our interdisciplinary approach.

1. The care manager notifies the UM regional clinician (or vice versa) of enrollees who have been admitted to a hospital or skilled nursing facility for rehabilitation therapy as soon as they receive notification from the admitting facility; coordination of benefits is reviewed.
2. The UM regional clinician conducts an initial and weekly concurrent review to facilitate a safe discharge. The UM regional clinician contacts the facility to request clinical records; if unable to obtain, the care manager assists the UM regional clinician with obtaining the medical records and scanning email to the UM regional clinician for review.
3. The care manager continues to manage day-to-day contact with the enrollee.
4. The UM regional clinician refers enrollees at risk for custodial placement to the transition clinician and Aetna's medical director for review through interdisciplinary case rounds

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

with the UM regional clinician and care manager. An interdisciplinary care team meeting with the enrollee's physician, caregivers, and care team may be required and is arranged by the enrollee's care manager as needed.

5. Interdisciplinary case rounds or care team meetings are documented in our electronic care management system.
6. The UM regional clinician builds relationships with the facility's discharge planning team/social worker to assist with identifying discharge needs and get them in place for the enrollee upon discharge.
7. The UM regional clinician alerts the care manager of the enrollee's discharge via notice of discharge to our care management staff, and he or she coordinates service decision review and processes prior-authorization requests.
8. Should an enrollee transition to custodial care at a nursing facility, the enrollee is referred to the transition clinician for follow-up.
9. Whenever appropriate, our medical director contacts the medical plan and conducts a peer-to-peer review to help ensure services are appropriate and provided in a safe manner.

### **Discharge Planning**

In addition to supporting successful discharge planning through a comprehensive staffing model, an interdisciplinary approach, and consistent interdepartmental communication, our discharge activities are supported by our formal internal referral processes, monitoring of discharge readiness, assessments, case rounds, and information system solutions.

### **Internal Referral Processes**

Aetna's internal referral processes support our team approach to discharge planning. Whenever the enrollee is admitted to an acute care facility, a care manager or UM regional clinician receives notification of admission through the inpatient alerts queue in our care management system. If the care manager is the first to receive a notification of admission, he or she completes a UM referral form and sends it to the UM regional clinician, who then conducts an initial review followed by an ongoing review based on the estimated length of stay to assess the enrollee's potential discharge needs. The care manager to UM referral identifies the following:

- The enrollee
- Name of the hospital or rehabilitation facility
- Admission date
- Admission diagnosis
- Brief summary of the enrollee's condition
- Discharge needs, if identified
- Hospital or rehab facility discharge planner contact information

The purpose of the Care Manager-to-UM referral and the UM-to-Care Manager referral is to facilitate bi-directional communication, keeping both the care manager and UM regional clinician informed of enrollee status. Upon notification of hospital admission, the care manager schedules a visit to meet with the enrollee at the facility. During the meeting, the care manager confers with the enrollee, family members, the facility's clinicians, physicians. Discharge tools are used with the enrollee to understand the physical, behavioral, and social root causes of the admission and to create a care plan to address them. With an understanding of the enrollee's

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

needs and desires, we develop the individual plan of care to determine the resources and services necessary to affect a successful transition. Through this comprehensive approach to information gathering, the care manager recommends modifications to the plan of care, which are reviewed with the enrollee for approval. If the enrollee disagrees, the care manager and the enrollee work through acceptable alternates that align with the enrollee's needs and preferences.

### **Case Rounds and Monitoring**

Enrollees with complex care and/or discharge needs and those with frequent level-of-care changes are presented to the medical director during interdisciplinary case rounds. This forum fosters proactive planning and coordination activities essential for transition of care. Case rounds are documented in the enrollee's electronic care management record. The care manager also updates the enrollee's care plan in the system and monitors the enrollee no less than weekly after discharge until the enrollee is stable, to determine any significant decline requiring a clinical assessment. If a significant decline is identified, the care manager conducts the appropriate assessment and intervenes to improve that enrollee's recovery or rehabilitation. Discharge readiness monitoring is an ongoing function of Aetna's integrated care management for enrollees who are hospitalized. The UM regional clinician continually evaluates the situation and notes which services will require authorization at discharge. Meanwhile, our care manager continues following the enrollee's progress throughout the hospitalization. They coordinate the enrollee's transition of care from the admitting facility to home or alternative settings in collaboration with other participants of the interdisciplinary care team.

### **Care Management Levels and Discharge Assessments**

Our care managers update the individual plan of care for enrollees residing in nursing facilities every 30 days for Level 3 intensive care management and every 90 days for Level 2 supportive care management. Enrollees are stratified as intensive or supportive based on an initial assessment. The assigned level of care management can change based upon a reassessment of the enrollee's needs during or after a hospital admission or due to a transition from a hospital to a nursing facility rehabilitation setting.

Our intensive level of care management is intended to help enrollees with complex conditions and comorbidities receive coordinated care customized to each individual's circumstances. It includes a highly individualized range of interventions to help enrollees and their families manage serious and complex conditions that are persistent and substantially disabling or life threatening. These conditions are marked by biological, psychological, and/or social comorbidities that interfere with standard care delivery. Intensive care management interventions include chronic condition management education as appropriate as well as assistance with accessing care across the continuum for as long as necessary to stabilize or improve care outcomes.

Aetna's supportive level of care management includes problem-solving interventions that focus on improving access to, and effectiveness and safety of, standard health care for individual enrollees. Supportive care management is targeted toward enrollees who have less clinical and biopsychosocial complexity and may include chronic condition management, longitudinal care management of enrollees in the long-term services and supports population, or brief and condition-focused care management, depending on the enrollee's needs.

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

To assist enrollees with appropriate transitions, the care manager or transition clinician uses a number of specialized tools including the following:

- Significant change visit workflow: The flow followed when there is a significant change in enrollee/caregiver health status; a face-to-face visit is completed within five days
- Level of care transition of placement workflow: The process followed when enrollee transitions from a nursing home to the home or community-based environment; a reassessment is completed to determine the new level of care
- Case formulation change in placement workflow: Steps followed when preparing for plan of care formulation
- Current care manager authorization hand-off process: The process followed when the care manager completes a service authorization and hands it off to the care manager associate to enter into the electronic claims management system
- Rehabilitation workflow: The flow followed when we receive a notification of admission
- Lapse-prevention workflow: The process followed when enrollee is admitted to a skilled nursing facility for rehabilitation therapy and is at risk for custodial placement in a nursing home
- Prior authorization required UM PA workflow: The flow followed by the UM department when a provider submits a request for prior authorization
- Long-term care contingency plan development guide desktop: This desktop procedure provides the backup plan process when there is a gap in service for home- and community-based enrollees, such as when a home health aide fails to show and the service is at risk for not being provided
- Long-term care transition of care job aid: This job aid provides the process our team follows when an enrollee is transitioning to another setting
- Long-term care condition-specific assessments desktop: These are condition-specific assessments for various diseases that are built into our electronic care management system

The tools previously described assist with the transition clinicians' evaluation of whether the enrollee who is residing in a nursing rehabilitative center is appropriate for a safe discharge to community with or without support services or whether the enrollee requires discharge to an alternative setting. The care manager may also identify the enrollee who is in a nursing home's readiness for transition when conducting the annual completion of the Florida Department of Elder Affairs 701B/T assessment. These processes assist us in preventing our enrollees from being deemed "custodial."

Whether the enrollee is in a nursing rehabilitative center or in a hospital setting, the care manager/transition clinician focuses on the enrollee's ability to perform ADLs and instrumental activities of daily living (IADLs). By reviewing the suitability of the home as a place to rehabilitate, along with the enrollee's ability to travel to and benefit from rehabilitation services, our staff can affect safe discharges. Specific assessment criteria include:

- Mobility: Is the enrollee able to move to and from lying position, turn side-to-side, and position and/or reposition self while in bed?
- Ambulation: Is the enrollee able to move from bed, chair, wheelchair, and/or standing position to another location or surface?
  - Is the enrollee able to perform tasks independently, or is supervision needed? If supervision is needed, is it limited or extensive assistance?

## **EXHIBIT A-4-c**

### **LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Is the enrollee is at risk for falls? Has there been any recent falls in the last 6 to 12 months?
- What is the enrollee's ambulatory status? Does enrollee use any assistive devices to ambulate?
- Support services and system: What is the enrollee's support system, including formal and informal supports, using the following rating scale?
  - Poor – No support system
  - Below average – No formal and/or informal support system on a regular basis
  - Average – Some formal and/or informal support system on a regular or fairly predictable basis
  - Good – Enrollee has a reliable support system on a regular basis
  - Excellent – Enrollee has a support system that is reliable, predictable, and able to assist enrollee more than 90% of the time
- Home environment: Will the enrollee's preferred physical environment allow for minimum safety and accessibility? Information should be obtained by observing, direct questioning, and professional judgment. Hallways must be clear, and there must not any clutter, exposed cables, area rugs, or narrow hallways that do not permit use of assistive devices (e.g., walkers or wheelchairs).
- Clinical needs: Does the enrollee have specific medical needs that require skilled nursing? Examples include the following:
  - Peg tube/G-tube
  - Tracheostomy
  - Ventilator
  - Foley and/or any other indwelling hardware
  - Injectable(s)
  - Ongoing therapies
  - Functional status
  - Wound care needs
  - Skin risk
- Durable medical equipment: Does the enrollee need a Hoyer lift, walker, wheelchair, commode, bedpan, urinal, grab bars, wheelchair ramp, incontinence supplies, ostomy supplies, or nutritional supplements?
- Self-determination for discharge: Does the enrollee have memory loss or cognitive impairments affecting his or her ability to self-administer medications or attain personal goals?

While our goal is to transition enrollees to lower-acuity care settings, results of our assessments indicate that is not always possible. Sometimes our enrollees require higher-acuity care. For example, frequent or recurring trips to the emergency room or inpatient hospital admissions may indicate the need for a higher level of care. Additionally, enrollees with dementia may require a higher-acuity setting to receive 24-hour monitoring. In these instances, we recognize the safety risks and know when to intervene on behalf of the enrollee.

If the enrollee transitions to custodial care and cannot be transitioned home, the transition clinician continues to monitor the enrollee's condition and to review on a quarterly basis his or her potential to transition to the community. We complete a transition assessment tool in our electronic care management system. The tool captures the enrollee's strengths, potential concerns, and identifies any behaviors that may interfere with the enrollee's ability to become fully functional in the community setting. The care manager/transition clinician assesses

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

whether the enrollee is appropriate for discharge to a community-based setting with or without support services and works with the enrollee to identify and overcome barriers to independent living.

### **Collaboration with Discharge Planning Staff and PCP**

Upon notification of an admission, the UM regional clinician collaborates with discharge planning staff, enrollees or their caregivers, care managers, primary care physicians, and other practitioners to facilitate discharge-planning efforts. The care manager or transition clinician attends daily rounds with the medical director and UM regional clinician staff, allowing the clinician to identify enrollees with upcoming discharges that will require assistance with transition. Based on the admitting setting, the transition clinician or care manager also contacts the hospital discharge planner to identify the enrollee's needs upon discharge. The information from the discharge planner and discharging physician is factored into our assessment results.

As part of our integrated care management approach, we require that our team contact hospital and nursing facility discharge planners and providers to offer assistance and connect with enrollees that have trigger diagnoses and need skilled care after discharge. In our experience, these enrollees are likely to have special needs that affect successful transition to a community-based setting that must be addressed. Examples of trigger diagnoses include:

- Chronic conditions such as diabetes and COPD
- End-of-life issues
- Cancer
- Dementia and Alzheimer's
- HIV/AIDS
- Traumatic brain injury
- Behavioral health issues
- Healthy behavior issues (smoking cessation, substance abuse, weight management)

Our CareUnify system enables us to exchange real-time information with the UM regional clinician care manager, the PCP, and discharge planner. By easing the burden of authorization processes for our providers and facilitating information sharing, we help ensure medical supplies, medications, home care, and nursing services are in place and ready at discharge and that PCP follow-up occurs within seven days of discharge.

### **Referral and Scheduling Assistance**

Whenever discharge readiness is identified, a key aspect of our transition planning activities is our referral and scheduling assistance. The enrollee's interdisciplinary care team coordinates with facility staff, the enrollee's primary care practitioner, and specialists such as behavioral health providers. Through this program, the following activities occur:

- Establishing timely follow-up appointments within seven days of discharge
- Setting up transportation for appointments
- Coordinating environmental assessments at receiving site to determine safety and need for modifications
- Obtaining medications and delivering of assistive devices and/or DME so they are available upon arrival at the new setting

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Making referrals for home health care, specialty health, and other services that may start as soon as one day after discharge
- Working with care takers, self-directed care staff, and HCBS providers so that services are in place and a backup plan for gaps or call-outs is available
- Verifying within 72 hours of discharge that appointments occurred and services were initiated

To help enrollees receive the services to which they are referred, our care manager is empowered to authorize referrals that expedite the process for the enrollee. We contact enrollees following scheduled appointments to make sure their needs were met and that they understand the provider's instructions. The enrollee's care plan is updated in our care management system to reflect the services received and any change in condition.

Our evidence-based, integrated care management model helps to create a one-stop shop for physical, behavioral, and social needs. Through the integrated care model, information pathways are created through which providers, with the permission of enrollees, can have conversations with one another to ensure proper follow-up with the enrollees' PCP, behavioral health, dental, vision, and other specialty providers. We collaborate with enrollees, their system of support, community-based care resources, PCPs, and other practitioners to enhance care outcomes. For the enrollee, there is no wrong door when attempting to access the care necessary for behavioral or physical health conditions.

Aetna's care managers educate our enrollees about their available provider options, assist them in scheduling appointments, and arrange transportation if needed. We encourage all enrollees to establish a relationship with a PCP. In cases where certain specialties—such as psychiatry—are scarce, we introduce the integrated care model for extending those services through PCPs. The enrollee's plan of care is always shared with the PCP, who can assess whether the enrollee has behavioral health needs that warrant treatment. Enrollees with higher needs will be referred to a partnering behavioral health provider for evaluation, treatment, and follow-up, while enrollees with lower needs can be managed by their PCP collaborating with a behavioral health provider.

### **Coordination with HCBS Providers**

To support the discharge plan and identify any new needs, the care manager/transition clinician contacts the enrollee within 72 hours following discharge. Our staff verifies the DME equipment, interventions, and in-home supports necessary to address the enrollee's needs are received and available for use. In addition, the staff determines whether any gaps have come up post-discharge, so they can also be addressed. The care manager/transition clinician reviews medications, answers questions, and interprets physician instructions about medications. This helps to identify barriers to medication adherence, along with other potential concerns or gaps. A face-to-face meeting must occur within five days of discharge.

To improve coordination, Aetna is releasing our telehealth platform as part of our remote patient monitoring. The platform provides virtual visits from a transition clinician and virtual meetings with other enrollees of the care team. The transition clinician, care manager, and enrollee partner together to reevaluate enrollee goals and revise the plan of care. The transition clinician makes use of evidenced-based screening tools to identify readmission risk and specific triggers.

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Aetna is currently developing a new provider communication tool that will feature the release of our CareUnify mobile application available for Android and iOS smartphones and tablets. The CareUnify mobile application will serve as a companion tool to our CareUnify platform, facilitating real-time clinical information flow between the application and the platform. The application offers providers a simple and efficient way to remain connected to their patients and extended integrated care teams, and it will help monitor patient panels and prompt timely notification of critical events.

Updates to the enrollee's care plan can be instantly shared and feedback can be obtained almost as quickly. Issues can be identified and responded to within hours instead of days. Care plans are uploaded to CareUnify and are available to the interdisciplinary care team in real time. As part of the care management process, the transition clinician regularly evaluates environmental and social determinants of health and intervenes as necessary.

### **Readmission Avoidance**

Aetna's avoidable-readmission program addresses the discharge needs of all enrollees, prioritizing enrollees at a higher risk of readmission and increasing the likelihood of successful discharge. The key components include:

- Identifying enrollees through risk stratification with potential for readmission within thirty days
- Targeting interventions based on evidence-based guidelines
- Preparing for enrollees' post-discharge needs by engaging patients and families in managing their health care needs
- Bridging the information gap between inpatient and outpatient settings
- Coordinating post-discharge care and timely post-discharge appointments across settings
- Facilitating medication reconciliation and enrollee access to post-discharge services and supports

Our readmission-reduction interventions are designed to address the needs of the enrollee and coordinate care across multiple settings and practitioners. The interventions focus on four evidenced-based conceptual domains:

- Use of enrollee discharge information documented in our electronic care management system to support both patient education and communication with practitioners
- Medication reconciliation and medication adherence
- Timely and appropriate follow-up after discharge
- Self-management education about conditions

Enrollees are contacted following discharge by designated staff (care manager or transition clinician) to support discharge plan success and to identify any additional needs the enrollee may have. Our staff:

- Determines whether the enrollee has obtained appropriate supplies and whether appointments have been scheduled and transportation arranged
- Determines whether enrollee has access to and has obtained the appropriate medications

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Determines whether the enrollee has post-discharge care management needs and refers or follows up with the enrollee to provide education for self-management, medication reconciliation and adherence, and other identified post-discharge support and services
- Evaluates environmental factors such as enrollee's fall risk, social support, and ability to function in the home and provides support services to address or mitigate identified risks

Our program includes readmission monitoring/measurement. The effectiveness of the discharge plan and outcomes as reflected in the following situations:

- Enrollee outcomes (readmissions and assessment of related discharge planning)
- Referrals to disease management and/or healthy behaviors programs
- Referrals to behavioral health
- Enrollee follow-up with primary care or specialist visits within 7 and 30 days post-discharge and follow-up with behavioral health provider 7 and 30 days post-discharge, if applicable
- Collaboration with Aetna's care managers to address the medical needs of enrollees to reduce the risk of readmission

The primary goal of our transition of care program is to improve enrollee outcomes and reduce enrollee admissions, readmissions, and emergency department utilization. We will use Aetna's CareUnify software to monitor the condition and stability of our enrollees. Our CareUnify tool supports monitoring, which is described as follows.

### **Use of CareUnify for Collaboration**

CareUnify features provider notifications of clinical information, such as inpatient or ER notifications; steps completed for shared care paths; lab data; appointment reminders; the ability to initiate and conduct a secure telehealth visit from phones or tablets; tracking medication fills; and access to cost and quality dashboards.

Our network providers obtain gaps-in-care reports from CareUnify telling them which enrollees require services such as HgA1c tests or diabetic eye exams. Additionally, providers use CareUnify to monitor for potentially avoidable emergency department visits, to educate enrollees about appropriate site or service, and to advise them about provider availability and the higher level of care integration and follow-up they will receive in the practitioner's office. Providers also receive information from CareUnify about what prescription medications enrollees are taking, who is providing them, and which pharmacies are dispensing them to reduce polypharmacy.

### **CareUnify: Results to Date**

According to data from the first quarter of 2017, Aetna's LTC enrollees in Virginia readmission rate was 13.3% in January 2017 and 11.1% in March 2017, a decrease of 2.2 percentage points.

According to data from March 2016 to March 2017, the average readmission rate was 12.5% in March 2016, and 11.1% in March 2017, a decrease of 1.4 percentage points. Our UM system shows a completion rate of 44% for discharge follow-up.

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

In addition, they increasingly received post-discharge assessments.

Virginia's care transitions teams for both physical and behavioral health were launched in October 2015, prompting a 567% increase in post-discharge assessments.

- October 2015 to present: 10,450
- October 2014 to September 2015: 1,840
- Face-to-face enrollee visits in 2016: 22,000

### **Measurement Approach**

For benchmarking purposes and to quantify the degree of improvement the transition of care process has achieved, we will utilize the following measures to monitor the effectiveness of our program and to determine whether we need to refocus our program, add additional resources, or revise our goals and objectives. On a regular basis, we monitor:

- Enrollee and family experience and satisfaction with care received
- Lapses and relapses

We monitor transition metrics to enhance all of our transition-of-care efforts and consider all relevant approaches as we expand our footprint in Florida. Strategies to improve our transition-of-care program include embedding transition clinicians in each region and assigning them to specific hospitals/facilities.

### **ENSURING ENROLLEE PRIVACY**

**CRITERION 2:** The extent to which the respondent's process and example ensure the protection of the enrollee's privacy consistent with confidentiality requirements

Aetna rigorously follows procedures to ensure that the privacy of enrollee information is protected in every interaction we have with each enrollee. All Aetna staff is required to adhere to our privacy policies and procedures when gathering or releasing information and receive Aetna's annual privacy training and position-specific training during their orientation with annual updates thereafter. Additionally, our Enrollee Services and Care Management staff receives position-specific training on our privacy processes, which are as follows.

- **Enrollee identification:** Any enrollee or enrollee representative who calls Aetna must provide three pieces of enrollee personal health information (PHI) as identification before release of the enrollee's information. The enrollee or authorized person is required to verify his or her 1) Florida Medicaid ID number, 2) first and last name, and 3) date of birth as displayed in our claims and authorization processing system. If one or more of the required pieces of identification information is unavailable, the enrollee's complete address and/or telephone number as displayed in our claims and authorization-processing system are acceptable substitutes. If three pieces of valid identification cannot be provided, the employee will ask the caller to call back once the information is obtained
- **Caller verification:** Any other caller who contacts Aetna must provide at least their 1) first name and 2) their relationship to the enrollee. If the caller is a provider or provider representative, he must identify as "John from Dr. Mary Smith's office" or "David from

## **EXHIBIT A-4-c**

### **LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Walgreens.” The enrollee’s PHI may be disclosed after both processes are completed and only to the following individuals:

- Physicians – A primary care physician or other doctor involved in the enrollee’s care
- Representatives from pharmacies or hospitals
- Authorized caregivers or enrollee representatives (e.g., parents if the enrollee is under age 18), care managers, advocates, individuals with medical power of attorney
- Note: A spouse is not automatically considered an enrollee representative; the representative must obtain verbal permission before sharing PHI with a spouse
- Multiple requestors: When multiple enrollees are involved in a request, the PHI process must be completed for each enrollee (even if on the same claims and authorization processing system account)
- Missing release forms: When an individual does not have an Authorization to Release PHI form or a Medical power of attorney on file, the staff person must determine which process best suits the enrollee’s situation:
  - Temporary Authorization to Release Protected Health Information (PHI)
  - Indefinite Authorization to Release Protected Health Information (PHI)
  - Medical power of attorney
- Breaches of sensitive information: Our staff members are thoroughly trained in how to look for information and navigate our claims and authorization processing system to look up and record Enrollee Release of Information and the steps to prevent a breach
- Release of information processes: Aetna has developed an enrollee release of information process to specify and document our compliance with federal, state, and local laws and regulations governing enrollee privacy rights. These rights include but are not limited to the Health Insurance Portability and Accountability Act (HIPAA) and applicable contractual requirements. It is essential when speaking to enrollees or their authorized representative(s) that we follow proper procedures to verify and document the identity of the enrollee to guard PHI. Our staff members are taught to consistently follow three components of the release of information process:
  - Direct an enrollee/representative to the health plan website, where they may download the Privacy Request Form, or
  - Obtain and validate the mailing address where the Privacy Request Form can be mailed
  - Explain to the enrollee/representative that they will be receiving a Privacy Request Form that must be signed and returned to the health plan. (If enrollee is unable to sign, they explain that the representative must complete the form and include their guardianship or power of attorney paperwork)
- Privacy form received: If Aetna has received a signed privacy form, our staff members take the following actions:
  - Receive legal documents confirming a person’s legal relationship to a enrollee
  - Record the legal documents in the enrollee’s record and save in a confidential and secure location so that it may be referenced by health plan staff who have a business need to review (enrollee services, PA, UM, ICM, LTSS, Compliance)
  - The health plan retains and stores copies of Advanced Directives made available to us.
- Role of our compliance manager: Our staff forwards documentation and requests to the compliance manager or designee immediately for review and disposition. The compliance manager confirms whether information is valid and complete as follows:

**EXHIBIT A-4-c**  
**LTC SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

- Review documentation submitted
- Call the enrollee or send a written request for any additional information needed
- Once the record is complete, the compliance manager will review and approve or deny the request and reply within two business days, unless there are extenuating circumstances
- If valid and complete, approve the request unless any of the following conditions apply:
  - o Aetna believes the release of records to the enrollee's personal representative may not be in the enrollee's best interest (e.g., in cases of domestic violence, abuse, or neglect)
  - o State or local law or regulation prohibits Aetna from providing a parent or other person with access to certain enrollee information such as birth control, treatment of sexually transmitted diseases, or mental health services received
- Upon receipt from the compliance manager, the enrollee services team creates a HIPAA Alert in the business application system with:
  - o Date permission received
  - o Specific document type received (HIPAA or Release of Information)
  - o Name, relationship and phone number of the person(s) granted permission
  - o No termination date
  - o Privacy Request Form saved as part of the permanent enrollee record
- Obtaining verbal permission to share enrollee information: If an Aetna representative receives a call from an enrollee authorizing permission to speak with someone else about his or her record or a representative of the enrollee calls in to the health plan on behalf of the enrollee.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

**EXHIBIT A-4-c**  
**LTC SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

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TRANSITION PLAN EXAMPLE

CRITERION 1: The extent to which the respondent's process and example address the following components of transition and discharge planning:

- (a) Assessment criteria for ensuring the enrollee can be served safely in the community;
- (b) Collaboration with providers' discharge planning staff (e.g., hospitals, institutional settings, assisted living facilities, ancillary providers);
- (c) Referral and scheduling assistance;
- (d) Coordination with home and community-based providers, including DME and home health providers as appropriate to meet the enrollee's needs; and
- (e) Processes to prevent unnecessary hospital or nursing facility readmissions

CRITERION 2: The extent to which the respondent's process and example ensure the protection of the enrollee's privacy consistent with confidentiality requirements

CRITERION 3: The extent to which the respondent's example provides appropriate timeframes for each step of the transition and discharge planning process

An example of a safe and effective discharge and transition process upon admission notification is outlined next; the names have been changed and information generalized. Cases are only discussed with members of the enrollee's interdisciplinary team who are bound by HIPAA and privacy law in a confidential setting. Interaction with Aetna enrollees occurs in a private and confidential manner.

Our UM staff received a prior authorization request from a local hospital. The request for skilled in-home nursing services was received after hours through ProFax for Mr. Jones, our enrollee. Mr. Jones had been in the hospital for eight days.

Day 1

[REDACTED]

[REDACTED]

[REDACTED]

**EXHIBIT A-4-c  
LTC SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA (10-2-17)**

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

**EXHIBIT A-4-c**  
**LTC SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

[REDACTED]

[REDACTED]

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[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

**EXHIBIT A-4-c**  
**LTC SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

**Evaluation Criteria:**

1. The extent to which the respondent's process and example address the following components of transition and discharge planning:
  - (a) Assessment criteria for ensuring the enrollee can be served safely in the community;
  - (b) Collaboration with providers' discharge planning staff (e.g., hospitals, institutional settings, assisted living facilities, ancillary providers);
  - (c) Referral and scheduling assistance;
  - (d) Coordination with home and community-based providers, including DME and home health providers as appropriate to meet the enrollee's needs; and
  - (e) Processes to prevent unnecessary hospital or nursing facility readmissions.
2. The extent to which the respondent's process and example ensure the protection of the enrollee's privacy consistent with confidentiality requirements.
3. The extent to which the respondent's example provides appropriate timeframes for each step of the transition and discharge planning process.

**EXHIBIT A-4-c  
LTC SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA (10-2-17)**

**Score:** This section is worth a maximum of 35 raw points with each of the above components being worth a maximum of 5 points each.

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**EXHIBIT A-4-c**  
**LTC SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**LTC SRC# 4 – Provider Network Agreements/Contracts (Regional):**

The Agency has identified some the key network provider types that will be critical in order for the respondent to promote the Agency's goals.

The respondent shall demonstrate its progress with executing agreements or contracts it had with providers in the region by submitting **Exhibit A-4-c-1**, Provider Network Agreements/Contracts (Regional) (10-2-2017):

**Response:**

The completed Exhibit A-4-c-1 can be found on the following page.

**Evaluation Criteria:**

For each service type the respondent may receive up to 60 points as described below. There are four (4) service types available in a region.

Percentage of agreements/contracts for each service type	Points
0.0%	0
1.0% - 25%	15
25.1% - 50%	30
50.1% - 75%	45
75.1% or greater	60

**Score:** This section is worth a maximum of 240 raw points based on the above point scale.

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**EXHIBIT A-4-c-1**  
**LTC SRC# 4 - PROVIDER NETWORK AGREEMENTS/CONTRACTS (REGIONAL)**  
**(10-2-2017)**

SRC Score		105		
Service Provider Type	Agreements/Contracts	Available Service Provider Types		%
Assisted Living Facility	3	48	6%	
Adult Day Care Center	2	3	67%	
Home Health Agency	7	14	50%	
Nurse Registry	1	4	25%	

**EXHIBIT A-4-c-1**  
**LTC SRC# 4 - PROVIDER NETWORK AGREEMENTS/CONTRACTS (REGIONAL)**  
**(10-2-2017)**

Score	
	15
	45
	30
	15

**EXHIBIT A-4-c**  
**LTC SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**C. RECIPIENT EXPERIENCE**

**LTC SRC# 5 – Transition from Nursing Facility to Community (Statewide):**

The respondent shall describe its experience with transitioning individuals from institutional to community settings and strategies to ensure individuals maintain successful community placement including:

- a. Experience and strategies pertaining to deploying transitional care teams and using evidence-based practices with support from other clinical resources and community-based organizations.
- b. Experience and strategies pertaining to individuals who reside in an institutional setting for rehabilitation, or have otherwise resided in a facility for less than one year.
- c. Experience and strategies pertaining to individuals who have resided in an institutional setting for more than one year.

**Response:**

Aetna seeks to change enrollees' lives for the better by helping them to return to their communities. In our transition program in Florida, for example, we are changing enrollees' lives by helping them to become more self-sufficient and engaged in their care—and improving their overall well-being. We share the Agency's goal of transitioning long-term services and supports by increasing the percentage of enrollees transitioning from facility-based to community-based services.

Aetna understands that seamless and successful transitions of care from institutional to community settings promote improved health and speedier, more complete recoveries. We diligently pursue successful and sustainable enrollee transitions back into the community. Our integrated care management model includes the use of strengths-based approaches for care planning. We provide comprehensive care management support and individual plans of care with a primary focus on enrollees' goals and preferences, along with the underlying root causes that are either driving adverse outcomes or creating barriers to improvement. Together with the enrollee, caregiver and the PCP or specialty provider (when indicated), we identify triggers that lead to avoidable emergency department (ED) visits and inpatient stays. In collaboration with the enrollee and his or her circle of support, we develop a person-centered plan of care based on the enrollee's self-identified hierarchy of needs, including the interventional strategies essential to preventing avoidable admissions and ED visits. For example, we engage enrollees post discharge via phone calls or face-to-face visits within 72 hours of discharge and provide follow-up treatment within five days of discharge.

To help meet the State's goals of moving enrollees into the most appropriate care settings to help them succeed at effectively meeting personal health objectives, we have developed and implemented nursing home transition teams with transition-of-care clinicians. The transition-of-care clinicians are located in each of our four current long-term care (LTC) regions. The

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

clinicians are licensed (registered nurse, licensed practical nurse, licensed clinical social worker) with the skills and experience necessary to work with enrollees transitioning to community settings. Transition-of-care clinicians work with enrollees and our care managers to assess the potential for successful transition to community-based settings, collaborating closely with enrollees, their circle of support, Home- and Community-Based Services (HCBS) providers, and other community resources to help ensure smooth transitions. This approach enables enrollees and their families/caregivers to become more self-sufficient and increase their engagement in their care so they can remain in their community.

### **EXPERIENCE AND STRATEGIES**

As part of our AHCA contract, Aetna is required to identify and successfully transition 3% of our institutionally based enrollees annually.

To continue to improve our results for the enrollees we serve—and for the Agency—Aetna developed a nursing home transition team that includes fully dedicated staff to perform tasks related to discharge and transition. In mid-2017, we deployed licensed transition-of-care clinicians in each region of the State, all of whom possess a distinct skillset. The experience and backgrounds of our transition staff include home health, nursing home, and acute inpatient services. These clinicians strengthen our efforts by coordinating closely with the nursing facility, vendors, hospital providers, physicians, and behavioral health specialists alike to help ensure successful transitions back to the community.

Our team approach was informed by our chief medical officer's extensive experience in utilization and care management for children and adults living with developmental disabilities. He is a strong advocate for transitioning long-term services and supports from institutional settings to the community whenever appropriate. He has also served at the forefront of several health care delivery initiatives where he has established strong working relationships with providers and facilities across the State, thus helping us to develop our processes, procedures, and approaches to care management. As a part of this team approach, our transition-of-care clinicians collaborate with facilities to identify candidates for transition. We offer assistance and connect with enrollees who require skilled services post-discharge and/ or who have trigger diagnoses, including:

- Chronic conditions such as diabetes and chronic obstructive pulmonary disease (COPD)
- End of life issues
- Cancer
- Dementia and Alzheimer's
- Human Immunodeficiency Virus /Acquired Immune Deficiency Syndrome (HIV/AIDS)
- Traumatic brain injury
- Behavioral health concerns

In addition to the 701B, we use our own transition screening to assess each enrollee's abilities and potential for transition. This tool is a condensed version, which provides a quick view into the enrollee's status, service needs, and assesses the best provider to fill their needs. Our tool collects information to better identify the enrollee's current and specific requirements and identifies an opportunity for follow-up and potential transition in the future. The data that both of these assessments gather provide the clinician with the information necessary to explore a less restrictive level of care with the enrollee. The enrollee must agree to the transition. The

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transition-of-care clinicians also review the enrollee's clinical records for information regarding medications, current functional status information, and more.

### **Evidence-Based Practices**

Aetna has a breadth of experience in LTC and Medicare Advantage dual special needs programs in many states. Our plans have evaluated what works and does not work, and our Shared Services division has developed a series of corporate best practices. Our integrated care management approach and practices also incorporate evidence-based practice, professional standards, and research from organizations such as:

- American Society on Aging
- National Council on Independent Living
- Administration for Community Living
- National Association of State Directors of Developmental Disabilities Services
- National Association of States United for Aging and Disability (NASUAD)
- Leadership Council of Aging Organizations
- The SCAN Foundation
- Community Living Policy Center

To augment this program further, we have incorporated evidence-based practices and national chronic care guidelines to create clinical algorithms that assist with conducting the most appropriate assessment and managing enrollees. Assessments and screening tools used by care managers and/or community health workers were developed using evidenced-based clinical practice guidelines promulgated by nationally recognized entities, including, but not limited to, the Centers for Disease Control and Prevention (CDC); National Heart, Lung, and Blood Institute (NHLBI); American Psychiatric Association (APA); American Congress of Obstetricians and Gynecologists (ACOG); American Diabetes Association (ADA); Healthy People 2020; and Substance Abuse and Mental Health Services Administration (SAMHSA).

### **DEPLOYING TRANSITIONAL CARE TEAMS**

**CRITERION 1:** The extent to which the respondent identifies how it will coordinate care with all individuals and/or entities necessary

Typically, our transition-of-care clinicians contact facility discharge planners to review enrollees' needs prior to discharge. Relying on the orders from the attending physician and the facility discharge planner's recommendations, the transition-of-care clinicians assess whether enrollees are appropriate for a safe discharge to home—with or without support services—or if they require discharge to an alternative setting. Our care managers and clinical care managers identify existing enrollees who have the potential or express the desire to move to a less restrictive setting. Additionally, our Care Management staff notifies our transition clinicians of new enrollees requiring assessment for potential transition.

Discharge determination includes the following criteria:

- Mobility/ambulation
- Home health needs
- Identifying risks and safety planning

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- Home support services from the family
- Home environment
- Clinical needs (for example, intravenous (IV) medications, treatments, wound care, etc.)
- Durable medical and supply needs
- Enrollee/responsible party self-determination for discharge with the involvement of the enrollee's PCP or medical director

The transition-of-care clinician completes an assessment and screening of the enrollee to determine his or her potential and to ascertain his or her interest in moving to a less restrictive setting. Options are discussed with the enrollee and his or her representatives. It is the enrollee's choice whether to accept a plan of care option for transition. If an enrollee is appropriate for transition and the enrollee and/or his or her representative expresses a desire to transition to an alternative setting, the transition-of-care clinician works in collaboration with the care manager to develop a comprehensive transition plan.

### **Transition Planning: Services Required Post-Discharge**

The transition-of-care clinician works with the enrollee/representative to identify what the enrollee will need to successfully transition from a nursing facility to home. He or she works to understand the enrollee's financial situation, such as having enough income for rent and other living expenses. Lack of income and other resources can be a major barrier to transition. Can the enrollee afford the expenses associated with moving? These typically include household furnishings, down payments, and deposits. Our care managers assist enrollees in identifying and applying for qualifying benefits such as supplemental security income (SSI) and food stamps. The transition-of-care clinician explores whether there are community resources and charitable organizations that can offer various types of support. Transition-of-care clinicians rely upon charities that operate locally; these can include the Salvation Army, Goodwill, St. Vincent De Paul, and others.

Finding affordable, accessible housing is generally among the most difficult challenges that transitioning enrollees face. Subsidized senior housing structures often have long waitlists. In our experience, community relations are critical to assisting with housing needs and resources. Aetna's regional Provider Services representatives establish relationships with assisted living facilities in the provider network and expand the overall scope of supports available to our enrollees.

Expanded Benefit: Aetna currently offers an expanded benefit of up to \$2,500 to assist enrollees with transitions from nursing facilities to their homes. This transition fund provides enrollees with money to buy furniture and household items, pay deposits and the initial rent, and meet other needs. Our medical director reviews all requests for transitional funds to help ensure the services are within the scope of the LTC program.

Implementing Appropriate Services: Enrollee-specific information, along with the enrollee's living preferences, is noted on the Freedom of Choice form, which informs the preparation of the transition plan. After the transition plan is formulated, the transition-of-care clinician and assigned care manager complete a variety of tasks including:

- Arranging for personal care services, home health services, therapies, medical equipment, and supplies as needed, possibly through the participant direction option

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- Transition-of-care clinician completes home assessment prior to discharge to identify required durable medical equipment (DME) items or home modifications
- Expediting authorization for services so that they will be available upon transition to the community
- Arranging transportation to and from medically-necessary covered services
- Assisting with scheduling follow-up appointments with providers/specialists
- Supporting the enrollees in accessing community services and resources
- Follow-up face-to-face visits and telephone calls to determine if the authorized services are meeting the needs of the enrollee

The care manager is responsible for overseeing and managing the enrollee's care in collaboration with the transition-of-care clinician and other medical providers throughout the transition process and on an ongoing basis. After the enrollee transitions to home or an alternative setting, the transition-of-care clinician (in collaboration with the care manager) conducts a face-to-face follow-up visit within 72 hours to assess whether the enrollee's clinical needs are met; including medication is available, ensuring in-home health services have begun, and scheduling follow-up appointments with medical providers. The care manager conducts a follow-up with the enrollee within five days to help ensure all required services and equipment are in place. The care manager completes all required documentation, and he or she reviews and updates the individual plan of care with the enrollee and his or her representative, if applicable. For the first 30 days, the transition-of-care clinician working with the care manager, focuses on ensuring the enrollee has the appropriate services and supports to safely remain in the community and do not return to the previous setting nor become hospitalized or end up in the hospital emergency department.

**Individuals in an Institutional Setting for Less Than One Year**

Aetna's approach to the successful transition to community-based settings by enrollees who have resided in an institutional setting for less than one year is highly strategic and is based upon our Florida and national experience of successfully supporting State transition initiatives. Our transition-of-care clinicians and care managers stratify enrollees for transition as follows:

- Enrollees who still own a home
- Enrollees who have lived with a relative or caregiver prior to the facility admission
- Enrollees who are rehabilitating from recent illnesses, injuries, and operations
- Enrollees with self-care deficits

The strategic approach used by our transition-of-care clinicians and care managers includes gathering information about the enrollee's living situation prior to entering the nursing facility, working collaboratively with the enrollee to garner an understanding of why the enrollee was originally placed in the nursing facility, and exploring where the enrollee wishes to reside. We have found that if the enrollee does not have a home to return to, transition can be challenging. An example of a successfully transitioned enrollee follows.

[REDACTED]

[REDACTED]

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[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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Individuals in an Institutional Setting for More Than One Year

Some nursing facilities resist losing enrollees to the HCBS setting—particularly longer-term residents. If an enrollee meets the criteria to be discharged and wishes to transition, the transition-of-care clinician works to assist him or her.

Our experience demonstrates that enrollees who have resided in a nursing facility for more than a year have more barriers to a successful transition. They are likely to have exhausted their assets and broken off community ties. Even so, there are enrollees that are motivated to leave the institutional setting and still have ties in the community. The transition-of-care clinician gathers information about the enrollee's living situation prior to entering the nursing facility. The transition-of-care clinician works to understand why the enrollee ended up in the nursing facility. The transition-of-care clinician explores where the enrollee wants to live and offers to help. If the enrollee does not have a home to return to, the clinician focuses on whether he or she can live with a family member or in an assisted or independent living setting. Those with a relative or caregiver to live with are the best prospects and the participant direction option (PDO) is offered as an incentive to families who may be able to provide care in the home.

Enrollees in nursing facilities longer-term may be comfortable in their environment and resistant to moving to an assisted living facility (ALF). Aetna's buddy system can help to influence the enrollee and produce positive results. Pairing the potential new resident with an enrollee who already lives in the assisted living facility can give the enrollee an appreciation of what life is like in the assisted living facility; an understanding of how things would work if he or she moved there; the opportunity to reside where his or her language is spoken; introduce a setting where their needs can be met in a home like environment. Our transition-of-care clinicians work with the assisted living facility to promote the buddy system, and they will arrange the transportation necessary for the enrollee to spend time at the ALF. The transition-of-care clinician will use motivational interviewing techniques and his or her knowledge of the stages of change when providing enrollees the positive reasons for transition—if that is desirable to the enrollee. The transition-of-care clinician and care manager listen to the enrollee's questions and concerns and address them objectively so that the enrollee can have the information needed to make an informed decision about a transition to the community.

Demonstrating Our Success

CRITERION 4: The extent to which the respondent demonstrates through data its success rate at transitioning individuals from institutional to community settings

CRITERION 5: The extent to which the respondent demonstrates through data its success rate at maintaining individuals who have transitioned from an institutional placement to community placements

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Since the transition program began, Aetna has increased the number of enrollees who left a nursing facility to reside in the community. For 2017 year to date, we have helped 113 enrollees living in nursing homes move to the community—for a 5.6% transition rate, exceeding the Agency goals of 3%. The success of this program is a direct result of the implementation of our nursing facility transition team and the appropriate coordination of services. In 2016, only 4 enrollees out of 109 who left the nursing home returned to the nursing facility because of declining health. We continue to monitor those 4 enrollees so they might one day return to living in their community.

Through regular checkpoint visits with our community-based enrollees, our care managers are building trusting relationships, which enable them to act as our enrollees advocates ensuring that the services that are in place remain high quality and are delivered as authorized. We can adjust our plan of care to meet the enrollees changing needs, with the goal of keeping them in the community for as long as possible. Our care managers make a genuine effort to understand what is important to the enrollee—from the enrollee's perspective—and to be mindful that a positive partnership with our enrollees has a significant impact on their outcomes.

For 2017, we are proud to report that 100% of enrollees who moved from nursing facilities to the community are still living in the community. We are confident this success directly relates to the implementation of the nursing home transition team, coupled with appropriate coordination of services and ongoing monitoring of enrollees' health status.

### **CAREGIVER ASSESSMENT AND RESOURCES**

**CRITERION 2:** The extent to which the respondent assesses potential caregiver willingness and availability in supporting the transition

Aetna's caregiver supplemental assessment is completed by the enrollee's care manager for each potential caregiver or informal support while completing 701B assessment. This assessment occurs during initial care planning and annually thereafter or as clinically indicated. Administering this assessment helps the care manager and transition-of-care clinician determine the types of assistance the enrollee can expect to receive from family, friends, and other support persons. It also helps the care manager and transition-of-care clinician to understand each caregiver's situation and how much the caregiver is able to provide to the enrollee in a community-based setting. Elements of the caregiver supplemental assessment include:

- The caregiver's relationship to enrollee
- The length of time the enrollee be safely left alone per day
- The specific ADLs the caregiver assists the enrollee in completing (e.g. bathing, dressing, grooming, and toileting), including the time per day spent providing this support
- The specific IADLs (e.g. eating including meal prep, shopping, transferring), including the time per day spent providing this support
- The caregiver's additional responsibilities (e.g., work, school, minors at home, another individual requiring care), including his or her schedule in completing them
- Anyone else assists the caregiver with the enrollee's care and what they do
- The effect caregiving has had on the caregiver's your personal well-being

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- The medical limitations or disabilities that would limit the caregiver's ability to participate in the care of the enrollee

If the caregiver expresses concerns with his or her ability to participate in the enrollees' care, or if caregiving is negatively affecting the caregiver's well-being, our care manager works with the caregiver on remediation which could include referrals to community resources, respite, and support groups.

### **Caregiver Resources**

As part of our conversation with the enrollee, we engage his or her caregivers and circle of support, who are charged with helping the enrollee live at home successfully. As part of the overall comprehensive assessment, we routinely evaluate caregivers through a series of tools and assessments (i.e., caregiver assessment and caregiver strain index). This routinely includes discussions around the caregiver's current responsibilities outside of the home, his or her willingness and ability to provide support, his or her personal health and well-being, stress levels, and respite care needs.

Aetna provides our caregiver support kit to those supporting enrollees in community-based settings, which provides valuable information and assists them in collecting and organizing important details related to providing support for the enrollee. The support kit contains the following sections:

- Enrollee information:
  - Contact information
  - Doctors names and contact information
  - Care managers
  - List of medications
  - Insurance information
- Helping your loved one stay safe and well:
  - Encouraging healthy eating
  - What to do about incontinence (loss of bladder control)
  - Recognizing incontinence due to Alzheimer's
  - Signs of bladder/kidney infections
  - Helping prevent falls
  - Managing diabetes
  - Managing COPD
  - Helping a loved one with heart disease or heart failure
- Advance directives and making decisions:
  - Advance health care directives
  - 5 wishes and elder law
  - Hospice versus palliative care
- Taking care of yourself:
  - Tips for coping with stress
  - Caring for someone with Alzheimer's
  - Resources/services for caregivers
  - Testimonials
- Important contacts and resources

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **ENROLLEES WITH SPECIAL CIRCUMSTANCES**

**CRITERION 3:** The extent to which the respondent's description addresses transitioning enrollees with special circumstances or medical conditions (e.g., complex needs); enrollees with ongoing needs; and enrollees who at the time of their transition have existing prior authorization or approval for ancillary services

Enrollees with special circumstances and medical conditions pose additional challenges to successful transitions. Transition-of-care clinicians examine their person-centered plans of care and identify any additional services that need to be implemented, based on their complex needs. If transition-of-care clinicians require guidance on how to resolve problems or arrange for the most appropriate services, they reach out to our medical director and our Utilization Management team for assistance. They complete weekly rounds with the medical director to review the most challenging situations, which could include:

- No family or friends to support the transition (we propose an assisted living facility placement)
- Limited or no finances available (we work with assisted living facility providers who are willing to work with enrollee's income)
- No home to transition to and the enrollee refuses the assisted living facility option
- The enrollee requires total care and family work or attend school
- The enrollee does not require total care, but requires 24/7 supervision and family have work or school obligations
- The enrollee requires total care and wants to leave nursing home, but the family refuses
- The enrollee requires minimal assistance with ADLs and/or IADLs, but finds comfort in living in an institutional setting; the community setting seems dangerous. For example, if an enrollee has a private room at the nursing facility and knows that at an assisted living facility he or she will not have access to private room so he or she resists moving. Whenever enrollees with special needs are targeted by our transition clinicians for potential transition, we take the following steps to identify:
  - The type of special circumstances and the resulting impact on services and costs
  - The impact of the special need on the environmental and safety needs of the enrollees
  - The impact of the special need on the enrollee's self-care capacity
  - The availability of natural supports and other caretakers to meet the needs
  - The current authorizations that are on file and the associated hours of service per day and per week
  - The level of community-based services needed and overall cost of the services in comparison to the cost of current services
  - The timeframe necessary to set up community-based services

Following a review of this information, the transition-of-care clinician determines if transition discussions with the enrollee are appropriate.

If the enrollee does not meet the criteria for moving to the community (for example, he or she cannot ambulate, require 24-hour supervision, and is receiving wound care, etc.) but still wants to transition, the transition-of-care clinician and/or care manager discuss the case with the medical director. The medical director makes the final decision as to whether it would be safe to pursue a transition. If the transition to HCBS is authorized, Aetna sends a Notice of Adverse

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Benefit Determination to the enrollee to confirm the termination of nursing facility services and provides a copy to the nursing facility.

To assist enrollees with appropriate transitions, the care manager or transition of clinician uses a number of specialized tools including our long-term care contingency plan development guide desktop. This desktop procedure provides the back-up plan process when there is a gap in service for home- and community-based enrollees.

Aetna's contingency plan includes information about actions the enrollee and/or representative should take to report any gaps in service. This may include resources available to the enrollee (i.e., on-call back-up caregivers and the enrollee's informal support system.) The objective of the contingency plan is to resolve unforeseeable gaps (e.g., regular caregiver illness, resignation without notice, transportation failure, etc.) within a timeframe that meets the enrollee's needs.

The purpose of the contingency plan is to determine:

- What to do and who to contact in the event the enrollee's service provider does not come as scheduled
- The enrollee's/representative's right to change his/her enrollee service preference level at the time of the incident based on his/her needs
- The importance of the enrollee/representative notifying the care manager soon as possible if there is any difficulty with a caregiver or the caregiver's agency

Our care managers assist enrollees in creating a contingency/back-up plan; this plan is reviewed with the enrollee and his or her representative at least quarterly, and we either obtain the enrollee's/ representative's signature or create a new plan. A new contingency plan is created at enrollee orientation and updated as follows:

- Annually, at a minimum
- Any time there is a care manager change
- Any time there is a change in the service, frequency of service delivery, and/or service provider
- Any time the informal support status changes
- Any time there is a change in health status that creates a need for a reassessment and re-evaluation of services

During the in-home visit, the care manager assists the enrollee/representative in identifying the enrollee service preference level using the following considerations:

- In-home services authorized for the enrollee for that review period based on the service authorizations in place in our care management system
- The enrollee's functional status in ADL and IADL and the urgency by which the enrollee requires back-up support (e.g., can he or she get out of bed or toilet themselves if no caregiver arrives)
- The cognitive, behavioral, and medical status of the enrollee, and if the service was not delivered as authorized, the impact it would have on the enrollee
- The availability of the enrollee's informal support system; it should not be assumed that the presence of an informal support system lowers the enrollee's risk level. The

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enrollee's friends and family should not be expected to provide back-up care for the enrollee.

Next, the care manager identifies the enrollee service preference level, as determined with the enrollee/representative. The care manager then documents in the InterRAI assessment the reason the enrollee service preference level was selected for that review period. The contingency plan is reviewed with the enrollee/representative.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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When Adult Cystic Fibrosis (ACF), Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI), and Project AIDs Care (PAC) waiver enrollees are transitioned into the LTC health plan, there is a continuity of care period for 60 days where we honor their current plan of care for covered, medically necessary services. During that time, we evaluate their level of need and the services required for short- and long-term care. Our care management staff is actively engaged in the intake process, completing appropriate assessments and plans of care for submission and review with the enrollee's PCP and our medical director. Interdisciplinary care team meetings are held with all of the involved parties, including the enrollee and their representatives. The health plan considers care management accommodations as needed for enrollees with very complex clinical needs to ensure the least amount of disruption to the enrollee and to provide stability and a smooth transition to our LTC program.

**Evaluation Criteria:**

1. The extent to which the respondent identifies how it will coordinate care with all individuals and/or entities necessary.
2. The extent to which the respondent assesses potential caregiver willingness and availability in supporting the transition.
3. The extent to which the respondent's description addresses transitioning enrollees with special circumstances or medical conditions (e.g., complex needs); enrollees with ongoing needs; and enrollees who at the time of their transition have existing prior authorization or approval for ancillary services.

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4. The extent to which the respondent demonstrates through data its success rate at transitioning individuals from institutional to community settings.
5. The extent to which the respondent demonstrates through data its success rate at maintaining individuals who have transitioned from an institutional placement to community placements.

**Score:** This section is worth a maximum of 25 raw points with each of the above components being worth a maximum of 5 points each.

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**LTC SRC# 6 – Care Planning (Statewide):**

The respondent shall provide a flowchart depicting how it will use the information contained in the State of Florida approved assessment (Florida Department of Elder Affairs 701B Comprehensive Assessment), the respondent's supplemental assessment (if applicable), and any additional information collected in its utilization and case management processes for LTC services, in order to properly complete the initial care planning process for a recipient in a facility-based setting and in a community-based setting.

**Response:**

Aetna serves as our enrollees' strongest advocates—joining them where they are to help discover what is truly important to them. In supporting enrollees, we help to shape a life plan that is tailored to meet their goals, needs, and preferences specifically. This person-centered planning and care improves quality of our enrollee's lives and enables them to reach their physical, cognitive, psychosocial, behavioral health, and long-term care goals.

Aetna's care planning flowchart illustrates the steps we use to conduct person-centered care planning in facility- and community-based settings for long-term care (LTC) enrollees. We provide comprehensive care management support and individual plans of care with a primary focus on enrollees' goals and preferences, along with the underlying root causes that are either driving adverse outcomes or creating barriers to improvement. Our care managers and transition nurses use a well-defined process to promote the active involvement of enrollees and their caregivers and guide staff practice of person-centered approaches. Our flowchart includes the complement of assessment tools necessary to determine the scope and detail of each enrollee's needs and steps required to help ensure his or her choice and voice drives all aspects of the care planning process.

**INITIATING CARE PLANNING**

The specific elements included in Aetna's person-centered care planning flowchart for enrollee's residing in nursing home- or community-based settings are listed in Figure LTC SRC 6-1: Care Planning Process in Attachment LTC SRC 6 in the order of the associated task:

1. Using a culturally appropriate, person-centered approach based on enrollees' preference of setting and any communication needs
2. Conducting a face-to-face orientation (within five days for enrollees residing in a community-based setting and within seven days for those residing in facility-based setting)
3. Completing all sections of the Florida Department of Elder Affairs 701B Comprehensive Assessment initially for all members and annually for community members and all sections of 701T Non-Community Placement Assessment annually for enrollees residing in facility-based settings or those intending to transition to a facility-based setting
4. Using supporting documents/supplemental assessments such as caregiver assessment, condition specific assessments, HCBS tool, clinical notes, hospice election forms, PASSR form, referrals from PCP, etc.
5. Developing the components of the care plan

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6. Completing required forms such as the plan of care, plan of care summary, freedom of choice, contingency plan, authorization for release of information, etc., and obtaining the enrollee's or guardian's signature
7. Develop contingency plan and service preference level
8. Determining medical necessity and documenting service needs in our electronic care management system. This included providing service authorizations for enrollees residing in a nursing home or providing the coordination of HCBS services for enrollees residing in community-settings.
9. Providing routine on-going monitoring, change in condition at interdisciplinary team request, quarterly plan of care reviews, and annual reassessments

### **USE OF THE COMPREHENSIVE ASSESSMENT IN CARE PLAN DEVELOPMENT**

CRITERION 1: The extent to which the flowchart outlines specific data components it will use from the State of Florida approved assessment in the development of the plan of care for enrollees

The Florida Department of Elder Affairs (DOEA) Comprehensive Assessment 701B enables us to understand the biopsychosocial needs of our enrollees and the social determinants of health that affect their quality of life. Our flow charts address the following components of the comprehensive assessment:

- Demographics
- Memory and cognitive ability
- General health, sensory and communication needs
- Activities of daily living (ADLs) and instrumental activities of daily living (IADLs)
- Health conditions and therapy needs
- Mental Health needs
- Residential living environment needs
- Nutritional needs
- Medications and Substance Use needs
- Social resource needs
- Caregiver needs

### **USE OF SUPPLEMENTAL ASSESSMENT AND SUPPORTING DOCUMENTATION**

CRITERION 2: The extent to which the flowchart outlines specific data components it will use from the respondent's supplemental assessment, and/or any additional informational sources, in the development of the plan of care for enrollees

We use comprehensive assessment findings to initiate the enrollee's person-centered plan of care. As depicted on our flow charts, Aetna enhances individualized care planning by obtaining the following types of supporting documentation as appropriate.

For all enrollees:

- 701B Comprehensive assessment
- Condition-specific assessments are conducted for LTC enrollees who are also in the Disease Management program. When enrollees with poor management of chronic

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conditions are identified, they are referred to our Integrated Care Management program for condition assessment and management by our medical management associates. These tools facilitate physical health, behavioral health, and pregnancy assessments, and they are geared to conditions affecting members of the LTC population. Our condition-specific tools include the following:

- Cancer
- Depression
- Diabetes
- End Stage Renal Disease
- Heart Failure
- HIV
- Hypertension
- Generalized Anxiety Disorder 7 (GAD-7)
- Patient Health Questionnaire 9 (PHQ-9)
- Advance directives

### **Nursing facility**

Supporting documents for enrollees residing in a nursing facility setting are:

- Transition screening tool: This tool collects data on transitioning criteria, including bed mobility, transferring from a position to another location or surface, toileting, and eating. It also includes screening of Behavioral Health, therapies and/or treatments, medications, and socioeconomic barriers to transitions back to the community. Tool measures enrollees' support system and their goals and expectations.
- Preadmission Screening and Resident Review (PASSR) form: The screening, conducted by the nursing facility staff, is for suspicion of mental illness and/or intellectual disability, to ensure appropriate placement in the least restrictive environment, and to identify the need to provide applicants with needed specialized services. PASSR screening applies to all new admissions into a Medicaid certified nursing facility. Our care manager reviews the PASSR for members residing in facility-based settings during initial care planning, and annually thereafter and bring necessary information into Aetna's electronic care management system.
- Additional DOEA screening and assessment forms to determine the nursing level of care, identify needs and resources associated with the enrollee, report demographic information, and to reassess clients to maintain eligibility for services. An example is the 701T Non-Community Placement Assessment. This shortened assessment is used for individuals residing in a nursing facility with no intent to return to the community or for individuals residing in the community, but who have the intent to enter a nursing facility.

### **Home and Community Based Services (HCBS)**

Supporting documents for enrollees residing in a community-based setting to assist with determining service plan for a new or transitioning enrollee:

- Aetna caregiver supplemental assessment: Collected for each caregiver or informal support, this assessment helps determine the caregiver's willingness and ability to provide necessary supports to enrollees living in community-based settings.

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- Supporting documents for enrollees residing in a community-based setting
- HCBS tool: Identifies any gaps in the enrollee's current services, as well as gaps that may exist in his or her health conditions or living environment.
- Incontinence Supply Utilization questionnaire
- Participant directed options
- Contingency back-up plan
- Home-like environment checklist

The review of enrollee data acquired provides us with a 360-degree view of the enrollee's needs. Additionally, it enables us to determine the person and/or caregiver's knowledge and understanding of the condition/s, historical treatment adherence pattern and self-management support needs. By compiling and analyzing these data sets, we can formulate an individual plan of plan.

### **PERSON-CENTERED APPROACH TO CARE PLANNING**

**CRITERION 3:** The extent to which the flowchart incorporates specific data components it will use to ensure a person-centered approach is achieved in the care planning process, including documenting personal goals

The individual plan of care is a dynamic, living document driven by each enrollee and his or her care team. As we conduct the 701B Comprehensive Assessment, we begin to develop enrollee-identified and prioritized goals, activities, cultural preferences, and information to foster the enrollee's ability to make informed decisions and navigate the delivery system. We work with the enrollee to identify his or her strengths that foster resiliency. Additionally, our process assists enrollees with identifying, reducing, and removing those barriers that may inhibit their ability to reach their goals.

Aetna's care planning flowchart outlines the goals and objectives of our face-to-face visits . Additionally, the flows describe our expectations for the active involvement of the enrollee and the person's support system in care planning decision-making. Our engagement with the enrollee and his or her support system facilitates the identification of needs and care plan documentation of the following:

- Enrollee problems such as general health, communication and or behavioral health needs
- Barriers to success such poor medication adherence
- Enrollee short- and long-term goals such as being able to attend church services weekly or returning to their home after nursing home rehabilitation
- Informal supports such as family, church members and friends
- All current services and funding sources, Medicaid and non-Medicaid
- Interventions and actions such as referrals for disease management, authorizing new services or hospice and coordinating care between providers

Once the care manager develops the individual plan of care, we review both required and supplemental forms with the enrollee and his or her identified support system. Once we explain the purpose of these documents, we obtain the enrollee or representative's signature as appropriate. Forms include the following:

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Freedom of Choice certification
- Signed plan of care
- Signed plan of care summary
- Authorization to release information

Our care managers also complete AHCA Certification of Enrollment Status (2515) and Client Discharge/Change Notice (2506A) forms. These are used to notify the Florida Department of Children and Families upon initial enrollment and upon a change of address/placement.

Once the individual plan of care is complete and accepted by the enrollee or his or her representative, Aetna authorizes medically necessary services. When the enrollee resides in a facility, we authorize their room and board and hospice services for end-of-life planning. Coordination of services based on needs identified through use of the HCBS tool and authorization of services requiring prior-authorization are performed for enrollees residing in a community-based setting.

Following the creation of the initial individual plan of care, our enrollees and their caregivers remain actively involved in all decisions about enrollee care and enrollee care plan revisions. We use face-to-face and telephonic meetings with enrollees and their caregivers to review the progress toward existing goals, establish new goals, review care decisions, answer questions, and educate the enrollee about their care.

We document each aspect of the individual plan of care in our electronic care management information system and use the system to record the progress the enrollee is making toward stated goals.

We share the care plan with the enrollee's interdisciplinary team through our proprietary CareUnify application. We review the plan quarterly and revise the plan at that time if the enrollee's health, services, self-management, environment, or placement has changed. We also make changes to the plan whenever requested by the enrollee or his or her representative.

### **AVAILABILITY OF FORMAL AND INFORMAL SUPPORTS**

**CRITERION 4:** The extent to which the respondent uses the caregiver assessment to determine the availability of family/informal support systems, and the amount of assistance the existing support systems are able to provide the enrollee, in making authorization decisions

Aetna's care planning flowchart is designed to enhance individualized care planning by including the Caregiver Supplemental Assessment in the list of supporting documents. This tool specifically addresses the availability of the family and informal supports to assist the enrollee in making authorization decisions. Additionally, the tool captures the following information:

- The amount of time the enrollee can be left alone
- The names and relationship of informal supports to the enrollee
- The ability of informal supports in the enrollee's day-to-day life
- The ability of informal supports to assist with the enrollee's needs, including the following:
  - The role of informal supports in the enrollee's day to day life

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Each informal supports day-to-day responsibilities, including an evaluation of each support member's work, school, and other schedule and responsibilities in addition to caring for the enrollee
- Each informal support's stress and well-being
- Any medical limitation or disability the informal support may have that would limit their ability to participate in enrollee care
- The willingness of the informal supports to participate in enrollee care

### **Completion of the Initial Care Plan**

Following collection of all of the data elements, the care manager develops a single, comprehensive, person-centered plan of care. This plan is specific to the enrollee's goals and needs that have been identified using the 701B Comprehensive Assessment, the Caregiver Supplemental Assessment, and any other supporting documentation. The enrollee or his or her authorized representative is consulted in the formal development of the plan of care.

The plan of care template includes the following minimum elements:

- Enrollee's name and Medicaid ID number and SSN
- Plan of care effective date (the first date a recipient is enrolled with Aetna)
- Plan of care review date (at a minimum, every ninety (90) days)
- Services needed, including routine medical and waiver services
- Each service authorization begin and end date
- All the services and supports to be provided regardless of the funding source
- All service providers
- The enrollee's assisted living service components provided by the ALF as well as the amount and frequency of those services if the enrollee resides in an ALF
- The number of units of each service to be provided
- The date on which Aetna will submit the completed Agency-required reassessment tool and required medical documentation to CARES
- Documentation that the process for enrollee grievance and appeals was clearly explained
- Care manager's signature
- Enrollee or authorized representative's signature and date

The plan of care, which is reviewed in face-to-face meeting with the enrollee and his or her guardian at a minimum every three months also includes:

- Enrollee goals and objectives, which are:
  - Enrollee-specific
  - Measurable
  - Include a timeframe for the attainment of the goals and objectives
- Service schedules
- Medication management strategies
- Potential and/or previously documented barriers to progress
- Detail of interventions to be used to meet the enrollee's goals and objectives

The care manager identifies the enrollee's primary care provider and specialty providers, obtains the signed Authorization to Release Information form, and coordinates care as

**EXHIBIT A-4-c**  
**LTC SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

appropriate. This includes forwarding copies of the plan of care within 10 business days of its development.

[REDACTED]

[REDACTED]

[REDACTED]

**Evaluation Criteria:**

1. The extent to which the flowchart outlines specific data components it will use from the State of Florida approved assessment in the development of the plan of care for enrollees.
2. The extent to which the flowchart outlines specific data components it will use from the respondent's supplemental assessment, and/or any additional informational sources, in the development of the plan of care for enrollees.
3. The extent to which the flowchart incorporates specific data components it will use to ensure a person-centered approach is achieved in the care planning process, including documenting personal goals.
4. The extent to which the respondent uses the caregiver assessment to determine the availability of family/informal support systems, and the amount of assistance the existing support systems are able to provide the enrollee, in making authorization decisions.

**Score:** This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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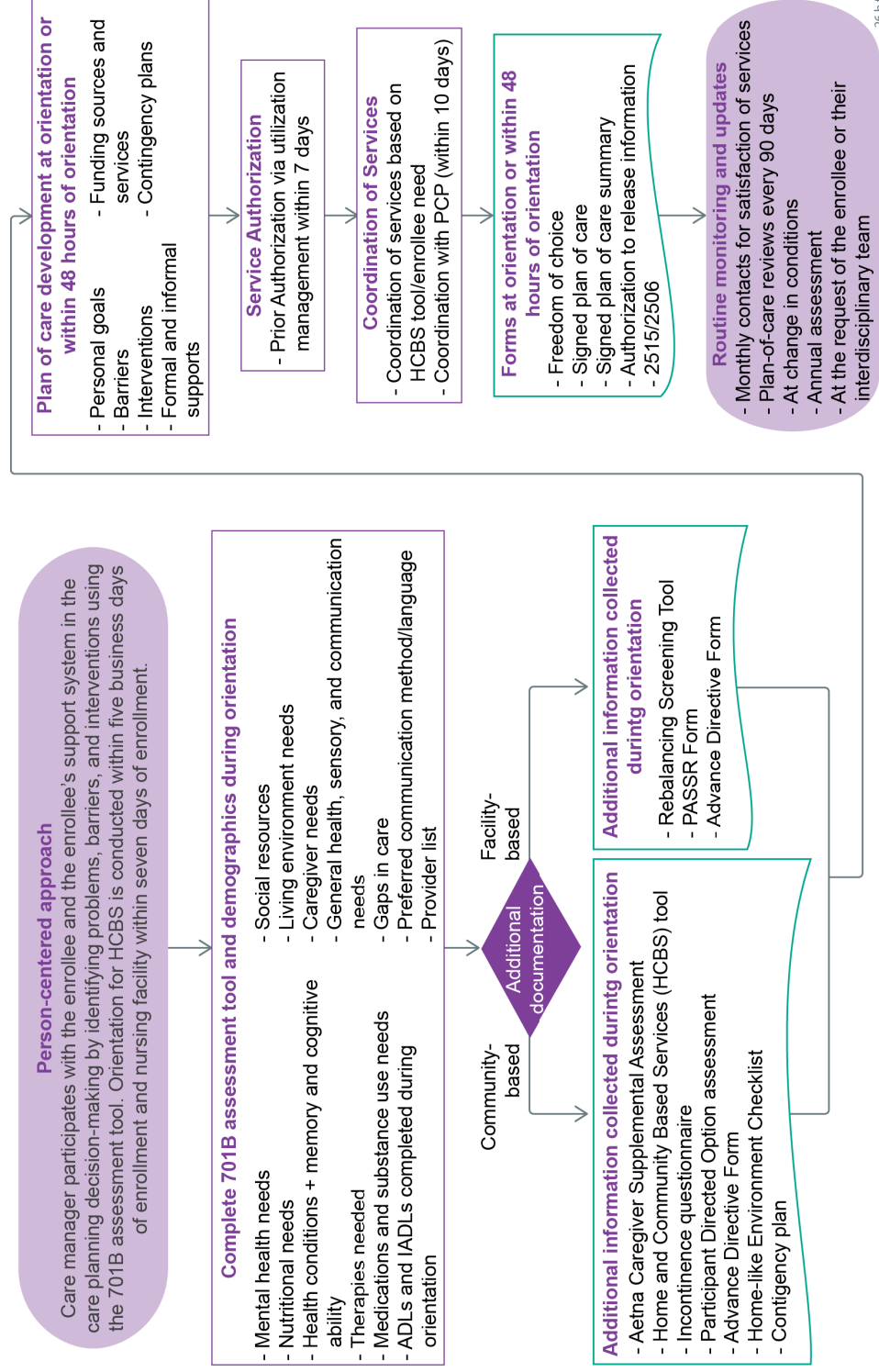
## **Attachment LTC SRC# 6**



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LTC SRC# 6: Figure LTC SRC 6-1: Care Planning Process



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Figure LTC SRC 6-1: Care Planning Process

Aetna's person-centered care planning process relies upon the Florida Department of Elder Affairs 701B Comprehensive Assessment and a range of supplemental assessments for enrollees living in facility- and community-based settings.

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**EXHIBIT A-4-c**  
**LTC SUBMISSION REQUIREMENTS**  
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**LTC SRC# 7 – Freedom of Choice & Residential Settings (Statewide):**

The respondent shall describe how it will address the enrollee's preference in residential settings (i.e., home, adult family care home, assisted living, or nursing facility). The respondent shall describe the safeguards it will have in place during the implementation of the re-procurement of the SMMC program to ensure enrollees do not have to move out of their current residence, by residential setting.

**Response:**

In our view, enrollees are the sole authority and principal voice on their preferences and goals for the best way to live their lives—our role is to serve as advocates to help ensure their voices are heard. Aetna's commitment to freedom of choice supports the States goal of transitioning long-term services and supports systems by increasing the percentage of enrollees receiving services in the community as opposed to an institution.

Utilizing the Florida Department of Elder Affairs 701B Comprehensive Assessment, we begin to develop enrollee-identified and prioritized goals, activities, cultural preferences, and information to foster the enrollee's ability to make informed decisions and navigate the delivery system. We work with the enrollee to identify his or her strengths that foster resiliency. Additionally, our process assists enrollees with identifying, reducing, and removing those barriers that may inhibit their ability to reach their goals.

Our outreach and engagement processes support shared decision-making that involves the enrollee, his or her caregiver, primary care provider (PCP), circle of support, and other stakeholders. Our goal is to educate and advocate for enrollees in a manner that enables them to choose the safest, least restrictive, and most appropriate residential setting. Our written policies and procedures, care manager training, electronic care management system, auto-routing tools, use of flow charts, and supervision processes facilitate consistency in our processes and ensure enrollees in need of long-term care services receive care in the most integrated and least restrictive setting possible. This includes promoting safe nursing facility transitions and providing services to enrollees in a community setting whenever possible.

Aetna's integrated care management model focuses on the needs and preferences of each enrollee and his or her support system (i.e., family, caregivers, health care providers, and community resources). An essential part of our integrated care management program, we include a face-to-face assessment by our care managers with our enrollees in the community. We visit enrollees in their home environments, in the institutional setting (hospital or rehabilitation), or accompany them to provider appointments. The goal is to increase enrollee engagement and improve outcomes by thoroughly evaluating the barriers that are preventing the enrollee from making progress; increasing access to and appropriate utilization of preventive and primary health care services; reducing the incidence of avoidable emergency room visits and hospital inpatient admissions; increasing enrollee engagement in care planning; and increasing the ability to locate hard to reach enrollees and establish rapport.

All enrollees who agree to intensive care management are offered quarterly face-to-face visits using motivational interviewing techniques. During our visits, we monitor changes in resources and home environment, reevaluate the care management level (i.e., Should this enrollee be stratified as intensive or supportive?), make referrals to appropriate community resources,

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monitor access to care, complete and document screeners or assessments as applicable, provide educational materials, review the care plan and revise as necessary, and conduct an interdisciplinary care team meeting. We also review any issues or concerns about safe living arrangements with the enrollee's PCP to determine what additional steps or services are needed to assist the enrollee.

Our processes reinforce Aetna's commitment to providing culturally competent services to all enrollees. Ensuring enrollees' freedom of choice in residential settings increases the likelihood that they receive their services from someone who shares their cultural values and speaks their preferred language. Our approach contributes to transitioning long-term services and supports systems by increasing the percentage of enrollees receiving services in the community instead of an institution.

### **ADDRESSING ENROLLEE PREFERENCE IN RESIDENTIAL SETTINGS**

**CRITERION 3:** The extent to which the respondent's description addresses how all residential settings are considered for enrollee placement

Each enrollee is assigned a care manager who conducts an initial face-to-face assessment within five to seven days of enrollment using the Affairs 701B Comprehensive Assessment and the Comprehensive Assessment and Review for Long Term Care Services (CARES). The enrollee's input is critical to every step of developing the individual plan of care, which is discussed during this initial assessment. The elements of this plan are not finalized without the agreement of the enrollee and, when appropriate, his or her circle of support. The enrollee or authorized representative completes and signs the freedom of choice (FOC) Certification within seven days of its effective date, receives an initial orientation, and is presented with the enrollee handbook. On a monthly basis, Aetna runs a freedom of choice report to ensure all enrollees have a signed FOC form. Whenever deficiencies are found on the report, we conduct a root cause analysis to identify and resolve the issue immediately. In these situations, care managers are retrained on the importance of having the form reviewed with the enrollee, signatures, and uploading to the system timely.

Care managers use an integrated care planning interview tool designed to guide them through the process of creating a realistic individual plan of care. We work with enrollees to define and prioritize both short- and long-term goals, translate those goals into measurable and achievable steps, and implement the individual plan of care in phases according to their activation level. Aetna does not duplicate or interfere with any existing clinical relationships; instead, we collaborate closely to promote opportunities for community-based living.

During the initial assessment, we gather information and documentation from the enrollee, including his or her support system, living situation, and short- and long-term goals. We discuss with the enrollee his or her preferences, such as his or her:

- Preferences as they relate to his or her living situation
- Knowledge regarding his or her preferences about all possible options, including:
  - The enrollee's own home or another home based setting (friend/family)
  - Adult family care home (AFCH): Family-type living arrangement in a private home for up to five aged or disabled people, not related to the owner. AFCH is licensed to provide housing, meals, and personal care services. Residents

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must be able to perform the activities of daily living (with supervision or assistance) like eating, walking, and toileting.

- Assisted living facility (ALF): A licensed facility that provides housing, meals, personal care services, and supportive services to older and disabled adults who are unable to live independently; ALFs are intended to be an alternative to more restrictive, institutional settings for individuals who need housing and supportive services, but who are not bedridden and do not need 24-hour nursing supervision. ALFs provide supervision, assistance with personal and supportive services, and assistance with or administration of medications to elders and disabled adults who require such services. In addition to a standard ALF license, there are three specialty ALF licenses: Extended congregate care, limited nursing services, and limited mental health.
- Nursing facility: Nursing homes, sometimes called skilled nursing facilities, serve both long-term residents and people who come for a short period for rehabilitative care (usually after a hospital stay). Some nursing homes also provide respite care, which is when a person comes for a short stay, to give relief to a primary caregiver. A nursing facility provides 24-hour nursing and personal care to resident meals and special diets, Physical, occupational, speech, and respiratory therapy, and social activities.
- Knowledge regarding the steps he or she believes may be necessary to attain preferences or other options
- Current capabilities in relationship to his or her preference or other options
- Daily needs and how we can assist the enrollee with attaining his or her living preference

Enrollees review their freedom of choice form with their care manager again anytime there is a change of placement, and they are asked to sign the updated version. Additionally, enrollee's residing in the a community-based setting review, update, and sign the form at their annual review and those residing in a nursing facility do so every six months.

[REDACTED]

[REDACTED]

[REDACTED]

Care Manager Training

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

CRITERION 2: The extent to which the respondent describes initial or ongoing case manager training to confirm enrollee preference in residential setting

Aetna's care managers initially participate in the 701B/T Certification training that is conducted virtually by the Florida DOEA. Our care managers also participate in updates to that training if provided by the DOEA. In addition, Aetna employs a comprehensive training program for our care managers. All care managers complete a full complement of face-to-face and technology-based trainings upon hire and annually thereafter. Each training module contributes to the care manager's ability to conduct comprehensive long-term care assessment, develop a person-centered plan of care, and incorporate enrollee choice and voice during the process of determining residential placements. Examples of training topics follow:

- CMS Final Rule Home and Community Based Services (HCBS): CMS 2249F and CMS 2296-F
- Transition training
- Motivational interviewing skills
- Cultural competency
- Alzheimer's disease and related disorders
- Continuity of care requirements
- Institutional- and community-based settings to include how to provide enrollees with a comprehensive review of residential settings
- Enrollee's rights and responsibilities
- Enrollee safety and infection control
- Freedom of choice certification processes to include initial and follow-up timelines
- Reviewing how to use the Enrollee Handbook and Provider Directory initially and annually with the enrollee, caretakers and other stakeholders and the Provider Directory with enrollee initially and new handbooks and directories annually
- Conducting a successful initial assessment using the Florida DOEA 701B/T and CARES tools
- Mitigating risks identified during the assessment process to promote the opportunity for enrollees to reside safely in their choice setting
- Documentation standards and training to ensure enrollee files are complete, current, and accurate
- Participant direction of services
- Care manager role and responsibilities
- Care management procedures
- Role of care manager during transitions to new settings or to a different plan
- Provider network and access to care standards
- General medical information
- Local resources
- Abuse, neglect and exploitation
- Behavioral health services and treatments
- Critical incident reporting
- Suspected fraud, waste and abuse identification and reporting
- Potential quality of care reporting
- Palliative care
- Ethics and compliance
- Assessment/observational skills
- Domestic violence

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- CPR

All trainings include a knowledge test, and only passing scores count towards completion of care manager training requirements. Care management supervisors monitor and audit freedom of choice forms to determine that all of the available placement options are reviewed with the enrollee and note when the form is to be updated to reflect current placement. Supervisors also conduct random chart audits to monitor and identify any new or ongoing training needs, which is in line with AHCA contract compliance requirement.

### **EDUCATING ENROLLEES ABOUT THEIR FREEDOM OF CHOICE**

**CRITERION 1:** The extent to which the respondent's description addresses the process it will use to ensure enrollees are educated about their choice in residential setting, including freedom of choice

With the goal of respecting enrollee's freedom of choice in residential settings, during the initial comprehensive assessment the care manager uses motivational interviewing skills and culturally responsive person-centered approaches to educate the enrollee on the full range of options of where they may choose to live. To ensure that the enrollee understands the setting choices, the care managers describe each setting in detail. Examples include the enrollee's home, adult family care home, assisted living facilities, and nursing facilities. They also discuss the enrollee's accessibility, care and safety needs, support system availability, and the wraparound community-based services available for each setting. After offering the descriptions of the settings and talking about the enrollee's needs related to settings, the care manager asks the enrollee and/or stakeholders to repeat what they have heard and to describe their view of the pros and cons of each. This step helps us to ensure enrollee understanding of the options and enables informed decision-making.

Aetna's care managers adhere to AHCA's August 2014 training on home- and community-based settings and transition planning and in accordance comply with 42 CFR 441.31099(c)(4). We review and teach enrollees how to use our enrollee handbook, which describes nursing homes and community-based settings and services and provider directory. In addition, we provide to enrollees the Aetna Better Health of Florida Managed Long-Term Care brochure, which details covered services, describes the coverage area, and explains eligibility criteria. In addition to being able to call the care manager with any subsequent questions, these resources provided in simple, easy to use format supports the enrollee ability to refresh their understanding of settings and services at their convenience.

We work collaboratively with the enrollee to complete the AHCA freedom of choice certification form designating the setting most appropriate to meet their needs. As noted earlier in this section, our processes facilitate enrollee or their authorized representative signatures on the form within seven days of its effective date. The freedom of choice certification, once signed, becomes a part of the enrollee's record. If the enrollee's living situation changes, the care manager will review the freedom of choice options with the enrollee representative and have him or her sign a new form and place in the enrollee record.

Safeguarding Enrollee Residence

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Protecting our enrollees from unnecessary disruption to their environments and living situations is of paramount importance. We monitor each step of the single case agreement and contracting process to ensure they go smoothly. Our care manager associates and care managers keep the enrollee and provider informed of the status of contracting, for example in the case of a re-procurement of the SMMC program. Aetna's processes are designed to maintain enrollees in their current residence, unless the enrollee chooses to move.

In instances where the plan receives a new enrollee who resides in a non-participating assisted living facility, the following process, including safeguards, is followed.

### **Safeguards through SCA and Contracting Processes**

Single case agreements (SCAs) are designed to facilitate stability in enrollee living environments when the person is residing in a setting not contracted with Aetna. They are detailed as follows:

- Initial outreach is completed by a care manager associate, who confirms the enrollee's placement, and the address, phone number, and contact information for the ALF.
- The care manager associate contacts the assisted living facility administrator to notify the ALF of the need of an SCA until a contract is fully executed. At this time, the tax ID, Medicaid provider number, NPI number, and a valid license number are obtained.
- The SCA is not initiated without a Medicaid provider number or a pending Medicaid provider number; if the provider does not have a valid Medicaid number, we contact our provider services team. A representative will meet with the facility to describe the process of Medicaid enrollment.
- The enrollee continues to reside in an assisted living facility under single case agreement (SCA) until the contract is executed.
- The SCA form request is submitted by the care manager associate to the provider services team assigned to developing SCAs.
- Upon receipt of the SCA, the assigned provider services team enrollee creates a provider record.
- Upon notification that the provider record is complete, the care manager associate updates the authorization with the name of the assisted living facility and resubmits it to the electronic care management system. The service authorization letter is faxed to the provider.
- The enrollee and his or her representative and assisted living facility are notified of the execution of the SCA.
- Currently, a request is sent to the provider services team to make the facility assignment in our electronic care management system and our electronic claims management systems (for capitation payments).
- In the case that the facility does not initially agree to sign the SCA, subsequent outreach attempts are made. We will not move the enrollee until after the 60-day continuity of care requirement is met. In this situation, we provide extensive education to the enrollee, obtaining the freedom of choice certification.

### **ENSURING ENROLLEE SAFETY**

## **EXHIBIT A-4-c**

### **LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

**CRITERION 4:** The extent to which the respondent's description includes safeguards the respondent has in place to ensure enrollees will not have to move out of their current residence, by residential setting

Aetna's care managers are dedicated to the safety and well-being of our enrollees. Through their training on continuity of care requirements, they ensure the stability of enrollees in their current setting if that is the preference of the person. At times, the care manager may have concerns over enrollee safety in his or her current residence. If the care manager identifies enrollee safety hazards, evidence of maltreatment, or other risks during the assessment process, the care manager will notify his/her supervisor and based on the acuity of issues a variety of actions may occur. Examples include notifying Adult Protective Services if the enrollee refuses to move and/or contacting AHCA to discuss expediting the transition of the enrollee to a setting of choice.

Aetna also requires our staff and any contracted providers of LTC services to report, respond to, and document all suspected incidents of abuse, neglect, and exploitation. As part of our standard policy, we are obligated to report any suspected occurrences of abuse, neglect, or exploitation of children or incapacitated or vulnerable adults to the appropriate authorities as required by State law. The reporting employee is also responsible for documenting the incident. To protect confidentiality, documentation is made using a secure application. The employee also documents and reports the incident to Aetna's Quality Management and Compliance departments verbally within 24 hours with a follow up written report within 48 hours. Aetna's Quality Management conducts an investigation on all reported events and tracks all these disclosures.

Enrollee safety also applies to assisting the community in times of emergency of disaster such as preparing for hurricane season. We delivered emergency meal packages (14 shelf stable meals) to over 1,400 home enrollees as an expanded benefit that Aetna Better Health of Florida LTC provided to our enrollees. Just prior to the hurricane, we reached out to all enrollees to ensure they were following their emergency plan or had alternate evacuation plans. We began with all special needs enrollees then expanded our efforts to home and facility enrollees. After the hurricane, we connected with every single enrollee to see whether they needed any assistance. By compiling a pre- and post-contact script, we documented the same things in our system and reported this information to the Agency on a daily basis. When we could not reach enrollees after the hurricane by telephone, we visited the enrollees to ensure they were safe and had supplies, water, etc. If they could not return home, we assisted with finding alternate temporary housing.

#### **Evaluation Criteria:**

1. The extent to which the respondent's description addresses the process it will use to ensure enrollees are educated about their choice in residential setting, including freedom of choice.
2. The extent to which the respondent describes initial or ongoing case manager training to confirm enrollee preference in residential setting.
3. The extent to which the respondent's description addresses how all residential settings are considered for enrollee placement.

**EXHIBIT A-4-c  
LTC SUBMISSION REQUIREMENTS  
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4. The extent to which the respondent's description includes safeguards the respondent has in place to ensure enrollees will not have to move out of their current residence, by residential setting.

**Score:** This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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**EXHIBIT A-4-c**  
**LTC SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**D. PROVIDER EXPERIENCE**

**LTC SRC# 8 Home and Community-Based Services (HCBS) Performance and Credentialing (Statewide):**

The respondent shall describe how its staff will create, collect, report and use internal provider performance measures and/or criteria for home and community-based, residential, and participant direction provider types. The respondent shall include how the performance measures will improve network quality and be utilized in recredentialing activities, and if/how the respondent will use the internally-developed performance measures to limit its provider networks pursuant to Section 409.982(1)(c), Florida Statutes.

**Response:**

The ability to live independently—with dignity—in the setting of his or her choice is the right of every enrollee. Aetna assumes a special obligation to help ensure enrollees with long-term care needs receive the supports and services they need to meet their preferences and goals. As part of our comprehensive long-term care plan, Aetna manages home- and community-based services, providing value for our enrollees and their families, as well as the Agency, in seeking solutions for expanding access, managing spending, and complying with federal regulatory requirements. For Aetna to continue delivering integrated care with positive outcomes, we create, collect, and report comprehensive quality performance measures we can use internally that objectively reflect our network quality and the needs and status of our provider types. We also communicate performance measure outcomes to contracted HCBS providers of various types and utilize information collected to inform the recredentialing process and develop corrective action plans, training, and support models.

Whether Aetna is assessing our home- and community-based providers, our residential providers, or the direct support workers in our participant-directed option (PDO), creating internal performance measures regarding our providers that supply us with reliable information. It provides us with a foundation for improving network quality while limiting our provider network, as appropriate. Ultimately, we connect provider goals, outcomes, and incentives by using our data and performance measures to improve the services we provide to our enrollees. Aetna monitors the quality and performance of each participating provider, including the use of performance measures adopted by and collected by the Agency, as well as additional measures agreed upon by the provider and Aetna (in conformance with s. 409.982(3), F.S.).

**CREATING, COLLECTING, AND REPORTING PROVIDER PERFORMANCE MEASURES**

**CRITERION 1:** The extent to which the respondent's description includes a plan to create, collect, report and use provider performance measures

Aetna plans, implements, and administers continuous quality assurance and performance improvement (QAPI) in our long-term care (LTC) programs. Creation of relevant performance measures for various LTC provider types and consistent collection and reporting of data is a key component of Aetna's approach to quality assurance and performance improvement. The measurable increases on key performance indicators and enrollee and provider satisfaction achieved by our QAPI program illustrate the effectiveness of our processes and positions Aetna

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

fully supports Florida's LTC program and its goal of achieving optimal quality outcomes while containing costs.

### **Performance Measures to be Collected by Provider Type**

There is little agreement between the federal government and state Medicaid agencies with regard to which performance measures are most appropriate for monitoring provider networks delivering services to our LTC enrollees, such as home- and community-based services (HCBS), residential, and PDO services. For many years, Aetna and its staff have participated, both nationally (e.g., National MLTSS Health Plan Association) and at the State level, in providing input on the planning process to help shape the development of HCBS provider performance measures. We are involved in national and local initiatives to spur the development of LTC performance measures for home and community-based services that will become the national, State, and corporate benchmarks for managed LTC programs. By participating in the planning for provider performance measures, Aetna helps to create a balance of the need for required metrics to manage LTC. While it is necessary to provide the information required by the State, it is also necessary to collect data for internal purposes to improve network quality for our HCBS, residential and PDO providers.

Aetna collects and reports the following home- and community-based services performance measures, certified by a qualified auditor, as outlined in Attachment II, Exhibit 8 of the AHCA LTC Model Contract:

#### **HEDIS:**

- Care for Older Adults (COA): Add age bands:
  - 18 to 60 years as of December 31st of the measurement year
  - 61 to 65 years as of December 31st of the measurement year
  - 66 years and older as of December 31st of the measurement year
- Call Answer Timeliness (CAT)

#### **Agency-Defined:**

- Call Abandonment (CAB) – Using the last issued specifications from the National Committee for Quality Assurance (NCQA).
- Required Record Documentation (RRD)
- Face-to-Face Encounters (F2F)
- Case Manager Training (CMT)
- Timeliness of Services (TOS)

#### **Survey-Based Measures:**

- Satisfaction with Long-Term Care Plan: CAHPS Supplemental Question and Enrollee Satisfaction Survey Item 11
- Satisfaction with Care Manager: CAHPS Supplemental Question and Enrollee Satisfaction Survey Item 5
- Rating of Quality of Services: CAHPS Supplemental Question and Enrollee Satisfaction Survey: Item 8

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Based on discussions between the health plan and our providers, Aetna's also utilized the following performance measures to provide additional pertinent information for across provider types:

- Timeliness in initiating services
- Proportion of authorized services to delivered services
- Emergency department visits/1000 (HCBS and residential providers only)
- Hospital admissions/readmissions (HCBS and residential providers only)
- Enrollee experience and satisfaction surveys:
  - Enrollee perception of quality of care
  - Access to care management services
- Potential Quality-of-Care issues:
  - Injuries or secondary health conditions typically experienced by LTSS recipients, such as falls, burns, skin ulcers, or involuntary weight loss
  - Client report of abuse and neglect
  - Mortality
  - Criminal victimization
  - Sense of safety, security, and order

In addition to the performance measures previously described, Aetna is also developing our capacity to collect data, following recommendations of national LTC and HCBS advocacy organizations, for participant direction providers and family and caregivers:

Participant-direction provider measures:

- Wages, benefits, work hours and conditions, turnover
- Training and/or certification
- Injuries
- Job satisfaction
- Local availability of workers to meet consumer demand

Family- and family caregiver-focused measures:

- Adequacy of caregiving support services
- Caregiving-related emotional stresses
- Caregiver physical injuries
- Caregiving-related financial stresses
- Interface of family caregiving and paid help

While Aetna's performance measure data collection and reporting processes address the standard metrics described above, we understand that many important LTC quality concerns are related to enrollee functioning and we are currently engaged in efforts to develop further our ability to measure, report, and use performance measures such as:

- Changes in daily activity function
- Availability of support with everyday activities when needed
- Presence of friendships
- Maintenance of family relationships
- Community integration

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- Receipt of recommended preventive healthcare services
- Respectful treatment by direct service providers
- Opportunities to make choices about services

### **Collection of Performance Measure Data**

Aetna utilizes a multi-pronged approach to collect performance measures including:

- Administrative data includes claims that providers bill for health care services. Aetna has a robust infrastructure through its electronic claims management system to collect and share this data.
- Medical records provide information regarding medical histories and current medical conditions. These records, maintained in our electronic medical record, are utilized to monitor services provided to ensure compliance with the enrollee's plan of care and to identify potential quality of care issues.
- Care management and utilization management records are data sources utilized to collect information regarding timeliness standards, services authorized including start and stop dates and a detailed description of the services that should be delivered.
- Qualitative data, such as data from enrollee surveys, enrollee advisory groups, and interviews, provide the level of detail needed for reporting enrollee experience measures.
- Quality audits, including peer reviews and service-specific on-site audits.

### **REPORTING PERFORMANCE MEASURE DATA**

**CRITERION 2:** The extent to which the respondent describes how performance measures are reported and trended for each participating provider type and incorporates utilization data, quality of care concerns, performance measure scoring, and provider and enrollee satisfaction in recredentialing activities.

Aetna understands the importance of performance measurement and analysis capabilities across the full continuum of care (primary, acute, behavioral care). Data integration assures that performance measures for the LTC population in managed care programs are tracked, organized efficiently, and trended to allow for meaningful analysis. Aetna looks forward to working closely with the Agency to leverage its system capabilities for reporting and analytics. Aetna uses the latest business intelligence (BI) solutions like Tableau, SQL Server Reporting Services, SAS, and Business Objects to develop necessary performance measure reports.

Aetna's data warehouse and BI solutions allow for storing and reporting of business and technical data in the form of traditional reports, dashboards, ad hoc queries, alerts, and other forms of data analytics for benchmarking trends and performing various types of analysis. Aetna has streamlined our HCBS reporting processes to decrease administrative complexity for the Agency and provide uniform information for enrollees and other stakeholders to compare. We emphasize reporting based on the use of standardized, population-based, valid, and reliable assessment tools. Aetna's customized, regular automated and report development capabilities allow us to monitor trends and patterns, analyze results, and drive decisions. Our subcontractors must adhere to our requirements for monitoring and transparent reporting of results.

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By July 1 of each contract year, Aetna will deliver to the Agency a report on performance measure data and a certification by an NCQA-certified HEDIS auditor that the performance measure data reported for the previous calendar year are fairly and accurately presented. Aetna will contract with a qualified, Agency-approved vendor to conduct an annual CAHPS survey, to include relevant LTC performance measures for various provider types.

Electronic Visit Verification

[REDACTED]  
a comprehensive platform designed to reduce paperwork and increase efficiencies, while providing compliance to ensure contracted services are documented and verified.

EVV helps us to monitor service use and real-time receipt of authorized services. This enables us to monitor and trend timeliness in initiating services and the proportion of authorized services to delivered services.

Event Notification Service

The Event Notification Service (ENS) provides real-time notice of patient encounters from over 200 participating hospitals to subscribing organizations like Aetna. This includes emergency department visits, inpatient admissions, and observation stays in the hospital setting. This service enables us to monitor and trend emergency department utilization and inpatient admissions/ readmissions for our LTC enrollees. Additionally, as we receive the notifications in real time, multiple times per day, indicating when our enrollees are admitted to a hospital or emergency department, we can work directly with the providers to enhance performance by understanding the root causes of avoidable utilization. We share utilization information with providers, who contact the enrollees and schedule follow-up appointments, enhancing care coordination efforts and improving the provider/enrollee relationship. We are also in the process of developing automated email notification for providers and ENS data integration with CareUnify.

CareUnify

Aetna's population health platform collects, aggregates, and presents data from multiple sources, including all physical and behavioral health claims data as well as key social determinants of health to create an individualized and comprehensive profile and care record tailored to each enrollee. Our platform also captures data from multiple sources (e.g., electronic health records, registries, and other data repositories) tied back to a single care record. The system is used by our care managers or our provider partners to manage each enrollee's needs at point of care or for global population health management, ensuring LTC enrollees with complex conditions, for example, receive specific care and services specific to their complex needs.

By capturing and sharing LTC enrollees' individualized plans of care through our fully integrated technology platform, information can be trended and analyzed to look at individual provider performance as well as group practices.

By the end of 2017, we will begin to offer selected LTC providers an external provider tool through our integrated CareUnify platform. CareUnify tracks all provider clinical interactions,

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including ADT (admissions, discharges, and transfers), clinical data, provider interactions, and referrals for our enrollees. Our goal is to use our population health management platform, CareUnify, to send notifications from our system to providers to manage real time performance. Mobile Technologies: Aetna is looking at several new and innovative ways to leverage mobile technologies to drive seamless care coordination regardless of the specific electronic health record systems various members of the integrated care team may be using. One innovation being designed is a short, simple enrollee satisfaction survey aimed at allowing the enrollee to use the mobile application to give real-time feedback on the providers with whom they interact. Such surveys would be extremely useful when looking at quality measures for participant driven outcomes, as well as HCBS and residential providers.

### **Performance Measure Information Collection and Recredentialing**

While Aetna has a policy regarding non-compliance with standards, which applies to tying quality metrics to recredentialing, the goal of our performance measurement program is to identify providers who are experiencing challenges and work with them to mitigate issues utilizing various tools that include additional training, ongoing and focused monitoring, corrective action or performance improvement plans. Failure to correct continued noncompliance and performance inadequacies could result in the inability to re-credential a provider and lead to termination. We are aware that enrollees often have close relationships with their providers in the LTC setting. Through value-based arrangements and/or steerage, we incent them to meet the performance measurements that result in high-quality enrollee care and services, while minimizing disruption in the enrollee/provider relationship. Aetna does track HCBS, residential, and participant-directed provider change requests and utilizes data collected to inform recredentialing decisions.

### **COMMUNICATION OF PERFORMANCE MEASURE OUTCOMES**

**CRITERION 3:** The extent to which the respondent's description includes a plan to communicate the performance measure results to providers, including any provider incentives or alternative payment methodology opportunities available.

Aetna has streamlined our approach to engaging, educating, and supporting providers throughout our 30 years of administering Medicaid plans. We use a deliberate and thoughtful approach to working with provider communities. This level of outreach uses a technological and hands-on, collaborative strategy structured to ensure that all types of providers fully understand their responsibilities in a managed care environment and their requirements under the contract. We seek to enhance communication and information exchange between varied entities such as physicians, HCBS provider staff, enrollees in residential placements, family members and caregivers of enrollees, pharmacies, and others.

At the beginning of the Contract period, Aetna notifies all its participating providers of the metrics used for evaluating the provider's performance and determining continued participation in the network (see s. 409.975(3), F.S.).

Aetna understands that many the LTC providers, especially those providing home and community-based services, operating smaller residential settings, or provider direct service via the PDO, may be non-licensed and have limited administrative capabilities (i.e., information system capabilities, billing capabilities, electronic communication capabilities, etc.). Taking that

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into consideration, performance measures are only useful if they are communicated to providers in an understandable and timely manner. Our communication with providers begins at the outset of engagement. Our provider network representatives assess those providers interested in becoming part of Aetna's network. Once a provider is added to our network, the orientation program includes a review of the following resources, all of which include detail on performance measures:

- Aetna's provider manual
- Policies and procedures (e.g., "Assessment of Network: Adequacy, Availability and Access to Care Monitoring Plan")
- Online provider portal

A focus of our provider orientation and continuous training is to ensure that our providers understand the goals of performance measurement and how it affects a provider's credentialing and his or her ability to participate in our network. We communicate that the health plan's goals include preventing the overuse, underuse, and misuse of health care services and ensuring patient safety; identifying what works and what doesn't – to drive improvement; holding providers accountable for providing high-quality care; measuring and addressing disparities in how care is delivered and in health outcomes; and helping our enrollees to make informed choices about their care.

Through provider orientation, and initial and ongoing training, providers are informed of performance measures that will be monitored based on their provider type. They are presented with information related to Aetna's LTC program goals and objectives and potential remediation activities should the measures be identified as outliers. Providers can attend orientation/training meetings by various means, including convenient, regionally located provider seminars, webinars, and one-on-one education in provider offices. Provider services liaisons follow up with all providers after orientation to address any questions and to ensure they know how to reach us for assistance.

While under contract with Aetna, providers receive regular newsletters that include recently produced data, and they are informed of provider services education seminars. These resources, in addition to the online provider portal, provide ease of access to providers and opportunities where they are able learn more about current measures on key performance indicators, Aetna's approach to potential changes to service delivery, new quality initiatives, or goals sets at a higher target if previous targets have been met. Aetna conducts informational meetings, webinars, or regional forums or symposia and invites providers of all types address areas where we see a need for improvement based on the meaningful performance measure data collected and analyzed.

In addition to information provided by Aetna described above, on an on-going basis Aetna LTC care manager conduct site visits of HCBS, residential and participant direct service providers. Part of our approach to conducting onsite visits is to share key metrics with the provider, such as claim and utilization data, and performance measures as part of our educational initiatives. Provider Incentive Initiative

Aetna has initiatives underway that incorporates provider incentives or alternative payment opportunities. We are also at the forefront of creating a value-based services system. We believe that payment for volume should be replaced with payment for performance. This

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includes the performance measures previously noted, along with other data required by federal and State regulations.



- LTC value-based purchasing: Aetna realizes that solutions have not yet been fully explored by the industry for HCBS, residential- and participant-direction providers. Only recently have there been national efforts to tie quality cost and outcomes to an incentive based program for the wide range of LTC providers. From our perspective, our goal is to stay informed on policy changes and align as much as possible to the State's goals. Overall, Aetna's VBS program will address the different types of providers with somewhat different solutions. This program would tie specific metrics, like those discussed previously, to reimbursement and quality incentives (e.g., emergency department visits/1,000, hospital readmission rates).

**Aetna's Success in Illinois**

Aetna and our LTC provider, Addus Homecare, have collaborated to implement a "Change in Condition" project for our shared population by utilizing evaluation of EVV and manual triggers from the homemaker to Aetna. This project allows Addus to communicate any non-medical changes and/or medical changes in an enrollee's condition to our LTC care managers to increase quality performance. This partnership aims to improve health outcomes by utilizing time sensitive communication focusing on early intervention and use of appropriate health services

The goals and objectives of this pilot project are as follows:

- Reduce avoidable ED utilization and in-patient hospital admissions by identifying escalating changes in condition and providing timely care coordination resulting in reduced medical cost.
- Increase compliance with HEDIS measures around 14-day Primary Physician appointments following ED visits
- Enhance enrollee utilization of primary care and preventative services
- Reduce acute inpatient readmissions within 30 days of a post-acute discharge

This project has also allowed us an additional opportunity to help increase quality care for those enrollees that have high utilization of services. Target enrollees are identified as enrollees having two or more ED visits or two or more hospitalizations within a month. Once these enrollees are identified by Addus they have their Quality Assurance Specialist (QAS) complete Wellness visits for them. We also take action and review the case for what may be needed from the plan to support these enrollees. Through this data collection and timely intervention the pilot group shows a reduction in ED and inpatient utilization/1000 and an increase in PCP visits after an ED visit compared to the control group. Reviewing data from pilots like these prove that LTC

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providers that participate in collaborative programs with Aetna's LTC care management team can create marked improvement in LTC quality metrics and health outcomes.

### **ESTABLISHING DATA-BASED TARGETS AND NOTIFICATION OF PERFORMANCE ISSUES**

**CRITERION 4:** The extent to which the respondent's description includes the establishment of data-based targets to determine the completion of provider corrective action plans and utilization of these targets pursuant to Section 409.982(1), Florida Statutes, including the ability for providers to be notified of performance issues prior to termination

There are initiatives underway to develop and apply uniform national quality measures for managed LTC and home and community-based services (HCBS) at the National Quality Forum (NQF), the NCQA, and CMS. Once the planning, creation, collection, and reporting begin, norms- or data-based targets will be implemented. Until that is completed, Aetna utilizes the data-based targets previously noted, such as:

- Timeliness in initiating services
- Proportion of authorized services to delivered services
- Emergency department visits/1000
- Hospital admissions/readmissions
- Enrollee complaints/grievances
- Enrollee experience and satisfaction surveys
- Potential Quality of Care issues
- Sanctions, final orders, unpaid fines, complaints as reflected on State FloridaHeathFinder.gov

Monitoring is performed as follows:

- Reviewing and evaluating contractual functions/services through regular reports
- Regularly confirming that contractual functions/services are carried out consistently and in compliance with Aetna's and applicable standards, and the mutually agreed upon arrangements
- Performing an annual file review audit, if applicable, to confirm compliance with Aetna and applicable standards.
- Monitoring ongoing corrective actions taken to address identified deficiencies to promote progress and take necessary action if improvements do not occur
- Reviewing the contracted organization's program that oversees the contractual function(s), and its quality program to verify it has appropriate quality improvement processes

Aetna supports efforts to transition enrollees from institutional settings to home and community environments with home and community-based services (HCBS), residential services and participant direction services to accommodate and support the enrollee's desire to live independently in the environment of his or her choosing. To advance this goal, Aetna has established relationships between our care managers and key stakeholders in the continuum of care, including enrollees and their integrated care team, skilled nursing facility specialists, rehabilitation facilities, and other nursing facilities. This facilitates the enrollee's transition to the community and enables the utilization of HCBS.

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Aetna adds the HCBS quality metrics to the assessment of network adequacy, availability, and access to care monitoring plan as separate reports. Once the committee reviews the reports, if any HCBS, residential, or participant-driven providers are found to be outside expected parameters, the committee may request a provider services education visit or formal corrective action plan. If improvement has not been obtained through the other means, the committee may trigger an off-cycle re-credentialing in which the quality measures are included as part of the re-credentialing review.

As part of the re-credentialing process, enrollee complaints, grievances, and appeals regarding providers are evaluated for each individual provider. During a provider's re-credentialing cycle, our grievance and appeals consultant provides information about the provider complaints, grievances, and appeals since the last credentialing event. In all instances, providers are notified of performance issues prior to any possible termination.

### **Utilization of Performance Measures to Improve the Provider Network Quality**

Aetna's Medicaid organization plans, implements, and administers continuous quality assurance and performance improvement (QAPI) in clinical and operational programs in the 14 states in which we currently manage health plans. The measurable increases in enrollee and provider satisfaction achieved by our QAPI program illustrate the effectiveness of our processes and positions Aetna to support fully Florida's LTC program and its goal of achieving optimal quality outcomes while containing costs. Our QAPI program is integral to maintaining compliance with accreditation standards of various external quality review organizations.

Our local Quality Management team leads quarterly QMOC meetings. During these meetings, representatives from all relevant functional areas, including: Service Improvement, Customer Service, Credentialing, Claims, Provider Network Management, Delegation, and Grievance and Appeal are present and participate. Data is reviewed and analyzed so that trends may be identified. QMOC monitors performance against established targets to determine whether the Model of Care is meeting established goals. QMOC assesses whether changes need to be made to our program delivery and if it is necessary to implement new quality initiatives to enhance performance and outcomes. When quality targets are met, goals are set to a higher target: this process supports continuous improvement of the Model of Care.

Aetna's Quality Management team engages in a constant cycles of measurement, followed by intervention, and intervention impact measurement. For example, for an initiative to improve adult access to daycare, we required more data and analysis; therefore, a longer study period was employed. Following the longer analysis period, we employed a brief period of intervention and then a follow-up study a few months later. We flex our review and analysis based on the needs of the issue. For that reason, there have been times we have addressed an issue that impacts quality within weeks. We benchmark and compare our outcomes to all types of plans including Aetna's LTC programs in other states, LTC programs in Florida, as well as other internal, national, and state benchmarks.

Aetna is therefore able to utilize LTC performance measures to accomplish the following:

- Ensure quality activities are designed to improve the quality of care and services provided to enrollees

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- Review, evaluate, and make recommendations on the results of enrollee/provider satisfaction survey results
- Advise or make recommendations to improve the LTC program
- Conduct peer review evaluations
- Make decisions regarding actions on the credentialing or re-credentialing information presented by the Committee for Service Improvement
- Review and evaluate data, surveys, and trends in enrollee and provider complaints, grievances, and appeals to identify opportunities for improvement in enrollee and provider satisfaction; formulate initiatives and recommendations to drive continuous improvement

### **Non-Compliance with Standards: A Case Study - Timeliness of Services**

Our goal is to work collaboratively with the provider to bring the practice into compliance. However, continued failures resulting in a pattern of non-compliance may result in a formal corrective action plan, and can lead to termination. When we are alerted to a problem or potential issue, we work collaboratively with the provider to assist in resolving the issue. We consider the provider's input on our findings and work to find a process to mitigate the issue. If non-compliant, we take the following steps:

- LTC care management calls the provider to confirm the issue of non-compliance and attempts to resolve the issue. If the provider cannot be reached, the call is then forwarded to the Quality Management/Utilization Management (QM/UM) departments to conduct outreach.
- QM/UM first evaluates the issue to see if it involves a quality of care issue. If so, we work collaboratively with the provider to resolve the issue and help to ensure the enrollee receives the appropriate care in the right setting to meet their needs.
- LTC care management staff educates the provider and staff on appointment standards and guidelines and collaborates with the provider to resolve the issue and develop processes and procedures to resolve or mitigate any potential future issues. Education can be performed during site visits, through conference calls, email, webinars, or letters.
- Following education initiatives, the group is re-evaluated the next month to determine if they are in compliance. If not, the provider is notified in writing that subsequent failures could lead to closing or freezing the provider's status pending compliance with this issue. Network management is informed to manage contracting efforts, if needed. We also evaluate if non-compliance could mean there is a need for more providers in that specific area to ensure access and availability standards are met for all providers in the area.
- As a last resort, we retain the right to terminate a participating agreement to remove any provider from the network for failure to provide timely services. We also allow the provider to appeal this decision if they can demonstrate they have sufficiently mitigated the issue and show they can be effective partners in the network. In Florida, we have never had to terminate a provider due to failure to provide timeliness of services.

If we determine there are any existing or potential accessibility issues, we perform outreach to locate additional providers within the geographic area to close any gaps in network access and if necessary, issue single-case agreements to ensure enrollees have access to needed services. To mitigate any potential accessibility issues, we continually assess all providers in our service area that are not currently in our network. If we identify providers who would add value or accessibility to our network, we perform outreach to educate them on Aetna, our services,

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and the value of serving our Medicaid enrollees and begin efforts to contract them for our network. Aetna's team performs both telephonic and one-on-one site visits to introduce these providers to our network and assist them in the contracting process. We provide orientation, education, and assistance through our LTC care management team, which is available at any time to answer questions, address concerns, and assist with billing questions and issues or enrollee concerns.

**Evaluation Criteria:**

1. The extent to which the respondent's description includes a plan to create, collect, report and use provider performance measures.
2. The extent to which the respondent describes how performance measures are reported and trended for each participating provider type and incorporates utilization data, quality of care concerns, performance measure scoring, and provider and enrollee satisfaction in recredentialing activities.
3. The extent to which the respondent's description includes a plan to communicate the performance measure results to providers, including any provider incentives or alternative payment methodology opportunities available.
4. The extent to which the respondent's description includes the establishment of data-based targets to determine the completion of provider corrective action plans and utilization of these targets pursuant to Section 409.982(1), Florida Statutes, including the ability for providers to be notified of performance issues prior to termination.

**Score:** This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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**LTC SRC# 9 – Claims Submission and Payment (Statewide):**

The respondent shall describe how it will educate and train LTC providers about claims submission and payment processes.

Note: Pursuant to Section 409.966(3)(c)6., Florida Statutes, response to this submission requirement will be considered for negotiations.

**Response:**

Aetna acknowledges that participating providers in the long-term care program range from small, family-run community providers to large-scale, corporate-run providers. Our understanding of the various levels of technical support that providers require guides the development of claims educational materials and our support of providers. Differences in the local delivery system of the communities we serve inform the way we manage changes to payment methodologies or processes. Our goal is to make the process from claims submission to payment straightforward and efficient for our providers and to meet the Florida statutes as outlined in Section 409.966(3)(c)(6).

**EDUCATING AND TRAINING PROVIDERS**

Aetna educates and trains providers to have a solid understanding of the claims submission requirements and timeliness standards, guiding them in submitting clean claims that result in payment within 10 business days of receipt of their claims. Information is reviewed at orientation and in ongoing provider education and training. Providers receive technical assistance and they are assigned a representative who can respond to questions or concerns. This approach has increased provider compliance with submission timeframes, and in turn, provider satisfaction. We give our providers the necessary information and training to comply with submission timeframes. Providers having difficulty with claims submissions are assisted and guided until they are able to submit claims successfully.

**INITIAL AND ONGOING TRAINING**

**CRITERION 1:** The extent to which the respondent describes the initial and ongoing training targeted to LTC providers, including the type, location, and frequency of training

Education and training targeted to long-term care providers is an important function of our Provider Services department. Training is available on an initial and ongoing basis for new providers and established providers as the necessity dictates. Trainers from Aetna present training in various settings, locations, and timeframes using a variety of materials that meet the needs of providers. Our education and training programs provide a comprehensive orientation to providers who join our network prior to the start of operations as well as to those who join our network after operations begin. It continues with routine, ongoing education for providers currently under contract. Telephonic, on-site, Web-enabled training and group-based/organizational training are offered as needed.

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### **Initial Training**

Newly contracted providers receive mandatory training prior to startup using comprehensive orientation kits augmented by our provider manual and the provider contract. Training for newly contracted providers and their claims submission or billing staff is conducted within 30 calendar days of their being designated as active (i.e., upon finishing the credentialing process). Online training webinars are available around the clock to support the initial teaching sessions.

Aetna's provider claims education and training program is multifaceted. In the initial orientation training, providers get an overview of claim submission processes for both paper and electronic data interchange claims that includes timeframes for submission, clean claim requirements, the use of the Agency coverage and limitations handbooks as a reference guide, Health Insurance Portability and Accountability Act (HIPAA) requirements, coordination of benefits and third-party liability, balance billing, provider complaint and appeal processes, and fraud and abuse.

We also conduct monthly new provider orientation webinars that include a general overview of claims submission and payment. Providers learn about the payment process and are encouraged to register on our secure HIPAA-compliant Web-portal so they can make claim status inquiries and see explanations of payment and payment history.

### **Ongoing Training**

Our field-based provider services liaisons have received extensive training on claims, and they provide ongoing technical assistance and guidance to providers who have billing challenges and experience claim rejections. Our provider manual also contains summarized information pertaining to the claims and payment processes. Provider newsletters, bulletins, and mailings supplement training and provide updates on any AHCA-required directives or changes related to the claims and payment process.

When a provider has a pattern of claim errors, problems, or omissions identified during the claims adjudication process, our claims management personnel analyze the trend reports and make recommendations to improve timeliness, completion, and accuracy. Our Provider Services personnel deliver this additional training at the provider's office. In cases of frequent provider claims errors, the Provider Services liaison reviews claims in detail during ongoing monthly educational visits. Blank claim forms are provided with detailed instructions for completion and submission processes outlined. We are developing an instruction sheet for providers with step-by-step details to ease the process of claims submission.

### **EXTENT OF ONGOING EDUCATION AND TRAINING**

**CRITERION 3:** The extent to which the respondent will provide ongoing education and training, including problem resolution, responding to provider requests for training and how the respondent will evaluate the effectiveness of its education and training activities, including provider satisfaction

Aetna offers training to all providers regarding claim submission requirements and payment processes. Our goal is to help providers submit accurate and timely claims. Ongoing training can be individualized or network-wide, depending on the need. Training development and delivery is triggered by the need for problem resolution, patterns in provider billing disputes,

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

provider complaints, feedback from our provider survey, changes to requirements from the Agency or any other national standards, and through systematic analysis of denied claims.

To support the development of tailored provider outreach and communication, Aetna conducts at least two cross-functional operations meetings a week with our claims team, provider services, health services manager, provider customer service staff, and plan operations leadership. One of the agenda items for this meeting is a review of the volume of denials after each check run. On a weekly basis, a denied claim report is generated and reviewed to look for patterns, reoccurring issues, and to conduct proactive outreach to providers with a high volume of denials. This report assists in identifying patterns of provider billing behaviors that must be addressed both at a global level and at a provider level. This review of denials has helped us tailor provider outreach and communications and has assisted us in working through submission errors with specific providers.

Assisted living or skilled nursing facilities may request that initial and ongoing training be provided to their staff on site to minimize care disruption and engage a larger segment of their staff at one time. Additionally, certain provider types, such as assisted living facilities, nursing facilities, home- and community-based providers, require training specific to their type of claims submission.

Aetna monitors training effectiveness and provider satisfaction by requesting that providers complete post-training surveys, by reviewing claims data to see if the training affected denial rates, through provider survey results, by monitoring provider complaints, and by reviewing weekly data on provider service line call types. Information obtained from these approaches helps to determine the development of additional action plans to address training gaps and to reach providers who continue to struggle with claims submission.

In 2015, Aetna insourced the administration and claims payment previously outsourced to a third party. As part of this transition, Provider Services conducted statewide provider forums and trainings. At least one forum was conducted in each region, and in some regions, more than three forums were conducted. A few of the forums focused specifically on assisted living facility administrators and billing staff. An end-to-end review was conducted on the basics of billing and on the key fields of the CMS 1500 form. In cases where training was not sufficient or the providers felt uneasy about submitting claims, our Provider Services team conducted one-to-one, on-site education and shadowed assisted living facility billing officers and administrators to make sure claims were completed properly prior to submission. This same approach was followed for durable medical equipment and home health providers that were identified as having claim payment issues and requiring additional guidance. The training yielded positive results as evidenced by fewer claims errors, positive provider feedback, and more timely submissions.

### **ADDRESSING FACILITY-BASED VERSUS COMMUNITY-BASED CLAIMS SUBMISSION AND PAYMENTS**

**CRITERION 2:** The extent to which the respondent's initial and ongoing training addresses characteristics unique to facility-based vs. community-based providers' claims submission and payment (e.g., rate changes, patient responsibility, Medicare coordination and crossover)

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

The content and scheduling for facility-, home-, and community-based service provider initial or ongoing training is handled on a case-by-case basis depending upon the addition of new providers, provider requests, provider complaints, or pattern of claim errors. Most do not submit standard industry claim forms (CMS 1500 versus UB-04) used by office-based or institutional providers and are accustomed to submitting claims for their services via an invoice. Claims-related training for these providers is tailored to their unique circumstances within the requirements of AHCA's contract provision governing the payment of claims. There may be training challenges related to atypical office hours, provider type, or region-specific considerations that affect English language proficiency. To overcome these barriers, we provide flexible training hours and employ staff that speaks several languages, including, but not limited to, the predominant non-English languages spoken for the areas proposed under this ITN: Spanish, French, and Creole. Web-enabled and telephonic training provide alternate means of support for initial and ongoing training to providers without an office. We found that a large number of our Assisted Living Facility (ALF) providers have limited English proficiency in Miami Dade County. Many of these providers are small and require intense assistance when they begin to work with managed care organizations. Aetna has translated materials and ensured that Provider Services staff assigned to work with these providers are proficient in either Spanish or Creole which are the two predominant languages spoken by our ALF administrators.

In 2015 Aetna insourced their claims payment and administrative functions for the Long Term Care Program. During this time, providers were asked to follow new billing guidelines to be in compliance with AHCA requirements, CMS billing guidelines and updated Correct Coding Initiatives. It took providers some time to adjust to the changes. However, during every step of the way our Provider Services team provided guidance and assistance. Some common mistakes were use of an incorrect bill type, incorrect place of service and missing modifiers. As we encountered patterns of claims issues due to errors, we developed tools tailored to the issue in order to assist providers in correctly submitting claims. As part of our change management plan, we conducted provider technical assistance training sessions and town-hall meetings as a way to understand provider issues and develop solutions collaboratively.

### **TRANSPARENT, EASY-TO-ACCESS MATERIALS AND TOOLS**

**CRITERION 4:** The extent to which the respondent ensures training materials and tools are transparent and easily accessible

Aetna's training tools and materials are developed to be provider-centric. Our process for the development of outreach materials, tools, and trainings involve requesting feedback from our internal subject matter experts, including our learning and performance team and our Community Advisory Forum (CAF). The CAF is a group of providers, community agencies, and enrollee advocates. The CAF reviews materials and provides feedback on outreach and training documents. They also have been instrumental in providing feedback to improve provider engagement and valuable insight into current and business IT platform. To prepare our providers for the changes, we conducted extensive outreach, proactive communication, and developed tools to serve as resources. The CAF reviewed our materials and strategy and they offered valuable suggestions to improve the impact of our tools and approach.

In early 2017, we successfully facilitated the migration to an improved claims and business IT platform. Senior leadership set the stage for success by providing a migration overview training to explain what this migration meant and the benefits for our providers (e.g., better availability

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

and accessibility of data, easier processing of prior authorization, more robust data, and improved claims payment). The providers were impressed by this effort and by the fact that all senior leadership for the health plan was present and delivering overviews and trainings.

To prepare our providers for the changes, we conducted extensive outreach, communicated proactively, and developed tools to serve as resources. The CAF reviewed our materials and strategy and offered valuable suggestions to improve the impact of our tools and approach. Aetna conducted statewide forums that included claims submission and payment training. These forums were well attended and very successful as evidenced by the positive feedback from our providers and by the continued communication beyond the forums. The providers were impressed by efforts undertaken and by the fact that all senior leadership for the health plan was present and delivering overviews and trainings. Migration overview training—during which senior leadership explained what migration meant—benefits providers (e.g., more availability of data, easier processing prior authorization, provide more robust data, improved claims payment). Senior leadership took an active role in the provider forums by engaging providers in dialogue about how the successful business migration could only occur in collaboration with our providers. Leaders explained the enhancements that would help providers manage the care of their members in a more effective manner and provided the context and business rationale for the change.

Feedback from the Forum: Ana L. Garcia, Managed Care Administrator at Jessie Trice Community Health Center, Inc. wrote:

“This letter is to thank you for all your dedication, support[,] and partnership. Your Community Provider Forum held on January 10, 2017 regarding the migration of Aetna Better Health of Florida provided all the information we needed to ensure a smooth transition. Because you took the time to educate us, we were able to respond to questions from our patients. I look forward to working with your team to continue supporting our community.”

Our approach to the development of the training materials and tools is collaborative, flexible, and tailored to the needs of our network of providers. Our goal is for providers to submit accurate claims so payment for services can be timely and not create an undue economic burden on them, so they can give our enrollees uninterrupted access to quality services.

### **MATERIALS PROVIDE INFORMATION ON HOW TO ACCESS MAXIMUS**

**CRITERION 5:** The extent to which the training materials provided to LTC providers include information on how to access the Agency’s third-party claims dispute resolution contract (Maximus)

Our goal is to make sure that providers understand their dispute rights. Aetna informs providers through the provider handbook and newsletters, training, provider orientation, the website, and through their Provider Services representative about their right to file a request for resolution organization review through the Agency.

We devote the necessary resources to the resolution organization review process and comply with all the required timeframes and processes stipulated in Title XXIX Section 408.7057.

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Aetna acknowledges and appreciates the support the Agency provides to dispute resolution outside of the legal system through MAXIMUS, an external review alternative. We have trained management and staff-level colleagues on the availability of this resource. Additionally, we inform providers of this option when appropriate. At this time, we have been able to manage escalated disputes through our own internal policies and processes. However, we would use the State's resolution organization in any instance where it would be conducive to expediting issue resolution and avoiding litigation.

Our Appeals and Grievances department has the overall responsibility for the integration and oversight of all provider complaints in the provider dispute process, regardless of the complaint referral source. Both contracting and non-contracting providers may file a request with AHCA. All parties submit resolution organization reviews within 12 months of Aetna's final decision. All parties submit any supporting documentation inclusive of the original decision and all information considered as part of the decision making to the resolution organization within 15 calendar days of the request. Aetna also provides any additional information requested by the Agency or the independent review organization. Failure to submit the documentation within the timeframe results in default and the claim in dispute is considered to be approved in accordance with Title XXIX Section 408.7057 (2) (b) (7) (f). The resolution organization sends a written recommendation to the Agency within 60 calendar days from the receipt of the supporting documentation, not to exceed 90 calendar days from receipt of the request for review. The Agency issues the final resolution within 30 days of receipt of the resolution organization recommendation.

At least quarterly, we analyze our grievance and appeal data to identify trends and opportunities for improvement. Data from health plan experience, results of oversight activities, and the need for any corrective action plans identified internally or by the Agency are presented to our Grievance and Appeal and Quality committees. These committees include cross-functional representatives from Enrollee Services, Provider Services, Compliance, Care Management, or other departments as needed. Participants on the Service Improvement Committee and the Quality Management Oversight Committee include senior leaders at the health plan. This helps ensure that individuals with authority take corrective action and participate in the decision-making. They must prioritize trends, opportunities for improvement, and corrective actions to address the issues affecting individual enrollee satisfaction, provider satisfaction, and to stabilize trends within the delivery system as a whole to meet performance standards.

### **TRAINING TO PROVIDERS ON MEDICAL NECESSITY**

**CRITERION 6:** The extent to which the respondent will provide training to providers on medical necessity criteria, as defined in the Contract pursuant to 42 Code of Federal Regulations 447.45 and in 59G-1.010(166), Florida Administrative Code

Aetna's provider training includes an overview of medical necessity as defined by 42 Code of Federal Regulations 447.45 and in 59G-1.010(166), Florida Administrative Code. In addition to definitions and orientation, the provider training includes references as required by the Agency to AHCA's coverage and limitation handbook. Information pertaining to medical necessity, including definitions, is published in the provider handbook. Aetna helps providers understand that medical necessity is determined on the criteria set by AHCA and other approved industry standard peer review guidelines. We help providers understand that medical necessity is determined on an individual basis by the enrollee's clinical dispositions and identified needs

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

(e.g., living situation, social support, and activities of daily living). Long-term Care Management and Utilization Management staff members are all trained to be proficient in the criteria used to establish medical necessity, and all utilization reviews are conducted under the supervision of a board-certified physician who can render an adverse benefit determination for the denial, reduction, or suspension of services.

Our Utilization Management and Care Management departments are prepared to discuss and verify the medical necessity definition in their interactions with providers. Provider Services informs providers of any revision(s) in the contractual definition through on-site visits and updates to the provider manual and website as well as through email blasts to all providers in the network. Our Utilization Management team provides guidance and orientation to providers when decisions rendered are not understood or when providers have questions pertaining to medical necessity criteria or the review process. The provider orientation process also reinforces the information in the handbooks and supports that use of the Agency handbooks as key guidance documents for determining the eligibility, service limits, and medical necessity of each service. Providers are also made aware that each case may be different and that while we follow the Agency approved criteria, decisions are also based on the clinical presentation and psychosocial circumstances of an enrollee. Our LTC medical director may determine that it is clinically appropriate to provide services in excess of the benefit limit, especially if said services are determined to be medically necessary and directly contribute to the success of the plan of care.

### **NOTIFICATION PROCESS FOR SYSTEM ISSUES**

**CRITERION 7:** The adequacy of the respondent's notification process when system issues are identified/resolved by the respondent and/or its subcontractor(s), including notification to all impacted parties of estimated time for resolution, and updates and notification to providers prior to launching system changes that may impact billing and payment

System issues or issues that may potentially affect claims, billing, or payment are communicated promptly to AHCA and any affected providers or subcontractors. Our priorities are to resolve issues as quickly as possible and to communicate to our providers the following information:

- Description of the issue
- Root cause
- Potential provider impact
- Remediation steps
- Timeline for resolution
- Schedule of next communication or update

System issues are communicated via blast fax, email, and when necessary, with outreach telephone calls, including both automated and live call-outs. Our LTC team is debriefed to provide information as they work with providers and enrollees. Provider Services customer service line staff is given talking points to answer questions, provide updates, and provide support to the notification process. As required by AHCA, we notify our Agency contract manager as soon as we become aware of the issue and provide scheduled updates until it is resolved. Since our providers may not have regular office hours and may require outreach beyond our standard work hours, we conduct targeted afterhours outreach telephone calls to be

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

able to keep them informed. Our goal is to resolve these issues quickly for minimal impact to our providers and enrollees.

Scheduled and planned system changes are managed through a comprehensive change management action plan. The action plan includes targeted provider communications at least 90 days prior to any scheduled change. Throughout these 90 days, providers are sent multiple notifications to keep them abreast of the changes. We use newsletters to provide frequently asked questions, talking points providers can use with their staff, and contact information to assist providers with questions. Part of this change management process includes conducting provider forums, individual technical assistance sessions, in-person, webinars, telephonic and the use of our field-based staff to conduct onsite education and assistance.

In February of 2017, we successfully executed the business migration of our MMA business to Aetna Medicaid's national platform. Our LTC business had already migrated to the standard platform in 2015, when we insourced the administration of the program. While all of the due diligence to ensure successful claims processing was undertaken, Aetna was still concerned with claims that require special configuration: namely LTC skilled nursing and hospice claims all being in the same environment at go-live. Our goal was to avoid claims issues that would affect cash flow for providers in the event there was problem with the system. We proactively communicated with the skilled nursing facility and hospice providers to advise of the potential for claim delays and to offer them an advance based on the historical volume of their claims. A large number of the providers accepted the advances and expressed appreciation for our thoughtfulness. While in the end there was no impact to the skilled nursing facility and hospice claims because of the migration, the decision to communicate proactively and extend advances contributed to strengthening our relationship with providers.

### **Evaluation Criteria:**

1. The extent to which the respondent describes the initial and ongoing training targeted to LTC providers, including the type, location, and frequency of training.
2. The extent to which the respondent's initial and ongoing training addresses characteristics unique to facility-based vs. community-based providers' claims submission and payment (e.g., rate changes, patient responsibility, Medicare coordination and crossover).
3. The extent to which the respondent will provide ongoing education and training, including problem resolution, responding to provider requests for training and how the respondent will evaluate the effectiveness of its education and training activities, including provider satisfaction.
4. The extent to which the respondent ensures training materials and tools are transparent and easily accessible.
5. The extent to which the training materials provided to LTC providers include information on how to access the Agency's third party claims dispute resolution contract (Maximus).

**EXHIBIT A-4-c**  
**LTC SUBMISSION REQUIREMENTS**  
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6. The extent to which the respondent will provide training to providers on medical necessity criteria, as defined in the Contract pursuant to 42 Code of Federal Regulations 447.45 and in 59G-1.010(166), Florida Administrative Code.
7. The adequacy of the respondent's notification process when system issues are identified/resolved by the respondent and/or its subcontractor(s), including notification to all impacted parties of estimated time for resolution, and updates and notification to providers prior to launching system changes that may impact billing and payment.

**Score:** This section is worth a maximum of 35 raw points with each of the above components being worth a maximum of 5 points each.

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**EXHIBIT A-4-c**  
**LTC SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**LTC SRC# 10 – Claims Submission and Payment (Statewide):**

The respondent shall describe how it will ensure that electronically-submitted nursing facility and hospice claims processes will enable claims payment within ten (10) business days after receipt of clean claims. (See Section 409.982 (5), Florida Statutes) The respondent shall provide the specific data metrics it will use to ensure compliance with this provision.

**Response:**

Timely and accurate claims processing and payment is paramount to the integrity of health care organizations. We are serious about our responsibility and accountability to the State and its statutes and to preserving the trust and confidence it places in Aetna to accurately and promptly make claims payments.

**ENSURING CLAIMS PROCESSES ENABLE TIMELY PAYMENT**

**CRITERION 1:** The extent to which the respondent describes the systems that will be used to measure timeliness of claims payment

Daily processing reports that contain claim age data are used to identify inventory that requires processor intervention. The team supervisor and manager monitor these reports frequently throughout the day to confirm inventory is addressed within the established timeframes.

Aetna utilizes a suite of tools, including, but not limited to, scheduled and ad hoc reports to monitor claim receipts, automated claims processing, manual claims adjudication, and check and remittance advice production/distribution:

- Claims inventory and workflow management: Aetna is committed to achieving the highest level of timeliness in the claims adjudication and payment process. This is accomplished through focused claims inventory and workflow management practices, data monitoring and analysis, and management oversight.
  - Pended claims tool and reports: Claims and other departments use the pended claims tool to track and manage claims that edit out of the auto-adjudication process for manual review. Populated hourly, the tool presents claims counts and billed dollars by pend reason and claim age, with drill-down capabilities for detailed information on each claim. The tool can sort and filter the data by claim age, claim type, claim form, network provider, and contract. Additionally, daily reports of pended claims inventory are generated for managerial or historical review.
  - Non-final claims tool and reports: Claims and other departments use the unfinished claims tool to track and manage all claims that are in process, whether a system batch process or pended for manual review and adjudication. Populated hourly, the tool presents claims counts by process status and claim age with drill-down capabilities for detailed information on each claim. Reports can sort and filter by claim age, claim type, claim form, network provider, and contract. Again, daily reports of

## **EXHIBIT A-4-c**

### **LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

pending claims inventory are generated for managerial or historical review.

- Claims payment processing reports: Finance and Information Technology departments generate and monitor several process control reports to achieve timely and accurate network provider check and remittance advice production and distribution, whether by mail or electronic funds transfer/electronic remittance advice file. The reports reconcile, through each major process step, the claim counts and amounts from claims waiting payment to payment and remittance advice distribution.

The use of these reports enables health plan operations to take appropriate action to address trends that indicate a potential issue, such as turnaround times or inventory levels for aging claims. It is our standard process to determine immediately a root cause and to develop and implement an appropriate action plan when issues or trends are identified. In the past, these remediation plans have included one or more of the following:

- System reconfiguration
- Staff overtime
- Workload balancing
- Training of staff and providers
- Hiring and training temporary workers to assist with the reduction of claim inventories

#### **Mitigating the Risk of Noncompliance**

To meet current Agency requirements for processing claims payments to SNFs and hospice providers within 10 business days after receipt of clean claims, Aetna has taken the following steps to mitigate the risk of noncompliance:

- Increased claims examiner resources to support SNF and hospice claim processing and created a core team to process only SNF and hospice claims:
  - Examiners are dedicated to handling only SNF and hospice claims daily.
  - A senior examiner is also dedicated to managing pends to other departments daily.
- Created a daily aging report focused solely on SNF and hospice claims:
  - New reporting was created and distributed to senior claims and health plan leadership in addition to business partners daily. Claims at day eight are highlighted so that leadership is aware of delays that can affect overall timeliness.
  - Claims processed beyond 10 days are reviewed to determine root cause of the delay, so we can manage any factors or issues that could affect other claims.
- Improved efficiency of check-run process resulting in savings of one full day from check finalization to check issue
- Conducted education on claim turnaround time expectations across supporting departments (e.g., Provider Relations, Eligibility, health plan) responsible for resolving claim pends:

## **EXHIBIT A-4-c**

### **LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Met with department leadership and market leads to make sure all areas responsible for claims handling are familiar with the turnaround times for the market
- Conduct ongoing dialogue and follow-up with business partners to address aged claims daily
- Leveraged technology to automate patient liability processing for SNF and hospice claims

Because of the actions above, results for LTSS have shown marked improvement. The plan met overall timeliness requirement of 50% in 7 days in the second quarter of 2017 (achieved 54% within 7 days versus target of 50%).

SNF and hospice claims did not achieve goal in second quarter 2017 (achieved 94% within 10 business days versus target of 100%). July showed marked improvement (99.48% in 10 days) and August is currently at 100%. With the implementation of the new automated process expected at the end of 2017, we anticipate we will meet or exceed service-level goals and will continue to evaluate opportunities for ongoing service improvements.

#### **Ensuring Claim Timeliness and Quality**

Aetna reviews, monitors, tracks, and trends the claims and encounters (timeliness of processing) processes. We conduct both random and focused reviews of processed claims for payment, financial accuracy, and procedural accuracy. We use established guidelines to conduct the audits; and under the direction of the chief executive officer, these audits are conducted daily and on an ad hoc basis. The Claims department monitors the claims payment process for accuracy and timeliness of payments and coordination of benefits. The information is reported to the Service Improvement Committee (SIC) or other designated committee, the QM/UM Committee (for review and recommendation for action), then to the Quality Management Oversight Committee (QMOC) and the board of directors.

The Claims Quality Review unit audits an established number of incoming provider telephone calls for each claims inquiry and claims research (CI/CR) representative on a monthly basis. Aetna shares audit results with Claims Management and provides reports to Service Improvement Committee (SIC) and the QMOC.

The information is reported to the Service Improvement Committee (SIC) or other designated committee, the QM/UM Committee (for review and recommendation for action), then to the QMOC and the board of directors.

#### **METRICS**

**CRITERION 2:** The extent to which the respondent's data metrics demonstrate an ability to comply with Section 409.982(5), Florida Statutes

We produce internal reports on a daily basis to track and monitor the processing of SNF and hospice claims to support compliance with AHCA's requirement to pay these claims within 10 business days. One of these reports is our SNF/hospice claims daily detail

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

tracker. This report includes a day count tracking of the process and handoffs for each claim assigned to the team that potentially has to work on a claim prior to adjudication and payment processing. At times, claims require review or research prior to the Claims department being able to proceed to processing. Each of the teams that potentially could be assigned to review a claim is assigned a queue in the system (also called a bucket). The report lists the volume of claims for each functional area (see queues below) at 0-5 days, 6 days, 7 days, 8 days and 9 days or greater. In addition to this report, each functional area receives a corresponding report that outlines the claim numbers and specific pend reason code so immediately the subject matter experts can focus on what is needed to move the claim along closer to adjudicating and finalize the claim for payment in 10 business days of receipt. All claims are tracked through this tool and a report is produced and disseminated to all applicable departments. We track the following queues:

- Business analysts (B Buckets)
- Claims analysts (C Buckets)
- Claims (QR) audit (E Buckets)
- Health plan review (H Buckets)
- Provider data system (PDS-P Buckets)
- Letter review (L Buckets)
- Finance team review (F Buckets)
- Medical Management team review (M Buckets)
- Fraud, waste and abuse review

To supplement our efforts to meet Section 409.982(5), Florida Statutes, we will leverage new technology and claims automation tools in addition to using our daily metrics reporting tool as described above.

### **WORKING WITH PROVIDERS WHEN TIMELINESS STANDARDS ARE NOT MET**

**CRITERION 3:** The extent to which the respondent describes how it will work with providers when the timeliness standards are not met

Aetna trains providers to have a solid understanding of the claims submission requirements and timeliness standards, assisting them in submitting clean claims that produce payment within 10 days of submission. Such information is provided during orientation and ongoing provider education and training continues. Providers receive technical assistance and are assigned a representative who can respond to questions or concerns. This approach has led to providers to be compliant with submission timeframes, and in turn, to increased provider satisfaction. We work with our providers so that they have the necessary information and training to comply with submission timeframes.

There are times when providers may not have accurate insurance information and fail to submit claims in a timely manner. Once root causes are identified, we will work with the provider to prevent ongoing and future issues related to timely filing. We provide education in that respect with multiple communication channels such as telephonic and/or on-site assistance from our field based staff. There may also be times that beyond education, providers request an exception for payment in extenuating

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

circumstances related to timely filing denials. When this occurs, the plan staff may request a waiver of timely filing on behalf of the provider. This request is reviewed and approved only by the health plan leadership. The criteria used to make an exception include a review of the provider history and the particular circumstances that led to untimely claims submission.

### **BILLING PLATFORM CHANGES**

**CRITERION 4:** The extent to which the respondent ensures that billing systems platform changes will be limited

We recently completed an upgrade to our claims processing system; therefore, no future platform changes are planned at this time. Enhancements to our current platform are evaluated and executed when there are gains to overall process efficiencies.

System changes, especially those with high impact to internal processes and/or staff, will be communicated to providers at least 90 days prior to system change. Throughout these 90 days, providers are sent multiple notifications to keep them abreast of the changes. We use newsletters to provide frequently asked questions, talking points providers can use with their staff, and contact information to assist providers with questions. Part of this change management process includes conducting provider forums, individual technical assistance sessions, in-person discussions, webinar, and telephonic assistance, and the use of our field-based staff to conduct on-site education and assistance. System changes that affect our providers must be carefully managed with disciplined action to reduce service disruption for them and our enrollees. At this time, Aetna has no projected plans to undergo any change in billing platform; the successful business migration to a new platform that occurred in February 2017 aligned all Florida operations to the national Aetna Medicaid organization.

Aetna conducts extensive system testing prior to any changes being implemented. All changes are closely monitored in production in order to ensure that the change process was successful. In addition, we conduct end-to-end testing, which includes the review of all processes and downstream applications impacted by changes.

### **Evaluation Criteria:**

1. The extent to which the respondent describes the systems that will be used to measure timeliness of claims payment.
2. The extent to which the respondent's data metrics demonstrate an ability to comply with Section 409.982(5), Florida Statutes.
3. The extent to which the respondent describes how it will work with providers when the timeliness standards are not met.
4. The extent to which the respondent ensures that billing systems platform changes will be limited.

**EXHIBIT A-4-c  
LTC SUBMISSION REQUIREMENTS  
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**Score:** This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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**EXHIBIT A-4-c**  
**LTC SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

**E. DELIVERY SYSTEM COORDINATION**

**LTC SRC# 11 – Case Vignette (Statewide):**

The respondent shall review the below case vignette, which describes potential Florida Medicaid recipients. Note: The vignette included below is fictional.

*Alisha is a 35-year old single mother who suffered from a major car accident when she was 27 years old, which resulted in incomplete paraplegia. Until she received Medicaid coverage, Alisha was unable to afford the recommended level of physical and occupational therapy treatments that would have assisted her in maintaining maximum mobility in her upper extremities. As such, Alisha requires assistance with almost all self-care tasks. Alisha has suffered from clinical depression since her accident. She is cognitively intact and since starting individual therapy sessions with a licensed mental health clinician, she has started to express a desire to be more engaged in her community. Alisha has a primary care physician (who specializes in internal medicine) and is also seen by a neurologist. Alisha's physician has ordered ongoing maintenance physical therapy; she also receives personal care services and durable medical equipment. Alisha gave birth to a son, Noah, one year before the accident. Alisha's mother assists with Noah's care as often as she can, but her mother recently accepted a job in a different city, which will mean Alisha will have less supports (both for herself and Noah). Alisha and Noah currently live with her mother. Because her mother is moving, Alisha has been looking for a new place to live, but she is having trouble finding a home that is functional for her needs. Since Alisha is experiencing changes in her support system and living situation, she requests assistance from her case manager.*

The respondent shall describe its approach to coordinating care for an enrollee with Alisha's profile, including a detailed description and workflow demonstrating notable points in the system where the respondent's processes are implemented:

- a. Comprehensive Assessment;
- b. Caregiver Assessment;
- c. Person Centered Care Planning;
- d. Transition Planning;
- e. Disease Management;
- f. Utilization Management/Service Authorization; and
- g. Grievance and Appeals.

Where applicable, the respondent should include specific experiences the respondent has had in addressing these same needs in Florida or other states.

**Response:**

CRITERION 4: The extent to which the respondent demonstrates experience providing services to enrollees with complex medical needs and provide evidence of strategies utilized that resulted in improved health outcomes.

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Aetna is highly experienced and qualified to support Alisha through our integrated system of care for medically complex, long-term care enrollees. Currently, we serve approximately 5,000 enrollees in our long-term care (LTC) program in Florida. Aetna holds a comprehensive managed medical assistance (MMA) and LTC contract in Region 11, and LTC contracts in Regions 6, 7, and 9. Our national experience includes our Long Term Services and Supports (LTSS) population, with more than 64,000 enrollees in 9 states receiving LTSS in their homes, communities, or nursing facilities. Our enrollees are diverse individuals with varying medical and behavioral health issues that are often complicated by socioeconomic or geographic factors. Serving this population requires services and supports that address each person's specific circumstances. We work with our LTC providers and community organizations to ensure we are providing appropriate services and supports to address all the needs of Alisha and her family in this vignette. The care manager coordinates Medicaid covered services as well as non-covered services and supports, including housing, food, and general community supports.

### **APPROACH**

Based on the information provided in this vignette, Alisha is an enrollee who presents with complex needs associated with her paraplegia, unstable housing situation, impending loss of her primary caregiver, and clinical depression. Prior to her enrollment with our plan, a major car accident eight years ago followed by insufficient therapies left Alisha unable to care for herself. Alisha's care manager will serve as an advocate, facilitator, and collaborator for Alisha, supporting her as she addresses her goals and desires to live a long, healthy life with her nine-year-old son, Noah. The care manager works with Alisha to identify services, both covered and non-covered, that may effectively meet her needs.

Alisha is excited to take steps to further her independence and establish her own home with her son, despite the challenges presented by Alisha's mother moving to another city. This change in support system and living situation is a significant undertaking for Alisha, but the support and coordination efforts of her Aetna care manager will help Alisha and Noah make a fresh start. Alisha's care manager focuses on coordinating services so that Alisha can live as independently as possible, in the most appropriate setting, and achieve her personal health ambitions with the best possible outcomes.

Alisha's care manager coordinates all services, including all service authorizations and referrals to community agencies and resources, as applicable. Alisha's care manager also uses Aetna's technology platforms (e.g., electronic case management system, CareUnify) to integrate and communicate data and information among Alisha's providers and supports. Figure LTC SRC 11-1: Workflow Depicting Significant Change in Attachment LTC SRC 11 illustrates a detailed graphical depiction of Aetna's Significant Change workflow showing notable points in the process is included at the end of this response.

### **DETAILED DESCRIPTION**

Our holistic, person-centered integrated care management model is a collaborative approach composed of biopsychosocial assessments, care planning, facilitation, care coordination, evaluation, and advocacy designed to meet our enrollees' and their circle of support's comprehensive care needs to promote high-quality, cost-effective outcomes.

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Beginning with Alisha, our objective is to understand her preferences and goals, physical and behavioral health care needs, family and community supports, strengths, and any barriers impacting her ability to access appropriate care—all with the overarching objective of optimizing Alisha's level of functioning and enabling her to maintain or achieve an optimal level of independence.

Alisha calls her care manager to report a significant change in her support system and living situation and to request assistance. The care manager learns that Alisha's mother (who is also Alisha's primary caregiver) is moving to a different city to start a new job. Alisha's care manager schedules a face-to-face visit at a time that is convenient for Alisha and her family, but within five business days of Alisha's notification. Alisha's care manager has years of experience working with physically disabled adults in the Medicaid LTC population.

### **COMPREHENSIVE ASSESSMENTS**

CRITERION 1(a): Description of the sources of data/information that would be utilized in the assessment process, including timeframes for completion;

CRITERION 1(b): Application of the respondent's case management risk stratification protocol, including a rationale for the decision;

CRITERION 2: The extent to which the respondent's workflows/narrative descriptions include timeframes for completion of each step in the care planning process

Based on Alisha's significant change, the care manager conducts a face-to-face visit within five days to review and update Alisha's 701B comprehensive assessment, and documents any actions taken as quickly as possible. During this meeting, Alisha and her care manager discuss the upcoming changes in Alisha's life, along with her feelings about the situation and her mother moving away. Together, they review Alisha's activities of daily living (ADLs) and independent activities of daily living (IADLs) needs, health conditions and medications, occupational and physical therapies, cognitive and mental health needs, nutritional needs, and her home living environment. With impending changes in Alisha's support system and living situation, Alisha and her care manager also complete additional assessment tools, such as the Home and Community Based Support (HCBS) tool to identify gaps in services (e.g., determine personal care and homemaker services). They also fill out an environmental checklist to review Alisha's current living situation as a benchmark for her housing needs. The care manager discusses the Participant Direction Option (PDO) with Alisha and they complete the prescreening tool. Together, the care manager and Alisha review and update Alisha's contingency plan and discuss any advance directives. The care manager also includes Alisha's mother, her primary caregiver, in these conversations and conducts a caregiver assessment. Using the caregiver assessment, the care manager can determine the gaps in services that will need to be coordinated before Alisha's mom moves away. It also gives the care manager an opportunity to gather additional information on Alisha's current needs and supports from her mother. The care manager assesses specifically for problems, barriers, or gaps experienced by Alisha. The care manager also looks for and identifies possible interventions and supports.

Aetna's assessments are comprehensive, evidence-based tools, which give us a deep understanding of who Alisha is and what her needs are from a medical, behavioral, social, functional, and cognitive standpoint. The assessment provides us with the information

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

necessary to create the framework for Alisha's care and service plans. Our assessment tools and instruments include clinical best practices and evidence-based guidelines, with a biopsychosocial scope to identify root causes and social determinants of health. Self-reported data, such as that elicited by our assessment tools, is a critical component of our integrated care model.

Based on her current assessments, Alisha's risk stratification is supportive level of care. In LTC, we stratify enrollees into two risk levels: intensive care management or supportive care management. Stratification occurs at the initial assessment (or at identification of a chronic condition) and then quarterly thereafter, using original stratification rules. Designed and customized to meet individual enrollee's needs, targeted interventions reflect an enrollee's stratification risk level and their ability to impact behavior.

The Consolidated Outreach and Risk Evaluation™ (CORE) predictive modeling identifies enrollees who are candidates for intensive and supportive care management and enrollees who are candidates for high- and low-risk chronic condition management. We have learned that complexity of condition is more important than diagnosis when identifying enrollees who are at high risk. Enrollees at high risk are usually challenged by the biopsychosocial complexities inherent in their lives. As a result, they are unlikely to benefit from standard care and most likely to benefit from our integrated care management model, which is built to address such complexities. The tool predicts the likelihood of integrated care management making an impact and ranks all plan enrollees from highest to lowest risk.

Our CORE model places enrollees within risk groups: high-risk for an emergency department visit, medium or high-risk for an inpatient admission, or high-risk for high costs and poor outcomes in the next 12 months. CORE risk stratification helps to guide our outreach to enrollees in the highest risk categories.

We further stratify enrollees into levels for care management and disease management based on the information we gather from the assessments and outreach activities, which identify their biopsychosocial complexity and the intensity of their needs. We also base stratification on an enrollee's self-reported conditions and health care utilization, such as emergency department encounters, hospital utilization, or chronic conditions. The predictive modeling tool identifies enrollees likely to be future high-utilizers based on claims and diagnostic data. These tools determine the enrollee's potential risk level and predict that care management interventions can effectively improve the enrollee's outcome.

Although Alisha has adequate strengths and supports to manage her biopsychosocial complexities, she requires assistance and service coordination for her complex conditions, such as clinical depression and incomplete paraplegia. The goal is to keep Alisha stable at a supportive level of care by linking her to needed services and supports before her mother moves away. Supportive care will also help Alisha move toward self-management by using preventive and routine care and services to promote health and wellness and to reduce avoidable hospital and emergency department utilization.

To evaluate Alisha's mental health and clinical depression, the care manager administers condition-specific assessments (e.g., K6, UNCOPE) as part of the comprehensive assessment. Even though Alisha is working with a licensed behavioral health professional, her care manager also screens Alisha for substance use disorder (e.g., stemming from pain management

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medications and depression) and indications of anxiety. Additionally, with Alisha's consent, the care manager contacts her mental health provider (member of Alisha's interdisciplinary care team) about the significant change in her housing and caregiver situation. Alisha's care manager also sends updates on changes in Alisha's support system and living situation to all of her physicians including, her primary care provider (PCP), neurologist, and her occupational and physical therapists.

The care manager uses motivational interviewing and reflective listening skills to speak to Alisha about her concerns regarding her ability to provide care for her son on her own. The care manager empowers Alisha by focusing on her strengths and reminding her of everything she can do for her son. The care manager suggests Alisha reach out to her son's school to discuss extended day and volunteer programs, as well as after school activities that will enrich Noah's educational goals and provide mentorship. The care manager includes local resources and support group information in the information packet she leaves with Alisha to follow-up on at a later contact.

### **Caregiver Assessment**

Alisha's primary caregiver is her mother, who will be moving to another city where she has accepted another job. Alisha's care manager conducts a caregiver assessment with Alisha's mother to capture the services she currently provides. The care manager also uses it to find out how Alisha's mom perceives Alisha is doing and to measure the potential service gaps left by the loss of this caregiver.

### **PERSON-CENTERED CARE PLANNING**

CRITERION 1(c): Application of a person-centered care planning approach

CRITERION 1(d): Identification of service needs (covered and non-covered) and a description for service referral processes that the plan has in place

CRITERION 2: The extent to which the respondent's workflows/narrative descriptions include timeframes for completion of each step in the care planning process

Aetna's integrated care management model ensures the right resources are available, organized, and coordinated so that Alisha can achieve her personal goals of being more engaged in her community and finding a new place to live. Alisha is the center of the care planning process and the expert on her goals and needs. During the care planning, Alisha and her care manager discuss the following:

- Development and prioritization of short- and long-term goals, including Alisha's health ambitions (e.g., finding a new home, living more independently, becoming more involved in her community, doing more things with Noah, etc.)
- Identification of barriers to meeting goals or complying with the plan (e.g., Alisha's mother moving to a different city and fewer supports for Alisha and Noah)
- Scheduling follow-up to determine whether Alisha has acted on referrals and to review progress toward goals
- Development of a self-management plan for Alisha's clinical depression stemming from her paraplegia

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- Monitoring and evaluation of care plan for effectiveness and modification, where appropriate
- Documentation of tasks and follow-up per the agreed upon goals and timeframes
- Developing a service gap contingency and back-up plan to identify actions Alisha can take to report any gaps in service and what resources are available to resolve unforeseen gaps in service

Alisha's plan of care takes into account covered and non-covered services, including services and support from community organizations, regardless of payer source. The care manager discusses the recent referral made by Alisha's primary care provider (PCP) for physical therapy to assist Alisha with improving her gross motor skills. The care manager also makes contact with the local Center for Independent Living (CIL) and provides information to Alisha on peer support and counseling services, independent living skills training, and vocational education programs. The center can link the care manager to additional community resources that will support Alisha's goals, including the Florida Supportive Housing Coalition, the Family Café, and Big Brothers Big Sisters Organization to assist with Noah.

In addition, the care manager reviews the LTC enrollee handbook and provider directory with Alisha, giving her the opportunity to make informed choices and decisions about service options that will help her achieve her personal goals. Alisha knows the overarching goal of her plan of care is to help her achieve and maintain her highest level of self-sufficiency. Alisha has requested her mother, a few friends, her PCP and physical therapist, and her mental health clinician to participate in the care planning process as part of her interdisciplinary care team. Alisha's updated plan of care addresses her most immediate needs and describes how the care manager and other members of Alisha's care team will work with her to mitigate issues that might affect her ability to live independently and support her son. The care manager works with Alisha to define and prioritize both her short- and long-term goals, translate those goals into achievable steps, and implement the care plan in phases according to her readiness to change. Alisha's short-term goals include improving her own functional abilities through physical therapy and occupational therapy and finding stable housing for herself and Noah. She has also expressed her desire to become more engaged in her community, to increase her independence, and to continue being a good mom to Noah. Taking a phased approach will help Alisha meet her short-term goals quickly and increase her confidence level early.

Once Alisha signs and approves her plan of care, she receives a copy from her care manager during the visit. Alisha's care manager ensures that her PCP receives a copy of the plan of care within 10 business days of development and each time the plan of care is updated. As part of the care planning process, the care manager also reviews the Grievance and Appeal section of the enrollee handbook with Alisha and explains service denials, including the distribution of a Notice of Adverse Decision letter, which includes steps to file a Medicaid State Fair Hearing. The care manager has Alisha sign forms, including Authorization to Release Information, Freedom of Choice, plan of care, and plan of care summary. Once Alisha moves into her new home, the care manager will complete Form 2515/2506 for change of address and assistance, and the care manager will submit it to Department of Children and Families within 10 business days. The care manager uploads Alisha's updated plan of care and forms into our electronic care management system, which feeds into our CareUnify system so that updated information is available to Alisha's entire interdisciplinary team in real time.

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Alisha's integrated plan of care includes care coordination, medical and behavioral health care plans, and chronic condition education (disease management) plans, and it is flexible to reflect her current and changing needs. Skilled at coordinating care with other delivery systems and our integrated care management approach, the care manager makes sure Alisha is not receiving duplicative services. Incorporating existing authorizations and pre-existing plans of care into Alisha's plan of care provides continuity of care for Alisha and her support system. Alisha's care manager knows that when multiple care plans exist, there is the potential for confusion, duplication, or omission of services; especially when one care plan mistakenly assumes another is covering the need. Alisha's plan of care will be available to her entire interdisciplinary team in real time through CareUnify.

After Alisha and Noah have successfully moved to their new home, the care manager follows up with Alisha every month, either in person or telephonically, and face-to-face every 90 days to help assure Alisha's well-being and to make sure services and supports are still meeting her needs. Reassessments are also conducted annually during a face-to-face visit with the care manager.

### **PROVIDER CAPACITY**

**CRITERION 1(g):** Description of the assessment of provider capacity to meet the specific needs of enrollees

Prior to meeting with Alisha, the care manager reaches out and identifies providers that employ staff with the appropriate experience, skillset, and availability necessary to meet Alisha's needs. The care manager informs Alisha of available providers with the capacity to provide services so that she can make informed choices. The care manager records Alisha's selection for her personal care services provider (or her direct service worker if Alisha decides to use the participant direction option to self-direct these services), durable medical equipment (DME) provider, PCP, neurologist, psychotherapist, and other providers in Alisha's plan of care and service plan. She also secures authorization from Alisha for the release of information to coordinate and communicate with Alisha's PCP and treating providers.

Aetna and Beacon Health Options (Beacon), Aetna's behavioral health subcontractor, have already identified, credentialed, and contracted with providers that can meet Alisha's specific needs. Alisha chooses her service providers from a region-wide network of providers. Aetna will also make certain that Alisha's personal services providers meet all minimum provider qualifications outlined by the State, including training and a satisfactory Level II background screening. Aetna's network contracting team is responsible for recruiting and contracting with providers serving LTC enrollees. If we cannot identify an in-network provider, we will go outside the network through a single case agreement to secure services.

In line with Aetna's commitment to diversity, we make every effort to recruit staff with lived experiences, including individuals with disabilities. As an example, Aetna reviews any service request for customized equipment to ensure the DME provider is requesting equipment appropriate to the enrollee's needs. Recognizing the importance of lived experience, our staff member who is responsible for reviewing requests for customized wheelchairs has paraplegia and uses a wheelchair. His or her expertise in custom wheelchairs comes from first-hand understanding as well as his or her professional training. Aetna will also make

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recommendations for additional equipment to support and enhance Alisha's functional needs and independence.

The care manager confirms all of Alisha's providers are Americans with Disabilities Act (ADA) accessible. In addition, we encourage our providers to adopt the new standards of the U.S. Access Board for Medical Diagnostic Equipment. Medical Diagnostic Equipment (MDE) standards "ensure medical diagnostic equipment, such as examination tables, examination chairs, weight scales, mammography equipment, and other imaging equipment used by health care providers for diagnostic purposes are accessible to, and usable by, individuals with disabilities."

### **INNOVATIVE STRATEGIES TO ENHANCE COMMUNICATION AMONG PROVIDERS**

CRITERION 1(j): Application of strategies to integrate information across the plan and various subcontractors when the respondent has delegated functions

CRITERION 3: The extent to which the respondent demonstrates innovative processes that it has in place to enhance communication among all service providers and subcontractors (for delegated functions).

CRITERION 6: The extent to which the respondent describes innovative strategies to integrate information across all systems/processes into its workflows

The care manager also talks to Alisha about new systems and technologies that will be in place to support Alisha and her interdisciplinary care team. For example, CareUnify, Aetna's population health platform (with an expected Florida go-live date in October 2017) digitally connects and shares data among all of Alisha's providers and community service agencies. Promoting effective and efficient care coordination and communication among providers, CareUnify provides an integrated, 360-degree view of Alisha's information with one common, comprehensive, and secure enrollee record.

CareUnify integrates and shares data with all stakeholders, including, but not limited to home and community based providers, community service agencies, DME and home health vendors, enrollees and their circle of support. With CareUnify, Aetna can coordinate Alisha's care across organizations and keep all of her electronic health record data and State agency information up to date. CareUnify can also transmit and receive data from the State's Event Notification System and any connected health information network or RHIOs (regional health information organizations). Additionally, Alisha can also use a computer to log onto the system's enrollee portal to download health information, view her plan of care, and communicate directly with her interdisciplinary care team. This technology supports stronger management of chronic conditions, medication management and reconciliation, collaboration with Alisha's physicians, person-centered care, self-directed care, levels of activation, and intervention to decrease reliance on more intensive care settings, such as acute hospitalization.

Aetna has successfully subcontracted with Beacon Health Options (Beacon) for the past 12 years, delegating management of the behavioral health benefits and the specialty behavioral health network. Beacon strongly supports Aetna's integrated care management model and has a strong record of accomplishment of promoting integrated behavioral health and primary care models in many locations across the State of Florida. Combining our mutual strengths and

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resources, Aetna and Beacon have formed an integrated partner model that is fully capable of meeting and exceeding the State's goals.

This integrated partner model goes well beyond simply co-locating clinical staff. Beacon and Aetna have an aligned clinical vision that will enable Beacon and Aetna clinical staff to work side-by-side to integrate utilization management and care management for all enrollees seamlessly. The experience of our enrollees and our providers will be that we speak with a single voice, doing what is best for our enrollees.

In addition, Beacon brings the strongest network of Medicaid behavioral health providers in the State of Florida, many of whom are already progressing toward full integration of physical and behavioral health. Tighter integration of physical and behavioral health resources within the plan will enable us to accelerate the growth of integrated behavioral health and primary care models throughout all regions of the State.

### **TRANSITION PLANNING**

CRITERION 1(e): Description of the interventions and strategies that would be used to facilitate community integration and transition planning

CRITERION 5: The extent to which the respondent demonstrates a system of coordinated health care interventions designed to achieve cost savings through the organized and timely delivery of high quality services

Our goal is to execute a strategy that will prevent a lapse of services provided in the home for Alisha. First, and foremost, the care manager works closely with Alisha to make sure all services are in place before her mother moves away and Alisha and Noah move to their new home. Aetna's transition planning process helps ensure smooth care transitions, helps prevent disruption of services, and provides a better experience for our enrollees. The care manager works with Alisha to link her to services, make telephone calls on her behalf, and assist her with scheduling appointments with available resources, community organizations, and agencies in Region 11, including:

- Miami Dade Housing Authority: 786-469-4106; 1-888-311-DADE
- Miami Dade County Special Needs Registry: 3-1-1; 305-324-2400 or 305-513-7700
- Agency for Persons with Disabilities: 866-273-2273
- Miami Behavioral Health Center: 305-774-3300
- Center for Independent Living of South Florida (CILSF): 305-751-8025
- Brain and Spinal Cord Injury Program: 850-245-4045

As part of the transition planning process, the care manager will complete an environmental assessment of the new residence to ensure Alisha can function in the home safely with all applicable adaptive devices such as wheelchair ramps, grab bars, and other assists.

Alisha's transition planning addresses all of her needs, as follows:

- Housing: The most pressing issues for Alisha involve her housing needs. Aetna's housing specialist will provide Alisha housing information, link her to housing resources, track her progress in finding stable housing, and provide ongoing support. The care

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manager helps Alisha explore all her options; from remaining in her mother's current home to qualifying for HUD, Section 8, and low-income housing options; including referrals to applicable agencies. Alisha's care manager will help her gather information on moving, home modifications and contacting prospective property owners, etc. In addition to comprehensive referral lists, Aetna care managers have deep local knowledge and tap into established community relationships whenever possible. Our care managers collaborate with one another to capitalize on their experience and direct agency relationships.

- Housing supports: Due to Alisha's special needs, the care manager assists in the coordination of any necessary home modifications for a new dwelling as well as moving and relocation fees. Aetna offers a \$250 emergency fund as an expanded benefit, which can assist Alisha in the transition. Because the \$250 benefit will be insufficient to cover all of these expenses, the care manager also links Alisha to other community resources that can offer assistance, such as the Florida Association for Centers for Independent Living (CILs) and spinal cord injury programs. In addition to setting up her own home, Alisha will need dishes, pots and pans, linens, and other household items. Aetna's housing specialist can assist her with finding funds to pay for her first month's rent, utility deposit, and other housing set up costs if needed. The care manager will also help her determine how she will move her belongings to a new home.
- Personal care: Because her primary caregiver (her mother) will no longer be providing care, Alisha will need additional personal care support to assist her with ADLs and IADLs. In addition to formal (paid) supports, the care manager also encourages Alisha to explore and expand her informal support network by identifying friends, relatives, and neighbors who might be able and willing to help her in specific ways. As noted earlier, the care manager and Alisha will explore the PDO for service delivery of personal care services. She will also address Alisha's need for assistance with meal preparation. It will be important to identify the aides' needs for training to maximize Alisha's independence and quality of life. Alisha's care manager also links Alisha to CILSF's skills classes, workshops, and one to one training on a wide range of topics promoting independent living.
- Physical and occupational therapy: The care manager will address with Alisha and her PCP an evaluation of her current mobility in her upper extremities and ongoing physical and occupational therapy needs to sustain maximum mobility and Alisha's independence.
- Depression: The care manager will address with Alisha, her PCP, and her mental health clinician Alisha's present state of depression and treatment options. The care team may also address additional options such as trauma-informed care, group therapy, and connecting Alisha with peer support with a single parent with similar disabilities. It is critical to monitor Alisha's depression with upcoming changes in Alisha's living situation and support system.
- Physical health: The care manager contacts Alisha's PCP and neurologist to obtain her medical history and ensure her treatment plans are current and accurate. The care manager also performs medication reconciliation with Alisha and encourages and/or helps her schedule all age-appropriate health screenings and preventive physical and behavioral health care. The care manager also provides education and care interventions to improve Alisha's functional status and her ability to self-manage her chronic conditions. Doing so minimizes the extent to which it interferes with Alisha and Noah's lives.

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- Transportation: With her mother's departure, Alisha will face increased transportation needs to get to her appointments, therapy sessions, and services. The care manager will arrange transportation with our vendor to make sure Alisha has specialized transportation when needed.
- Durable medical equipment: Once Alisha's housing situation is resolved, the care manager will conduct an additional environmental assessment to identify additional DME supports Alisha may need, such as a shower chair, grab bars, assistive devices for the bath and kitchen, and other items. Alisha's care manager will arrange for referrals and prior authorizations as needed.
- Assistance with Noah: Alisha and the care manager also explore the various supports for Noah, including his transportation needs to and from school, after-school programs, and youth support groups. Alisha's care manager also provides Alisha with references to community programs and assists her in developing a plan to accommodate Noah's activities. For example, she links Alisha to the Boys and Girls Club of Miami-Dade, along with the Big Brothers Big Sisters of Miami to get Noah more involved in after-school activities and area sports leagues.
- Employment: Alisha's care manager also discusses employment opportunities with Alisha and links her to the Workforce Development and Vocational Education programs through CILSF.
- Peer support: Alisha and her care manager discuss the importance of peer support and counseling for Alisha and connecting with others who have similar experience as she works toward maintaining independence for herself and Noah. Alisha's care manager shares an article she downloaded from the CILSF website: "Encouraging My Spinal Cord Injured Peers To Attend My Peer Support Group" (June 22, 2017). Alisha's care manager also links her to the peer mentoring services through Florida Spinal Cord Injury Resource Center (FSCIRC).
- Social connectedness: Because Alisha has expressed a desire to be more involved in her community, her care manager encourages her to take part in social and creative activities. She suggests Alisha join the Spinal Cord Injury Support Group (SCISG) Miami Chapter, which meets on the fourth Wednesday of each month. She also invites Alisha to take part in activities like CILSF's All Abilities Art Workshop, which encourages adults with disabilities to express themselves through participation in an art workshop with a local artist. The workshop provides assistive devices for individuals like Alisha who have limited hand functioning and coordination.

### **DISEASE MANAGEMENT**

CRITERION 1.h: Identification of strategies that promote self-management and compliance with the plan of care

CRITERION 5: The extent to which the respondent demonstrates a system of coordinated health care interventions designed to achieve cost savings through the organized and timely delivery of high quality services

Our disease management program incorporates an integrated process focusing on providing support and education to help care for and improve the health and quality of life for the enrollees living with complex conditions in the home. It is the goal of the program to properly educate and empower enrollees towards self-management and to provide resources for the enrollees

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through an extensive network of community resources. Through the program, we also coordinate care with the enrollee's primary care provider.

We identify enrollees, like Alisha, for disease management through the State-approved comprehensive assessment tool completed during the initial enrollment and during routine visits between the enrollee and the care manager, scheduled quarterly face-to-face visits, annual reassessments, and upon a new onset diagnosis. Other sources of identification include self-identification by the enrollee, inpatient referrals, along with PCP or care management referrals. Aetna delivers disease management programs within the framework of our integrated care management program. Enrollees learn about the benefits of the disease management program, including how to enroll in it, how to use the program to manage chronic conditions, and how to opt out if they choose. The objectives of Aetna's disease management program are to:

- Promote appropriate medication management
- Decrease the risk of adverse outcomes
- Encourage reduction and/or elimination complicating factors (e.g. smoking, poor diet, obesity, self-damaging behaviors)
- Identify and facilitate treatment of problems early, before they become catastrophic or more complex
- Educate enrollees on the signs and symptoms of their primary and comorbid conditions

All of Aetna's disease management programs have the following key components: enrollee education, enrollee confidence building and emotional support, symptom management, and medication management.

Education based on enrollee assessment of health risks and chronic conditions: All enrollees identified for disease management receive information on self-care management as it pertains to the specific disease state diagnosis. Alisha's care manager will reach out to her psychotherapist to ensure that our care coordination and enrollee education efforts align with the work that Alisha is doing with her therapist. We determine the type and frequency of information based on the specific disease state and the enrollee's acuity level. In addition to print materials, Aetna offers Web-based education and Web links, which provide additional information. Alisha's care manager provides Krames educational information on depression.

The care manager and Alisha also discuss how to recognize suicide risk signs and substance use disorder. The care manager makes sure Alisha knows about our Informed Health Line (nurse line) and our Behavioral Health Crisis Stabilization Line—both available 24/7. Alisha also receives a list of community mental health resources such as American Psychological Association, American Foundation of Suicide Prevention, National Institutes of Health Centers of Disease Control (CDC), Department of Health, Behavioral Health Crisis Line, and National Alliance on Mental Illness. Alisha also receives a condition-specific newsletter on depression twice a year, information on Aetna's Website, and links to other mental health resources. Alisha's care manager will work with her psychotherapist to ensure care coordination and education.

Enrollee and caregiver confidence building and emotional support: The disease management program's assessment questions allow enrollees/caregivers to build rapport with the care manager. The State-approved assessment tool includes questions addressing caregiver stress, emotional issues, and support needs for the caregiver. This assessment "opens the door" to

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addressing other emotional issues, which the enrollee or caregiver faces in dealing with chronic conditions. Care manager interventions feature specific emotional support tools for enrollees and caregivers and that foster conversations between care managers and enrollees on coping with daily care. For example, with Alisha's mother relocating, her role will be changing as caregiver and she will no longer be able to provide daily physical supports. However, she will always be connected to Alisha and Noah. The relationships are not ending, but they may all experience the loss acutely. In alignment with Alisha's therapist, our care manager will work with Alisha and Noah to reframe this as a change in which some things are no longer occurring day-to-day, but the emotional and mentoring role of a parent and grandparent will continue. Using creative thinking on how to support the family relationship, our care manager assisted Alisha's mother in learning how to use Skype and texting on her mobile phone, so that she could regularly communicate with Noah and Alisha.

Dialogue with the care manager also allows enrollees and caregivers to demonstrate competencies, which instills caregiver confidence. The dedicated assignment of a single care manager to each enrollee strengthens the relationship between enrollee/caregiver and care manager. Additionally, care managers can refer enrollees to a clinician, who can facilitate a wider range of interventions for emotional support over a longstanding series of encounters. Interdisciplinary care teams also facilitate referrals for community resources, home health, DME, and respite care. All enrollees are eligible to receive visits from a LTC clinician to assist with community resource management and referral to appropriate resources and/or agencies.

Symptom management: All enrollees are eligible and encouraged to participate in setting appropriate health goals related to their chronic conditions. Symptom management also includes and addresses the enrollee's needs and any issues related to behavioral management. Enrollees can work on goal setting with their care manager and/or the LTC clinician. Enrollees like Alisha will have a tailored plan of care with measurable goals and outcomes so that the enrollee can assess his or her progress towards meeting the individual enrollee goals. The care manager will support the work of the psychotherapist who is the primary driver of how Alisha manages her depression. With the input of Alisha's therapist, the care manager will be responsible for following up, reviewing, and updating Alisha's care plan until she demonstrates improved depression management skills with a goal of discharge from the disease management program. Alisha's providers will collaborate with her care manager and her interdisciplinary care team as needed, including providing clinical information needed to appropriately educate and direct Alisha to improve her depression management.

Medication management: All enrollees have a comprehensive medication review with their PCP and other providers. Medication reconciliation makes sure the enrollee is taking prescribed medications correctly and not suffering any adverse effects and/or interactions from contraindicated medications. Care managers collect the list of medications from all enrollees/caregivers at the initial assessment and update this list no less than quarterly. Our clinicians or pharmacists communicate with PCPs when a medication review reveals medication duplication, adverse risk, drug-drug interaction, or a contraindication. Alisha's care manager will follow up with her PCP, licensed mental health clinician, and her neurologist to ensure treatment and medications are appropriate for Alisha's depression.

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CRITERION 1.b: Application of the respondent's case management risk stratification protocol, including a rationale for the decision;

Our disease management programs provide targeted interventions according to an enrollee's risk level. We stratify enrollees into two risk levels: intensive care management or supportive care management. Stratification occurs at the initial assessment (or at identification of a chronic condition) and then quarterly thereafter using original stratification rules. Designed and customized to meet individual enrollee's needs, targeted interventions reflect an enrollee's stratification risk level and ability to influence behavior. Targeted interventions address topics of healthy behavior, such as smoking cessation, substance abuse, weight management, and diagnosis appropriate diet and/or nutritional requirements. Aetna embraces a multidisciplinary approach to addressing enrollee needs.

All disease management interventions are completed in collaboration with the enrollee's care manager or an LTC clinician. Aetna's LTC model for disease management provides a stratification process for enrollees at high risk (intensive) to enrollees at low risk (supportive). All enrollees are eligible to transition to a higher level of stratification based on their self-referred needs. With a risk stratification of supportive level of care, Alisha's care management includes problem-solving interventions that focus on improving access to, as well as effectiveness and safety of, standard health care for Alisha.

Disease management interventions often include specific behavioral changes and lifestyle management changes recommended to the enrollee, specific support services, and linkage to community resources or other payers (where necessary) to provide services, even when those services extend beyond the scope of benefits available to the enrollee under Aetna's coverage limits in accordance with the Medicaid Summary of Services.

Alisha's care manager enlists Alisha, her family, and her circle of support to aid in the maintenance of her wellness activities. The care manager also provides education and self-management techniques to help Alisha manage her conditions effectively. Condition management interventions include telephonic and print education on self-monitoring, referral for appropriate medical testing, and assistance with techniques to follow medication regimens and treatment plans. Condition management interventions also address the enrollee rationale for non-compliance, and enlist collaboration (with the enrollee's consent) with providers and caregivers. Because behavioral health and substance use issues are commonly co-occurring, we screen enrollees for both conditions to monitor for any changes and to engage appropriate resources and services.

### **DEPRESSION SECONDARY TO SPINAL CORD INJURY (PARAPLEGIA)**

CRITERION 1.h: Identification of strategies that promote self-management and compliance with the plan of care

With her incomplete paraplegia and history of clinical depression, Alisha is eligible for disease management. Paraplegia, sometimes called partial paralysis, is a form of paralysis in which impedes function substantially from the waist down. The problem resides in either the brain or spinal cord, which cannot send or receive signals to the lower body because of injury or disease. Depression secondary to spinal cord injury is common to this population.

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Complex condition management aims to improve the quality of care and condition outcomes for enrollees living with depression. The care manager encourages Alisha to assume greater responsibility for her health through a multidisciplinary approach to depression management and self-management support. We do this through collaboration, engagement, identification of strengths and leveraging those strengths to enhance resiliency, which will help Alisha improve condition management and self-efficacy. Our care manager coordinates a three-way discussion with Alisha and her therapist to clear what the work of therapy includes, and what ancillary disease management resources would support Alisha's engagement in therapy.

Successfully managing her clinical depression will help Alisha:

- Understand the risks of living with depression so that she can change health-related behaviors to impact her health and wellness positively
- Improve her functional status and ability to self-manage her depression
- Enlist family or other support entities to aid in maintenance of wellness and depression symptom management
- Identify and manage co-morbid conditions as needed
- Reduce or delay morbidity (complications) and mortality associated with depression

Strategies for Alisha's self-management of depression include sleep, hygiene, healthy eating, and avoidance of alcohol or other central nervous system (CNS) depressants. Social support is critical and can be achieved many ways, including faith-based support groups, peer support, meaningful work, continuing individual/group therapy, and medication as prescribed.

Alisha's care manager will also help her develop a depression Wellness Recovery Action Plan (WRAP) to support her resilience and recovery. The care manager encourages Alisha to implement a personal wellness toolbox with a list of resources she can use to develop her WRAP. Alisha's WRAP includes reminders to contact friends and peer support specialists, use focusing exercises, relaxation and stress reduction exercises, journaling, exercise, diet, and getting a good night's sleep to promote personal health and well-being.

Communicating effectively with providers: We provide practitioners and PCPs with information about the LTC disease management programs available to our enrollees. This information gives instructions on how to use our services and how Aetna works with patients to help them better manage their chronic conditions. We mail, fax, and make this information available through our Website. If requested, Aetna will send providers a list of their patients enrolled in our disease management programs. Similarly, if requested, we will provide Alisha's providers with the informational materials on paraplegia and depression we provided to her to optimize care coordination efforts for her.

Additionally, Aetna will monitor and educate providers on the importance of following nationally recognized and evidence-based guidelines for evaluation and treatment of depression and collaborate with care management on Alisha's plan of care. Alisha's plan of care focuses on her needs, including cultural, socio-economic, transportation, education, and barriers to managing her depression. The care manager sends Alisha's plan of care to her PCP, neurologist, and mental health clinician to support communication and care coordination.

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Ongoing monitoring: Alisha's care manager will continue to monitor Alisha's progress and update her treatment/care plan as appropriate. The care manager documents all steps of the care management process to record interactions, interventions, and outcomes.

Alisha's vignette demonstrates that supporting enrollees who have experienced a traumatic event does not end with the physical healing—it is important to note that the passage of time does not always heal the feelings caused by trauma. In Alisha's case, her complex physical conditions were complicated by depression and a major life change as her mother, the primary caregiver, was moving out of the area. Alisha and her son, Noah, were entering a new chapter in their lives and Aetna's integrated care management staff was there to support this journey. As noted throughout this vignette, our care manager supported Alisha every step of the way through this transition; from assisting with securing housing, arranging for therapies, both physical and behavioral health, supporting Noah by encouraging ongoing communication with his grandmother, and much more. Our care manager served as Alisha's trusted advocate and continues to play an important role in helping this family. Alisha is pursuing employment through Workforce Development and is attending the Spinal Cord Injury Support Group—Miami-Dade Chapter, that meets monthly. Noah joined the Boys and Girls Club of Miami, and he is increasingly involved in after-school and athletic activities. Alisha has been educated on how to arrange for transportation services, and she continues to receive personal care and physical/occupational therapy. As an enrollee in our disease management program, Alisha is learning the importance of self-care and the ways in which it affects positive health outcomes. Most importantly, Alisha has learned that her care manager is a true partner who is there to provide positive and proactive support and solutions.

### **UTILIZATION MANAGEMENT/SERVICE AUTHORIZATION**

**CRITERION 1.f:** Application of coordination protocols utilized with other insurers (when applicable), primary care providers, specialists, other service providers, and community partners particularly when referrals are needed for non-covered services;

**CRITERION 1.i:** Application of utilization management protocols (i.e., identification of the criteria that will be utilized, processes to ensure continuity of care, etc.)

We validate all services in need of authorization against other health care coverage for possible coordination of benefit (COB). Care managers verify enrollees' health coverage with Medicare, Medicaid, Veterans Administration benefits, and commercial insurance and/or other statewide waiver programs at all times. For example, enrollees with Medicare coverage have all home health skilled nursing and DME needs covered through Medicare. If Alisha needs assistance with current or future DME, her care manager will coordinate benefits (such as Medicare or MMA benefits) and identify any needs still to be addressed.

Our goals are to provide quality of care to our enrollees and, whenever possible, avoid the risks associated with overuse, underuse, and misuse of health care interventions while removing barriers to accessing care. To support prior authorization decisions, Aetna uses nationally recognized, evidence-based criteria, which are applied based on the needs of individual enrollees and characteristics of the local delivery system. We use Milliman Clinical Guidelines (MCG), nationally recognized evidence-based guidelines for physical health. Our medical management clinical criteria policies and procedures define eligible criteria sources and the process for adoption, review, and approval of clinical criteria. Aetna utilizes national policies and

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

processes for adopting and updating evidence-based clinical practice guidelines and preventative services guidelines from recognized sources that follow National Committee for Quality Assurance standards.

Beacon's utilization management program encompasses management of care from the point of entry through discharge for all MMA enrollees. Using its Florida Medicaid Level of Care Criteria (LOCC) for mental illnesses and ASAM criteria for substance use disorders, Beacon manages behavioral health care with objective, scientifically based clinical criteria and treatment guidelines in its service authorization process. Intensive utilization management is reserved for high-cost, highly restrictive levels of care and cases that represent potential clinical complexity and risk. Licensed behavioral health clinicians base their reviews on clear and concise criteria developed specifically to guide level of care, treatment, and length of stay determinations.

The care manager manages prior authorization for all the home- and community-based services (HCBS) and DME Alisha requires. We have different levels of approval. Alisha's care manager can approve any service with a Level 1 approval. For example, Alisha's care manager can approve up to 15 hours of individual or combined services for direct care/PDO services (non-skilled or skilled) supported by the HCBS and CES tools. As noted above, the care manager always verifies coordination of benefits to prevent duplication of services. Level 2 requires approval from utilization management regional clinician and Level 3 requires approval from the health plan's medical director. All services requiring prior authorization by utilization management require a Level 2 approval. In Alisha's case, this includes her DME, any home modifications, physical therapy, and occupational therapy.

When making referrals for skilled services (e.g., physical therapy), the physical therapy provider assesses Alisha to see if her physical therapy goals are attainable. If they are, the medical director will authorize services for a specific period, and re-review to ensure Alisha is progressing toward her goals. Aetna will authorize the assessment and, considering the recommendations of the physical therapy provider, she will authorize the frequency and length of treatment. When coordinating benefits, we go to Medicare first, then to Medicaid based on medical necessity and justification. We follow utilization management criteria for authorization of these services. In Alisha's case, the physical therapy provider completes a prior authorization request, which is sent to our Prior Authorization department via fax. The medical director reviews the request for medical necessity. If approved, the care manager updates Alisha's plan of care to include physical therapy. The same process applies to occupational therapy, DME and other similar services.

### **Grievances and Appeals**

Aetna's grievances and appeals processes afford Alisha the opportunity to voice her issues, concerns, and problems in a non-threatening manner. Our process is available to our enrollees and our approach to identify and resolve grievances and appeals timely ensures that our enrollees, from all racial, ethnic, and cultural backgrounds, receive equitable and effective treatment in a culturally and linguistically appropriate manner. Our grievance system responds to and supports all enrollee requests for State Fair Hearings. Our process conforms to all applicable State and federal laws and regulations. The care manager will review the grievances and appeals section of the enrollee handbook with Alisha during her initial face-to-face visit. The care manager also explains that when an enrollee or designated representative requests the review of an action where we denied, reduced, suspended, or terminated an item or service,

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typically through a Notice of Adverse Benefit Determination, the review will be conducted in accordance with our enrollee appeals process.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

**Evaluation Criteria:**

1. The adequacy of the respondent's approach in addressing the following:
  - (a) Description of the sources of data/information that would be utilized in the assessment process, including timeframes for completion;
  - (b) Application of the respondent's case management risk stratification protocol, including a rationale for the decision;
  - (c) Application of a person centered care planning approach;
  - (d) Identification of service needs (covered and non-covered) and a description for service referral processes that the plan has in place;
  - (e) Description of the interventions and strategies that would be used to facilitate community integration and transition planning;

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- (f) Application of coordination protocols utilized with other insurers (when applicable), primary care providers, specialists, other service providers, and community partners particularly when referrals are needed for non-covered services;
  - (g) Description of the assessment of provider capacity to meet the specific needs of enrollees;
  - (h) Identification of strategies that promote self-management and compliance with the plan of care;
  - (i) Application of utilization management protocols (i.e., identification of the criteria that will be utilized, processes to ensure continuity of care, etc.); and
  - (j) Application of strategies to integrate information across the plan and various subcontractors when the respondent has delegated functions.
2. The extent to which the respondent's workflows/narrative descriptions include timeframes for completion of each step in the care planning process.
  3. The extent to which the respondent demonstrates innovative processes that it has in place to enhance communication among all service providers and subcontractors (for delegated functions).
  4. The extent to which the respondent demonstrates experience providing services to enrollees with complex medical needs and provide evidence of strategies utilized that resulted in improved health outcomes.
  5. The extent to which the respondent demonstrates a system of coordinated health care interventions designed to achieve cost savings through the organized and timely delivery of high quality services.
  6. The extent to which the respondent describes innovative strategies to integrate information across all systems/processes into its workflows.

**Score:** This section is worth a maximum of 75 raw points with each of the above components being worth a maximum of 5 points each.

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## **Attachment LTC SRC# 11**



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LTC SRC# 11: Figure LTC SRC 11-1: Workflow Depicting Significant Change

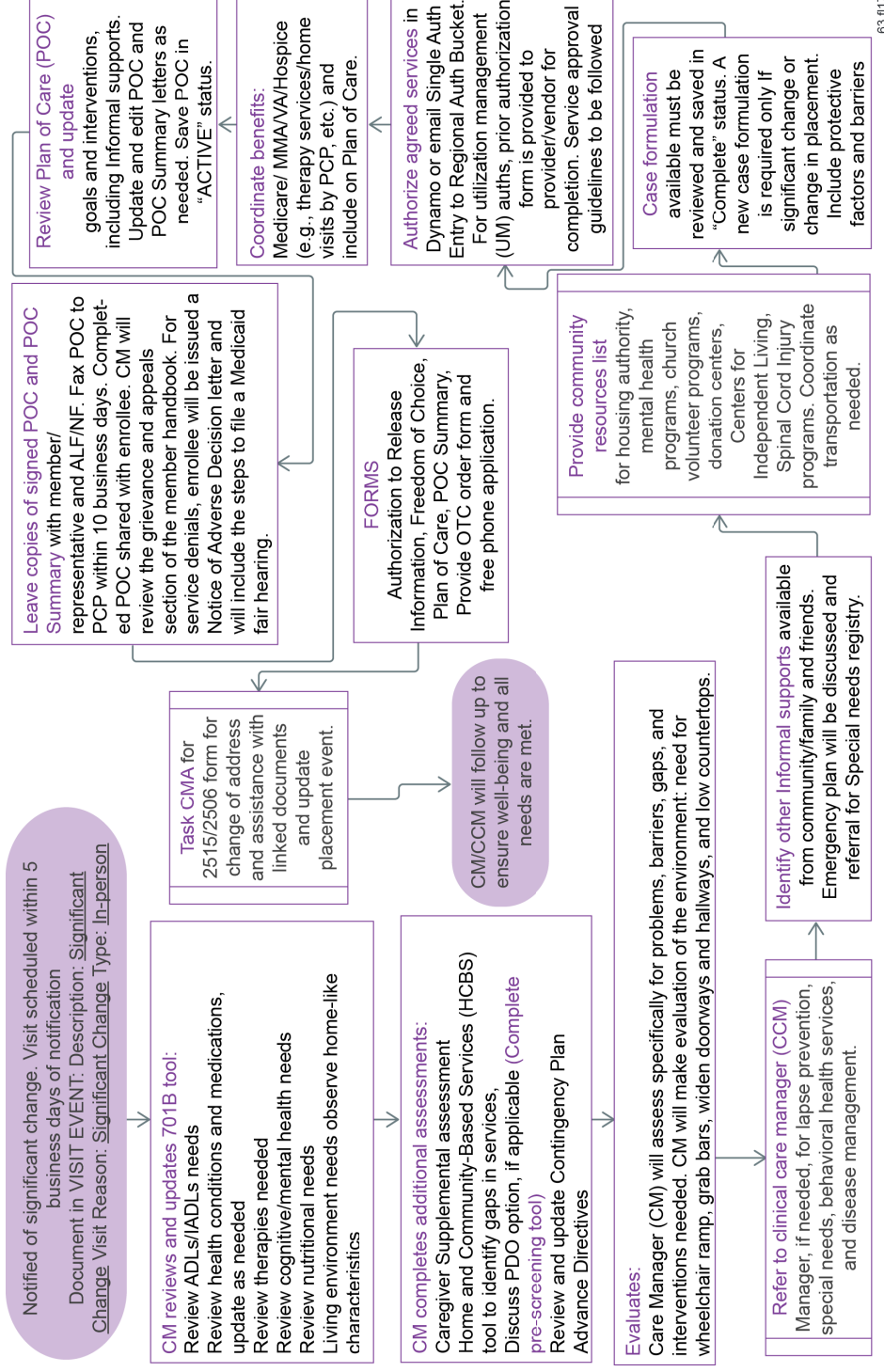


Figure LTC SRC 11-1: Workflow Depicting Significant Change

*This Significant Change workflow depicts Aetna's approach to coordinating care for an LTC enrollee with paraplegia and clinical depression. It includes a detailed description of notable points in the care management process, including comprehensive assessment, caregiver assessment, person-centered care planning, transition planning, disease management, utilization management/service authorization, and grievances and appeals.*

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**EXHIBIT A-4-c**  
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**LTC SRC# 12 – Case Vignette (Statewide):**

The respondent shall review the below case vignette, which describes potential Florida Medicaid recipients. Note: The vignette included below is fictional.

*Mr. and Mrs. Smith are a husband and wife, both in their early 70s. They have an adult daughter who lives in State. The Smiths are both enrolled in Medicaid managed care and are dual-eligible for Medicaid and Medicare. The Smiths are enrolled in Medicare FFS. Mr. Smith is enrolled in a Managed Medical Assistance plan, while Mrs. Smith is newly enrolled in your LTC Plus Plan or Comprehensive Plan. Mrs. Smith has moderate to severe dementia that is progressing. She is able to walk with the aid of a walker and she can feed herself. However, she needs assistance with bathing and dressing, and she needs supervision due to wandering. Mrs. Smith was admitted to the hospital three months ago for pneumonia but was discharged to a nursing facility, as her husband was unable to care for her on his own anymore. Mrs. Smith would like to move home. Mr. Smith would like for her to move home, but he is concerned that he cannot meet all of her needs on his own. Mr. Smith has a single, below-the-knee amputation, but is otherwise healthy. Their small home is cluttered, and they have many pets. Mr. Smith says he is overwhelmed because she needs more care than he can provide by himself.*

The respondent shall describe its approach to coordinating care for an enrollee with Mrs. Smith's profile, including a detailed description and workflow demonstrating notable points in the system where the respondent's processes are implemented:

- a. Comprehensive Assessment;
- b. Caregiver Assessment;
- c. Person Centered Care Planning;
- d. Transition Planning;
- e. Disease Management;
- f. Utilization Management/Service Authorization; and
- g. Grievance and Appeals.

Where applicable, the respondent should include specific experiences the respondent has had in addressing these same needs in Florida or other states.

**Response:**

Mr. and Mrs. Smith are excited at the prospect of Mrs. Smith returning home after receiving care in a nursing home for three months. Married for 53 years, the Smiths have rarely spent time apart. The past three months have placed both of them under a great deal of physical and emotional strain. Returning home, however, presents multiple challenges for both Mrs. and Mr. Smith. Most important is Mr. Smith's concern that he cannot properly care for Mrs. Smith by himself at home. Transitioning Mrs. Smith from the nursing facility back home will require coordination of care efforts to facilitate the move, secure home and community-based services (HCBS) services, maintain safe living conditions, as well as consistent and ongoing monitoring to help Mr. and Mrs. Smith remain together in their home.

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

### **EXPERIENCE**

CRITERION 4: The extent to which the respondent demonstrates experience providing services to enrollees with complex medical needs and provide evidence of strategies utilized that resulted in improved health outcomes

When our long-term care (LTC) program began in 2014, our care management staff was charged with coordinating enrollee transitions from the institutional setting to home or an alternative setting. While effective, we believed as a health plan that we could do a better job to ensure our enrollee transitions were successful. We identified many barriers to enrollees' transition from nursing facilities to home, including resistance from the nursing facilities and providers. In some instances, the enrollees themselves experience some anxiety with regard to moving back to the community. In identifying these barriers, we found more resources were necessary to address these multi-factorial issues. As a result, we have created new positions and staffed the program with transition of care clinicians who are qualified to work with enrollees, plan staff, vendors, providers, physicians, and behavioral health specialists.

Using our person-centered approach, we begin a conversation with Mr. and Mrs. Smith about where she wants to live. In our experience, we discover that many enrollees are not aware they have a choice or that financial assistance is available to support them. Once Mr. and Mrs. Smith tells us where she wishes to live, we begin to develop and coordinate the plan, including assigning a transition of care clinician, for Mrs. Smith to return home.

Since the transition program began, Aetna has increased the number of enrollees who left a nursing facility to reside in the community. So far in 2017, we have helped 113 enrollees living in nursing homes move to the community. The success of this program is a direct result of the implementation of our nursing facility transition team and the appropriate coordination of services. In 2016, only 4 enrollees out of 109 who left the nursing home had to return to the nursing facility because of declining health. We continue to work with the four enrollees so they might one day return to living in their community.

In the process of working with these enrollees, we discovered the need for increased education for nursing facility staff so that they were better able to understand the positive benefits of helping enrollees to reside in their communities. In turn, this education allows the facilities to care for enrollees with higher levels of needs. This relationship allows us to develop preferred provider networks of nursing facilities that actively help in identifying enrollees who are best served in the community, while creating access for our enrollees who are transferring from the hospital to a nursing facility.

In addition to the nursing facility staff, we also discovered the need to engage the nursing facility physicians early in the process so they can support and help us develop an appropriate transition plan of care for the enrollee. In many instances, we discovered the need to re-engage the primary care provider (PCP) or re-establish a primary care relationship. This is critical to helping ensure enrollees successfully remain in the community.

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

We are continuously examining our own processes in Florida, as well as glean information regarding the successes of our other Long Term Services and Supports (LTSS) programs across the nation. For example, Aetna has successfully helped enrollees live in the least restrictive settings possible, as demonstrated by our transition statistics for a health plan we manage in Arizona. Currently, 75% of that health plan's LTSS enrollees in Arizona reside in the community compared to only 5% in 1989 when the managed LTSS program began.

LTC program enrollees are diverse individuals with complex physical and behavioral health issues, often impacted by socioeconomic or geographic factors. Aetna provides LTC enrollees with a seamless system of services and supports to meet their daily care needs, enhance their quality of life, and improve their health outcomes. Our care managers work with enrollees and their circle of support to remove barriers that limit their ability to manage their own health and well-being. We offer education on managing physical and behavioral health conditions, community resources, and strategies for self-care to help enrollees maintain community living. Care management services support enrollees' personal and cultural values, beliefs, and preferences so they can reach their individual life goals and live in the community.

### **DETAILED DESCRIPTION**

CRITERION 1.a: Description of the sources of data/information that would be utilized in the assessment process, including timeframes for completion

CRITERION 1.b: Application of the respondent's case management risk stratification protocol, including a rationale for the decision

CRITERION 2: The extent to which the respondent's workflows/narrative descriptions include timeframes for completion of each step in the care planning process

Prior to meeting with Mrs. Smith, the care manager reviews our Consolidated Outreach Risk Evaluation™ (CORE) predictive modeling report to determine her initial stratification, the nursing facility medical record, the discharge instructions from the hospital, and current medications. The care manager also reaches out to Mrs. Smith's PCP to see if there are any additional issues or concerns. After compiling this information, the care manager schedules an on-site assessment visit with Mrs. Smith and her family (Mr. Smith and their daughter) within seven business days of Mrs. Smith's effective date of enrollment. During the visit, the care manager gives the Smiths information on the LTC program and the benefits available to support Mrs. Smith, including covered services and non-covered services in addition to what would be available to them through Medicare should she decide to return home. The care manager confirms in writing Mrs. Smith's receipt of an enrollee handbook, provider directory, and Aetna ID card. The care manager also explains Mrs. Smith's rights and responsibilities, including procedures for filing a grievance, appeal, or Medicaid State Fair Hearing, and how to report suspected abuse, neglect or exploitation, along with providing a the toll-free reporting number. This begins the care planning process. All enrollee materials presented to the Smiths are culturally and linguistically appropriate and written at the proper literacy level. The care

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

manager, also aware that Mr. Smith is part of Aetna's Managed Medical Assistance (MMA) plan, takes the time to review his benefits with him during this meeting.

The care manager uses motivational interviewing and open-ended questions to develop a trusting relationship with Mrs. and Mr. Smith, exploring their life goals and what is important to them. During this conversation the care manager completes the 701B comprehensive assessment and transition screening tool/assessment. The care manager reviews Mrs. Smith's activities of daily living (ADLs), instrumental activities of daily living (IADLs), health conditions, medications (updating them as needed), cognitive and mental health needs, nutritional needs, needed therapies, and informal supports.

The care manager conducts the caregiver assessment and HCBS needs assessment tool with the Smiths to identify and coordinate additional services Mrs. Smith may need once she transitions back into the community. The HCBS needs tool helps the care manager identify the types and amounts of HCBS services needed for Mrs. Smith to maintain a safe residence. It identifies specific HCBS needs and any unpaid caregivers providing assistance in housekeeping and cleaning, laundry, shopping, meal preparation and clean up, eating and feeding, bathing, dressing and grooming, toileting, mobility, transferring, and general supervision. The care manager also performs a Cost Effectiveness Study (CES). The CES provides a mechanism to compare and monitor Mrs. Smith's specific HCBS costs to those of a nursing facility or institutional setting. This provides an opportunity to identify HCBS enrollees most at risk.

### **Risk Stratification**

The CORE predictive modeling tool identifies enrollees who are candidates for intensive and supportive care management and enrollees who are candidates for high- and low-risk chronic condition management. We have learned that complexity of condition is more important than diagnosis when identifying enrollees who are at high risk. Enrollees at high risk are almost always challenged by the biopsychosocial complexities inherent in their lives. As a result, they are unlikely to benefit from standard care and most likely to benefit from our integrated care management model which is built to address such complexities. The tool predicts the likelihood of integrated care management making an impact and ranks all plan enrollees from highest to lowest risk.

CORE places enrollees within risk groups: high-risk for an emergency department visit, medium or high-risk for an inpatient admission, or high-risk for high costs and poor outcomes in the next 12 months. CORE helps to guide our outreach to enrollees in the highest risk categories.

CORE identifies enrollees likely to be future high-utilizers based on claims and diagnostic data. This effective tool determines the enrollee's potential risk level and predicts that care management interventions can effectively improve the enrollee's outcome. However, our care managers are responsible to identify enrollees for supportive or intensive levels of care management and disease management based on the information we gather from the assessments and outreach activities, which identify enrollee's biopsychosocial complexity and

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

the intensity of their needs. Assigning enrollees to different levels of care management utilizes a combination of the enrollee's self-reported conditions and health care utilization information, such as emergency department encounters, hospital utilization, or chronic conditions.

Mrs. Smith was placed in care management at the supportive level since she is in a nursing facility where her care needs are being met. When Mrs. Smith transitions home, she will continue at a supportive level of care since the necessary services and supports will be in place before Mrs. Smith discharges home. Being able to transition into the community means Mrs. Smith has the services and supports in place to ensure a safe and successful transition.

### **TRANSITION PLANNING**

**CRITERION 1.e:** Description of the interventions and strategies that would be used to facilitate community integration and transition planning

The care manager continues her discussion about the Smiths' life goals and together, they explore Mrs. Smith's concerns about help with mobility and her desire to walk in her neighborhood. Mr. Smith also has concerns about not being able to care for Mrs. Smith, given her diagnosis and needs. Because Mr. Smith is hesitant in talking about his concerns, Mrs. Smith's care manager uses motivational interviewing and active listening to help him explore his feelings and ambivalence about his wife returning home. She focuses on Mrs. Smith's specific ADL deficits (bathing, dressing, and ambulation/transferring), her wandering, the areas she will need assistance with when she returns home, and what Mr. Smith feels he can handle.

The care manager speaks to them both about Mrs. Smith's need for supervision, and the likely progression of her disease. Knowing that Mr. and Mrs. Smith will have help through paid caregivers, Mr. Smith feels much more confident in his ability to take care of and keep Mrs. Smith safe. The care manager confirms Mrs. Smith's desire to return home.

Since the care manager determined that Mrs. Smith is willing and able to transition back to her home, she involves the transition of care clinician. The transition of care clinician and care manager work in tandem to support Mr. and Mrs. Smith throughout the transition process. Like the care manager, the transition of care clinician visits Mrs. and Mr. Smith in the nursing facility to conduct a screening to assist with the transition of care. Mrs. Smith's transition of care clinician coordinates with the nursing facility, discharge planner, Mrs. Smith's PCP, and her support system.

To prepare for Mrs. Smith's transition home, the Smiths and transition of care clinician develop a transition plan that incorporates:

- Safe housing needs
- HCBS services and supports to assist the Mrs. Smith personal care needs

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Comprehensive disease management to help Mrs. and Mr. Smith manage her chronic conditions (dementia and Alzheimer's) as well as her functional and behavioral health needs
- Medication management and reconciliation
- PCP visits post-transition
- Preventive health care and services, including age appropriate health screenings
- Non-Medicaid covered community services to improve health and quality of life

The transition of care clinician arranges with Mr. Smith to conduct an in-home environmental assessment to assess and address any safety issues in the home (e.g., clutter, multiple pets). Working with the Smiths, the transition of care clinician identifies any barriers to independent living for Mrs. Smith. The transition of care clinician also coordinates with the care manager to make sure they identify all of Mrs. Smith's needs: durable medical equipment (DME) and supplies ordered, home visits by PCP or physical therapy/occupational therapy (PT/OT) arranged (as needed), behavioral health needs addressed, and housing needs/environmental modifications completed.

The transition of care clinician makes sure supports are available and in place for Mr. Smith as the primary caregiver. These supports include education, respite care, support group referrals, peer mentoring, and family counseling. Our goal is to make sure we support the Smiths before, during, and after the transition occurs.

### **Post-Transition**

When Mrs. Smith moves from the nursing facility back to her home, her quality of life may improve; however, we are also aware of the potential for re-admission to the nursing facility. We therefore, create a plan of care to monitor the changes in her health and safety to ensure that she is able to stay at home. After Mrs. Smith's transition home, both the transition of care clinician and the care manager schedule face-to-face meetings with Mrs. Smith to monitor this significant change event. The transition of care clinician visits Mrs. Smith within 72 hours of her transition home to assess Mrs. Smith's clinical needs. For example, prescriptions are part of Mrs. Smith discharge planning; so, the transition of care clinician will make sure Mrs. Smith has her medications at discharge and will perform a medication review at this home visit.

The care manager sees Mrs. Smith within five business days of her discharge home to evaluate Mrs. Smith's supportive needs. During this visit, the care manager makes sure all appropriate services are in place and Mrs. Smith continues to agree with the plan of care as authorized. Both the transition of care clinician and care manager schedule their visits for days/times convenient for the Smiths.

The transition of care clinician conducts another in-home visit the following month to prevent any type of lapse and to ensure all needed services are still in place. Based on Mrs. Smith's

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

supportive risk stratification level, her care manager will continue to monitor Mrs. and Mr. Smith through monthly follow-up calls, a face-to-face visit every 90 days, and an annual face-to-face re-assessment. The care manager also conducts a face-to-face visit within five business days of notification of a significant change event or change in placement for Mrs. Smith.

### **COMPREHENSIVE ASSESSMENTS (PRE AND POST TRANSITION)**

**CRITERION 1.a:** Description of the sources of data/information that would be utilized in the assessment process, including timeframes for completion

Completed during the initial assessment meeting at the nursing facility, the care manager updates Mrs. Smith's 701B comprehensive assessment during the post-transition visit (within five business days of Mrs. Smith's return home). The care manager assesses specifically for problems, barriers, service or care gaps, and any additional interventions needed. The care manager evaluates Mrs. Smith's home environment for DME or home modifications. The care manager reviews Mrs. Smith's medications and completes the Incontinence Questionnaire and Caregiver Supplemental Assessment with Mrs. and Mr. Smith. The care manager and the Smiths review her home and community based services, PDO options, and Mrs. Smith's contingency plan. The care manager completes the 2515/2506 form for change of address/assistance with linked documents/update placement event to Department of Children and Families (DCF) within 10 business days of Mrs. Smith's discharge from the nursing facility.

Together, the Smiths and the care manager review and identify informal supports available from the community, family and friends. They discuss Mrs. Smith's emergency plan and referral to the special needs registry. The Smiths also receive a community resources list for Alzheimer's and dementia support groups, as well as local agency contacts.

Aetna's assessments are comprehensive, evidence-based tools, which gives us a deep understanding of what Mrs. Smith's needs are from a medical, behavioral, social, functional, and cognitive standpoint. The assessment provides us with the information necessary to create the framework for Mrs. Smith's transition plan and care plan. Our assessment tools and instruments are based on best practices and clinical guidelines, with a biopsychosocial scope and elements of root-cause analysis and social determinants of health. Self-reported data, such as that elicited by our assessment tools, is a critical component of our integrated care management model. Our model addresses physical, behavioral, and social health, which is necessary for supporting vulnerable enrollees like Mrs. Smith.

Our integrated care management program identifies opportunities to make a significant difference in the lives of our vulnerable enrollees. Having effective mechanisms to identify and monitor enrollees with complex needs is a critical first step in delivering appropriate, coordinated, and cost effective physical and behavioral health care. Our integrated care management program addresses each enrollee's medical, behavioral and social needs in a unique and individual way.

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

We use a fully integrated and advanced electronic care management system that enables our care managers to address each enrollee's physical and behavioral health concerns. Our Web-based electronic care management system provides a complete suite of functional, physical, and behavioral health assessments, care planning tools, and monitoring functions. With our secure, proprietary system and its remote access capabilities, Mrs. Smith's care manager can take a laptop into the Smiths' home on face-to-face visits and immediately research and answer their questions, enter enrollee information in real-time, access and verify information, and develop/update and upload Mrs. Smith's comprehensive care and service plans. Similarly, care managers and enrollees can use the Internet to access Aetna's website for Medicaid and health care information and educational materials. Using a secure login, enrollees (including Mr. Smith or his daughter) can also use the enrollee Web-portal to view their care plan.

The care manager documents and uploads all assessments and care plan activity in our electronic care management system, including authorization requests, Health Insurance Portability and Accountability Act (HIPAA) forms, and any hospitalization information on Mrs. Smith.

### **Caregiver Assessment**

During the face-to face meetings, both the care manager and transition of care clinician assessed Mr. Smith as Mrs. Smith's primary caregiver. The care manager will continue to re-evaluate Mr. Smith in this role, especially as Mrs. Smith's dementia progresses. Additional caregiver assessments include the Caregiver Strain Index. The care manager gives Mr. Smith Aetna's caregiver support toolkit and makes sure Mr. Smith understands the importance of respite care. The toolkit contains information on Alzheimer's, along with tips for coping with stress, caring for someone with Alzheimer's, and resources/services for caregivers. The care manager and Mr. Smith talk about the having his daughter become more involved in his wife's care. (Although their daughter wants to help, she does not live nearby. She has offered to be available for six hours on Saturdays to give Mr. Smith time for himself.) The care manager also conducts a caregiver assessment with the Smiths' daughter and gives her literature on caregiver stress and burnout to ensure she does not compromise her own health in caring for her mother.

To enhance Mr. Smith's knowledge and understanding of Mrs. Smith Alzheimer's disease and its progress, the care manager refers Mr. Smith and his daughter to caregiver training and community resources through the Alzheimer's Association. Mr. Smith and his daughter may also be interested in attending the various support groups offered by the Alzheimer's Association to help alleviate some of their stress and concerns.

### **PERSON-CENTERED CARE PLANNING**

CRITERION 1.c: Application of a person-centered care planning approach

CRITERION 1.h: Identification of strategies that promote self-management and compliance with the plan of care

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Aetna's integrated care management model ensures the right resources are available, organized, and coordinated to help Mrs. Smith achieve her personal goals and health ambitions. Keeping Mrs. Smith in the least restrictive setting of her choosing helps to minimize preventable use of high-intensity, high-cost health services, such as inpatient hospitalization, long-term residential/institutional care, and emergency department visits.

As noted earlier in this section, the care manager conducts care planning with the Smiths during the initial face-to-face assessment at the nursing facility and during the comprehensive on-site visit within five business days of Mrs. Smith's return home. All person-centered care planning includes the following:

- Development, prioritization, and review of Mrs. Smith's short- and long-term goals (Mrs. Smith wants to live at home with her husband.)
- Identification of barriers to meeting goals or complying with the plan (e.g., Mrs. Smith's progressing Alzheimer's coupled with Mr. Smith's worry about taking care of Mrs. Smith by himself)
- Scheduling follow-up to review progress toward goals
- Development of self-management plans to help Mrs. Smith with her dementia
- Monitoring and evaluation of care plan for effectiveness and modification
- Documentation of tasks and follow-up per the agreed upon goals and timeframes
- Developing a service gap contingency and back-up plan to identify actions the Smiths can take to report any gaps in service and what resources are available to resolve unforeseen gaps in service

During the care planning process, the care manager completes the comprehensive 701B assessment during the initial assessment, and updates it when Mrs. Smith transitions to the community, to determine support and services needed based on Mrs. Smith's personal and health care goals. This includes her choice to live at home in an HCBS setting (documented on the Freedom of Choice form) and both covered and non-covered services, regardless of payer source. The overarching goal of Mrs. Smith's plan of care is to help her achieve and maintain her highest level of self-sufficiency and to provide supports to meet her care needs. Mrs. and Mr. Smith have requested their daughter to be involved in the care planning process.

Throughout the care planning process, the care manager uses a teach-back method to make certain the Smiths understand an issue, recommendation, and next steps by asking them to repeat back what they heard. Although Mr. Smith has power of attorney, Mrs. Smith is still competent and can participate in her own care plan and decision-making. Therefore, it is important to make sure she has a voice and choice in her care planning and understands her care plan. Similarly, it is important to hear what Mr. Smith understands of the care planning process and to make sure he does not feel overwhelmed.

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Our care manager explores Mr. and Mrs. Smith's personal values and preferences so that meaningful activities can be incorporated into her plan of care, such as weekly trips to the hairdresser or attending church on Sundays. Also, Mrs. Smith expressed a desire to spend additional time with her daughter, going to the park and moving safely around the neighborhood. All of these preferences need to be considered when selecting the home care provider and integrated into care planning.

The plan of care is not complete until Mrs. Smith and Mr. Smith agree the plan makes sense and they commit to the activities in the plan of care. Working with the Smiths to define their short- and long-term goals, the care manager translates these goals into achievable steps. This phased approach increases the confidence level of Mrs. Smith and Mr. Smith as they begin to achieve her short-term goals (transitioning Mrs. Smith home and keeping her safe). The care manager encourages and provides positive feedback to the Smiths through mentoring, coaching, skill building, and emotional support.

Mrs. Smith's plan of care is easy to understand and accessible. It incorporates her cultural, linguistic, and special needs. The Smiths receive a signed copy of Mrs. Smith's plan of care upon completion/approval and can request additional copies at any time. The plan of care is a reference for Mrs. Smith, her interdisciplinary care team, and all in-home caregivers and care providers. The care manager works within our care management system to update the plan of care (in real time). In addition, the care manager forwards a copy of the care plan to Mrs. Smith's PCP within 10 business days of initial development.

### **PROVIDER CAPACITY**

**CRITERION 1.g:** Description of the assessment of provider capacity to meet the specific needs of enrollees

Mrs. and Mr. Smith can select service providers from a region-wide network of providers. Aetna will also make certain that providers of Mrs. Smith's services meet all minimum provider qualifications outlined by the State, including training and a satisfactory Level II background screening. In addition, we consider the following when determining provider capacity to work with Mrs. Smith:

- Does the care provider offer the specific services that Mrs. Smith needs; is the staff trained in dementia care or have experience working with someone with dementia?
- Are those credentials verified; and what is the procedure if the care provider is sick, on vacation or resigns?

Aetna's network contracting team is responsible for recruiting and contracting with qualified providers serving LTC enrollees. If we cannot identify an in-network provider, we will go outside the network through a single case agreement to secure services.

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

We evaluate the actual services provided utilizing electronic visit verification (EVV). EVV helps us to monitor service use and real-time receipt of authorized services. If a provider consistently experiences issues with meeting the scheduling requirements of the position we would be made aware through EVV and that could result in changing caregivers and/or replacing providers. It would also impact whether we would utilize a provider for other cases when considering provider capacity to service our enrollees.

Aetna will use EVV for HCBS, residential and participant-directed services and will work in collaboration with providers in the community who may already be using EVV, to develop a solution that effectively protects our enrollees from fraud, waste, and abuse.

We continuously evaluate the actual performance of the providers on a continuous bases, we evaluate:

- Home- and community-based providers:
  - Timeliness in initiating services
  - Proportion of authorized services to delivered services
  - Emergency department visits/1000
  - Hospital admissions/readmissions
  - Enrollee complaints/grievances
  - Enrollee experience and satisfaction surveys
- Residential providers:
  - Timeliness in initiating services
  - Proportion of authorized services to delivered services
  - Emergency department visits/1000
  - Hospital admissions/readmissions
  - Enrollee complaints/grievances
  - Enrollee experience and satisfaction surveys
- Participant-direction providers:
  - Timeliness in initiating services
  - Proportion of delivered services to authorized services
  - Enrollee complaints/grievances

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

- Enrollee experience and satisfaction surveys

Network development and maintenance are important components of successful transition and aging in place initiatives. Aetna develops effective partnerships with Area Agencies on Aging (AAAs), Centers for Independent Living (CILs), State agencies, community-based mental health associations, federally qualified health centers, faith-based organizations, and others involved in serving our enrollee populations.

### **INNOVATIVE STRATEGIES TO ENHANCE COMMUNICATION AMONG PROVIDERS**

CRITERION 1.j: Application of strategies to integrate information across the plan and various subcontractors when the respondent has delegated functions

CRITERION 3: The extent to which the respondent demonstrates innovative processes that it has in place to enhance communication among all service providers and subcontractors

CRITERION 6: The extent to which the respondent describes innovative strategies to integrate information across all systems/processes into its workflows

Prior to a move home, the care manager will coordinate the services that Mrs. Smith will require with the appropriate participating subcontractors. The care manager will work with the Utilization Management (UM) staff to obtain clinical information for medical director review and ensure that the authorizations are expedited and documented in the UM business application system. The care manager and DME vendor will coordinate the time and location for delivery of any needed equipment and supplies, such as a shower chair, grab bars, and a raised toilet seat. Home health services will be arranged with a home health vendor for homemaker and respite services.

A participating provider will be selected, all required documentation will be obtained, and prior authorization will be completed through the UM process. Other services to coordinate include in home meals and non-emergency transportation. The care manager assumes the lead on identifying the services needed and, with the agreement of Mr. and Mrs. Smith, works with the UM staff to ensure that required authorizations are complete. The care manager also monitors to be sure that the services are delivered as requested. Services that are not covered benefits, but could support a safe and successful transition to home may be considered under the expanded benefit of transitional funds. An example would be a door alarm system for an enrollee with dementia. Again, the care manager takes the lead, obtaining supporting documentation and reviews with the medical director.

The care manager talks to the Smiths about new systems and technologies that will be in place to support Mrs. Smith and her interdisciplinary care team. For example, Mrs. Smith's interdisciplinary care team will have electronic access to her plan of care through our enrollee and provider portals, and our CareUnify system. CareUnify, Aetna's population health platform digitally connects and shares data among all of Mrs. Smith's providers and community service agencies. Promoting effective and efficient care coordination and communication among

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

providers, CareUnify provides an integrated, 360-degree view of Mrs. Smith's information through a common, comprehensive, and secure enrollee record.

CareUnify integrates and shares data with all stakeholders, including but not limited to: HCBS providers, community service agencies, DME and home health vendors, enrollees and their circle of support. With CareUnify, Aetna can coordinate Mrs. Smith's care across organizations and keep all of her electronic health record data and state agency information up to date. CareUnify can also transmit and receive data from the State's Event Notification System and any connected health information network or regional health information organization (RHIOs). Digital integration and communication among providers supports stronger management of chronic conditions, medication management and reconciliation, collaboration on Mrs. Smith's plan of care, and early intervention to decrease reliance on more intensive care settings, like acute hospitalization.

### **PROVIDING FORMAL AND INFORMAL SUPPORT AND SERVICES TO ENROLLEES**

CRITERION 1.d: Identification of service needs (covered and non-covered) and a description for service referral processes that the plan has in place

CRITERION 1.e: Description of the interventions and strategies that would be used to facilitate community integration and transition planning

CRITERION 1.f: Application of coordination protocols utilized with other insurers (when applicable), primary care providers, specialists, other service providers, and community partners particularly when referrals are needed for non-covered services

CRITERION 5: The extent to which the respondent demonstrates a system of coordinated health care interventions designed to achieve cost savings through the organized and timely delivery of high quality services

The care manager encourages Mrs. and Mr. Smith to maintain relationships with their community groups and actively participate in community activities for social connectedness. She also helps them expand their support network by linking them to additional community resources and supports to increase integration within the community. Including community-based resources and non-covered services in the care planning process gives the Smiths' choice, access, and control over their services and supports. Whenever possible, the care manager draws on direct relationships with community organizations to communicate and assist the Smiths with securing services as needed. The care manager also works with advocacy groups, faith-based groups, and other community-based organizations offering key services and information related to independent living. These include local, State, and federal resources, including regional AAAs, CILs, food pantry programs, utility/heating assistance, housing assistance, vocational services, and federal emergency assistance programs.

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

The care manager is responsible for giving the Smiths the tools, education, and resources to be successful and to maintain strong community tenure after Mrs. Smith transitions home, including:

- Personal care – Mrs. Smith will need personal care services to assist her with bathing and dressing. Since Mr. Smith has already indicated he does not want to exercise the participant direction option, the care manager will identify potential agencies for the personal care services.
- Homemaker services – Based on the home environmental assessment, Mrs. Smith's care manager addresses the need to declutter the house. The care manager has specifically identified that the clutter and pets pose a fall risk for both Mr. and Mrs. Smith. The care manager suggests an extensive cleaning be undertaken by adding agency provided homemaker services, with routinely scheduled homemaker services to ensure a safe and clean environment. The care manager also discusses the risk factors caused by having multiple pets in the home. Mr. Smith and his daughter discuss developing a restricted area in the house for the pets. The care manager also provides the numbers for local community resources, such as Animal Services for Seniors, which provides information on how to care for pets and why pets are great for seniors. In addition, the care manager advises the Mr. Smith that it may be necessary to consider a natural support for their pet care that could include engaging a teenage neighbor to help with walking the dogs after school.
- Durable medical equipment – To address Mrs. Smith's wandering, the care manager has suggested the Smiths consider an alarm system for their exterior doors. This alarm system would alert Mr. Smith or other caregivers to Mrs. Smith's departure from the home. Transitional funds of \$2,500 are available to the Smiths, which they can use to purchase and install the alarm system. Based on the environmental assessment and discussions with Mr. Smith, the care manager also suggests additional DME to assist with Mrs. Smith's bathing and toileting needs and ensure her safety, specifically a shower chair, grab bars, and a raised toilet seat in the bathroom. The care manager arranges for referrals and prior authorizations based on the environmental assessment.
- Respite/sitter services – As the primary caregiver, Mr. Smith will need support to ensure he maintains his own health and well-being. The care manager discusses with the Smiths routinely scheduled respite and/or sitter services that will enable Mr. Smith to take a break from caring for Mrs. Smith. Since respite is a covered LTC service, the care manager discusses paid respite and caregiver options with Mr. and Mrs. Smith and links them to these agencies. The Smiths' daughter has indicated she and her husband are willing to provide respite for Mr. Smith on a weekly basis (six hours on Saturdays). In addition, both Mr. Smith and Mrs. Smith have mentioned deep involvement with their church and that they have friends from church who have offered to help them when Mrs. Smith transitions back home. Mr. Smith has expressed some hesitancy at letting others help. The care manager works with Mr. Smith to help him overcome his reluctance by

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

talking about the importance of respite services (paid/unpaid), the possibility of caregiver burnout, and the impact of caregiving on his own health. She encourages Mr. Smith to accept help from friends willing to provide additional respite for him when needed.

- Physical health – The care manager contacts Mrs. Smith's PCP to obtain her medical history and ensure her treatment plans are current and accurate. She discusses Mrs. Smith's dementia diagnosis and reviews her current medications with Mrs. Smith's PCP. If needed, the care manager will assist Mrs. Smith in scheduling a visit with her physician and regular appointments for routine preventive care, age appropriate health screenings, and the flu vaccination (to reduce the risk of pneumonia). The care manager also coordinates transportation to these appointments as needed.
- Transportation – The care manager coordinates local transportation services to help Mrs. Smith get rides to and from her doctor appointments, community activities, and her Alzheimer's counseling and peer support groups.
- Home-delivered meals – If home delivered meals are identified as a gap or a service need, the care manager will coordinate the service. Additionally, the care manager links the Smiths to Meals on Wheels for help with hot meal preparation and delivery.

### **DISEASE MANAGEMENT**

CRITERION 1.b: Application of the respondent's case management risk stratification protocol, including a rationale for the decision

CRITERION 1.h: Identification of strategies that promote self-management and compliance with the plan of care

Aetna delivers dementia/Alzheimer's disease management services within the framework of our integrated care management program. The goal of the disease management program is to improve our enrollees' functional status and to reduce longer-term premature morbidity (complications) and mortality of the condition. Aetna has designed our disease management program to address those enrollees like Mrs. Smith who are likely to be high utilizers of inpatient admissions related to their diagnosis and severity of illness. Enrollees are encouraged to follow age-appropriate screenings and health-maintenance guidelines, as well as evidence-based care for chronic physical and behavioral illnesses. Every assessment and encounter includes attention to comorbidities and reducing unhealthy behaviors in a person-centered manner. We help enrollees identify issues related to their physical and behavioral health concerns, social determinants of health, as well as caregiver issues and circle of support's needs, community health support needs, transportation challenges, access-to-care challenges, and knowledge gaps that prevent them from achieving their personal health care goals.

Our disease management programs provide targeted interventions according to an enrollee's risk level. We stratify enrollees into two risk levels: intensive care management or supportive care management. Stratification occurs at the initial assessment (or at identification of a chronic

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

condition) and then quarterly thereafter. Designed and customized to meet individual enrollee's needs, targeted interventions reflect an enrollee's stratification risk level and their ability to impact behavior. For Mrs. Smith, targeted interventions address topics of healthy behavior, including appropriate diet and/or nutritional requirements. Aetna embraces a multidisciplinary approach to addressing enrollee needs. All disease management interventions are completed in collaboration with the enrollee's care manager or an LTC clinician. Aetna's LTC model for disease management provides a stratification process for enrollees at high risk (intensive) to enrollees at low risk (supportive). All enrollees are eligible to transition to a higher level of stratification based on their self-referred needs.

Disease management interventions often include specific behavioral changes and lifestyle management changes recommended to the enrollee, specific support services, and linkage to community resources or other payers (where necessary) to provide services, even when those services extend beyond the scope of benefits available to the enrollee under Aetna's coverage limits in accordance with the Medicaid Summary of Services.

Based on Mrs. Smith's current state and comprehensive assessments, her risk stratification is supportive level of care. Her level of care management includes problem-solving interventions that focus on improving access to, as well as effectiveness and safety of standard health care for Mrs. Smith. Supportive care management targets enrollees who have fewer clinical and biopsychosocial complexities; yet it includes chronic condition management, longitudinal care management of enrollees in the LTC population, along with brief and/or condition-focused care management, depending upon an enrollee's needs.

The care manager provides culturally aligned education and support for Mrs. and Mr. Smith. In addition to individualized support from the care manager, Mr. Smith will receive Krames Patient Education materials specific to dementia and Alzheimer's.

The care manager refers the Smiths to the following resources:

- Alzheimer's Disease Education and Referral (ADEAR) Center, 800-438-4380, website: [nia.nih.gov/alzheimers](http://nia.nih.gov/alzheimers)
- Alzheimer's Association, 800-272-3900, website: [alz.org](http://alz.org)
- Alzheimer's Foundation of America, 866-232-8484, website: [alzfdn.org](http://alzfdn.org)
- Eldercare Locator, 800-677-1116, website: [eldercare.gov](http://eldercare.gov)
- Family Caregiver Alliance, 800-445-8106, website: [caregiver.org](http://caregiver.org)

For ongoing disease management of Mrs. Smith's Alzheimer's, the care manager assesses and monitors changes at least every 90 days to include routine daily activities like eating, bathing, and dressing. The care manager will evaluate safety needs in the Smiths' home and assess for environmental modifications and task simplification. Because people living with Alzheimer disease may have or develop other chronic conditions, such as heart disease, diabetes and

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

depression, the care manager will identify and provide appropriate care management interventions for these potentially treatable diseases as needed.

### **INNOVATIVE STRATEGIES TO INTEGRATE INFORMATION ACROSS SYSTEMS AND PROCESSES**

**CRITERION 6:** The extent to which the respondent describes innovative strategies to integrate information across all systems/processes into its workflows

If Mrs. Smith develops any of these chronic conditions, she may be eligible for Aetna's remote patient monitoring (RPM) program. This innovative program supports enrollees in self-management of chronic conditions by using web-enabled devices (blood pressure cuff, scale, pulse oximeter, glucometer) to monitor enrollees with select chronic conditions (e.g., heart failure, diabetes, and hypertension) from their homes. These devices capture data and automatically send it through a Wi-Fi signal. CareUnify, our population health platform, captures and distributes the data set. If Mrs. Smith develops any of the chronic conditions included in the program, the care manager may recommend RPM (if available in Mrs. Smith's geographic area).

The care manager encourages Mrs. Smith to complete all preventive health screenings and regular dental checkups to maintain her health and well-being. These screenings and checkups allow for monitoring of signs of the disease's progression, which can manifest as oral and dental disease, the possibility of malnutrition (as eating and swallowing become more difficult and appetite reduces), as well as respiratory, eye, and skin infections. The care manager will continue to assess for barriers related to social determinants of health on an ongoing basis. The care manager explains the use of our Informed Health Line (available 24/7).

The care manager will continue to recommend a nutritious diet, physical activity, social engagement, and mentally stimulating pursuits for Mrs. Smith to help minimize the impact of cognitive decline from Alzheimer's disease. The care manager will rely on input from Mr. Smith and other caregivers to determine Mrs. Smith's ongoing needs as her dementia and Alzheimer's disease progresses.

Since depression and anxiety are often associated with dementia and Alzheimer's, the care manager will continue to assess for these conditions and keep Mrs. Smith's PCP informed of any changes. The care manager will refer Mrs. Smith to behavioral health professionals and peer support as needed. She will also provide information and education to help the Smiths self-manage any anxiety or depression.

Caring for someone with Alzheimer's disease is demanding physically, emotionally, socially and financially. Therefore, the care manager provides Mr. Smith and his daughter with information on how to maintain their own health and quality of life as they care for Mrs. Smith. The care manager's focus is to help Mr. Smith maintain his physical and mental health as he manages Mrs. Smith's daily care, including options to support life balance and giving him the tools to respond to challenging behaviors.

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

Good coping skills, a strong support network, and respite care are other ways that help caregivers handle the stress of caring for a loved one with Alzheimer's disease. The care manager discusses the importance of respite care and encourages the use of respite services. The care manager also provides Mr. Smith with education on providing or accessing care specific to the Mrs. Smith's needs. The care manager is flexible in care planning to support Mr. Smith's participation in support groups and social interactions. She teaches Mr. Smith some ways to respond to Mrs. Smith's challenging behaviors:

- Try not to take behaviors personally
- Remain patient and calm
- Explore pain as a trigger
- Do not argue or try to convince
- Accept some behaviors as a reality of the disease

The care manager makes sure Mr. Smith understands that an acute behavior change may be the result of illness (often a respiratory or bladder infection) and should precipitate a call to the PCP.

An enrollee's preferred support system is often the first to recognize a physical, cognitive, or emotional decline or a change in condition. Through education and teaching, the care manager will help Mrs. Smith's caregivers (Mr. Smith and Mrs. Smith's paid personal attendants) identify red flags—such as changes in cognition, behavior, and ADLs, which serve as triggers for a re-evaluation—and notify the care manager of the changes. The care manager will reassess Mrs. Smith when there is any change in her emotional, functional, or cognitive status, and at regularly scheduled intervals.

The care manager links Mr. and Mrs. Smith to support groups that can teach coping strategies individually and in group therapy settings to help them maintain their psychological health. Additionally, the care manager makes referrals and links the Smiths to community health workers and appropriate informational and social agencies as a way to maximize Mrs. Smith's function in daily activities. As part of the care management process, the care manager and the Smiths also discuss end-of-life planning, including palliative and hospice care.

### **UTILIZATION MANAGEMENT/SERVICE AUTHORIZATION**

**CRITERION 1.f:** Application of coordination protocols utilized with other insurers (when applicable), primary care providers, specialists, other service providers, and community partners particularly when referrals are needed for non-covered services

**CRITERION 1.i:** Application of utilization management protocols (i.e., identification of the criteria that will be utilized, processes to ensure continuity of care, etc.)

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

CRITERION 5: The extent to which the respondent demonstrates a system of coordinated health care interventions designed to achieve cost savings through the organized and timely delivery of high quality services

Aetna validates all services in need of authorization against other health care coverage for possible coordination of benefits (COB). Care managers verify enrollees' health coverage with Medicare, Medicaid, Veterans Administration benefits, and commercial insurance and/or other statewide waiver programs at all times. For example, enrollees with Medicare coverage have all home health skilled nursing and DME needs covered through Medicare. If Mrs. Smith needs assistance with current or future DME, her care manager will coordinate benefits (such as Medicare or MMA benefits) and identify any needs still to be addressed.

Our goals are to provide quality of care to our enrollees and whenever possible, avoid the risks associated with overuse, underuse, and misuse of health care interventions while removing barriers to accessing care. To support prior authorization decisions, Aetna uses nationally recognized, evidence-based criteria, which are applied based on the needs of individual enrollees and characteristics of the local delivery system. We use Milliman Clinical Guidelines (MCG), nationally recognized evidence-based guidelines for physical health, and Beacon uses Florida Medicaid Level of Care Criteria (LOCC) for mental illnesses and ASAM criteria for substance use disorders. Our medical management clinical criteria policies and procedures define eligible criteria sources and the process for adoption, review, and approval of clinical criteria. Aetna utilizes national policies and processes for adopting and updating evidence-based clinical practice guidelines and preventative services guidelines from recognized sources that follow National Committee for Quality Assurance standards.

The care manager manages prior authorization for all HCBS and DME Mrs. Smith requires. We have different levels of approval. Mrs. Smith's care manager can approve any service with a Level 1 approval. For example, Mrs. Smith's care manager can approve up to 15 hours of individual or combined services for direct care/PDO services (non-skilled or skilled) supported by the HCBS and CES tools. As noted above, the care manager always verifies coordination of benefits to prevent duplication of services. Level 2 requires approval from utilization management regional clinician and Level 3 requires approval from the health plan's medical director. All services requiring prior authorization by utilization management require a Level 2 approval. In Mrs. Smith's case, this includes her DME or any home modifications.

When coordinating benefits, we go to Medicare first, then to Medicaid based on medical necessity and justification. We follow utilization management criteria and State guidelines for authorization of these services. When requesting authorization, the provider completes a prior authorization request form and faxes it to our Prior Authorization department. Prior authorization staff reviews the request for medical necessity. If approved, the care manager updates Mrs. Smith's plan of care to include authorized service or DME.

Over the course of Mrs. Smith's care management, her care manager continues monitoring service delivery and evaluating the quality of services and supports Mrs. Smith receives, along

**EXHIBIT A-4-c**  
**LTC SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

with determining whether Mrs. Smith is meeting the goals she established in her care plan. Monitoring Mrs. Smith's health status includes completing periodic reassessments and care plan reviews. If her care manager sees any changes in Mrs. Smith's conditions while performing an assessment or receives a report of a change from Mrs. Smith, her husband, or caregiver, the care manager will complete an in-person visit within five business days of the noted change. We also review Mrs. Smith's claims data to determine gaps in care. Mrs. Smith's interdisciplinary team will also review all of these items to make certain she achieves and stays at her optimal health.

**Grievances and Appeals**

Aetna's grievance and appeal processes afford the Smiths the opportunity to voice their issues, concerns, and problems in a non-threatening manner if not resolved with the care team or when working with the care manager or the transition of care clinician. Our process is available to our enrollees and our approach to identify and resolve grievances and appeals timely ensures that our enrollees, from all racial, ethnic, and cultural backgrounds, receive equitable and effective treatment in a culturally and linguistically appropriate manner. Our grievance system responds to and supports all enrollee requests for State Fair Hearings. Our process conforms to all applicable state and federal laws and regulations. The care manager reviewed the grievance and appeals section of the enrollee handbook with the Smiths during her initial face-to-face visit in the nursing facility (new enrollment) and during the home visit after Mrs. Smith's transition home (significant change event). When an enrollee or 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 will be conducted in accordance with our enrollee appeals process.

[REDACTED]

[REDACTED]

[REDACTED]

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Figure LTC SRC 12-1: Workflow Depicting Significant Change in Attachment LTC SRC 12 illustrates a workflow for a significant change.

**APPROACH**

As noted in this vignette, Mrs. Smith was admitted to the hospital three months ago for pneumonia, and then discharged to a nursing facility for rehabilitation. Assuming Mrs. Smith's custodial status (after her Medicare days ran out), she was enrolled in the State's Medicaid program. Because of Mrs. Smith's nursing facility placement, she is enrolled in Aetna's LTC program and assigned a care manager. Mrs. Smith's care manager will serve as her advocate, facilitator, and collaborator throughout the care management process.

Upon receipt of the enrollment information, the care manager reaches out to Mrs. Smith and the nursing facility to identify any urgent needs that require immediate action and to arrange an initial face-to-face visit at a time convenient for Mrs. Smith and her family. During this call, the

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care manager learns that Mrs. Smith wants to return home with her husband but she presents with moderate to severe dementia and uses a walker to assist with mobility. She needs assistance with bathing and dressing and supervision due to wandering. The care manager learns that Mr. Smith holds power of attorney for Mrs. Smith.

Before the initial assessment and care planning development, the care manager obtains and reviews Mrs. Smith's nursing facility medical records for information on her diagnosis, current medications and treatment orders, Pre-Admission Screening and Resident Review (PASRR), Minimum Data Set (MDS), and other documentation, including a copy of the Power of Attorney document. The care manager also learns that Mrs. Smith has a PCP to whose service she will return after discharge from the nursing facility. The care manager contacts Mrs. Smith's PCP and requests her medical records as part of the assessment and care planning processes.

During the scheduled face-to-face meeting, the care manager will assess Mrs. Smith and her situation and begin the care planning and transition planning processes as appropriate. The care manager will conduct the initial face-to-face visit within seven business days of the Mrs. Smith's effective date of enrollment. During this initial assessment, the care manager will confirm Mrs. Smith's desire to return home and determine the HCBS services and supports needed to make Mrs. Smith's transition viable. The care manager will work with Aetna's transition clinician to facilitate Mrs. Smith's transition home. (In mid-2017, Aetna began deploying transition clinicians in each region of Florida. These licensed registered nurses possess a distinct skillset, including expertise and experience in transitions of care, home health, nursing facility transitions, and patient-centered care.) Transition clinicians strengthen the care manager's efforts by working closely with enrollees like Mrs. Smith, our health plan staff, vendors (home health, durable medical equipment, personal care attendants, etc.), hospital and nursing facility providers, physicians, and behavioral health specialists alike to facilitate successful transitions back into the community. A graphical depiction of Aetna's Significant Change workflow (Figure 12.1 above), outlining Mrs. Smith's transition from a nursing facility to a community setting, is included at the end of this section.

Mrs. Smith's person-centered care planning will include care coordination, integrated medical and behavioral health care, and chronic condition education (disease management). It is flexible to reflect her current and changing needs. Skilled at coordinating care with other delivery systems and our integrated care approach, the care manager will make sure Mrs. Smith is not receiving duplicative services. Incorporating existing authorizations and preexisting plans of care into Mrs. Smith's integrated care plan provides continuity of care for Mrs. Smith, Mr. Smith, and their support system. In fact, when multiple care plans exist, there is always the potential for confusion, duplication, or omission of services, especially when one health plan mistakenly assumes another is covering the need.

Our care management activities integrate physical health and behavioral health, along with social supports and services, to maximize community integration and tenure for enrollees living in the communities and care settings of their choice. We incorporate support from within our Florida communities by engaging with an enrollee's current support system and building on

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these existing relationships. Moreover, we collaborate with community organizations and resources to offer additional services and supports to our enrollees.

We use integrated information management tools, including predictive modeling and CareUnify (our population health platform) to identify and stratify our enrollees by risk, capture information relevant to their care, share information and data with providers, and monitor our program's effectiveness. We use comprehensive assessments to understand enrollees' physical health, behavioral health, pharmacy, and service needs to pinpoint opportunities for addressing care gaps and enhancing community living. Providing appropriate utilization of services supports transition efforts between institutional care and home and community-based services.

Interdisciplinary care teams are a key feature of Aetna's approach to our integrated care management model. Interdisciplinary care team meetings are instrumental in our efforts to manage challenging behaviors, frequent emergency department visits, hospitalizations, or other complex needs that create a significant risk to HCBS placement. As part of the care planning process, Mrs. Smith and Mr. Smith will choose the participants on her interdisciplinary care team. We connect members of an interdisciplinary care team through the enrollee's plan of care and our technology platforms.

### **Evaluation Criteria:**

1. The adequacy of the respondent's approach in addressing the following:
  - (a) Description of the sources of data/information that would be utilized in the assessment process, including timeframes for completion;
  - (b) Application of the respondent's case management risk stratification protocol, including a rationale for the decision;
  - (c) Application of a person centered care planning approach;
  - (d) Identification of service needs (covered and non-covered) and a description for service referral processes that the plan has in place;
  - (e) Description of the interventions and strategies that would be used to facilitate community integration and transition planning;
  - (f) Application of coordination protocols utilized with other insurers, (when applicable) primary care providers, specialists, other service providers, and community partners particularly when referrals are needed for non-covered services;
  - (g) Description of the assessment of provider capacity to meet the specific needs of enrollees;
  - (h) Identification of strategies that promote self-management and compliance with the plan of care;
  - (i) Application of utilization management protocols (i.e., identification of the criteria that will be utilized, processes to ensure continuity of care, etc.); and
  - (j) Application of strategies to integrate information across the plan and various subcontractors when the respondent has delegated functions.
2. The extent to which the respondents workflows/narrative descriptions include timeframes for completion of each step in the care planning process.

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3. The extent to which the respondent demonstrates innovative processes that it has in place to enhance communication among all service providers and subcontractors (for delegated functions).
4. The extent to which the respondent demonstrates experience providing services to enrollees with complex medical needs and provide evidence of strategies utilized that resulted in improved health outcomes.
5. The extent to which the respondent demonstrates a system of coordinated health care interventions designed to achieve cost savings through the organized and timely delivery of high quality services.
6. The extent to which the respondent describes innovative strategies to integrate information across all systems/processes into its workflows.

**Score:** This section is worth a maximum of 75 raw points with each of the above components being worth a maximum of 5 points each.

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## **Attachment LTC SRC# 12**



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LTC SRC# 12: Figure LTC SRC 12-1: Workflow Depicting Significant Change

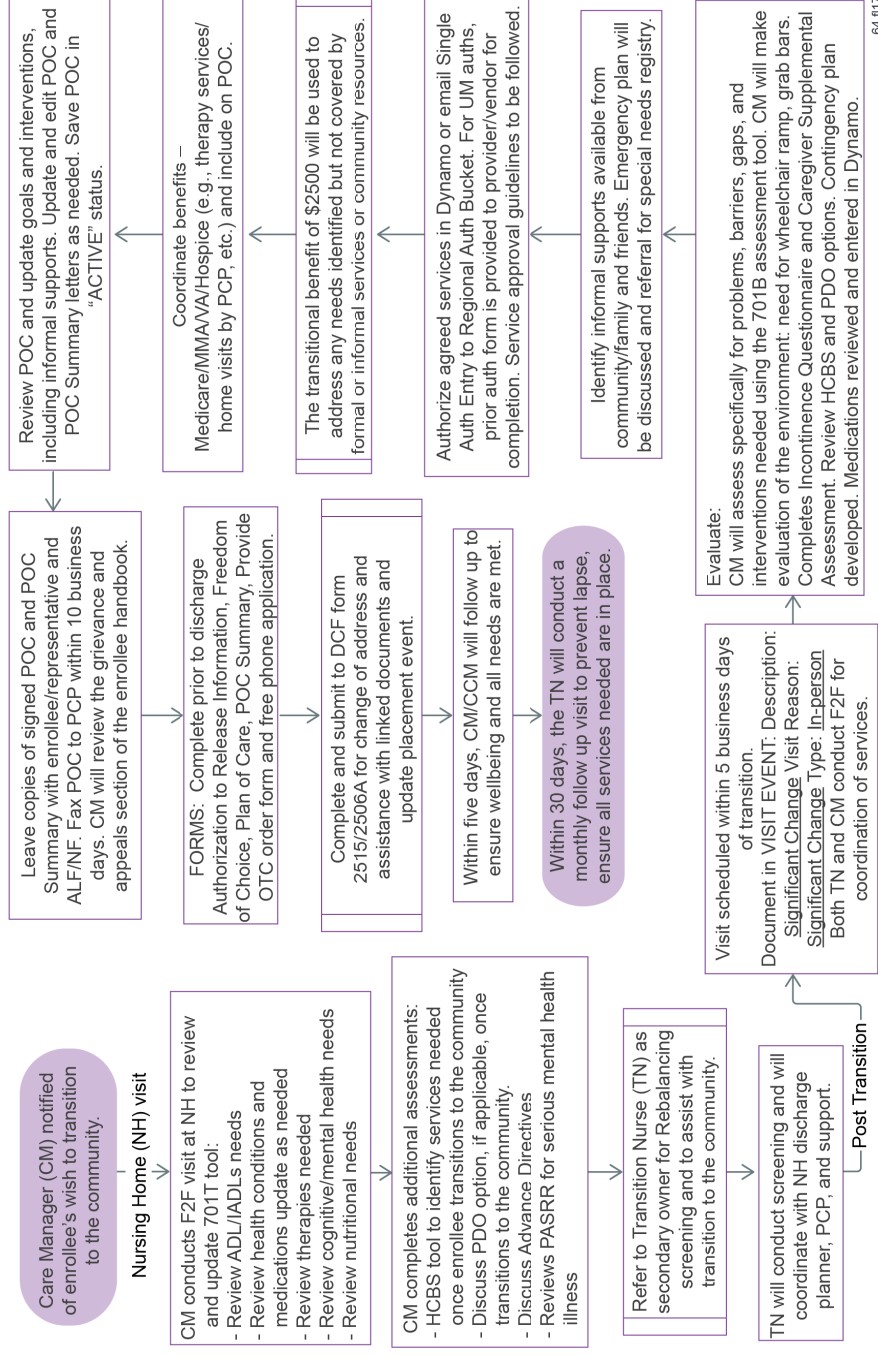


Figure LTC SRC 12-1: Workflow Depicting Significant Change

*This Significant Change workflow depicts Aetna's approach to transitioning and coordinating care for an LTC enrollee with Alzheimer's who successfully transitions from a nursing facility into the community. It includes a detailed description of notable points in the system: comprehensive assessment, caregiver assessment, person-centered care planning, disease management, utilization management/service authorization, and grievance and appeals.*

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**F. OVERSIGHT AND ACCOUNTABILITY**

**LTC SRC# 13 – Management Experience and Retention (Statewide):**

The respondent shall describe its approach to the hiring and promoting retention, throughout the Contract term, of executive managers (e.g., CEO, COO, CFO, CMO, vice presidents, senior managers) who have expertise and experience in serving elders and adults with disabilities who require LTC, and document such expertise and experience. The respondent shall describe the relevant experience of their current management team. [See Section 409.981(3)(a), Florida Statutes]

**Response:**

Based on three decades of experience serving Medicaid populations, we have learned that our most vulnerable, highest-risk enrollees are confronted with multiple physical and behavioral conditions, biopsychosocial risk factors, and limited protective factors. Our approach to hiring executive managers with in-depth experience and expertise serving elders and adults with disabilities who require long-term care (LTC) is to retain exceptional local candidates who share our value, our vision, and our passion for delivering high-quality, innovative health care to these enrollees.

Aetna has extensive experience building managed care plans and programs from the ground-up in Florida and nationally. Our clearly defined staffing model is designed to be flexible and supportive, as well as adaptable to the changing needs of the State's LTC program that may occur over time. With a commitment to the practice of developing talent and promoting from within, Aetna actively engages with and supports our leaders in achieving their professional development and leadership goals.

**APPROACH TO HIRING AND PROMOTING RETENTION**

**CRITERION 3:** The degree to which the respondent provides evidence, data, or metrics to demonstrate the effectiveness of its approaches to staff retention, including staff tenure, by contract, for the respondent's two (2) most recent contracts

Retaining experienced executive managers begins with hiring the right candidates at the outset. Aetna's reputation as an employer of choice enables us to attract and retain the best-qualified candidates in each market we serve. Aetna is one of only nine companies—and the only one in our industry—to have achieved a 100% rating each year since the Human Rights Campaign Foundation introduced their Corporate Equality Index in 2002. We were recently recognized as a Best Places to Work for Disability Inclusion by the United States Business Leadership Network and the American Association of People with Disabilities for our disability-inclusive business practices. Additionally, we were included for the tenth time since 2001 on DiversityInc's list of the Top 50 Companies for Diversity.

Our hiring tools and techniques clearly define the knowledge, education, skills, and competencies required to attract top candidates who have expertise and experience in serving those in need of long-term care. Our hiring team is experienced, skilled in interviewing, and equipped with tools that include competency-focused behavioral interviewing techniques to

## **EXHIBIT A-4-c LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)**

assess candidates' ability to perform and function within our organization. To thrive as a member of our team, successful candidates will share Aetna's values of integrity, excellence, inspiration, and caring, and our passion for keeping our enrollees at the forefront of all we do. In choosing candidates for senior positions in our LTC program, we seek talented individuals with experience serving elders and adults with disabilities, and who understand the unique needs of those needing long-term care, as well as their providers.

Once hired, executive managers participate in a structured orientation that includes a comprehensive overview of Florida-specific information and regulatory requirements, as well as Agency-specific program elements; leadership curricula and training courses; cultural competency initiatives; mandatory Medicare and Medicaid compliance and ethics training; and fraud, waste, and abuse prevention. At the same time, our orientation and training programs emphasize Aetna's holistic, person-centered approach to addressing the unique requirements of those needing long-term care. Our managers learn to help elders and adults with disabilities achieve improved health outcomes through our fully integrated care model, which is focused on transitioning long-term services and supports systems from institutional care to community-based care, continuous quality improvement, and better preventive and disease condition management to reduce potentially preventable inpatient and outpatient hospital events. By providing a strong initial orientation program for new leaders that emphasizes our integrated, enrollee-centered approach, we set the foundation for continuous professional development and growth. Our organization prioritizes connection of executive leaders across the country with LTC experience, leveraging the expertise of our national team, including identification of effective interventions to promote positive health outcomes.

We retain top talent through the implementation of several key strategies designed to avoid employee turnover. Aetna understands that when employees are motivated, appreciated, and offered the opportunity to contribute to the corporate culture in quantifiable ways, they are more committed to staying, growing, and thriving with their current employer. As employees demonstrate development of their knowledge and skills over time, we support them by providing additional opportunities for growth as part of our commitment for promoting from within. As an example, one of our top managers began her career as a care coordinator before advancing to care manager, then supervisor, and then manager. Employees are required to have a written career development plan, and we review progress via regular one-on-one meetings between the employee and his or her manager. We maintain evidence of employees' Florida-specific and job-specific training and any related certifications, and emphasize succession planning as part of individual development.

Aetna conducts business using a clear, strongly held set of core beliefs and values that reflect who we are and how we approach the hiring, development, and retention of our staff. Our core values of integrity, excellence, caring, and inspiration shape our culture. Molding our work culture to be positive, transparent, and inclusive is a deliberate and thoughtful endeavor. Routine management team retreats, all staff town hall meetings in which all levels of management present updates and new projects, and the implementation of various employee engagement and recognition programs have all served us well to improve employee satisfaction and retention year over year.

Aetna's Servant Leadership Award is one of several examples of our employee recognition programs. Servant leaders are driven to serve their employees, their customers, and their communities. When leaders practice servant leadership, employees are more engaged and

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productive, and create more value for the organization. Leaders who demonstrate a commitment to nurturing employee performance and development through listening, coaching, and mentoring; empowering their teams; and inspiring those they lead to serve others are nominated by their employees. Another example is our Florida A-OK program that rewards acts of kindness in the workplace. Any employee can nominate another, leaders can nominate other leaders, and line staff can nominate their colleagues without restriction. This program promotes a positive and collaborative work culture that rewards treating others with kindness and promoting interpersonal mindfulness.

Aetna measures employee satisfaction annually through the employee engagement survey; the results of this survey are reviewed and an annual employee engagement work plan is drafted. Our annual employee engagement work plan includes interventions designed to address areas of employee dissatisfaction and suggestions provided through comments. As a result of our 2016 survey and work plan, we implemented off-site employee team building activities such as a family picnic and a wellness committee that encourages the use of Aetna's wellness incentives, disseminates health information, and coordinates on-site wellness activities, including pet therapy.

In the past, when Medicaid and Medicare were combined, executives were the same for both programs. Recognizing that Medicaid work requires a different skillset, we introduced a new, stand-alone Medicaid model in 2014. While our LTC managers have been with Aetna for many years, our Medicaid-dedicated executive team has been in place for three years. In that time, only two positions have turned over.

We are proud of the dynamic team that we have assembled to serve LTC enrollees. The following are brief biographies of our executive managers. These biographies highlight our executive managers' expertise and experience in implementing innovative care delivery systems serving elders and adults with disabilities who require long-term care. In addition, we provide resumes for each in Attachment LTC SRC 13.

### **EXPERIENCE OF CURRENT MANAGEMENT TEAM**

**CRITERION 1:** The extent to which executive managers have expertise and experience in implementing innovative care delivery systems serving elders and adults with disabilities who require LTC

**CRITERION 2:** The extent to which executive managers have expertise and experience for their respective positions

Aetna takes pride in identifying and retaining top leaders to support our LTC enrollees, along with coaching and developing future leaders across the organization.

Since implementing LTC in 2013, our leadership team retention rate in Florida is exceptional. Of our executive managers, we have retained over 85% of our leadership over a three-year period. We focus on developing and preparing our LTC team for positions of leadership, harnessing their experiences and building competencies. All of our current managers began their careers as care managers in our nursing home diversion program, and they were promoted to supervisors and then managers. Similarly, we have successfully promoted care managers to

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LTC supervisors where our LTC management team boasts a combined 30 years of tenure with Aetna.

Chief Executive Officer Heidi Garwood's personal experience growing up alongside a sibling with cerebral palsy informed her decision to serve Floridians who receive Medicaid. An attorney by training, Heidi is proud to serve on the board of directors of United Community Options of South Florida (formerly United Cerebral Palsy), whose mission is to provide community integration programs for special needs children. A Florida health care attorney for more than 20 years, Heidi served as a senior attorney with Humana for 12 years, managing Florida and Puerto Rico legal issues affecting Medicare, Medicaid, and commercial operations. She also served as attorney for Humana's Nursing Home Diversion Program from its inception in 2006. Heidi also served as senior attorney for Florida's Agency for Health Care Administration (AHCA) where she was the lead attorney for AHCA's initiative to oversee and improve managed care in Florida. She was director of government relations for the Florida Association of Health Plans (formerly Florida Association of Health Maintenance Organizations), where she was actively involved in the association's efforts in long-term care. Heidi has over six years of experience as an executive manager of Medicaid programs, during which she has worked to implement innovative care delivery systems serving those needing long-term care. Some of these initiatives include:

- Programs to improve transition success through routine care manager success sharing and close scrutiny of unsuccessful transitions as a means of continuously improving the plan's success in identifying transition opportunities and ensuring that enrollee transitions are successful long-term
- Creating the \$2,500 transition benefit to help enrollees transition from nursing home to the community; this benefit has helped enrollees pay for incidental expenses such as utility deposit, beds, and household incidentals that are necessary for a successful transition
- Developing processes to align care managers with enrollees and/or populations with whom they have prior experience to ensure continuity and establish care manager relationships that best serve the enrollees' needs
- Developing programs to ensure smooth transitions from fee-for-service to managed care, including contracting with previous providers utilized by the enrollee while in FFS and hiring, where possible, care managers formerly working in the FFS environment and serving enrollees that moved to the plan; also contracting with atypical providers that are crucial to meeting the needs of enrollees with disabilities

Chief Operations Officer Claudia Lamazares has worked in various roles with Medicaid programs and enrollees since 2002. A master-level, Florida-licensed mental health counselor, she has significant experience working with disabled children and adults living with substance abuse and other behavioral health disorders. Claudia began her career at the University of Miami Medical School (Miller School of Medicine) where she worked closely with grassroots organizations, community mental health organizations, and public health providers. Claudia also holds a master's degree in business administration. During the early part of her career, she co-authored various journal articles focused on maternal health and child development (published under Claudia Del Valle). She also served as the local evaluator for several research programs. Claudia has served on various advisory boards, including Judge Liefman's Miami-Dade County Task Force on Mental Health and the University of Miami Behavioral Health (UMBH) board of directors. Claudia was the executive director of the Bascom Palmer Eye Care Network at the

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University of Miami, and under her leadership, the network grew to serve Medicaid enrollees in Region 11 who were enrolled in the Jackson Memorial Health Plan. Claudia served as the director of quality improvement and training for the Ryan White Title I program in Miami-Dade County; under her leadership and as a result of extensive technical assistance and auditing, key HIV providers in the county successfully meet their annual quality metrics.

A managed care professional for the past 15 years, Claudia has implemented innovative care delivery systems focused on behavioral health integration, prevention, and patient education. Most recently, she was a key contributor in the development of Magellan Complete Care (MCC), the first Medicaid specialty plan in the country focused on individuals living with severe and persistent mental illness. She developed the plan's policies, procedures, and operating model, as well as a provider-focused education and relationship model that helped support the plan's model of care. Claudia contributed to the successful bid for all eight regions that were awarded by the Agency, and she was responsible for the plan's successful readiness audit. She also served as the chief operations officer of this program until she joined Aetna's leadership team in 2015.

Chief Financial Officer (CFO) [REDACTED] joined Aetna in March 2013 and is a graduate of the Experienced Financial Leadership Program (EFLP). [REDACTED] graduated magna cum laude from Arizona State University where he received his Bachelor's degree in Finance. He holds an MBA from the University of Connecticut and he has passed all levels of the CFA exam. [REDACTED] has transitioned to Aetna Better Health of Florida from Aetna Better Health of New York, a \$330 million Duals and LTSS plan, where he held the CFO position and helped the plan achieve profitability.

Previously, [REDACTED] served on Aetna's National Accounts Finance team where he was responsible for financial planning and analysis. Prior to joining National Accounts, he served as a member of the Accountable Care Solutions (ACS) Finance team where he led the day-to-day financial planning and analysis for ACS and helped to set up accountable care organizations. Prior to joining Aetna, [REDACTED] was a member of Cigna's Financial Development program where he held a number of roles supporting the Underwriting department. He counts the following as a few of his accomplishments:

- Helped to transition providers to value-based payment arrangements that improve the quality of care for elders and adults with disabilities who require long-term care
- Identified opportunities to improve quality measures which ultimately led to a top tier quality score for Aetna Better Health of New York
- Volunteers at a local nursing home as part of a pet therapy team with his golden retriever to help relieve stress and raise residents' spirits

Chief Medical Officer Dr. Jorge Cabrera has over 28 years of experience in clinical practice as a board-certified pediatrician. For over 20 years, he served as the medical director for Miami Cerebral Palsy Residential Services. His extensive experience in providing medical care for children and adults living with developmental disabilities informs his expertise in all facets of utilization and care management, contracting, quality, compliance, and retroactive claims and coding review. A strong advocate for transitioning long-term services and supports from institutional settings to the community whenever appropriate, Dr. Cabrera has been at the forefront of several Florida health care delivery initiatives including:

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- Use of home care physicians for delivering care to those in underserved areas or unable to attend doctor's visits or leave home
- Use of telemedicine services to bring specialist consults to remote or underserved areas as well as a way of avoiding prolonged wait times for specialty visits
- Providing direct outreach to physician partners, providing innovative tips and education on improving utilization in order to distribute limited resources more equitably and efficiently
- Co-developing a tool for tracking and monitoring high-cost/high-need cases in conjunction with concurrent review nurse and senior medical economics analyst to more accurately manage, track, and accrue for high-cost/high-need cases

Vice President of Clinical Health Services Denise Kissane oversees our clinical LTC and MMA programs. A registered nurse with a master's degree in health management, a certified care manager, and an entrepreneur, Denise has clinical experience in the intensive care, medical-surgical, and orthopedic units, and has worked in hospital, retirement facility, nursing home administration, and Medicaid managed care. For more than a decade, Denise ran her own business providing care management for elders and disabled adults with medical, social, and behavioral health needs. In this capacity, she also worked with Florida's guardianship program, completed capacity evaluations of elders and adults with disabilities, and made recommendations to the county regarding legal capacity determinations. This experience enabled her to gain an understanding of the importance of considering the social determinants of health, including how an individual's environment and relationships can positively or negatively affect his or her overall well-being and ability to cope with complex physical and behavioral health issues.

Director of Long Term Care Debra Wingo complements Denise's strong clinical background with equally extensive experience in health care financial operations, compliance, and administration. Debra has over 25 years of experience and has more than 6 years of Florida LTSS experience. She served as executive director of a nursing home diversion program, and was regional director and audit director of the largest LTC plan in the State. She holds a CPA license and has extensive experience in financial reporting, planning, budgeting, and financial and operational auditing. Debra utilizes this knowledge in her oversight of a large group of care managers, ensuring cost-effective care planning by leading her team in training and monitoring care planning efforts.

As director of LTC, she helps to ensure the program is compliant and meeting the State's objectives. Under Debra's direction, we have significantly improved compliance scores. For example, the results from the latest Department of Elder Affairs audit of our enrollee file documentation showed improvement in 26 out of 51 compliance measures. Of the 51 measures, 21 did not change from previous 100% compliance results or were not applicable. Of the 26 measures that improved, 17 of them improved by 25% or more. Our 2017 quarterly results from AHCA Case Management Case File Audit Reports and Case Manager Monitoring & Evaluation Reports showed improvement, as well. Audit results showed our case file compliance improved from 93.83% in the first quarter to 94.19% in the second quarter, and our timeliness assessments improved from 81.25% compliant in the first quarter to 87.37% compliant in the second.

Director of Health Care Quality Management Sharon Hatch has 19 years of managed care leadership experience encompassing quality improvement, operations, HEDIS, grievance and

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appeal, risk management, case and disease management, utilization management, auditing, compliance, practice management, and accreditation. She is presently a doctoral candidate in population health. Under her leadership, our plan has achieved the highest NCQA rating in the State for the second consecutive year.

Sharon has served in quality in support of Agency programs for approximately seven years, first under the previous home- and community-based services contract and currently under the SMMC contract. In her experience prior to her work in managed care, Sharon served for three years as a care manager for adults with developmental disabilities residing in group homes, intermediate care facilities, and independent living in Broward County. She is chair of the board of directors for the Florida Diabetes Alliance, Inc., a non-profit statewide partnership for medical professionals, institutions, and community organizations to promote diabetes care. This organization collaborates with the Florida Department of Health in support of the State's diabetes strategic plan.

Medical Director for Long Term Care Dr. Darwin Caraballo has over 17 years of experience as a physician working to promote best practices for elders and adults needing long-term care in both institutional and community-based settings. Along with Aetna's team of over 100 care managers, he provides oversight, coordination of care, and services for over 5,000 enrollees residing in the community, assisted living facilities, and nursing homes. Dr. Caraballo and our team have successfully transitioned dozens of enrollees from nursing homes back into their communities, while serving those with significantly limited access to care or with special needs already residing in the community.

Prior to joining Aetna, he served as senior vice president and medical director for a health care company providing services such as home health skilled nursing care modalities, durable medical equipment, and infusion specialty pharmacy services for over 4.5 million Medicaid enrollees in seven states. During this time, Dr. Caraballo had direct oversight of the Utilization Management department, comprised of over 100 pre-certification clinical review nurses serving 12 major health plans.

As a physician in the Volusia County area, he was in charge of completing all new daily admissions, medication reconciliation and transitional stepdown care from the hospital setting to a health and rehabilitation facility, as well as provided care for over 150 patients residing in nine different nursing homes. After relocating to the south Florida area, Dr. Caraballo served as associate medical director for a practice where he conducted home visits for Medicare and Medicaid enrollees. He has also served as medical director for a Medicare Advantage organization's institutional and institutional-equivalent special needs plan (SNP). There, he and a team of eight advanced registered nurse practitioners and over 20-community home visiting primary care physicians provided acute and chronic disease management care to over 800 enrollees located in the Miami-Dade County area. Among his achievements, he and the team lowered the SNP program MLR down to 55%, and kept enrollees safe at home with significantly fewer avoidable emergency room visits by providing in-home services such as primary care, X-rays, ultrasounds, wound care, and routine blood work.

Director of Reporting and Analysis [REDACTED] has over 22 years of experience in managed care, 16 of which she served Medicaid and long-term care enrollees. She oversees the submission and tracking of weekly encounter files to the State of Florida for the Medicaid and LTC lines of business, and generates and submits accurate reports to the appropriate State

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agencies within the established timeframes. She is responsible for remediation of all errors, and adhering to the completeness, accuracy, and timeline standards as outlined in our contract. Since January 2014, under [REDACTED] leadership, our reporting has been at or above 97% accuracy. In addition to State reporting requirements, [REDACTED] produces operational reports for management. These include, but are not limited to, membership reports, retention reports, analysis of enrollment add and term reasons, provider network reports, claims utilization and aging reports, financial reports, and reports to assist with our enrollee growth and cost-savings initiatives.

Director of Network Management [REDACTED] holds a master's degree in health services administration and has over 20 years of managed care leadership experience, including extensive contractual arrangements and management of providers for improved HEDIS, appropriate utilization, and enhanced enrollee experience. [REDACTED] spent the last five years performing extensive analytical work for cost containment and quality effectiveness of physician groups and hospital-owned practices, leading teams through complex implementation and management of value-based and risk arrangements for over 20,000 enrollees. In addition, [REDACTED] oversaw provider operations and directed the team responsible for appeals and grievances.

Her prior managed care experience includes six years of network contracting and management for all levels along the behavioral health continuum of care, including services for adults with developmental disabilities and a wide spectrum of mental health and substance abuse issues. During this time, [REDACTED] served as treasurer of the Managed Behavioral Health Association, a non-profit partnership of behavioral health care companies whose sole purpose was to improve services and advance behavioral health treatment and coverage.

[REDACTED] spent 10 years working for providers, including six years managing a family practice physician group with a large dual-eligible patient base that required extensive work with families and triage for home health and long-term care. She also worked in medical concierge and for the largest nationwide neonatology/anesthesiology practice.

Director of Service Operations [REDACTED] holds a Master of Business Administration and is a master-level, Florida-licensed mental health counselor with more than 15 years of managed care leadership experience. She is responsible for maintaining oversight of functions, including Complaint Management and Enrollee Services functions. [REDACTED] has been responsible for overseeing the operations of the service center handling customer service functions, including claims, enrollee and provider services, billing, enrollment, accounts receivable and implementation services. She has built call centers for Aetna and Magellan, and has five years of direct experience working with the LTC population providing in-home therapy as a mental health counselor.

Medicaid Compliance Officer [REDACTED] has 21 years of experience in managed care and more than 15 years of experience in regulatory compliance for managed care. [REDACTED] has served in several management positions in our Compliance department. She has extensive knowledge of management theories and practices related to federal and State regulatory contracts.

[REDACTED] holds a Master of Business Administration from Nova Southeastern University, and a Bachelor of Science in Marketing from the University of Phoenix. She has professional

**EXHIBIT A-4-c**  
**LTC SUBMISSION REQUIREMENTS**  
**AND EVALUATION CRITERIA (10-2-17)**

affiliations with the National Association of Women MBAs, National Black MBA Association, and Nova Southeastern University Alumni.

Senior Compliance Consultant [REDACTED] holds a Master of Public Administration and is back-up for the plan's compliance officer. [REDACTED] has more than nine years of experience working with the LTC population and LTC waiver programs. Prior to joining Aetna, she worked in long-term care for the AHCA and for the Florida Department of Elder Affairs. Currently, she ensures the health plan complies with applicable statutory and regulatory requirements, and any contract amendments or regulatory changes. She also develops and communicates routine compliance procedures. [REDACTED] serves as co-chair for the health plan's quarterly compliance and fraud, waste, and abuse meetings.

As a medical health care program analyst for the AHCA, [REDACTED] approved and monitored compliance policies and procedures. She also served as an LTC contract liaison, which included providing technical assistance, direction, and monitoring of plan initiatives.

Director of Pharmacy [REDACTED] leads our Florida plan's clinical pharmacy organization and has five years of pharmacy experience. She has direct experience working with the LTC population as staff pharmacist for Kindred Long Term Acute Care hospital in Las Vegas, Nevada. She holds a Doctor of Pharmacy from the University of Southern Nevada.

Director of Provider Services [REDACTED] has served in the managed care industry for more than 20 years. Previously, while at Humana, [REDACTED] worked in California, Kentucky, Arizona, and Florida where she led various teams in program initiatives. In addition to her direct experience in Provider Services, [REDACTED] also worked in Account Services managing large provider groups and facilities, strategy, and integration.

Manager of Community Development and Outreach Carl Lee has over 21 years of experience in managed care. He holds a Master of Social Work. As an intern, he worked with LTC enrollees, including many with disabilities, in Palm Beach County. Carl provided care management where he helped to ensure enrollees received needed services necessary to help them remain in the community, as opposed to nursing facilities, while maintaining a safe and healthy environment.

**Evaluation Criteria:**

1. The extent to which executive managers have expertise and experience in implementing innovative care delivery systems serving elders and adults with disabilities who require LTC.
2. The extent to which executive managers have expertise and experience for their respective positions.
3. The degree to which the respondent provides evidence, data, or metrics to demonstrate the effectiveness of its approaches to staff retention, including staff tenure, by contract, for the respondent's two (2) most recent contracts.

**Score:** This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

**EXHIBIT A-4-c  
LTC SUBMISSION REQUIREMENTS  
AND EVALUATION CRITERIA (10-2-17)**

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COVENTRY HEALTH CARE OF FLORIDA, INC. DBA  
AETNA BETTER HEALTH® OF FLORIDA

## **Attachment LTC SRC# 13**



COVENTRY HEALTH CARE OF FLORIDA, INC. DBA  
AETNA BETTER HEALTH® OF FLORIDA

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**Resumes – LTC SRC# 13**

**Trade secret as defined in Section 812.081, Florida Statutes**

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## Exhibit A-4-d: Specialty Submission Requirements and Evaluation Criteria and Applicable Attachments/Exhibits



A mother and her son arrive at a monthly Head Start parent meeting to discuss student development plans and to obtain information on Aetna Better Health® of Florida services.

Head Start promotes school readiness for children under age five from low-income families through education and health, social, and other services.

*All photos herein are presented with the express and written consent of the individuals in them.*

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COVENTRY HEALTH CARE OF FLORIDA, INC. DBA  
AETNA BETTER HEALTH® OF FLORIDA

**Exhibit A-4-d**  
**Specialty Submission Requirements and**  
**Evaluation Criteria is not applicable.**



COVENTRY HEALTH CARE OF FLORIDA, INC. DBA  
AETNA BETTER HEALTH® OF FLORIDA

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## Exhibit A-5: Summary of Respondent Commitments



Ted E. Bear M.D. poses for a photo while participating in the Embrace Girls Foundation's community book fair, at which he promotes reading and literacy.

The Embrace Girls Foundation, Inc. is a mentoring program through which girls ages 4 to 12 learn to become healthy, confident, ambitious, and academically excellent individuals.

*All photos herein are presented with the express and written consent of the individuals in them.*

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## EXHIBIT A-5

### SUMMARY OF RESPONDENT COMMITMENTS

**PURPOSE:** The Agency will review and utilize this Exhibit during the negotiation process, for respondents who are invited to negotiations, to capture commitments made by the respondent in response to this solicitation.

**INSTRUCTIONS:** The respondent shall identify each commitment made/proposed in the solicitation. Commitments include, but are not limited to: innovations that assist in achieving the Agency goals, improvements in service delivery coordination and quality outcomes for enrollees, improving the enrollee experience, commitments made in the respondent's provider engagement approach which result in an improved provider experience, and commitments reducing overall costs to the Medicaid program. The respondent shall identify the solicitation section/sub-section (Attachment X, Exhibit Y, Subsection Z), as applicable where the commitment can be found.

Category	Commitment (Brief Summary/Description)	Solicitation Section Reference
<u>Example:</u> Agency Goals	(Respondent to complete)	Exhibit A-4-a, Section B., Agency Goals, MMA SRC# 1 - Potentially Preventable Events (Regional)
Improvements in service delivery coordination and quality outcomes for enrollees; Improving the enrollee experience; Reducing overall costs to the Medicaid program	<p>Dental benefits for adults:</p> <p>Twice yearly: periodic oral evaluation, screening of a patient, assessment of a patient, dental prophylaxis adult, topical fluoride varnish, topical app fluorid ex vrnsh, oral hygiene instruction</p> <p>2 per tooth per 6 months: interim caries arresting medicament application</p> <p>Once yearly: dental imaging (various code types)</p> <p>1 every 3 years: extraoral first film, extraoral posterior radiograph</p> <p>1 per tooth per 3 years: dental sealant per tooth (along with various other procedures, by code)</p> <p>The respondent will offer this benefit in its entirety, including all procedure codes (and minimum quantity limits) listed in Exhibit A-4-a-2.</p>	Exhibit A-4-a, Section C., Recipient Experience, SRC# 9 - Expanded Benefits; Exhibit A-4-a-2
Improvements in service delivery coordination and quality outcomes for enrollees; Improving the enrollee experience; Reducing overall costs to the Medicaid program	<p>Over-the-counter benefits:</p> <p>(LTC - up to \$15) (MMA - up to \$25)</p> <p>Over the counter benefits in the following categories up to \$25 per member per month provided:</p> <p>Cough, cold and allergy medications</p> <p>Vitamins and supplements</p> <p>Ophthalmic/Otic preparations</p> <p>Pain relievers</p> <p>Gastrointestinal products</p> <p>First aid care</p> <p>Hygiene products</p> <p>Insect repellant (deet and non-deet)</p> <p>Oral hygiene products</p> <p>Skin care</p> <p>The respondent will offer this benefit in its entirety, including all procedure codes (and minimum quantity limits) listed in Exhibit A-4-a-2.</p>	Exhibit A-4-a, Section C., Recipient Experience, SRC# 9 - Expanded Benefits; Exhibit A-4-a-2

**EXHIBIT A-5**  
**SUMMARY OF RESPONDENT COMMITMENTS**

Improvements in service delivery coordination and quality outcomes for enrollees	Occupational Therapy benefits for adults: 1 per year: eval & re-evaluation 7 per week: Therapy visits The respondent will offer this benefit in its entirety, including all procedure codes (and minimum quantity limits) listed in Exhibit A-4-a-2.	Exhibit A-4-a, Section C., Recipient Experience, SRC# 9 - Expanded Benefits; Exhibit A-4-a-2
Improvements in service delivery coordination and quality outcomes for enrollees	Physical Therapy benefits for adults: 1 per year: eval & re-evaluation 7 per week: Therapy visits The respondent will offer this benefit in its entirety, including all procedure codes (and minimum quantity limits) listed in Exhibit A-4-a-2.	Exhibit A-4-a, Section C., Recipient Experience, SRC# 9 - Expanded Benefits; Exhibit A-4-a-2
Improvements in service delivery coordination and quality outcomes for enrollees; Improving the enrollee experience	Hearing benefit for adults: 1 per year: hearing aid monaural in ear 1 every 2 years: hearing evaluation, assessment for hearing aid, hearing aid fitting/checking (plus additional related codes) The respondent will offer this benefit in its entirety, including all procedure codes (and minimum quantity limits) listed in Exhibit A-4-a-2.	Exhibit A-4-a, Section C., Recipient Experience, SRC# 9 - Expanded Benefits; Exhibit A-4-a-2
Improvements in service delivery coordination and quality outcomes for enrollees; Improving the enrollee experience	Vision benefit for adults: 1 per year: eye exam 1 every 2 years: frames 6 months supply with prescription: contact lens The respondent will offer this benefit in its entirety, including all procedure codes (and minimum quantity limits) listed in Exhibit A-4-a-2.	Exhibit A-4-a, Section C., Recipient Experience, SRC# 9 - Expanded Benefits; Exhibit A-4-a-2
Agency Goals: Improving birth outcomes; Improvements in service delivery coordination and quality outcomes for enrollees; Reducing overall costs to the Medicaid program	Prenatal benefit: 1 per year: hospital grade breastpump (rental, PA is required) 1 per 2 years: breastpump (rental, no PA required) Antepartum Management: 14 visits for low risk /18 visits for high risk Postpartum care: 3 visits within 90 days following delivery The respondent will offer this benefit in its entirety, including all procedure codes (and minimum quantity limits) listed in Exhibit A-4-a-2.	Exhibit A-4-a, Section C., Recipient Experience, SRC# 9 - Expanded Benefits; Exhibit A-4-a-2
Improvements in service delivery coordination and quality outcomes for enrollees	Respiratory Therapy benefit for adults: 1 per year: eval & re-evaluation 1 per day: Therapy visits The respondent will offer this benefit in its entirety, including all procedure codes (and minimum quantity limits) listed in Exhibit A-4-a-2.	Exhibit A-4-a, Section C., Recipient Experience, SRC# 9 - Expanded Benefits; Exhibit A-4-a-2
Improvements in service delivery coordination and quality outcomes for enrollees	Speech Therapy benefit for adults: 1 per year: speech eval & re-evaluation; swallow eval 7 per week: speech therapy visits 1 per year: AAC eval & AAC re-evaluation The respondent will offer this benefit in its entirety, including all procedure codes (and minimum quantity limits) listed in Exhibit A-4-a-2.	Exhibit A-4-a, Section C., Recipient Experience, SRC# 9 - Expanded Benefits; Exhibit A-4-a-2

**EXHIBIT A-5**  
**SUMMARY OF RESPONDENT COMMITMENTS**

Agency goals: Reducing potentially preventable hospital events, and unnecessary ancillary services; Improvements in service delivery coordination and quality outcomes for enrollees; Improving the enrollee experience; Reducing overall costs to the Medicaid program	Additional Primary Care services benefit:  Unlimited The respondent will offer this benefit in its entirety, including all procedure codes (and minimum quantity limits) listed in Exhibit A-4-a-2.	Exhibit A-4-a, Section C., Recipient Experience, SRC# 9 - Expanded Benefits; Exhibit A-4-a-2
Improvements in service delivery coordination and quality outcomes for enrollees	Newborn Circumcision benefit: 1 per lifetime  The respondent will offer this benefit in its entirety, including all procedure codes (and minimum quantity limits) listed in Exhibit A-4-a-2.	Exhibit A-4-a, Section C., Recipient Experience, SRC# 9 - Expanded Benefits; Exhibit A-4-a-2
Agency goals: Reducing potentially preventable hospital events, and unnecessary ancillary services; Improvements in service delivery coordination and quality outcomes for enrollees; Reducing overall costs to the Medicaid program	Home Health Care benefit: Home visit services provided home health aide or nurse	Exhibit A-4-a, Section C., Recipient Experience, SRC# 10 - Additional Expanded Benefits; Exhibit Exhibit A-4-a-3
Agency goals: Reducing potentially preventable hospital events, and unnecessary ancillary services; Improvements in service delivery coordination and quality outcomes for enrollees	Medically Related Lodging & Food benefit: Max \$150 per day for travel/food for medically necessary services over 200 miles from service area	Exhibit A-4-a, Section C., Recipient Experience, SRC# 10 - Additional Expanded Benefits; Exhibit Exhibit A-4-a-3
Agency goals: Reducing potentially preventable hospital events, and unnecessary ancillary services; Improving the enrollee experience; Reducing overall costs to the Medicaid program	Nutritional Counseling benefit: Unlimited nutritional counseling by health plan network providers	Exhibit A-4-a, Section C., Recipient Experience, SRC# 10 - Additional Expanded Benefits; Exhibit Exhibit A-4-a-3

**EXHIBIT A-5**  
**SUMMARY OF RESPONDENT COMMITMENTS**

Agency goals: Reducing potentially preventable hospital events, and unnecessary ancillary services	Physician Home Visits benefit: One (1) additional PCP home visit per month; One (1) additional specialist home visit per month.	Exhibit A-4-a, Section C., Recipient Experience, SRC# 10 - Additional Expanded Benefits; Exhibit Exhibit A-4-a-3
Post-Discharge Meals benefit: Ten (10) home delivered meals after hospital discharge; Limit – two (2) discharges per year.	Post-Discharge Meals benefit: Ten (10) home delivered meals after hospital discharge; Limit – two (2) discharges per year.	Exhibit A-4-a, Section C., Recipient Experience, SRC# 10 - Additional Expanded Benefits; Exhibit Exhibit A-4-a-3
Agency Goals: Increasing the percentage of enrollees receiving services in the community instead of an institution; Improving the enrollee experience; Reducing overall costs to the Medicaid program	Transition Assistance benefit (LTC): Transition from nursing home to community; up to \$2,500 per lifetime for deposits, household furnishings/supplies, and moving expenses for your own home from a skilled nursing facility	Exhibit A-4-a, Section C., Recipient Experience, SRC# 10 - Additional Expanded Benefits; Exhibit Exhibit A-4-a-3
Improvements in service delivery coordination and quality outcomes for enrollees	Waived Copayment benefit: Copayments waived on all covered services and enhanced benefits	Exhibit A-4-a, Section C., Recipient Experience, SRC# 10 - Additional Expanded Benefits; Exhibit Exhibit A-4-a-3
Improvements in service delivery coordination and quality outcomes for enrollees; Improving the enrollee experience	Bed Hold benefit: 21 bed day hold for ALFs and AFCHs	Exhibit A-4-a, Section C., Recipient Experience, SRC# 10 - Additional Expanded Benefits; Exhibit Exhibit A-4-a-3
Improvements in service delivery coordination and quality outcomes for enrollees; Improving the enrollee experience	Emergency Financial Assistance: Maximum of two hundred and fifty dollars (\$250) per community-based enrollee per year	Exhibit A-4-a, Section C., Recipient Experience, SRC# 10 - Additional Expanded Benefits; Exhibit Exhibit A-4-a-3

Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida

Respondent Name

*Debra J Bacon*

10-27-17

Authorized Official Signature

Date

Debra Bacon

Authorized Official Printed Name

Chief Financial Officer, Aetna Medicaid

Authorized Official Title

## EXHIBIT A-5 SUMMARY OF RESPONDENT COMMITMENTS

**PURPOSE:** The Agency will review and utilize this Exhibit during the negotiation process, for respondents who are invited to negotiations, to capture commitments made by the respondent in response to this solicitation.

**INSTRUCTIONS:** The respondent shall identify each commitment made/proposed in the solicitation. Commitments include, but are not limited to: innovations that assist in achieving the Agency goals, improvements in service delivery coordination and quality outcomes for enrollees, improving the enrollee experience, commitments made in the respondent's provider engagement approach which result in an improved provider experience, and commitments reducing overall costs to the Medicaid program. The respondent shall identify the solicitation section/sub-section (Attachment X, Exhibit Y, Subsection Z), as applicable where the commitment can be found.

Category	Commitment (Brief Summary/Description)	Solicitation Section Reference
<u>Example:</u> Agency Goals	(Respondent to complete)	Exhibit A-4-a, Section B., Agency Goals, MMA SRC# 1 - Potentially Preventable Events (Regional)
Agency goals: Reducing potentially preventable hospital events, and unnecessary ancillary services; Reducing overall costs to the Medicaid program	Adult Influenza Vaccine benefit: Two (2) vaccinations per year	Exhibit A-4-a, Section C., Recipient Experience, SRC# 10 - Additional Expanded Benefits; Exhibit Exhibit A-4-a-3
Agency goals: Reducing potentially preventable hospital events, and unnecessary ancillary services; Improving the enrollee experience; Reducing overall costs to the Medicaid program	Adult Shingles Vaccine benefit: One (1) vaccination per lifetime; prior authorization required for enrollees less than sixty (60) years old	Exhibit A-4-a, Section C., Recipient Experience, SRC# 10 - Additional Expanded Benefits; Exhibit Exhibit A-4-a-3
Agency goals: Reducing potentially preventable hospital events, and unnecessary ancillary services; Improving the enrollee experience; Reducing overall costs to the Medicaid program	Adult Pneumonia Vaccine benefit: One (1) vaccination per lifetime; prior authorization required for enrollees less than sixty (60) years old	Exhibit A-4-a, Section C., Recipient Experience, SRC# 10 - Additional Expanded Benefits; Exhibit Exhibit A-4-a-3

**EXHIBIT A-5**  
**SUMMARY OF RESPONDENT COMMITMENTS**

Agency goals: Reducing potentially preventable hospital events, and unnecessary ancillary services; Improving the enrollee experience; Reducing overall costs to the Medicaid program	Shelf-stable Meals: Ten (10) shelf-stable meals and two (2) cases of water prior to a hurricane or other disaster for enrollees at significant nutritional risk.	Exhibit A-4-a, Section C., Recipient Experience, SRC# 10 - Additional Expanded Benefits; Exhibit A-4-a-3
Improvements in service delivery coordination and quality outcomes for enrollees, Improving the enrollee experience; Reducing overall costs to the Medicaid program	Project ECHO™: Project ECHO™ is an evidence-based model for enhancing behavioral health treatment in the primary care setting. Using Project ECHO, an interdisciplinary team of behavioral health clinicians meets in a central location and videoconferences with primary care practitioners, who are usually in remote areas. These are clinical case conferences in which the PCP describes challenges and concerns of caring for a particular patient and the team works with the clinician to develop a treatment plan to address each person's biopsychosocial situation and achieve an optimal outcome. As a result of these case conferences, PCPs become more proficient in specialty care practices.	Exhibit A-4-a, Section B., Agency Goals, SRC# 5 – Disease Management (DM) Program (Statewide); SRC# 8 – Vignette (Statewide); Section E., Delivery System Coordination, SRC# 23 - Behavioral Health/Primary Care Integration (Statewide), Exhibit A-4-b, Section B., Agency Goals, MMA SRC# 4 – Telemedicine (Regional)
Agency Goals: Improve birth outcomes and Provider engagement approach, resulting in an improved provider experience	MMA Physician Incentive program includes provider incentives for appropriate reduction of C-section rates	Exhibit A-4-b, Section B., Agency Goals, MMA SRC# 1 – Potentially Preventable Events (Regional); MMA SRC# 3 – Patient Centered Medical Homes (Regional); MMA SRC# 7 – MMA Physician Incentive Program (MPIP) (Statewide)
Improving the enrollee experience	Member Incentives - diapers: Qualifying enrollees will receive 200 diapers of their preferred brand and size, delivered to their homes.	Exhibit A-4-b, Section B., Agency Goals, MMA SRC# 1 – Potentially Preventable Events (Regional); MMA SRC# 2 – Birth Outcomes (Statewide); Section E., Delivery System Coordination, MMA SRC# 17 – Coordination of Carved Out Services (Statewide)
Agency Goals: Provider engagement approach, resulting in an improved provider experience Improvements in service delivery coordination and quality outcomes for enrollees	Pediatric practitioners are eligible to be reimbursed at 100 percent of the Medicare rate, with the objective of remove reimbursement as an obstacle to accepting Medicaid patients.	Exhibit A-4-b, Section B., Agency Goals, MMA SRC# 7 – MMA Physician Incentive Program (MPIP) (Statewide)

**EXHIBIT A-5**  
**SUMMARY OF RESPONDENT COMMITMENTS**

<p>Agency Goals:</p> <p>Provider engagement approach, resulting in an improved provider experience</p> <p>Improvements in service delivery coordination and quality outcomes for enrollees</p> <p>Improve birth outcomes</p> <p>Reduce overall costs to the Medicaid program</p>	<p>OB/GYN practitioners are eligible to be reimbursed at 100 percent of the Medicare rate, with the objective of remove reimbursement as an obstacle to accepting Medicaid patients.</p>	<p>Exhibit A-4-b, Section B., Agency Goals, MMA SRC# 7 – MMA Physician Incentive Program (MPIP) (Statewide)</p>
<p>Agency Goals:</p> <p>Medicaid enrollees receive all medically necessary services in a timely manner</p> <p>Provider engagement approach, resulting in an improved provider experience</p> <p>Reduce overall costs to the Medicaid program</p>	<p>Pediatric sub-specialist practitioners are eligible to be reimbursed at 100 percent of the Medicare rate, with the objective of remove reimbursement as an obstacle to accepting Medicaid patients. Eligible sub-specialist categories: cardiology, endocrinology, nephrology, neurology, and psychiatry.</p>	<p>Exhibit A-4-b, Section B., Agency Goals, MMA SRC# 7 – MMA Physician Incentive Program (MPIP) (Statewide)</p>
<p>Agency Goals: Care received in an appropriate and cost effective setting</p> <p>Achieve the best possible quality outcomes while containing costs</p>	<p>Physician incentives for:</p> <ul style="list-style-type: none"> <li>-percentage of enrollees for 3 of the 4 age bands who had a visit with a PCP during the measurement period (benchmark - NCQA Medicaid 50th percentile)</li> <li>-ED utilization of all assigned enrollees fewer than 650 visits/1,000 enrollees</li> <li>-Office hours after 6 p.m. or on weekends</li> <li>-Percentage of children with lead screening before 2nd birthday (benchmark - NCQA Medicaid 50th percentile)</li> </ul>	<p>Exhibit A-4-b, Section B., Agency Goals, MMA SRC# 7 – MMA Physician Incentive Program (MPIP) (Statewide)</p>
<p>Agency Goals: Care received in an appropriate and cost effective setting</p> <p>Achieve the best possible quality outcomes while containing costs</p> <p>Improve birth outcomes</p>	<p>OB/GYN practitioner incentives for:</p> <ul style="list-style-type: none"> <li>-percentage of enrollees who had 81% or more of expected prenatal visits (benchmark - NCQA Medicaid 75th percentile)</li> <li>-percentage of enrollees who had a postpartum visit on or between 21 and 56 days after delivery (benchmark - NCQA national Medicaid mean)</li> <li>-percentage of single births delivered by C-section (benchmark - less than 35%)</li> </ul>	<p>Exhibit A-4-b, Section B., Agency Goals, MMA SRC# 7 – MMA Physician Incentive Program (MPIP) (Statewide)</p>
<p>Agency Goals: Care received in an appropriate and cost effective setting</p> <p>Achieve the best possible quality outcomes while containing costs</p> <p>Reduce PPEs</p> <p>Improve birth outcomes</p>	<p>Value-based provider contract relationships - PCP risk contracts tied to quality metrics and after hours availability</p>	<p>Exhibit A-4-b, Section B., Agency Goals, MMA SRC# 7 – MMA Physician Incentive Program (MPIP) (Statewide)</p>

**EXHIBIT A-5**  
**SUMMARY OF RESPONDENT COMMITMENTS**


Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida

Respondent Name

*Debra J Bacon*

10-27-17

Authorized Official Signature

Date

Debra Bacon

Authorized Official Printed Name

Chief Financial Officer, Aetna Medicaid

Authorized Official Title

## Exhibit A-6: Summary of Managed Care Savings



Community partner FLIPANY engages children in hands-on learning as they prepare trail mix and fruit parfaits.

FLIPANY serves youth and families, including seniors, through collaboration with community centers, parks, and social services agencies in low-income communities.

*All photos herein are presented with the express and written consent of the individuals in them.*

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**EXHIBIT A-6**  
**SUMMARY OF MANAGED CARE SAVINGS**

**PURPOSE:** The Agency will review and utilize this Exhibit during the negotiation process, for respondents who are invited to negotiations, to identify managed care savings included by the respondent in response to this solicitation.

THE AGENCY RESERVES THE RIGHT TO INCLUDE ANY OR ALL MANAGED CARE SAVINGS LISTED HEREIN, OR AS NEGOTIATED, AS PART OF THE RESULTING CONTRACT.

INSTRUCTIONS: THE RESPONDENT SHALL IDENTIFY EACH MANAGED CARE SAVINGS PROPOSED IN ITS RESPONSE TO THIS SOLICITATION AND IDENTIFY BOTH THE SOLICITATION SECTION(S)/SUBSECTION(S)/ITEM(S), AND THE SECTION/COLUMN OF THE COST PROPOSAL TEMPLATE (ATTACHMENT C) IN WHICH THE MANAGED CARE SAVINGS IS PROPOSED. (SEE EXAMPLE BELOW) ADDITIONAL PAGES MAY BE INCLUDED AS NEEDED.

[illegible]

Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida

**Respondent Name**

Authorized Official Signature

Date \_\_\_\_\_

Debra Bacon

Authorized Official Printed Name

Chief Financial Officer, Aetna Medicaid

Authorized Official Title

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## Exhibit A-7: Certification of Drug-Free Workplace (if applicable)



During an Aetna Better Health® of Florida health fair, an attendee receives information about early childhood learning and development and about ways to enhance her child's learning skills.

*All photos herein are presented with the express and written consent of the individuals in them.*

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## EXHIBIT A-7

### CERTIFICATION OF DRUG-FREE WORKPLACE PROGRAM

In the event of Identical or Tie Bids/Proposals: Preference shall be given to businesses with drug-free workplace programs. Whenever two or more bids which are equal with respect to price, quality, and service are received by the State or by any political subdivision for the procurement of commodities or contractual services, a bid received from a business that certifies that it has implemented a drug-free work place program shall be given preference in the award process. Established procedures for processing tied awards will be followed if none of the tied vendors have a drug-free workplace program. In order to have a drug-free workplace program, a business shall:

- 1) Publish a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the workplace and specifying the actions that will be taken against employees for violations of such prohibition.
- 2) Inform employees about the dangers of drug abuse in the workplace, the business's policy of maintaining a drug-free workplace, any available drug counseling, rehabilitation, and employee assistance programs, and the penalties that may be imposed upon employees for drug abuse violations.
- 3) Give each employee engaged in providing the commodities or contractual services that are under bid a copy of the statement specified in subsection (1).
- 4) In the statement specified in subsection (1), notify the employees that, as a condition of working on the commodities or contractual services that are under bid, the employee will abide by the terms of the statement and will notify the employer of any conviction of, or plea of guilty or nolo contendere to, any violation of chapter 893 or of any controlled substance law of the United States or any state, for a violation occurring in the workplace no later than five (5) days after such conviction.
- 5) Impose a sanction on, or require the satisfactory participation in a drug abuse assistance or rehabilitation program if such is available in the employee's community by, any employee who is so convicted.
- 6) Make a good faith effort to continue to maintain a drug-free workplace through implementation of this section.

As the person authorized to sign the statement, I certify that this firm complies fully with the above requirements.

**Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida**

**Respondent Name**

Laurie Brubaker

**Authorized Official Signature**

10/17/18

**Date**

**Laurie Brubaker**

**Authorized Official Printed Name**

**Chief Executive Officer, Aetna Medicaid**

**Authorized Official Title**

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## Exhibit A-9: Regional Preference Hierarchy (if applicable)



Young participants of the Embrace Girls Foundation's community book fair engage with Miami-Dade Police Department first responders, during which they toured the police truck and talked with officers to learn about the importance of community service.

The Embrace Girls Foundation, Inc. is a mentoring program through which girls ages 4 to 12 learn to be healthy, confident, ambitious, and academically excellent.

*All photos herein are presented with the express and written consent of the individuals in them.*

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**EXHIBIT A-9**  
**REGIONAL PREFERENCE HIERARCHY**

**RESPONDENT NAME:** Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida

The Agency shall award one (1) additional Contract in a region to each successful respondent who receives a Region 1 or 2 Contract award. The Agency shall award the additional Contract in the respondent's highest desired region of preference in which the respondent submitted a responsive reply and negotiates a rate acceptable to the Agency.

Respondents shall complete the Regional Preference Hierarchy Table below, to indicate its preference for receipt of additional Contract awards.

If the Regional Preference Hierarchy Table is left blank, the respondent indicates that it does not desire any additional region awards.

Respondents shall indicate the region(s) in hierarchy order (highest desire being 1 and lowest desire being 10).

REGIONAL PREFERENCE HIEARCHY	
Order Requested for Additional Award	By Region
1.	11
2.	10
3.	6
4.	7
5.	9
6.	8
7.	5
8.	4
9.	3
10.	2

Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida  
**Respondent Name**

Debra Bacon  
**Authorized Official Signature**

10-27-17  
**Date**

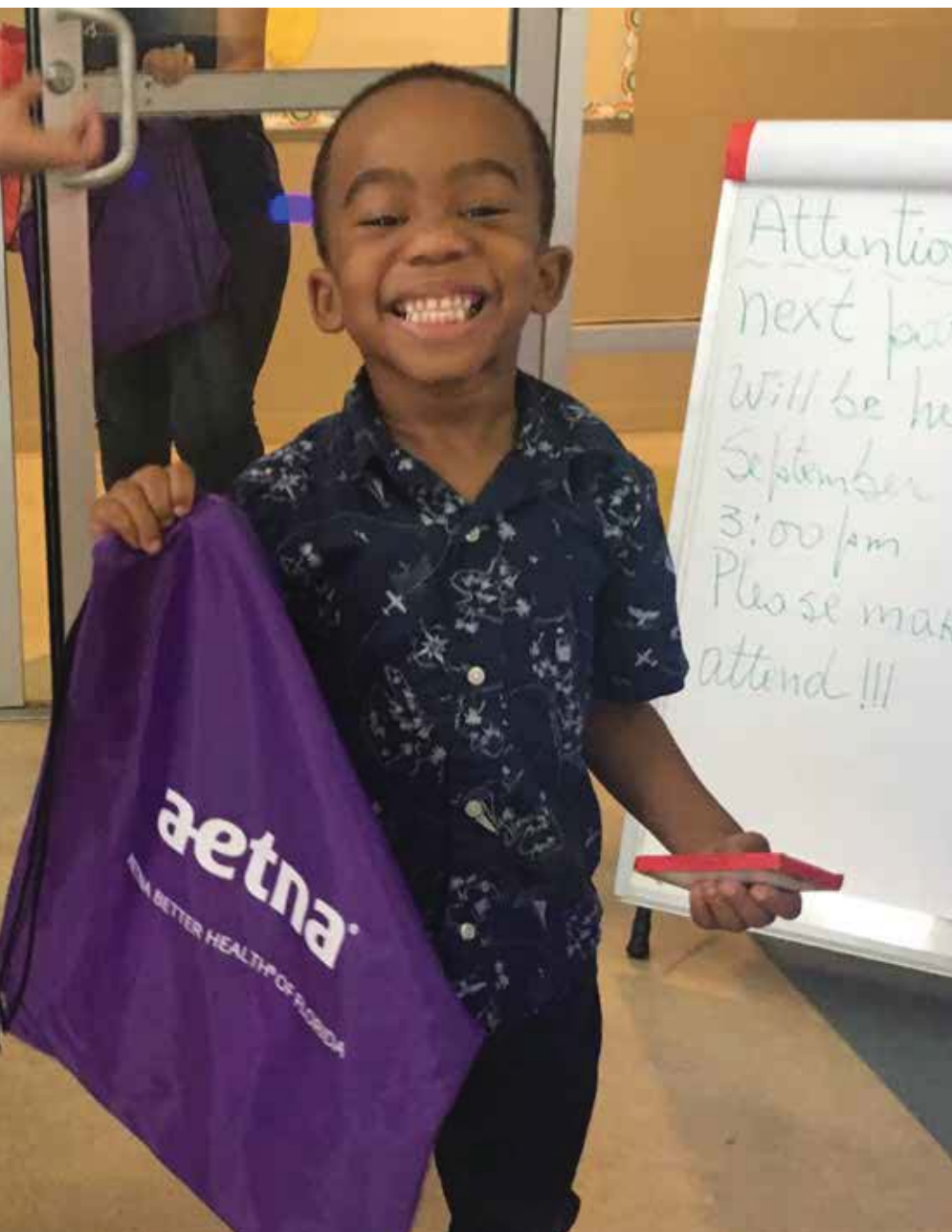
**Debra Bacon**  
**Authorized Official Printed Name**

**Chief Financial Officer, Aetna Medicaid**  
**Authorized Official Title**

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## Attachment C: Cost Proposal and Instructions, including Applicable Exhibits



An excited child receives goodies from Aetna Better Health® of Florida as he leaves his classroom at the Haitian Youth and Community Center's after-school program in North Miami. Aetna was invited to attend the center's monthly open house event.

The Haitian Youth and Community Center, Inc. is a not-for-profit 501(c)3 membership organization that provides a variety of services including after-school care, summer programs, youth services, childcare services, and family and community partnership.

*All photos herein are presented with the express and written consent of the individuals in them.*

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**Attachment C – Cost Proposal and Instructions, including Applicable  
Exhibits**

**Trade secret as defined in Section 812.081, Florida Statutes**

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