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Delegation management guide

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Inside

I. Introduction to delegation management

Aetna® is committed to quality-based health care, and we recognize the critical role you play in providing our members with quality and cost-effective medical care.

This guide is a reference tool to help contracting delegates and their staffs understand how to perform delegated functions in accordance with Aetna standards.

It is important that your organization — delegated for credentialing, patient management, customer service management and/or claims — follows the standards outlined in this guide to help make sure all Aetna members experience consistent service. All staff members accountable for complying with these standards should be trained and retrained, as needed, on these standards.

The role of Aetna® and the Delegated Entity

Delegation is a process through which Aetna agrees to grant an external entity the ability to perform specified functions or activities on its behalf. Each contracted Entity must conform to the Aetna program requirements for all delegated activities. Performance of these activities by the Delegated Entity is documented in an agreement between the parties. It is important that providers delegated for administrative functions follow the criteria and standards designed by Aetna and ensure consistency with the standards of the National Committee for Quality Assurance (NCQA) and, where applicable, the American Accreditation Healthcare Commission/ Utilization Review and Accreditation Committee (URAC), the Centers for Medicare & Medicaid Services (CMS), and applicable state regulatory authorities and other governing agencies outlined in this guide.

A Delegated Entity's compliance with standards and criteria outlined in this guide will be evaluated through annual oversight audits or as required to meet regulatory and accreditation requirements and/or identify performance deficiencies for functions delegated. All staff members having accountability for compliance with these standards should be trained on these standards. The Delegated Entity is responsible for maintaining records of the training program, including, at a minimum, dates, attendees and a summary of the training provided.

Keep in mind that as additional standards, policies and procedures are developed, this guide will be updated. Delegated Entities will be sent the updates and will be required to comply with changes in the standards. Aetna has policies and procedures that, in addition to those in this guide, apply to the contract provisions.

The information now or hereafter incorporated into this guide is the property of Aetna, and it must be treated as confidential by the Delegated Entity. The information is for use by the contracted Delegated Entity in conjunction with Aetna plans and may be disclosed to third parties as necessary to effectively administer these plans.

II. Financial oversight

In accordance with the Delegated Claims Agreement, Aetna will maintain financial oversight and assess the financial condition of the Delegated Entity in order to determine whether the participating medical group or hospital can maintain financial solvency as an ongoing business concern. Oversight shall include:

- At a minimum, an annual financial review of the Delegated Entity's (and/or parents') audited and interim financial statements
- An assessment of financial performance in accordance with Aetna financial standards
- A requirement for financial protection, if necessary, in the form of a letter of credit, performance bond or insolvency reserve
- Submission of the financial review to various Aetna oversight committees

Policies and procedures

Policies

Aetna will perform a financial review of all Delegated Entities at least annually to provide oversight of the contractor's continuing compliance with and ability to meet Aetna standards. This detailed review will help determine the risk exposure to Aetna and provide a basis for calculating a letter of credit or insolvency reserve. Performance of this financial due diligence is considered a contractual obligation.

Procedures

The network manager and/or the Aetna financial auditor will obtain the following statements and forward them to the financial auditor for review:

- Audited financial statements including balance sheet, income statement, statements of cash flow, IBNR lag tables and accompanying notes for the most recent fiscal year
- Internal unaudited interim financial statements
- The self-reported audit tool — Assessment Criteria for Delegated Provider Reimbursement and Finance (required for initial contract evaluation only)

The financial auditor will review the submitted documentation. This review will include an assessment of equity reserves, results of operation, liquidity of current assets and sufficiency of cash to pay claims payable and to maintain financial reserves.

In some cases, if the documentation will not be forwarded by the contractor or is considered proprietary or subject to certain protections, the auditor will perform a review onsite.

The Financial Ratios Worksheet will be used consistently to determine financial ratios compared to industry standards. Each ratio is given a score based on the difference of the ratio to the standard. The contractor will be scored according to the following scale:

Total score of 0 to 1.49 — noncompliance with Aetna® standards

Total score of 1.50 to 2.99 — partial compliance with Aetna standards

Total score of 3.0 to 3.99 — substantial compliance with Aetna standards

Total score of 4.0 to 5.0 — full compliance with Aetna standards

Upon completion of the audit or onsite review, the auditor will complete a written report on the findings of the audit using the Assessment Results document. Based on the overall score, the financial auditor will determine audit frequency and recommend financial protections to the applicable Delegation Oversight teams.

The applicable Delegation Oversight teams will review and discuss the financial findings, and make recommendations for follow-up actions, including adjusting the letter of credit, securing a reserve or terminating a contractor. The recommendations will be forwarded to the Oversight Committee.

The Oversight Committee will discuss the recommendations and record the findings. Appropriate actions will be assigned. Any contingency plans based on poor financial audit results will be submitted to the controller and network head for implementation.

Insurance
Delegated Entity will maintain insurance at minimum levels no event less than: (a) comprehensive general liability insurance in minimum amounts of one million dollars ($1,000,000) per occurrence and one million dollars ($1,000,000) aggregate; (b) professional liability and/or errors and omissions insurance in minimum amounts of one million dollars ($1,000,000) per occurrence and one million dollars ($1,000,000) aggregate covering the Delegated Entity for all Delegated Functions performed pursuant to this contract.

Delegated Entity will give Aetna proof of insurance coverage upon request. Delegated Entity must give company at least thirty (30) days' advance notice of any cancellation or material changes to these policies.

III. Privacy breach reporting resources

What is a Privacy Incident?

A privacy incident is when Protected Health Information (PHI), Personally Identifiable Information (PII), or financial data is known or suspected to be improperly accessed, viewed, used, or disclosed. This can include, but is not limited to:

- Sending information to the wrong recipient/location (mail, email, fax, text, online chat)
- Verbally disclosing information to unauthorized individuals (on the phone, loudly in your surroundings)
- Misplacing or losing information
- Colleagues accessing or providing access to the information outside of job responsibilities and company policy
- Unauthorized external sources accessing company confidential information, such as by hacking or company device theft

REMEMBER: Time is of the essence. If you know of or suspect any improper disclosure of Aetna information, you must report your concerns to Aetna's Privacy Office right away.

WHY?

Aetna's Privacy Office must comply with many federal, state, local and international privacy laws, as well as ensure compliance with our contractual obligations — some requiring the Privacy Office to provide notice as soon as 24–48 hours after anyone in the organization becomes aware of the issue.

WHAT IF I'M NOT SURE?

Report it anyway! Even if you're unsure whether to report the suspected privacy incident, always err on the side of caution and report it right away. Aetna's Privacy Office will review and investigate all reported submissions.

HOW?

There are two ways that privacy incidents can be reported to Aetna:

1. Send an email to the privacy office: **privacyaetna@aetna.com**
2. Use the incident submission form in Radar: **https://app.radarfirst.com/incidents/new/?token=7a8d3d51-aafa-4d49-8699-29f8ae8f1442#/guest-form**

IV. Credentialing for delegated providers

Aetna delegates credentialing to established physician organizations when key credentialing program components are in place and conform to Aetna requirements.

Requirements for delegation:

- Entity must have a direct provider agreement or group agreement in place prior to executing a delegation agreement.
- Entity has a minimum of 50 practitioners/providers/facilities that fall within the scope of credentialing.
- Entity conducts full credentialing – Primary Source Verification (PSV) and Decision Making.
- Entity has a credentialing program that has been in place for at least 12 consecutive months.
- Entity has credentialed their entire network of practitioners/providers.
- Entity has held at least three credentialing committee meetings.
- If the Entity is a health system that has multiple facilities and a centralized process, the Entity's credentialing policies must also be centralized and include the appeals process. This includes appeals process language that meets NCQA and CMS regulations, if applicable.

Aetna maintains oversight of all delegated credentialing activities.

- The Delegated Entity develops and maintains a credentialing program, which at a minimum includes all applicable Aetna policies and standards, external accreditation standards, and state and federal regulations. In addition, the Delegated Entity agrees to the following:
- Satisfy Aetna requirements for compliance with policies and procedures and for implementing any recommendations for improvement.
- Comply with periodic assessments of delegated activities at least annually, but more frequently if deemed necessary.
- Obtain prior written consent from Aetna for all subdelegated arrangements. These arrangements must have a mutually agreed upon contract, agreement or other written record that meets Aetna requirements. The Delegated Entity must maintain oversight of the credentialing and recredentialing services furnished by the Subdelegate on behalf of Aetna.
- Provide Aetna staff, the NCQA, the state and CMS (if applicable) access to practitioner and organizational provider files, medical documentation, policies and procedures, and related Quality Improvement Committee or subcommittee minutes as deemed necessary by Aetna for monitoring and oversight of all aspects of the delegated credentialing function.

Aetna retains the right to approve new practitioners and organizational providers and to terminate or suspend individual practitioners and organizational providers in accordance with any agreements and this provider guide.

Credentialing requirements

The Delegated Entity is required to provide Aetna® with credentialing and performance information on all practitioners under contract with the Delegated Entity.

Practitioner information

The Delegated Entity must obtain, maintain and provide, as needed, the following information for each primary care physician, specialty care physician or other allied health care practitioner:

- Application and attestation to comply with Applicable Law/Accreditation Requirements and time frames.
- Current valid license to practice health care for each state in which the practitioner will see Aetna members
- Clinical privileges in good standing or coverage arrangements, as applicable
- Current valid unrestricted DEA or CDS certificate or appropriate waiver for each state in which the practitioner will see Aetna members
- Current board certification(s) in the appropriate specialty
- Education and training in practicing specialties, if not board certified
- Five years of work history with documentation of gaps greater than six months
- Current professional liability insurance within Aetna-approved limits

- Review of Medicare/Medicaid sanction activity
- Review of professional liability claims history (NPDB or equivalent body)
- Review of state sanctions, restrictions on licensure, and limitations on scope of practice
- Review of Medicare/Medicaid Exclusions, including without limitation the state Medicaid exclusion query
- Review of the Medicare opt-out report, as applicable
- Site visit policies and procedures to comply with Applicable Law/Accreditation Requirements, at a minimum to conduct site visit for a member complaint
- Ongoing monitoring of Medicare/Medicaid sanction and exclusions lists, state license sanctions, limitations, and expiration dates at least every 30 days. If Delegated Entity identifies findings in its ongoing monitoring process, it will report findings to its credentialing committee and implement interventions as needed.
- For all provider types, Delegated Entity agrees to perform ongoing review of: (a) complaints upon receipt (including provider's history of complaints if applicable) and the history of complaints for all providers at least every six (6) months; and (b) adverse events at least every thirty (30) days. If Delegated Entity identifies findings in its ongoing monitoring process, it will report findings to its credentialing committee and implement interventions as needed.
- State and/or Medicaid requirements, as applicable

Organizational provider information

The Delegated Entity must obtain, verify, maintain and provide information on the following for each provider prior to contracting and at least every 36 months based on Applicable Law/Accreditation Requirements:

- A current valid and unencumbered license or a certification or certificate of occupancy in the state in which the Delegated Entity's participating health care provider is located
- Professional liability insurance within Aetna®-approved limits
- A Medicare Certification Number (as applicable)
- A review of current or previous sanction activity by Medicare or Medicaid
- Accreditation status by an agency that Aetna recognizes (e.g., TJC, AOA, CHAP, DNV, AAAHC, QUAD A)
- A current, compliant CMS or state survey or results from an onsite quality assessment in lieu of an approved accreditation
- A copy of the Advance Directives policy, unless accredited or certified by Medicare

Assessment/audit of delegated credentialing

The Delegated Entity agrees to an annual assessment/audit, when requested for the credentialing program. The credentialing program includes policies and procedures, Credentialing Information Integrity audits and reports, minutes, monitoring logs, files and subdelegation activities.

Practitioner file audit

Aetna will review credentialing/recredentialing files using NCQA methodology: 1) The 8/30 rule evaluating each file factor until a rate of 8/8 or a denominator of 30 is achieved; or 2) The 5%/50 method, where 5% or 50 files, whichever is less, are reviewed.

Organizational provider file audit

Aetna will review organizational files through the submission of a tracking spreadsheet or by using NCQA methodology: 1) The 8/30 rule evaluating each file factor until a rate of 8/8 or a denominator of 30 is achieved; or 2) The 5%/50 method, where 5% or 50 files, whichever is less, are reviewed.

Subdelegation

If a Delegated Entity contracts with another organization to perform any credentialing function on their behalf, Aetna will review agreements and oversight documentation between the Delegated Entity and the organization.

The Delegated Entity and the organization must have a mutually agreed document that meets all accreditation and regulatory requirements. The agreed upon document must describe the following:

- All delegated activities as addressed under the Practitioner Information section of this manual and decision making responsibilities.
- The Credentialing Information Integrity language under the Credentialing requirements section of this manual.
- Indicate reporting frequency, content of reports, and how and to whom reports are submitted.

- How the Delegated Entity will evaluate the organization.
- Describe the remedies including termination based on performance.

If a subdelegate is being added, Aetna is to be notified prior to entering the arrangement in order to evaluate the Delegation Oversight and the agreement. The subdelegate is expected to fully participate and cooperate with requests to supply information and to support regulatory or accreditation needs.

Corrective action plan

If Aetna determines that the Delegated Entity has failed to carry out the credentialing and recredentialing services in accordance with the terms of this Agreement or with reasonable performance expectations, Aetna may take such steps, as it deems necessary, as outlined in the Delegation Agreement.

Recredentialing

All Delegated Entity practitioners are recredentialed, at a minimum, every three years or as otherwise determined by Aetna or by a regulatory accrediting body. As part of the recredentialing process, all credentialing information must be reverified except for work history and education and training.

Credentialing Information Integrity

Credentialing information integrity refers to maintaining and safeguarding the information used in the credentialing and recredentialing process against inappropriate documentation and updates. Delegated Entity will maintain credentialing information integrity policies and procedures (that include monitoring and evaluating subdelegates if applicable), and perform credentialing information integrity staff training, annual audits, qualitative analysis of audit findings, corrective actions and reaudits in accordance with Applicable Law/Accreditation Requirements. Without limitation of the foregoing, Delegated Entity agrees that inappropriate documentation of or updates to credentialing information includes:

- Falsifying credentialing dates (e.g., licensure date, credentialing decision date, staff verifier date, ongoing monitoring dates)
- Creating documents without performing the required activities
- Fraudulently altering existing documents (e.g., credentialing minutes, clean file reports, ongoing monitoring reports)
- Attributing verification or review to an individual who did not perform the activity
- Updates to information by unauthorized individuals

Mergers/Acquisitions

If Delegated Entity or its affiliate or parent organization acquires or takes operational responsibility for a new entity and its providers after the effective date of a delegated agreement, Delegated Entity agrees to notify Aetna's Delegation Oversight Team. Delegated Entity agrees that such acquired providers will not automatically be subject to the delegation agreement. Delegation Oversight may conduct a validation audit to determine whether and when Delegated Entity shall perform the delegated functions for such acquired providers.

Credentialing oversight reports

Quarterly/semiannual credentialing oversight reports must include the following along with a credentialing activity roster:

- Credentialing committee dates for the reporting period
- Total number of initial credentialed and recredentialed (primary care practitioners, specialty practitioners, nonphysician practitioners and facilities)
- Total number of suspensions, terminations and resignations for quality
- Total number of site visits conducted
- Improvement activities for the reporting period

Notification of changes

The Delegated Entity will provide monthly reports to Aetna to maintain accurate directory information. The reports should include the following:

- Provider name (last, first, middle)
- National Practitioner Identifier (NPI)
- SSN (needed only at time of de-delegation)
- Date of birth
- Gender
- Service address(es)
- Service address telephone number
- Billing address(es)
- Billing address telephone number
- Primary specialty

- Secondary specialty or specialties
- Board certification status
- Board certification specialty or specialties
- Board certification effective date(s)
- Degree
- Medical school
- Graduation year
- Foreign language spoken by provider
- Medical/professional license number
- License expiration date
- Hospital affiliation (par affiliation)
- Role of provider (PCP, specialist, etc.)
- Accepting new patients (yes, no)
- Termination date
- Tax Identification Number

Prompt notification to Aetna of changes related to the Delegated Entity's practitioners and organizational providers helps ensure the accuracy of information in the provider directories.

Aetna requires advance written notice, as specified in the Delegated Credentialing Agreement, prior to the following changes:

- Address or addition of office sites
- Closure of office sites
- Telephone numbers
- Tax Identification Number
- Billing address

Aetna must be notified immediately of the addition or deletion of any practitioner or organizational provider from the Delegated Entity.

The Delegated Entity must notify Aetna when a provider appears on the Medicare opt-out list.

Under the terms of the Agreement, any Delegated Entity's practitioners and organizational providers must be credentialed and approved prior to providing covered services to members.

Notification of actions

The Delegated Entity agrees to notify Aetna about any of the following actions taken by or against a Delegated Entity's practitioner. The notification must be in writing, and it must be received within five business days of becoming aware of the action.

- The surrender, revocation, restriction or suspension of a Delegated Entity's practitioner state license, DEA registration or state narcotics license
- The restriction, suspension or revocation of medical staff privileges for a period of time greater than 30 days
- The filing of a report with the National Practitioner Data Bank or state professional medical disciplinary board, Office of Personnel Management Department List or Office of Inspector General List
- The notice, commencement, settlement or judgment of any malpractice claim
- Any lapse or material change in the professional liability limits as required by the Agreement
- Any indictment, arrest or conviction for a felony or any criminal charge related to the participating health care practitioner
- Any adverse action taken by a peer review organization or other similar committee
- Any other circumstances that would materially affect the ability of the Delegated Entity's practitioner to carry out his or her duties and obligations under the Agreement or materially change the representations made in the credentialing application.

V. Claims management for delegated providers

Aetna delegates claim administration functions (claims) to established medical groups, IPAs, PHOs or other provider entities when key claim management or other components are in place and conform to Aetna, NCQA, CMS and state and federal requirements.

Aetna will retain the ultimate decision-making authority for delegated claim functions and will provide oversight of delegated activities. Oversight is conducted via annual audits, ad-hoc audits if deficiencies are identified, and periodic evaluation of performance reports as outlined in the delegation agreement.

The Delegated Entity's claim processes must comply with, at a minimum, all applicable Aetna standards as outlined in the delegation agreement, external accreditation standards, and CMS and state and federal regulations. In addition, the Delegated Entity must agree to:

- Satisfy Aetna requirements for compliance with policies and procedures and implementation of any Aetna corrective action plan recommendation for improvement.

- Undergo periodic assessments of delegated activities at least annually or more frequently if deemed necessary.
- Obtain consent of Aetna for all outsourced/subdelegation of claim functions.
- Provide Aetna staff, NCQA, state and federal regulators access to claim records and files and to the entity's claim policies and procedures, program documents and committee minutes as deemed necessary by Aetna for monitoring the oversight of all aspects of the delegated claim functions.

Delegated claims management function requirements

The Delegated Entity will provide claim management functions for covered services as more fully described below. The covered services, which are included here, will be for all services provided by the Delegated Entity as specifically outlined in the delegation agreement.

A prospective claim delegate should meet the following prerequisites:

- The Entity must have applicable provider agreement or group agreement in place prior to executing a delegation agreement.
- Prospective delegated functions have been fully operational for at least 12 consecutive months.
- Claims management functions must include:
  - A claim platform
  - Claim system capabilities to:
    - Receive and ingest membership and plan benefits for claims adjudication
    - Support contractual and regulatory reporting
- Claim examiners must have a minimum of one year of experience.
- The Entity must have an internal claim quality program.
- The Entity must have security controls.
  - Delegated Entity shall maintain written system security control policies and procedures as required by Mandates, accreditation standards, and this Agreement.

Assessment/audit of delegated claims

The Delegated Entity agrees to a minimum of an annual assessment/audit to assess compliance with the delegated claim functions. The delegated claims audit includes an assessment of claim delegates operational policies and procedures and a performance audit to assess compliance with delegation agreement and Aetna, CMS, state, and federal requirements.

Operational review questionnaire (ORQ)

The operational assessment includes a review of the Delegated Entity's administrative structure, staffing and claims management functions/workflow, including policies and procedures.

The ORQ is used to capture information on the claims process, the policies and procedures, and the tools used by the Delegated Entity.

The completed ORQ and requested attachments are to be submitted as instructed by the Aetna auditor.

Performance audit

The performance audit includes a random sampling of claims to validate that the entity is administering claims compliant with applicable regulatory, contractual and/or Aetna standards.

The Aetna auditor will outline:

- The claim universe period
- The universe report and submission requirements
- Selected claim sample requirements

Assessment/audit results

On completion of the audit and approval by Aetna's applicable oversight committee(s), the Aetna auditor will distribute the final audit report.

Corrective action plan

If Aetna determines that the Delegated Entity has failed to carry out claim administration in accordance with the terms of the this Agreement or with reasonable performance expectations, Aetna may take such steps, as it deems necessary, as outlined in the Delegation Agreement.

All orrective action plans must include:

- Root cause
- Implementation time frame
- Resolution plan
- Completion date

The corrective action plan is monitored through closure by the Aetna auditor, network, applicable oversight committee and Delegated Entity.

Transmitting data

Regular email transmission of this data is neither secure nor compliant under HIPAA and will be deleted without being read.

Below are examples of HIPAA-compliant delivery methods to send the request universe information to Aetna.

- The Aetna secure encryption email process — attach the reports and reply to the email that was sent via the Aetna secure encryption process.
- Grant direct access to a secure internal network or FTP site.
- Request access to the Aetna secure FTP site.

Claim definitions

Clean claim

Unless otherwise required by law or regulation, a claim which (a) is submitted with proper time frame as set forth in this Agreement, (b) has (i) detailed and descriptive medical and patient data, (ii) a corresponding referral (whether in paper or electronic format), if required for the applicable claim, (iii) whether submitted via an electronic transaction using permitted standard code sets (e.g., CPT-4, ICD-10, HCPCS) as required by the applicable federal or state regulatory authority (e.g., U.S. Department of Health & Human Services, U.S. Department of Labor, state law or regulation) or otherwise, all the date elements of the UB-92 or HCFA-1500 (or successor standard) forms (including but not limited to member identification number, Social Security number, date(s) of service, and complete and accurate breakdown of services), (c) does not involve COB, and (d) has no deficit or error (including any new procedures with no Current Procedural Terminology (CPT) code, experimental procedures or other circumstance not contemplated at the time of execution of the Delegated Claims Agreement) that prevents timely adjudication.

Medicare's definition of a clean claim is as follows: A claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim and a claim that includes the substantiating documentation needed to meet the requirements for encounter data submission and meet the original Medicare "clean claim" requirements.

Clean claim examples

- A new claim that automatically adjudicates through the claims system on the first pass, and the submitted charges are either paid or denied; the claim is neither pended nor referred, and no request for additional information is made
- A claim that includes all the necessary information for processing and submission; that is, the employee's name, patient's name, plan sponsor name, control number, date of service, valid CPT-4/Healthcare Common Procedure Coding System (HCPCS) code, diagnosis/International Classification of Diseases (ICD)-10 code, itemized billed amount, place of service, provider's name, provider's address, provider's tax identification number
- Claims that have been pended for internal review of medical necessity with Aetna® when the medical information needed to review the claims has been submitted by the provider or member
- Claims referred for patient management review if patient management has all the records it needs and does not have to go outside Aetna for information to complete the review
- Claims pended requiring a nonparticipating provider identification number assignment
- Claims involving coordination of benefits when information to determine the primary payer and the primary plan's EOB has been submitted with the claim

Nonclean claim

If additional documentation is needed that involves a source outside of Aetna (e.g., medical records), the claim is considered not clean.

Nonclean claim examples

- Pended claims that need additional information from the employee, provider, employer or another party outside of Aetna
- Pended claims that need proof-of-loss information (e.g., last debts and liability statement, pre-existing questionnaires, subrogation/workers' compensation injuries and all other inquiries that are relevant to completing the proof of loss) from the employee
- Claims that need medical records, office notes, operative reports, emergency room reports, etc., from the provider to make a medical necessity or patient management determination
- Claims pended from providers when there is no referral on file authorizing the services
- Accident claims that need accident details
- Claims where other insurance status is unknown and payment is withheld, and the carrier's EOB is requested or Medicare's EOB is requested to determine the liability of Aetna for the claim
- Claims billed without an ICD-10 diagnosis code or a description of the condition being treated
- Claims received without a valid CPT-4 or HCPCS code and without description of services

Turnaround time (TAT)

The following procedures have been established to ensure timely handling of claims in order to comply with prompt payment legislation and to monitor processor performance through automated reports.

- All mail must be date stamped when received in an Aetna office or Delegated Entity office.
- An inappropriate entry of the received date will affect the measurement of the TAT for the claim.
- TAT objectives may also be included in performance guarantees with plan sponsors.
- The received dates entered during claims processing are used in determining the TAT of a claim.

State TAT

- Most states have TAT requirements (through fair claim settlement legislation), which are monitored for compliance by their state insurance departments.
- Most TAT objectives are based on the receipt date by the correct payer.

CMS TAT

- TAT is based on the earliest receipt date, regardless of forwarding or rerouting.
- All clean claims from noncontracted providers for Medicare members that are not paid within 30 calendar days of receipt must have an interest payment applied. According to Section 1842(c)(2)(C) of the Social Security Act, interest must be paid from the date in which the claim should have initially been paid. **Note:** All other claims, regardless of whether the provider is contracted or noncontracted, must be paid or denied within contractual requirements from the date of receipt.
- There must be a procedure to identify payers (which are primary to Medicare), determine the amounts payable and coordinate benefits.
- There must be written procedures to make accurate determinations of emergency, urgently needed services and covered benefits so that claims are appropriately processed.
- Contracts between the Delegated Entity and contracted providers must contain prompt payment provisions.
- The CMS website is **cms.hhs.gov**.

Claim reporting

The Delegated Entity shall submit required monthly self-reports to Aetna by the 15th of each month, reporting the prior monthly activity. The required reports may include any or all the reports listed below, depending on the level of delegation and applicable corrective actions as identified through the oversight process.

- Claims audit report — quality review report
- Monthly self-report or claims inventory reports
- Daily/weekly/monthly/YTD receipts
- Daily/weekly/monthly/YTD on-hand
- Production reports
- Interest paid reports
- Monthly denied claims report by denial reason
- Pended claims report
- Timeliness (TAT) reports

Notification of changes

Prompt notification to Aetna of changes related to the contacts and location of the Delegated Claim Entity helps ensure accurate and timely communication.

- Aetna requires advance written notice of the following:
- Address or addition of claims office site
- Closure of claims office site
- Telephone numbers
- Tax Identification Number (TIN)
- CA only: DMHC — Risk Bearing Organization ID # (RBO ID #)
- Claims contacts
- Change in subdelegate
- Change in management service organization
- Mergers/acquisitions
  - If Delegated Entity or its affiliate or parent organization acquires or takes operational responsibility for a new entity and its providers after the effective date of a delegated agreement

All changes must be submitted in writing to your Aetna Relationship Manager.

Notification of complaints

The Delegated Entity will notify Aetna, within 24 hours of receipt, of any complaints, either oral or written, received by the Delegated Entity from or about members or participating providers and all attorney contacts involving members or participating providers. Although the Delegated Entity may respond to a complaint, Aetna does not delegate the resolution of complaints, grievances or appeals.

Subdelegation

If a Delegated Entity contracts with another organization to perform any part of the delegated process, Aetna will review agreements and oversight documentation between the Delegated Entity and the organization.

- If a subdelegate is being added, Aetna is to be notified prior to entering the arrangement in order to evaluate the Delegation Oversight and the agreement.
- The subdelegate is expected to fully participate and cooperate with requests to supply information and to support regulatory or accreditation needs.
- Subdelegation and/or outsourcing includes any claim administrative function where delegated entity shares Aetna member PHI or PII with another entity or vendor.

VI. Call Center for delegated providers

Aetna delegates call center functions to established medical groups, IPAs, PHOs or other provider entities when key claim management or other components are in place and conform to Aetna, NCQA, CMS and state and federal requirements.

Aetna will retain the ultimate decision-making authority for delegated call center functions and will provide oversight of delegated activities. Oversight is conducted via annual audits, ad-hoc audits if deficiencies are identified, and periodic evaluation of performance reports as outlined in the delegation agreement.

The Delegated Entity's call center processes must comply with, at a minimum, all applicable Aetna standards as outlined in the delegation agreement, external accreditation standards, and CMS and state and federal regulations. In addition, the Delegated Entity agrees to the following requirements:

- Satisfy Aetna requirements for compliance with policies and procedures and implementation of any Aetna corrective action plan recommendation for improvement.
- Undergo periodic assessments of delegated activities at least annually or more frequently if deemed necessary.
- Obtain consent of Aetna for all outsourcing/ subdelegation of call center functions.
- Provide Aetna staff, NCQA, state and federal regulators access to call center records and files and to the Entity's call center policies and procedures, program documents and committee minutes as deemed necessary by Aetna for monitoring the oversight of all aspects of the delegated call center functions.

Delegated call center function requirements

The Delegated Entity will provide call center functions for covered services as more fully described below. The covered services, which are included here, will be for all services provided by the Delegated Entity as specifically outlined in the delegation agreement.

A prospective call center delegate should meet the following prerequisites:

- The Entity must have applicable provider agreement or group agreement in place prior to executing a delegation agreement.
- Prospective delegated functions have been fully operational for at least 12 consecutive months.
- Call Center functions must include:
  - Aetna-specific toll-free number, if applicable to agreement
    - Call platform
    - Call system capabilities to:
    - Validate member eligibility and plan benefits
    - Support contractual and regulatory reporting
    - Customer service representatives (CSR) with minimum of 1 year experience
    - Internal call quality program
    - Security controls
      - Delegated Entity shall maintain written system security control policies and procedures as required by Mandates, accreditation standards, and this Agreement.

Assessment/audit of delegated call center

The Delegated Entity agrees to a minimum of an annual assessment/ audit to assess compliance with the delegated call center functions. The delegated call center audit includes an assessment of call center delegates operational policies and procedures and a performance audit to assess compliance with delegation agreement and Aetna, CMS, state, and federal requirements.

Operational review questionnaire (ORQ)

The operational assessment includes a review of the Delegated Entity's administrative structure, staffing and call center functions/workflow, including policies and procedures.

- The ORQ is used to capture information on the call center process, the policies and procedures, and the tools used by the Delegated Entity.
- The completed ORQ and requested attachments are to be submitted as instructed by the Aetna auditor.

Performance audit

The performance audit includes a random sampling of calls to validate that the entity is administering calls compliant with applicable regulatory, contractual and/or Aetna standards.

- The Aetna auditor will outline:
- The call universe period
- The universe report and submission requirements
- Selected call sample requirements

Assessment/Audit Results

On completion of the audit and approval by Aetna's applicable oversight committee(s), the Aetna auditor will distribute the final audit report.

Corrective action plan

If Aetna determines that the Delegated Entity has failed to carry out claim administration in accordance with the terms of this Agreement or with reasonable performance expectations, Aetna may take such steps, as it deems necessary, as outlined in the Delegation Agreement.

All corrective action plans must include:

- Root cause
- Implementation time frame
- Resolution plan
- Completion date

The corrective action plan is monitored through closure by the Aetna auditor, network, applicable oversight committee and Delegated Entity.

Call reporting

The Delegated Entity shall submit to Aetna, by the 15th of the following month, monthly reports showing that Service Level Agreements (SLAs) were met. The required reports may include any or all the reports listed below, depending on the level of delegation and applicable corrective actions as identified through the oversight process.

- Average speed of answer for telephone calls placed by members and/or providers is 30 seconds, or as defined by the delegation agreement or SLA
- Telephone abandon rate is 5% or less , or as defined by the delegation agreement or SLA

- Telephone service factor of 75% of all calls answered in 30 seconds, or as defined by the delegation agreement or SLA
- Elements of internal random call monitoring with a scoring criteria standard of 96.25%, or as defined by the delegation agreement or SLA

Transmitting data

Regular email transmissions of this data is neither secure nor compliance under HIPAA and will be deleted without being read.

Below are examples of HIPAA-compliant delivery methods to send the request universe information to Aetna.

- The Aetna secure encryption email process: attach the reports and reply to the email that was sent via the Aetna secure encryption process.
- Grant direct access to a secure internal network or FTP site.
- Request access to the Aetna secure FTP site.

Notification of changes

Prompt notification to Aetna of changes related to the contacts and location of the Delegated Claim Entity helps ensure accurate and timely communication.

Aetna requires advance written notice of the following:

- Address or addition of call center site
- Closure of call center site
- Telephone numbers
- Tax Identification Number (TIN)
- Call center contacts
- Change in subdelegate
- Change in management service organization
- Mergers/acquisitions
  - If Delegated Entity or its affiliate or parent organization acquires or takes operational responsibility for a new entity and its providers after the effective date of a delegated agreement

All changes must be submitted in writing to your Aetna Relationship Manager.

Notification of complaints

The Delegated Entity will notify Aetna, within 24 hours of receipt, of any complaints, either oral or written, received by the Delegated Entity from or about members or participating providers and all attorney contacts involving members or participating providers. Although the Delegated Entity may respond to a complaint, Aetna does not delegate the resolution of complaints, grievances or appeals.

Subdelegation

If a Delegated Entity contracts with another organization to perform any part of the delegated process, Aetna will review agreements and oversight documentation between the Delegated Entity and the organization.

- If a subdelegate is being added, Aetna is to be notified prior to entering the arrangement in order to evaluate the Delegation Oversight and the agreement.
- The subdelegate is expected to fully participate and cooperate with requests to supply information and to support regulatory or accreditation needs.
- Subdelegation and/or outsourcing includes any claim administrative function where Delegated Entity shares Aetna member PHI or PII with another entity or vendor.

VII. Clinical delegation

Aetna delegates clinical functions [utilization management (UM) and/or population health management (PHM)] to established medical groups, IPAs, PHOs or other provider entities when key utilization management or other components are in place and conform to Aetna, NCQA, CMS and state and federal requirements.

Aetna will retain the ultimate decision-making authority for delegated clinical functions and will provide oversight of delegated activities. Oversight is conducted via annual audits, ad-hoc audits if deficiencies are identified, and periodic evaluation of performance reports as outlined in the delegation agreement.

The Delegated Entity's clinical processes must comply with, at a minimum, all applicable Aetna standards as outlined in the delegation agreement, external accreditation standards, and CMS and state and federal regulations. In addition, the Delegated Entity agrees to the following requirements:

- Satisfy Aetna requirements for compliance with policies and procedures and implementation of any Aetna corrective action plan recommendation for improvement.

- Undergo periodic assessments of delegated activities at least annually or more frequently if deemed necessary.
- Obtain consent of Aetna for all subdelegation of clinical functions. Prior to any subdelegation, Aetna will conduct a preassessment on the subdelegation arrangement. In addition, if the entity subdelegates clinical functions, then, in addition to providing advance notification to Aetna, there must be a mutually agreed upon contract, agreement or other written record that meets Aetna requirements. The Delegated Entity and Aetna shall maintain oversight of the clinical services furnished by the subdelegate on behalf of Aetna.
- Provide Aetna staff, NCQA, state and federal regulators access to clinical records and files and to the entity's clinical policies and procedures, program documents and committee minutes as deemed necessary by Aetna for monitoring the oversight of all aspects of the delegated clinical functions.

Delegated clinical functions requirements

The Delegated Entity will provide clinical functions services for covered services as more fully described below. The covered services, which are included here, will be for all inpatient and outpatient services provided by the Delegated Entity as specifically outlined in the delegation agreement.

A prospective clinical delegate should meet the following prerequisites:

- The entity intends to execute a delegation agreement with Aetna.
- Prospective delegated functions have been fully operational for at least 12 consecutive months.
- The entity must have a Utilization Review Agent (URA) license, certification or registration as applicable.
- The entity has coverage for urgent issues seven days a week during business hours.
- The entity provides a contact to the health plan in order to address any issues that arise.
- The entity must manage the function being delegated from start to finish as defined in the delegation agreement.
- The entity has the ability to accept referrals from the health plan for UM and CM services and take action.
- The entity has a financial risk arrangement that includes downside risk in place with the health plan.
- The entity must have the ability to report UM data (including HEDIS data) through a timely and systematic process that Aetna is able to accept (EDI/278 transaction) and must address errors on the entity's part.
  - The entity must have the ability to send/receive secured communications (such as emails/data exchange) that can be opened and read by Aetna and Entity.
  - The entity privacy processes must include three-point member identity verification.
- If delegated for PHM
  - The entity's case management program must include STAR gap closure. Entity must be able to transfer that information to Aetna if requested.
  - The entity's case management program must include readmission avoidance, chronic comorbidities, advanced illness, and end of life.

UM Information Integrity

UM information integrity refers to maintaining and safeguarding the information used in the UM denial decision process against inappropriate documentation and updates. Delegated Entity will maintain UM information integrity policies and procedures (that include monitoring and evaluating subdelegates) and perform UM information integrity staff training, annual audits, qualitative analysis of audit findings, corrective actions, and reaudits in accordance with Applicable Law/ Accreditation Requirements.

Without limitation of the foregoing, Delegated Entity agrees that inappropriate documentation of or updates to UM information includes:

- Falsifying UM dates (e.g., receipt date, UM decision date, notification date)
- Creating documents without performing the required activities
- Fraudulently altering existing documents (e.g., clinical information, board-certified consultant review, denial notices)
- Attributing review to someone who did not complete the activity (e.g., appropriate practitioner review)
- Updates to information by unauthorized individuals

Clinical program procedures

The Delegated Entity will maintain a formal program that includes policies and procedures to evaluate criteria, information sources and processes used to review and approve the provision of services to members. These policies and procedures must be consistent with Aetna policies and procedures and must comply with applicable law/accreditation requirements and contractual obligations. The Delegated Entity's utilization management plan description should be revised as needed and submitted in writing to Aetna for review and approval at least annually, and more often if required by Aetna to keep Aetna apprised of the Delegated Entity's obligations under this Agreement.

Utilization management committee

The Delegated Entity will establish a utilization management committee, which will be responsible for overseeing utilization management activities. The Delegated Entity's utilization management committee membership should include a senior medical director of the Delegated Entity and other licensed physicians as necessary. For Medicare Delegates, CMS requires that the UM committee be led by a designated Medical Director. The utilization management committee will meet on a regular basis — at least quarterly, with additional meetings as necessary. A utilization management representative from Aetna is entitled to attend any utilization management committee meeting. Minutes of the committee meetings are to be maintained in a secure manner by the Delegated Entity and made available to Aetna for review.

Written utilization management review decision guidelines

The Delegated Entity will maintain a set of utilization management review decision protocols that are based on reasonable medical evidence and consistent with Aetna standards and guidelines. The Delegated Entity agrees to review and update the criteria as needed, but no less than annually, and provide Aetna with a written copy of any revision within 10 days. The Delegated Entity agrees to maintain and monitor consistent application of the criteria through the monitoring review mechanisms of physicians and other reviewers. The Delegated Entity agrees to inform practitioners and providers of utilization management decision guidelines and to provide criteria to Aetna, any government agency with jurisdiction, members and providers upon request.

Utilization management recommendations and decisions

The Delegated Entity agrees to comply with Aetna benefits coverage guidelines. The Delegated Entity will use qualified medical professionals to make benefits coverage decisions and to supervise review decisions. Utilization management review decisions must be made in a timely manner, in accordance with NCQA, CMS, state regulatory and Aetna time frames.

Time frames will accommodate clinical urgencies. The Delegated Entity agrees to monitor compliance with such time frames and will take all actions as are necessary to ensure compliance with such time frames.

All utilization management review decisions by the Delegated Entity will reflect professional judgment exercised with the degree of care and skill customarily exercised by providers of health care services and in accordance with generally accepted medical standards. Utilization management recommendations by the Delegated Entity will be based on the review of the entire record available and such additional information that the Delegated Entity determines to be necessary and appropriate to conduct patient management services.

A physician will conduct a review of any denial recommendation based on medical necessity and will use board-certified consultants when necessary to conduct the review of such denials. If so required by applicable law or contractual obligation, the physician making the review decision must be licensed to practice medicine in the state in which the member resides or is receiving services.

The Delegated Entity will ensure that the reason for any denial is clearly documented and is part of the notification sent to the member and attending physician. Notification of a denial will include appeals process information and comply with Aetna requirements. The Delegated Entity's physician reviewer will make the initial denial/determination, and Aetna retains the responsibility for the final decision on the denial determination.

The Delegated Entity will cooperate with and participate in Aetna's applicable appeal, grievance and external review procedures, provide Aetna with the necessary information, and abide by decisions of Aetna's appeals, grievance and review committees.

Medical technology

The Delegated Entity will have written policies and procedures in place to distribute and implement Aetna's guidelines/protocols/clinical policy bulletins (CPBs) pertaining to the appropriate use of new medical technologies or new application of established technologies, including medical procedures, drugs and devices. Aetna retains the final authority over all decisions relating to clinical policy regarding new medical technologies and new applications of established technologies.

Quality-of-care concerns

The Delegated Entity will have a written policy and procedure to identify quality-of-care concerns. Aetna must be notified within 24 hours of an identified concern. Aetna retains the responsibility to investigate, review, track and trend all potential concerns.

Utilization management functions

The Delegated Entity will perform various utilization management functions identified by Aetna, which may be subject to change. Any such change in utilization management functions will not be considered an amendment to the Agreement. The Delegated Entity agrees that all services will be provided through participating providers. Exceptions may be made in accordance with delegation agreement. Utilization management functions include but are not limited to:

- Receipt of authorization requests and verification of member eligibility, benefits, and network.
- Initial determinations for services in accordance with the Delegated Entity's utilization management agreement with Aetna.
- Preservice review of elective services, both inpatient and outpatient, including requests for out-of-network services at an in-network benefit level.
- Concurrent review of outpatient services and procedures. Review of inpatient admissions and associated services (acute and post-acute) including initial review, ongoing review, and all discharge planning needs.
- Retrospective review of those same service categories delegated for Preservice or Concurrent above.
- If Delegated Entity is delegated for Population Health Management, it shall refer to the Delegated Function – Population Health Management (PHM) Exhibit for its obligations concerning the PHM delegated function. If Delegated Entity is not delegated for PHM, Delegated Entity agrees to collaborate with Aetna in PHM activities, as requested by Aetna, including but not limited to notifying Aetna when it identifies Members who would potentially benefit from Aetna's PHM program(s).

Utilization management reporting requirements

Aetna agrees to monitor and evaluate utilization management reports from the Delegated Entity on a regular basis. Reports are to be submitted via either joint meetings or directly via email, or other agreed upon electronic means, to the assigned Aetna Clinical Delegation Oversight Auditor or Relationship Manager of the Agreement. At a minimum, the Delegated Entity agrees to provide Aetna with the following reports. Note: Individual delegates may have additional reporting requirements and should refer to the delegation agreement for additional details. Additional reports, data, and information may be requested from time to time to enable Aetna to fulfill accreditation and/or regulatory filing and auditing requirements.

- Annual:
  - UM Program Description
  - UM Program Evaluation
  - UM Work Plan
  - UM Information Integrity Annual Analysis
- Semiannual (Aetna member-specific data for each line of business):
  - Bed days/1,000
  - Admits/1,000
  - Average length of stay
  - For each type (preservice, concurrent or retrospective):
    - Number of UM cases (inpatient or outpatient)
    - Number of denials and percentage rate, including emergency services denials
    - Timeliness reports that include average turn-around time and that calculate rates of adherence to time frames for UM decision-making and notification of UM decisions (urgent and non-urgent)
- Quarterly:
  - If delegated for Medicare, Medicare Part C organizational determinations
- Monthly:
  - CA Commercial HMO only: speech therapy denials log and files

Population health management (PHM) reporting requirements

Aetna agrees to monitor and evaluate PHM reports from the Delegated Entity on a regular basis. Reports are to be submitted via either joint meetings or directly via email, or other agreed upon electronic means, to the assigned Aetna Clinical Delegation Oversight Auditor or Relationship Manager of the Agreement. At a minimum, the Delegated Entity agrees to provide Aetna with the following reports. Note: Individual delegates may have additional reporting requirements and should refer to the delegation agreement for additional details. Additional reports, data, and information may be requested from time to time to enable Aetna to fulfill accreditation and/or regulatory filing and auditing requirements.

- Annual:
  - PHM program description
  - PHM population assessment
  - Effectiveness of PHM program(s), including, at a minimum, the four identified PHM measures
  - Evaluation of member experience with PHM program(s), including satisfaction with the PHM program(s) and member complaints
- Semiannual (Aetna member-specific data for each line of business):
  - Total member population delegated
  - Number of members identified for each delegated PHM program
  - Number of member cases opened during reporting period for each delegated PHM program
  - Number of referrals to Aetna for non-delegated PHM functions

Population health management (PHM) functions

The Delegated Entity will provide a PHM program that is comprehensive and addresses complex member needs across the continuum of care. The Delegated Entity agrees to perform various PHM functions identified by the company, which may be subject to change. Delegated PHM functions include but are not limited to the following:

- Annual population assessment to determine actionable categories for intervention (as applicable).
- Ability to receive referrals for PHM services from multiple avenues, including health plan, 24-Hour Nurse Line, discharge planner, member/caregiver self-referral, and/or practitioner referrals.
- Providing eligible members with information on member eligibility criteria, how to opt in or opt out of the program, and how to use program services.
- The program(s) must include time frames for assessment and ongoing management of members that adheres to Aetna's established timeframes.
- Utilize a PHM system based on evidence-based clinical guidelines or algorithms. The system shall include automatic documentation of staff ID, the date and time of action on the case or when member interaction occurred and have automated prompts for follow-up.
- If delegated for complex case management, the program shall include, without limitation: (1) end of life/advanced illness; and (2) readmission avoidance program. The Delegated Entity's complex case management process includes but is not limited to the following:
  - Members' right to decline participation or disenroll from case management programs and services offered by the Delegated Entity
  - Initial assessment of Member's current health status, including condition-specific issues and medication review
  - Documentation of clinical history, including past medications
  - Initial assessment of activities of daily living
  - Initial assessment of behavioral health status, including cognitive function
  - Initial assessment of social determinants of health
  - Initial assessment of life-planning activities
  - Evaluation of cultural and linguistic needs, preferences, or limitations
  - Evaluation of visual and hearing needs, preferences, or limitations
  - Evaluation of caregiver resources and involvement
  - Evaluation of available benefits
  - Evaluation of community resources
  - Development of an individualized care plan, including prioritized goals that consider member and caregiver goals, preferences, and their desired level of involvement in the care plan

- Identification of barriers to the member meeting goals or complying with the care plan
- Facilitation of member referrals to resources and a follow-up process to determine whether member acts on referrals
- Development of a schedule for follow-up and communication with the member
- Development and communication of member self-management plan
- A process to assess the member's progress against the care plan

- At least annually, Delegated Entity will conduct comprehensive analysis of the overall effectiveness of the PHM program(s) using at least four measures relevant to the delegated function(s), which shall include: one clinical measure; one cost or utilization measure; and one member feedback measure from two different PHM programs and in alignment with the goals described within the PHM program description. For each measure, the Delegated Entity will:
  - Identify a relevant process or outcome
  - Use a valid method that provides quantitative results
  - Set a performance goal(s)
  - Clearly identify the measure's specifications
  - Analyze results. Including quantitative and qualitative analysis
  - Identify opportunities for improvement, if applicable
  - Develop a plan for intervention and implement at least one intervention to improve performance
  - Perform a remeasurement
- At least annually, the Delegated Entity will evaluate experience with its PHM program by obtaining feedback from members and analyzing members' complaints.
- The Delegated Entity will contact Aetna when members are identified who would potentially benefit from PHM services that are not delegated or when there is a need for coordination and integration between medical and behavioral health services.

Contact person

Delegated Entity agrees to provide members and practitioners with access to an individual in their organization who is available to receive and respond to communications relating to their responsibilities under the delegation agreement. Delegated Entity agrees and is responsible for communicating with members and practitioners about their PHM and UM processes and decisions.

Surveys

The Delegated Entity will conduct regular surveys no less than annually involving members and participating providers to determine satisfaction with the Delegated Entity's patient management activities provided pursuant to the delegation agreement. The Delegated Entity will develop and implement action plans to improve any patient management processes that have been identified as problems through the member or participating provider surveys.

Aetna does not delegate the evaluation of provider and member satisfaction. Evaluation results, however, are shared with the Delegated Entity, and collaborative efforts are made toward improved satisfaction.

Sharing clinical information

Aetna does not prohibit the Delegated Entity from collecting clinical and member experience data. Aetna will provide member experience and clinical performance data relevant for delegated functions upon request by the Delegated Entity to the assigned clinical auditor or network manager.

Notification of complaints

The Delegated Entity will notify Aetna, within 24 hours of receipt, of any complaints, either oral or written, received by the Delegated Entity from or about members or participating providers and all attorney contacts involving members or participating providers. Although the Delegated Entity may respond to a complaint, Aetna does not delegate the resolution of complaints, grievances or appeals.

Subdelegation

If a Delegated Entity contracts with another organization to perform any part of the delegated process, Aetna will review agreements and oversight documentation between the Delegated Entity and the organization. If a subdelegate is being added, Aetna is to be notified prior to entering the arrangement in order to evaluate

the Delegation Oversight and the agreement. The subdelegate is expected to fully participate and cooperate with requests to supply information and to support regulatory or accreditation needs.

VIII. The U.S. Centers for Medicare & Medicaid Services (CMS) compliance program requirements

Aetna is required to identify and oversee its First Tier Entities according to CMS requirements. Aetna uses various oversight activities to ensure that its first tier, downstream, and related entities (FDRs) are compliant. These oversight activities may include an attestation, audit/assessment review and/or a monitoring survey on an annual basis for all entities that participate in Medicare as part of their Delegated Agreement and to confirm the Delegated Entity's compliance with applicable CMS regulatory and contractual obligations specific to the Medicare Compliance Program requirements.

Examples of annual audits include Code of Conduct requirements, Federal Health Care Program Exclusions Lists (OIG/GSA) and record retention. These requirements also apply to any of the downstream entities you use for Aetna Medicare business. The requirements, which are published in both Pub. 100-18, Medicare Prescription Drug Benefit Manual, chapter 9; and in Pub. 100-16, Medicare Managed Care Manual, chapter 21, are identical.

As a First Tier Entity, you/your organization must comply with the Medicare Compliance Program requirements and/or contractual obligations, including compliance training and Code of Conduct distribution.

Medicare Compliance Program requirements are listed below and apply to all services that your organization, an Aetna® First Tier Entity, provides for Aetna Medicare business. The requirements also apply to any of the downstream entities you use for Aetna Medicare business.

1. Standards of conduct and/or compliance policies

   My organization needs to have standards of conduct and/or compliance program policies that explain its commitment to comply with federal and state laws, ethical behavior and compliance program operations. These standards or policies should be distributed to employees within 90 days of hire, upon revision, and annually thereafter.

2. U.S. Department of Health & Human Services Office of Inspector General (OIG) and General Services Administration's System for Award Management (SAM) exclusion screening

   My organization screens the **OIG** and the **SAM** exclusion lists prior to hire or contracting, and monthly thereafter, for our employees and Downstream Entities. My organization immediately removes any person/entity from working on Aetna Medicare business if found on either of these lists, and we will notify Aetna right away.

3. Reporting mechanisms

   My organization communicates to employees how to report suspected or detected non-compliance or potential fraud, waste or abuse, and that it is their obligation to report without fear of retaliation or intimidation against anyone who reports in good faith. My organization *either* requests that employees report concerns **directly to Aetna** or maintains confidential and anonymous mechanisms for employees to report internally. In turn, we report these concerns to Aetna, when applicable.

4. Offshore operations

   If my organization and/or our Downstream Entities perform work that involves the receipt, processing, transferring, handling, storing or accessing of Protected Health Information (PHI) offshore, we have submitted the Aetna **Offshore Services Attestation**: Required Information form and have received approval from an authorized Aetna representative.

5. Downstream entity oversight

   My organization either doesn't use Downstream Entities or uses Downstream Entities for Aetna Medicare business and conducts oversight to ensure that they abide by all laws, rules and regulations that apply to me as a First Tier Entity. This includes ensuring that my organization's:

   A. Contractual agreements with Downstream Entities contain all CMS-required provisions

   B. Downstream Entities comply with the Medicare compliance program requirements described in this attestation

   C. Downstream Entities comply with any applicable Medicare operational requirements

6. Operational oversight

   My organization conducts internal oversight of the services that we perform for Aetna Medicare business to ensure that compliance is maintained

with applicable laws, rules and regulations including CMS regulatory/sub-regulatory guidance.

The Centers for Medicare & Medicaid Services (CMS) requires all Medicare Advantage Organizations (MAOs) and Part D plan sponsors, like Aetna, and their FDRs to comply with these requirements. Initially, upon contracting and annually thereafter, Aetna will provide you with a link to our Code of Conduct and compliance policies for your organization's use.

You may use our online Code of Conduct and Medicare compliance policies or provide your own comparable versions.

Please note: Effective January 1, 2019, CMS does not require the use of its Fraud, Waste & Abuse and General Compliance training. However, CMS expects that organizations will continue to provide compliance training for the services provided by their FDRs.

Aetna® will continue to issue initial and annual compliance training packets, which include links to our Code of Conduct and compliance policies, to our FDRs. We'll also continue to conduct routine monitoring, auditing and oversight of our FDRs.

Key requirements of our Medicare Compliance program include but are not limited to the following:

- Downstream Entity oversight
- Reporting mechanisms
- Standards of conduct and/or compliance policies, which must be distributed within 90 days of hire or contracting and at least once a year after that
- The U.S. Department of Health & Human Services Office of Inspector General (OIG) and General Services Administration's System for Award Management (SAM) exclusion screening, prior to hiring or contracting, and monthly thereafter

As part of the annual attestation process, an authorized representative from your organization will be asked to attest to your organization's awareness, completion and compliance with these requirements. In addition, as part of the audit process, Aetna and/or CMS may also ask that you provide evidence of your compliance.

IX. Business continuity plan requirements

Aetna is required to confirm that its First Tier Entities are compliant with all Centers for Medicare & Medicaid Services (CMS) requirements. Aetna uses various oversight activities to ensure that its FDRs are compliant. These oversight activities may include an attestation, audit/assessment review and/or a monitoring survey on an annual basis.

Effective January 1, 2016, CMS requires a business continuity plan for Medicare Advantage (MA) and Prescription Drug Benefit programs.

MA organizations, Part D sponsors and their contracted FDRs must develop, maintain and implement business continuity plans that meet certain minimum standards. The plans must contain policies and procedures to ensure the restoration of business operations after disruptions. Examples of disruptions include natural or man-made disasters, system failures, and emergencies, including pandemic public health emergencies, as well as the threat of these disruptions.

Minimum requirements are:

- A documented mitigation strategy
- Annual testing and revision
- Annual training
- Business communication plans
- Chain of command
- Completion of a risk assessment
- Identification of essential functions
- Record keeping
- Business operations disruptions planning must include preparations for pandemic public health emergencies.

As part of the annual attestation process, an authorized representative from your organization may be asked to attest to your organization's awareness, completion and compliance with these requirements. In addition, as part of the audit process, Aetna and/or CMS may also ask that you provide evidence of your compliance.

- **First Tier Entity** is a party that is acceptable to CMS and enters into a written arrangement with a Medicare Advantage Organization or Part D plan sponsor or applicant in order to provide administrative services or health care services to a Medicare-eligible individual under the Medicare Advantage program or Part D program.

- **Downstream Entity** is a party that is acceptable to CMS and enters into a written arrangement with persons or entities involved with the Medicare Advantage benefit or Part D benefit, that are below the level of the arrangement between a Medicare Advantage Organization or applicant or a Part D plan sponsor or applicant and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
- **Related Entity** is any entity that is related to a Medicare Advantage Organization or Part D sponsor by common ownership or control
  - *and* performs some of the Medicare Advantage Organization or Part D plan sponsor's management functions under contract or delegation
  - *or* furnishes services to Medicare enrollees under an oral or written agreement, or leases real property or sells materials to the Medicare Advantage organization

X. Health care reform and Delegated Entities

The Affordable Care Act (ACA) is the most sweeping health care legislation passed by Congress since the adoption of Medicare in the 1960s. The precise impact of the ACA will continue to be shaped by new rules and guidance developed by the federal agencies in support of the law.

There are certain provisions in your Delegated Agreement with Aetna® that require some delegates, depending on delegated function, to update systems and transactions to be compliant with all requirements related to ACA, including but not limited to information related to section 1104 of the ACA, Administrative Simplification. Aetna may request information necessary to comply with certification requirements related to the ACA, including but not limited to information related to section 1104 of the ACA. This may include status updates, test results and other documentation we request.

Please visit **Aetna.com/health-reform-connection** for more information about the Affordable Care Act and the Aetna commitment to comply. (The summaries and questions and answers throughout this site are provided for informational purposes only.)

We are committed to complying with health care law and to helping you understand its impact.

XI. Third Party Risk Governance (TPRG)

The TPRG team is responsible for the security risk management and oversight of entities and providers that are delegated for claims, customer service, enrollment management and clinical functions (such as utilization review and medical management). The goal of the program is to ensure adherence to local, state and federal cybersecurity laws and CVS Health® established security and privacy standards.

As part of this program, TPRG conducts a mandatory cybersecurity risk assessment of delegated providers precontractually and annually. If missing or weak security controls are identified, remediation is required within a reasonable period of time. If the time for remediation will exceed 6 months, business rationale must be provided. Our assessments are designed to validate that required security controls are in place in key areas, including but not limited to the following:

- Access management
- Asset management
- Communications security
- Cryptography
- Information security incident management
- Information security policies
- Operations security
- Personnel
- Physical and environmental security

XII. Washington OIC HCBM registration

The Washington State Office of Insurance Commissioner requires that entities providing certain services to carriers annually registered as a Health Care Benefits Manager.

"Health Care Benefits Manager" means a person or entity providing services to, or acting on behalf of, a health carrier or employee benefits programs, that directly or indirectly impacts the determination or utilization of benefits for, or patient access to, health care services, drugs, and supplies including, but not limited to:

- Prior authorization or preauthorization of benefits or care
- Certification of benefits or care
- Medical necessity determinations
- Utilization review
- Benefit determinations
- Claims processing and repricing for services and procedures
- Outcome management
- Provider credentialing and recredentialing
- Payment or authorization of payment to providers and facilities for services or procedures
- Dispute resolution, grievances, or appeals relating to determinations or utilization of benefits
- Provider network management; or
- Disease management

Please refer to the Office of the Insurance Commissioner's website for a full explanation of their interpretation of the law, as well as their filing instructions: **https://www.insurance.wa.gov/registering-health-care-benefit-manager-hcbm**. Please note, failure to register or renew your registration will preclude your organization from conducting health care benefit services in the State of Washington and therefore, with Aetna®. Registration must be completed within thirty (30) days of the effective date of your agreement with Aetna.

[WAC 284-180-220, 284-180-230, 284-180-240, 284-180-460 and RCW 48.200.020, 48.200.040]

XIII. Glossary

Adverse event — An unusual situation that is harmful, or may result in harm, to a member. Examples include suicide, homicide, medicine errors and criminal action by a staff member to a member.

Appeal process — The formal process that a member, or a provider on behalf of a member with the member's consent, can use to request review of a plan decision. Typically, the issues involve benefits, utilization management, quality of care and service.

Automatic adjudication — Automated processing of claims entered via EDI or data entry. These claims do not require claim examiner intervention.

Board-certified physician — A physician who has successfully completed a medical board's examination and has been certified by the board as a specialist in a particular area of practice. Before sitting for such an examination, the physician must meet the specialty training requirements of the applicable board. Aetna only recognizes ABMS and AOA boards.

Capitation — A method of payment in which the Provider is paid a fixed amount for each member who is eligible for the contracted services, over a set period of time. The capitation method may be used for primary care physicians, specialists or groups of physicians (IPAs). Also, the cost of providing an individual with a specific set of services over a set period of time, usually for a month or a year.

Case/Population health management — A process under which health care benefits are assessed, coordinated, evaluated and monitored to meet an individual member's needs.

Case/Population health management notification — A process initiated by the provider under which the provider notifies the company of proposed procedures, treatments or referrals, and the company issues a length of stay assignment.

Case/Population health management records — All data, information and documentation related to the Delegated Entity's performance of Patient Management.

CMS 1500 form — A standardized billing template developed by the Centers for Medicare & Medicaid Services. Physicians and suppliers use it when submitting to Medicare and third-party payors.

Complaint — An oral or written expression of dissatisfaction by a member (or provider or representative on behalf of a member) regarding services performed either by the Delegated Entity or participating providers.

Concurrent review — A telephonic or onsite assessment of the medical necessity and appropriateness of continued inpatient stay or level of care after the initial length of stay or assigned course of treatment has expired.

Contractor — A vendor of medical goods and/or services.

Coordination of Benefits (COB) — Guidelines developed by the National Association of Insurance Commissioners (NAIC) to help eliminate duplication of medical payments made to providers when a person is covered by more than one health insurance carrier.

Copayment — The HMO member's financial responsibility for services.

Covered benefits — Those medically necessary services and supplies that are covered according to the terms and conditions of the member's plan.

Credentialing — The process by which qualifications, certifications and licenses of practitioners are examined and approved for network participation, according to Aetna guidelines.

Delegation — A formal process by which the organization gives another entity the authority to perform certain functions on its behalf. Although the organization may delegate the authority to perform a function, it may not delegate the oversight responsibility for ensuring that the function is performed appropriately.

Discharge plan — Continuing treatment plan for a member being transferred from one level of care to another.

Emergency services — Unless otherwise defined in the member's plan, the medically necessary services to preserve life or stabilize health, available on an inpatient basis, 24 hours per day, 7 days a week.

Encounter — A member's visit to their primary care physican's office. These visits are documented in various records.

Explanation of Benefits (EOB) statement — An explanation from the primary insurance company of how the claims were processed for payment determination.

Evaluation — A face-to-face interview conducted by either a contagious disease or childhood disease/mental health (CD/MH) practitioner to determine the appropriate service and level of care.

Evaluator — A contagious disease or childhood disease/mental health (CD/MH) practitioner who conducts an initial face-to-face interview with an individual in order to determine a treatment plan.

Facility — Service site for the delivery of various levels of care.

Financial protection — An instrument (usually a letter or credit or performance bond) obtained by the delegate for the benefit of Aetna® to protect Aetna from a delegate's potential future insolvency or failure to pay claims to downstream providers.

Grievance, Level I — A written request by a member (or a provider or representative on behalf of a member) for reconsideration of an HMO or patient management decision or determination.

Grievance, Level II (also referred to as an "appeal") — A written request by a member (or a provider or representative on behalf of the member) for reconsideration of a Level I grievance decision.

Grievance process — A process by which a member can submit complaints and seek resolution of issues.

Group master contract — A contract between an HMO and an employer that sets forth plan benefits and the administration of the particular HMO plans.

Health professionals — Physicians and other professionals, including certified nurse midwives, who are engaged in the delivery of health care services and who are licensed, if licensing is a required state law.

HEDIS® (Healthcare Effectiveness Data and Information Set) — A set of standardized performance measures designed to ensure that purchasers and consumers have the information they need in order to reliably compare the performance of managed care plans. The major areas of measurement include effectiveness of care, satisfaction with the experience of care, health plan stability, cost of care, informed health care choices and health plan description information.

Hospital affiliation — A contractual agreement between an HMO and one or more hospitals where the hospital provides the inpatient benefits offered by the HMO.

ID number — A combination of letters and numbers on a member's insurance card assigned by an HMO and used to identify the member.

Inquiry — A request for information or opinion, including but not limited to issues regarding the scope of coverage for health care services, denials, cancellations, terminations or renewals.

Interest payment — A calculation based on the state or a CMS late-interest payment percentage for all claims processed outside of the required state guidelines.

IPA (Independent Practice Association) — An organization through which Aetna maintains and manages certain provider relationships for our HMO products. IPAs are groups of providers who have the same specialty (such as radiologists or chiropractors). An IPA can include both PCPs and specialists. Providers within an IPA usually subcontract with a management service organization (MSO), which provides administrative services, such as utilization management or claims administration.

Medically necessary and medical necessity — Health care services that a physician, while exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, or disease, or its symptoms, and that are all of the following:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease
- Not primarily for the convenience of the patient, physician or other health care provider, and not more costly than an alternate service or sequence of services that are at least as likely to produce equivalent therapeutic or diagnostic results such as the diagnosis or treatment of that patient's illness, injury or disease

For these purposes, "generally accepted standards of medical practice" means standards that are based on any of the following:

- Credible scientific evidence published in peer-reviewed medical literature
- Generally recognized by a relevant medical community
- Consistent with a medical specialty society's recommendations
- Consistent with the views of physicians practicing in relevant clinical areas
- Consistent with any other relevant factors

Medical services — Health care provided by physicians, paramedical personnel and other health professionals. These services can include but are not limited to diagnosis, prevention, therapy and surgery.

Medicare — A nationwide federal health insurance program designed for people ages 65 and above, regardless of their health status, and for people younger than 65 who are disabled or have chronic kidney disease (also called "end-stage renal disease"). Medicare Part A covers the hospital portion of the program, while Part B covers the physician's services.

Member —An individual who is entitled to health care services under an HMO plan.

Mixed services guidelines — Aetna® guidelines that delineate and clarify accountabilities and the financial utilization management responsibilities of the medical or surgical and psychiatric or chemical dependency services.

NCQA — The National Committee for Quality Assurance.

Organizational provider — An institutional provider and supplier of health care services that include but are not limited to the following:

- Freestanding surgical centers (including freestanding abortion centers)
- Home care agencies
- Hospitals
- Nursing homes
- Skilled nursing facilities (SNFs)

Behavioral health can be freestanding or hospital-based organizations and include but are not limited to the following:

- Mental health and chemical dependency hospitals
- Residential treatment facilities and ambulatory settings including partial hospital programs, intensive outpatient programs, crisis stabilization centers, clinics and community mental health centers

For Medicare, the organizational providers must include the following:

- Federally qualified health centers
- Laboratories
- Outpatient diabetes self-management training providers
- Portable X-ray suppliers
- Rehabilitation agencies (such as comprehensive outpatient rehabilitation facilities, outpatient physical therapy and speech pathology providers)
- Renal disease services
- Rural health clinics

Participating provider — An appropriately credentialed provider that is selected by and/or under contract with Aetna to provide covered services/ expenses to our members.

Patient — An individual receiving health care services.

Physician — A duly licensed member of a medical profession, practicing within the scope of such license.

Practitioner — A person skilled in medicine.

Precertification — A process that assesses the medical necessity and appropriateness of the proposed services and level of service, such as inpatient hospitalizations, outpatient surgeries or diagnostic procedures.

Primary Care Provider (PCP) — A provider who provides all routine and preventive care, such as annual physicals, treatment for flu, well-baby visits and routine childhood immunizations. If the PCP feels that a particular condition requires specialty care that they cannot perform in their office, they will issue a written referral for the patient to visit an appropriate participating physician or facility.

Provider — A physician or other health care professional, or a facility that provides health care such as a hospital, skilled nursing facility or home health agency.

Provider appeal — A formal written request by a provider for reconsideration of a claim or provider payment decision. **This does not include requests for reconsiderations of decisions made on behalf of the member.**

Quality assessment — A formal set of activities that monitor the quality of direct patient services, administrative services and/or support services. These activities include specifying and taking corrective action to remedy any deficiencies identified through the assessment process.

Recredentialing — Process by which qualifications, certifications and licenses of practitioners are re-examined for re-approval according to Aetna guidelines.

Referral — An authorization given by the PCP for medical care required outside their office.

Registration — Notification to an HMO by a provider regarding the patient's level of care.

Retrospective review — After care has been provided, a review of medical information to determine medical necessity and appropriateness of care and whether it's covered by the member's plan.

Specialist physician — A physician who provides medical care in any generally accepted medical specialty or subspecialty.

Student assistance program (SAP) — A school-based program designed to assist students and schools with the identification and resolution of problems.

Subcontractor — A practitioner or group who has a contractual agreement with the providers to provide clinical services.

Subdelegation — A delegate of a managed care organization (MCO) that gives a third entity the authority to carry out a function that has been delegated by the MCO. Any subdelegation requires prior approval by Aetna. Any delegated activity performed by a subdelegate requires a preassessment audit and an annual audit.

Subscriber — An individual who meets applicable eligibility requirements, has enrolled in an HMO and is subject to premium requirements.

UB-04 form — A standardized billing template used by physicians.

Utilization management — The process of monitoring and evaluating, on a prospective, concurrent and retrospective basis, the medical necessity and appropriateness of health care services that health care providers provide to members.

Utilization review — The review of a hospital stay or other service for appropriate admission, treatment and discharge. Any day(s) or treatment denied as inappropriate will not be paid by the HMO or the health insurance policy that's in effect.

Vendor — A provider of care or services. This can be an individual, such as a physician or other health professional, or a facility, such as a hospital or home health agency.

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