



Delegation Provider Guide

A manual for physicians, hospitals and health care providers

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Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna).

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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 provider guide is a reference tool developed to help contracting delegates and their staff understand how to perform delegated functions in accordance with standards set forth by Aetna. It is important that your organization — delegated for credentialing, patient management, customer service management and/or claims — follow the standards outlined in this manual to ensure consistent service to all Aetna members. 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 you the ability to perform specified functions or activities on its behalf. Each contracted Entity must conform to Aetna's 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's plans and may be disclosed to third parties as necessary to effectively administer these plans.

Financial review of delegated providers

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's 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 Aetna's various 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 Aetna's risk exposure 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.

Credentialing for delegated providers

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

Aetna retains ultimate decision-making authority for delegated credentialing activities and maintains oversight of credentialing activities. Oversight is maintained through written communications and through minimum annual oversight audits of all credentialing activities delegated to the Delegated Entity.

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's 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:

- 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 for each state in which the practitioner will see Aetna members
- Current board certification(s) in the appropriate specialty
- Education and training 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 the Medicare opt-out report, as applicable
- Site visit process, including a policy that identifies a comprehensive way to conduct site visits and follow-up site visits when deficiencies meet Aetna's threshold, as applicable
- Ongoing monitoring of sanction activity, including Medicare/Medicaid, state license sanction and limitations (within 30 days), and Medicare opt-out (quarterly), as applicable; reports must be reviewed within a prescribed timeline of source publication (where states do not supply regular publications, review is required at least every six months)
- Ongoing reviews of applicable complaints from members, as applicable; recredentialing performance data, including quality improvement activities and member complaints, as applicable
- 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:

- 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 Aetna-recognized accrediting agency (e.g., TJC, AOA, CHAP, DNV, AAAHC, AAAASF)
- 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
- A CMS Certification Number for hospitals with more than 50 beds (or formal documentation of an exception)

Assessment/audit of delegated credentialing

The Delegated Entity agrees to, and will assist Aetna with, when requested, an annual assessment/audit for the credentialing program. The credentialing program includes policies and procedures, 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 audit

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.

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 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
- CMS directory update attestation

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.

All changes must be submitted in writing to:

Aetna Inc.
Network Management
<Address line 1>
<Address line 2>

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.

Claims management for delegated providers

The Delegated Entity will develop and maintain a claims administration program, which at a minimum should include all applicable Aetna policies and standards and applicable state and federal regulations. In addition, the Delegated Entity agrees to:

- Submit copies of its claims management policies and procedures, along with any revisions, to Aetna on an annual basis and at such other times as Aetna may request, for its review and approval
- Permit Aetna to conduct an assessment or audit of any documents or materials related to services rendered under this Agreement, during regular business hours and upon the passing of 30 calendar days after receiving written notice, unless a shorter period is necessary to ensure that Aetna complies with applicable law, including Medicare requirements, if applicable
- Permit Aetna's designated agent(s); federal, state and local governmental authorities having jurisdiction; and any applicable accrediting organization to audit, during regular business hours and upon the passing of at least 10 calendar days after receiving written notice (unless a shorter period is necessary to ensure that Aetna complies with applicable law, including Medicare requirements, if applicable), any and all documents and materials related to services rendered under this Agreement
- Submit to Aetna monthly self-reports on claims management services provided by the Delegated Entity on Aetna's behalf; reports outlined in the contract will be provided in accordance with Attachment 1 of the Delegated Claims Agreement and at such other times as Aetna requests or as the Delegated Entity deems necessary or appropriate to ensure that Aetna is fully apprised of the Delegated Entity's activities on behalf of Aetna

- Retain all data, information, records and documentation related to its performance of claims management under this Agreement (“Claims Management Records”) for the longer of seven years following the date of service or the period required by applicable state law; with respect to Medicare plans, retain all Claims Management Records for the longer of 10 years following the date of service or the period required by law (see additional requirements outlined in the **CMS compliance program requirements section**)
 - Provide the Aetna federal, state and local authorities that have jurisdiction with access to all claims management records; this record retention provision will survive the termination of this Agreement, and all claims forms and accompanying records and information submitted by providers to the Delegated Entity for which the Delegated Entity is obligated to provide claims management hereunder are the property of Aetna; and the Delegated Entity has no right, title or interest in same except for the Delegated Entity’s right to maintain copies of such records
3. Upon receipt of the universe reports, Aetna makes a random sample selection.
 4. The sample selection and sample instructions are sent to the Delegated Entity. The Delegate Entity supplies the supporting claim documents, including but not limited to the following:
 - A. A copy of each claim
 - B. The Explanation of Benefits (EOB) document(s), the Explanation of Payment (EOP) document(s), or the Remittance Advice (RA) document(s); note that claims history printouts are not acceptable
 - C. A copy of a canceled check or a copy of the original draft and bank statement
 - D. A copy of the original denial communication
 5. The Delegated Entity sends the completed assessment and claims samples to the Aetna auditor as instructed.
 6. The audit is conducted:
 - A. Onsite audits consist of a minimum of one day onsite
 - B. In-house audits, or desk audits, consist of phone interviews that follow the basic agenda below:
 - i. Introductions
 - ii. Purpose of the audit
 - iii. Assessment review
 - iv. Walk-through (only for onsite audits)
 - v. Claims review
 - vi. Issue of preliminary report

Oversight program

The Delegated Entity provides and demonstrates consistent and accurate claims management practices. Aetna’s oversight includes an operational assessment and a performance audit to validate claims administration. Audits may be conducted onsite or as desk audits, depending on regulatory requirements. Aetna will contact the Delegated Entity at a minimum of 30 days prior to the scheduled audit date to coordinate the audit prework.

Audit process

The audit process consists of the following steps:

1. The Aetna auditor coordinates the assessment/audit date with network management and the Delegated Entity.
2. Aetna sends an audit confirmation letter to the Delegated Entity with:
 - A. The Operational Review Questionnaire (ORQ)
 - B. The claims universe audit period, the universe report requirements and the submission requirements
3. Upon completion of the audit, the Aetna auditor presents the final report to the applicable delegation oversight committee for approval.
4. The audit report is sent to the Delegated Entity. The audit report should include:
 - A. Operational assessment results
 - B. Performance audit results
 - C. Corrective action plan requirements
 - D. Re-audit plan
5. In the event that Aetna determines that the Delegated Entity has failed to carry out claims administration in accordance with the terms of this

Agreement or reasonable performance expectations, Aetna will outline corrective action requirements.

The corrective action plans must include:

- A. Root cause
- B. Implementation timeframe
- C. Resolution plan
- D. Completion date

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

Operational review questionnaire (ORQ)

The operational assessment includes a review of the Delegated Entity's administrative structure, staffing and claims management 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 to the Aetna auditor either prior to the assessment/audit date or the day the auditor arrives onsite. The Aetna auditor will provide guidelines when the assessment is sent.

The ORQ covers four general areas.

1. Claims department staffing, structure and location(s)
 - A. Health plan agreement summary
 - B. Staffing/structure
 - i. The Delegated Entity will ensure that the claims processors whom Delegated Entity has retained to perform the claims management services under this Agreement have an average of three years of processing experience.
 - C. Membership
 - D. Claims volume
 - E. Training
 - i. Confidentiality and Code of Conduct
 - ii. Claims administration
 - iii. HIPAA
 - iv. Fraud, waste and abuse
 - a. Include a copy of latest attendance roster pertaining to formal fraud, waste and abuse

training administered to claims processing staff due to state legislative requirements.

- b. Educate claims processors on how to identify and properly handle potential fraudulent claims.

F. Auditing

- i. An audit is a formal set of activities meant to monitor the quality of services provided. Included are corrective actions taken to remedy any deficiencies identified through the assessment process. Comprehensive quality assessment includes mechanisms to monitor the quality of both direct patient services and administrative and support services.
- ii. Include samples of forms and sample reports used throughout the audit.

G. Customer service

- i. Include sample tracking logs and sample forms related to customer service guidelines or processes.
- ii. Aetna does not delegate complaints and appeals.
- iii. A delegate may handle an inquiry (verbal or written question) that may be answered and resolved to the member's/provider's satisfaction by the customer service professional (CSP).
- iv. All other member inquiries, complaints or appeals are to be forwarded Aetna as soon as possible so that Aetna can satisfy its obligations under applicable federal and state laws and regulations regarding such inquiries.

2. Claims processing

A. Inventory controls

- i. Claims workflow process: mail receipt through check mailing
 - a. Claim definition — clean/nonclean claim
- ii. Include samples of all forms and reports utilized throughout this process.
- iii. Date stamp all claims that are received in the office.
- iv. The date stamp should include the group's name.
- v. Sort mail into commercial correspondence, Medicare correspondence, etc.
- vi. Track and log all incoming and outgoing mail.

- B. Pending process
 - i. Procedure on how and when to pend a claim
 - ii. Pending codes and appropriate EOB messages
 - iii. Ability to produce a pend report on claims that are pending in the claims system
 - iv. Appropriate acknowledgement letters to advise the provider/member of the delay of the claim payment
 - v. Sample tracking logs, sample forms/top sheets utilized through this process
- C. Misdirected claims handling
 - i. Tracking log
 - ii. Compliance with regulatory requirements
- D. Claims acknowledgement
- E. Claims process/check procedures
 - i. Recalculations — regulatory compliant workflow and turnaround standards
 - a. Recalculate claim and cross-reference it with the original claim that was processed in error and with state-specific requirements.
 - b. Send Explanation of Benefits (EOB) message advising the provider/member of the recalculation.
- F. Payment methodology and turnaround time
 - i. Internal, state and/or federal Turnaround Time (TAT) Compliance Process
 - ii. Copy of your standard provider contract outlining provider reimbursement time frames
- G. Coordination of Benefits (COB)
 - i. The Delegated Entity will coordinate benefits in accordance with Aetna standards, policies and procedures and plan benefits. Guidelines were developed by the NAIC (National Association of Insurance Commissioners) to help eliminate duplication of medical payments made to providers when a person is covered by more than one health insurance carrier.
 - ii. COB is generally not involved with *outpatient capitated* services. Services are provided without respect to the primary payer.
 - iii. For COB for *inpatient* benefits, follow standard COB guidelines (i.e., primary payer vs. secondary payer).
 - iv. Aetna follows the NAIC's order of benefits determination rules to determine primary and secondary coverage responsibility, unless otherwise required by law.
 - v. Order of benefits determination rules
 - a. No Coordination of Benefits rule
 - b. Nondependent/dependent rule
 - c. Dependent child/parents not separated or divorced rule
 - d. Dependent child/separated or divorced parents rule
 - e. Longer/shorter rule
 - f. Continuation rule
- H. Overpayment and offset process
 - i. Include sample forms used throughout this process.
- I. Medical review process/procedure
- J. Denial process
 - i. Sample denial letters/remittance advice for both member and provider details
 - ii. Listing of all denial reasons and reason codes
 - iii. Need to have formal denial format and approved language that includes applicable state and federal regulatory requirements for both member and provider denials
 - iv. Follow ERISA guidelines on the right to appeal
- K. Explanation of Payments or Explanation of Benefits (EOP/EOB)
 - i. Aetna issues all CMS member EOB statements and IDNs (Integrated Denial Notices)
 - ii. CMS noncontracted requirements
 - iii. CMS QMB (Qualified Member Beneficiary) requirements
- L. Regulatory requirements
 - i. All applicable for scope of claims administration
 - ii. Emergency — the Delegated Entity must have written policies and procedures with the "Prudent Layperson" language. Aetna follows the "Prudent Layperson" emergency room policy set forth in the Balanced Budget Act of 1997. Under this act, an emergency medical condition is "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses average knowledge of health and

medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.”

- M. Provider Dispute Resolution (PDR) process
 - i. Sample tracking logs and sample forms used throughout this process
- 3. System/reporting capabilities and business contingency
 - A. System capabilities
 - B. System security
 - C. Reporting capabilities
 - D. Record retention
 - E. Business contingency and emergency procedures
 - i. The impact of loss on each of the vital business functions and systems must be identified, evaluated and categorized according to the required time frames for recovery of the function.
 - ii. Business continuity planning will address disaster response mechanisms that ensure life safety, minimize loss, optimize recovery of critical business operations and facilitate an orderly and timely return to normal operations.
 - iii. Establish a clear and organized response strategy supported by a comprehensive set of predefined response measures for each key business operating area. These plans will be maintained within the business area so that they can be invoked on demand as the means to avoid and/or minimize subsequent business impact losses.
 - iv. For Medicare plans, refer to the additional requirements outlined under CMS compliance program requirements.
- 4. Policies and procedures
 - A. The Delegated Entity must have written policies and procedures for claims management that are consistent with Aetna law and with state and federal law.
 - B. The Delegated Entity must demonstrate compliance with any contractual and regulatory requirements, based on the book of business delegated to the Delegated Entity.

Performance audit

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

Reporting requirements are based on the agreement with Aetna and the products supported. Claims universes include, but are not limited to, the following:

Universe types	Products		
	Commercial	Medicare	Medicaid
Paid contracted	X	X	X
Paid noncontracted	X	X	X
Member denials	X	X	X
Provider denials	X	X	X
Provider disputes	X — CA only	X	X — CA only
Adjustments	X — CA only		X — CA only

The standard audit period is three months. Each report will be reviewed to determine a statistically valid sample size for the claims review and/or will meet state or federal regulatory requirements for sample size.

If the Delegated Entity is unable to supply the required reports in the format(s) listed above, the Aetna contact will work directly with the Delegated Entity to obtain necessary reports in other format(s) acceptable to both parties.

The preferred format for the universe reports is Excel 7.0 or higher, or DBF 2 with no more than 10K records per file on CD. An Excel template with field requirements is included with the audit confirmation letter.

Transmitting data

Regular e-mail 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.

- Aetna’s secure encryption e-mail process — attach the reports and reply to the e-mail that was sent via Aetna’s secure encryption process.

- Password-protected CD-ROM. Delivery requirements — UPS or FedEx, signature required, to designee noted in the audit confirmation letter.
- Grant direct access to a secure internal network or FTP site.
- Request access to Aetna's secure FTP site.

Claims 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 data 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 Aetna's liability 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 60 calendar days 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**.

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 of 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

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

Subdelegation audit

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.

Delegated call center for delegated providers

In accordance with the Delegated Call Center Agreement, Aetna will maintain oversight of the Delegated Entity's call center activities furnished by the Delegated Entity on behalf of Aetna. Such oversight shall at a minimum include:

- Submission of copies of the Delegated Entity's written policies and procedures for call center services to Aetna on an annual basis and at such other times as Aetna may request, for its review and approval.
- Permission for Aetna to conduct onsite audits, or desk audits, including a review of calls (recorded, taped or live) upon 30 calendar days prior written notice, unless a shorter period is necessary to ensure Aetna's compliance with applicable law, including, without limitation, CMS requirements.
- Permission for Aetna's designated agent(s); federal, state and local governmental authorities having jurisdiction; and any applicable accrediting organization, to audit, during regular business hours and upon at least 10 calendar days prior written notice (or upon shorter notice in the event that Aetna determines a shorter period is necessary to ensure Aetna's compliance with applicable federal and state law) any and all documents and materials related to services rendered under this Agreement. In addition, designated agent(s); federal, state and local governmental authorities having jurisdiction; and any applicable accrediting organization will be permitted by the Delegated Entity to conduct a site visit and/or audit at any site at any time where the Delegated Entity performs services under the terms of the Delegated Call Center Agreement. Any such audit shall be permitted during the term of the Delegated Call Center Agreement. The Delegated Entity and Aetna are responsible for their own expenses incurred related to such audit.

- Submission to Aetna of periodic reports, accompanied by a certification of an executive officer of Delegated Entity as to the reports' accuracy on call center services provided by Delegated Entity. Such reports will be provided in accordance with Aetna's requirements and at such other times as Aetna requests or as Delegated Entity deems necessary to ensure Aetna is fully apprised of the Delegated Entity's activities.
- The Delegated Entity is responsible for retention of all data, information, records and documentation related to its performance of call center services under this Agreement ("Call Center Records") for the longer of seven years following the date of service or the period required by applicable state law. The Delegated Entity will provide to Aetna and to federal, state and local authorities having jurisdiction, access to all Call Center Records. This record retention provision will survive the termination of the Delegated Call Center Agreement.

Delegated call center oversight

The Delegated Entity provides and demonstrates consistent and accurate call center services. Aetna's audit process will review all call center services policies and procedures. The Delegated Entity's policies and procedures should include, but are not limited to, those outlined below. These call center service policies and procedures are reviewed annually during the onsite assessment/call center audit.

- 1. Procedures.** The Delegated Entity agrees to establish procedures to ensure consistent and accurate management of customer service. A customer service quality control program will be maintained by the Delegated Entity at all times during the term of the Agreement.
- 2. Education.** The Delegated Entity agrees to provide education to customer service staff regarding proper call procedures.
- 3. Toll-free number.** The Delegated Entity will establish and maintain customer call centers where Aetna members can call a toll-free number if they have questions, appeals, grievances or complaints between the hours of 8:00 AM and 5:00 PM, Monday through Friday, for all time zones.
- 4. Ability to observe service.** The Delegated Entity will provide the capability to record and monitor live calls to ensure compliance with the Call Center Agreement and Aetna's call handling procedures, and to identify training opportunities.

5. Reporting. The Delegated Entity will submit to Aetna, by the first of the month, a monthly report showing that the following requirements were met:

- A. Average speed of answer for telephone calls placed by members and/or providers is 30 seconds
- B. Telephone abandon rate is 5 percent or less
- C. Telephone service factor of 75 percent of all calls answered in 30 seconds
- D. Elements of internal random call monitoring with a scoring criteria of the standard of 96.25 percent

6. Data security. The Delegated Entity will have procedures in place to ensure the security of Aetna member data. All materials, including but not limited to training material and equipment, must be secured in a locked environment. Security violation reporting must be provided to Aetna on a monthly basis.

7. Facilities. The Delegated Entity will provide all environmental support required for maintaining computer hardware at the site, including space, power, cooling, emergency power supply and uninterruptible power supply. The Delegated Entity will provide immediate response to problems and continuous support through resolution.

Clinical delegation

Aetna delegates clinical functions 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, URAC, 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 will be maintained through quarterly and annual reports, any corrective action plan status reports, file reviews, meetings and a minimum of annual audits of all clinical activities delegated to the provider entity.

The Delegated Entity will develop clinical processes, which at a minimum include all applicable Aetna standards as outlined in the patient management 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 patient management functions. Prior to any subdelegation, Aetna will conduct a preassessment on the patient management operation of the subdelegate. In addition, if the entity subdelegates patient management 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's requirements. The Delegated Entity and Aetna shall maintain oversight of the patient management services furnished by the subdelegate on behalf of Aetna.
- The Delegated Entity agrees to provide Aetna staff, the NCQA, the state government and the CMS (if applicable) access to patient management records and files and to the entity's patient management policies and procedures, program documents and committee minutes as deemed necessary by Aetna for monitoring the oversight of all aspects of the delegated patient management functions.

Delegated utilization management requirements

The Delegated Entity will provide utilization management 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 Delegated Utilization Management Agreement.

A prospective Delegated Entity 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 CM and UM 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.
- For CM delegation, the entity's CM program must include STAR gap closure. The entity must be able to transfer that information to the health plan if requested.
- For Medicare CM delegation, the CM program must include the following components: readmission avoidance, chronic comorbidities, advanced illness and end of life.

Utilization management program procedures

The Delegated Entity will maintain a written utilization management plan description 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's policies and procedures and must comply with the accreditation standards of the NCQA, URAC and the CMS (when applicable), as well as statutory and regulatory 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.

Patient 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. The patient 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 to 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.

Patient management recommendations/decisions

The Delegated Entity agrees to comply with Aetna's 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 and the appeal process.

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, except in an emergency, all services will be provided through participating providers. Utilization management functions include but are not limited to:

1. Registration
2. Authorization of referrals in accordance with the Delegated Entity's utilization management plan as approved by Aetna
3. Precertification of hospital admissions for non-emergency services and elective outpatient procedures
4. Precertification of items or services to be provided by a skilled nursing facility or other sub-acute facility, durable medical equipment company, home health agency, hospice, diagnostic testing facility; or other

outpatient services in accordance with the member's benefits plan and Aetna's precertification requirements.

5. Concurrent review
6. Discharge planning
7. Retrospective review
8. Case management, which will be managed jointly by Aetna's case management department and the Delegated Entity unless otherwise determined through a separate delegation approval process
 - A. Detailed procedures for ongoing case management will be determined on a case-specific basis. In all such cases, Aetna shall be provided with weekly (or other mutually agreed upon specified interval) status of the member's care.
 - B. The Delegated Entity agrees to promptly notify Aetna of all members who would benefit from case management or disease management. These include, but are not limited to:
 - i. Members whose cost of care is approaching or is anticipated to reach the threshold in a stop-loss insurance plan
 - ii. Members who are receiving services associated with catastrophic conditions
 - iii. Members who are receiving services associated with Aetna's disease management programs

Utilization management reporting requirements

Aetna agrees to monitor and evaluate utilization management reports from the Delegated Entity on a regular basis. The Delegated Entity agrees to provide Aetna with patient management information, including but not limited to:

- A patient management plan and any updates or revisions as applicable
- An annual written evaluation of the utilization management program
- A copy of or access to the Delegated Entity's clinical review criteria at least annually
- Patient management committee minutes describing patient management activity
- A summary report containing categories of information that the parties agree to, which will at a minimum include data on admissions, types of care, denials, referrals, utilization measures (including HEDIS® utilization management measures), call center activity

and performance of delegated functions from/about a member, practitioner or provider, including attorney contacts; the frequency reporting shall be mutually agreed on by the parties as outlined in the Delegation Agreement but will be submitted to Aetna at least semiannually

- Precertifications (approvals and denials) completed; outline the frequency and format in the Delegation Agreement
- Certifications completed for all services that are noncapitated or that require processing by Aetna's claims system; outline the frequency and format in the Delegation Agreement
- Other reports, data and information requested from time to time by Aetna and in a format acceptable to Aetna, including but not limited to timely, accurate and appropriate data and information (including demographics) to enable Aetna to fulfill NCQA, accrediting organizations, and federal and state regulatory filing and auditing requirements, and meet the HEDIS standards
- Complete and accurate encounter data by type of primary care service rendered to members in the form and manner as specified by Aetna; the provider certifies that such encounter data is truthful and complete

Contact person for members

The Delegated Entity agrees to provide members with access to the individual in the Delegated Entity's organization who is available to receive communications from and provide necessary services to members relating to the Delegated Entity's responsibilities under the Delegation Agreement.

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 Delegated Patient Management 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. Aetna's 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.

Population health management for delegated providers (complex case management/disease management)

The covered services provide health care benefits, which are assessed, coordinated, evaluated and monitored to meet an individual member's needs. The Delegated Entity agrees to maintain a written program description outlining the delegated functions. This includes policies and procedures to evaluate criteria, information sources, and processes used to review and approve the provision of services to members. These policies and procedures must be consistent with company policies and procedures and must comply with the accreditation standards of NCQA and URAC (when applicable), as well as statutory and regulatory requirements and contractual obligations. The Delegated Entity's program description should be revised as needed and submitted in writing to the company for review and approval at least annually and more often if required by the company to keep the company apprised on the Delegated Entity's obligations under this Agreement. The Delegated Entity agrees to establish procedures to ensure consistent and accurate management of the delegated process. A population health quality control program will be maintained by the Delegated Entity at all times during the term of this Agreement.

Prerequisites for evaluating a prospective Delegated Entity include the following:

- The entity intends to execute a delegation agreement with Aetna.
- The prospective delegated functions have been fully operational for at least 12 consecutive months.
- 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 case management (CM) and utilization management (UM) services and take action.
- The entity has a financial risk arrangement, including downside risk, in place with the health plan.
- For CM delegation, the entity's CM program must include STAR gap closure. The entity must be able to transfer that information to the health plan if requested.
- For Medicare CM delegation, the CM program must include the following components: readmission avoidance, chronic comorbidities, advanced illness and end of life.

Utilization management committee

The Delegated Entity agrees to establish a utilization management committee, which agrees to be responsible for overseeing delegated activities. The Delegated Entity's utilization management committee membership should include at least three members who are physicians (one of whom agrees to be a senior medical director of the Delegated Entity) and who are representative of the primary and/or specialty care being reviewed. The utilization management committee agrees to meet on a regular basis but no less than quarterly. A utilization management representative from the company agrees to be entitled to attend any utilization management committee meeting. Minutes of the committee meetings will be maintained in a secure manner by the Delegated Entity and made available to the company for review.

Recommendations and decisions

The Delegated Entity agrees to comply with the company's benefits coverage guidelines. The Delegated Entity agrees to use qualified medical professionals to make benefits coverage decisions and to supervise review decisions. Complex CM/DM review decisions must be made in a timely manner, in accordance with time frames mutually agreed on between the company and the Delegated Entity. The Delegated Entity agrees to monitor its compliance with such time frames and will take all actions necessary to ensure compliance with such time frames. All complex CM/DM 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 information that the Delegated Entity determines to be necessary and appropriate to conduct complex CM/DM services.

Case management and disease management functions

Complex case management

The Delegated Entity agrees to perform various case management functions identified by the company, which may be subject to change. Any such change in case management functions will not be considered an amendment to this Agreement. Case management functions include but are not limited to the following:

1. Initial assessment utilizing various data sources that include but are not limited to claims, hospital discharge, pharmacy and PM processes to identify member eligibility for case management. The Delegated Entity's case management process will include an initial assessment that must be consistent with company policies and procedures and must comply with the accreditation standards of NCQA and URAC (when applicable), as well as statutory and regulatory requirements and contractual obligations.
2. Multiple avenues for members to be considered for case management services, including health information line referral, discharge planner referral, UM referral, member or caregiver self-referral and/or practitioner referral.

3. The case manager must accept the member into the case management program within the established time frames.
4. Utilize a case management system for documenting the implementation and prompts for follow-up of case management activities with corresponding dates. The Delegated Entity's case management program utilizes evidence-based clinical guidelines or algorithms to conduct assessment and management.
5. The Delegated Entity's case management process includes but is not limited to the following:
 - A. Members' right to decline participation or disenroll from case management programs and services offered by the Delegated Entity
 - B. Initial assessment of members' health status, including condition-specific issues
 - C. Documentation of clinical history, including medicines
 - D. Initial assessment of activities of daily living
 - E. Initial assessment of behavioral health status, including cognitive function
 - F. Initial assessment of social determinants of health
 - G. Initial assessment of life-planning activities
 - H. Evaluation of cultural and linguistic needs, preferences or limitations
 - I. Evaluation of visual and hearing needs, preferences or limitations
 - J. Evaluation of caregiver resources and involvements
 - K. Evaluation of available benefits
 - L. Evaluation of community resources
 - M. Development of an individualized case management plan, including prioritized goals and consideration of member and caregiver goals, preferences, and member-desired level of involvement in the case management plan
 - N. Identification of barriers to the member meeting goals or complying with the plan
 - O. Facilitation of member referrals to resources and a follow-up process to determine whether member acts on referrals
 - P. Development of a schedule for follow-up and communication with members
 - Q. Development and communication of self-management plan for the member
 - R. A process to assess the member's progress against the case management plans
6. The Delegated Entity will measure/re-measure overall effectiveness of the case management process using three measures. For each measure, the Delegated Entity will:
 - A. Identify a relevant process or outcome
 - B. Use a valid method that provides quantitative results
 - C. Set a performance goal(s)
 - D. Clearly identify the measure's specifications
 - E. Analyze results
 - F. Identify opportunities for improvement, if applicable
 - G. Implement at least one intervention to improve performance
 - H. Develop a plan for intervention, if applicable, and perform a remeasurement
7. At least annually, the Delegated Entity will evaluate experience with its complex case management program by obtaining feedback from members and analyzing members' complaints. Feedback is specific to the complex case management program and covers, at a minimum:
 - A. Information about the overall program
 - B. The program staff
 - C. Usefulness of the information disseminated
 - D. Members' ability to adhere to recommendations
 - E. Percentage of members who indicated that the program helped them achieve their goals
8. The Delegated Entity will contact the company when members are identified who would potentially benefit from the company's disease management programs
9. The Delegated Entity will notify the company when there is a need for coordination and integration between medical and behavioral health services.
10. The Delegated Entity will notify the company when members' case management plans are discontinued in the delegate's case management program.

Disease management

The Delegated Entity agrees to perform various disease management (DM) functions identified by the company, which may be subject to change. Any such change in DM functions will not be considered an amendment to this Agreement. DM functions include but are not limited to the following:

1. Identification of members who qualify for DM programs by the use of data sources including but not limited to claims; hospital discharge papers; pharmacy records; health appraisal results; lab results; data from health management, wellness or health coaching programs; health information Zline referrals; information from EHRs; data collected through the UM process, case management processes, and care management processes; member referrals; and practitioner referrals.
2. The Delegated Entity's DM process will include an initial assessment that must be consistent with the company's policies and procedures and must comply with the accreditation standards of NCQA as well as all statutory and regulatory requirements and contractual obligations. Interventions will be based on the individual needs of the member identified in the member assessment or stratification process.
3. The disease manager must accept the member into the DM program within the established time frames.
4. Utilize a DM system for documenting the implementation and prompts for follow up of DM activities along with corresponding dates. The Delegated Entity's DM program utilizes evidence-based clinical guidelines or algorithms to conduct assessment and management. The Delegated Entity's DM process includes but is not limited to the following:
 - A. Monthly systematic identification of members who qualify for each DM program
 - B. Distribution of member information to the member
 - C. Interventions provided to the member, based on assessment
 - D. Annual measurement of active member participation rates
 - E. Informing and educating practitioners
 - F. Integration of member information to facilitate access to member health information for continuity of care from a health information line and the following programs: DM, case management, utilization management and wellness
 - G. Condition monitoring (including self-monitoring and medical testing)
 - H. Adherence to treatment plans (including medicine adherence, as appropriate)
 - I. Medical and behavioral health co-morbidities and other health conditions (e.g., cognitive deficits, physical limitations)
 - J. Health behaviors
 - K. Psychosocial issues
 - L. Depression screening
 - M. Information about the patient's condition provided to caregivers who have the patient's consent
 - N. Encouraging patients to communicate with their practitioners about their health conditions and treatment
 - O. Additional resources external to the organization, as appropriate
5. The Delegated Entity will annually measure active member participation rates.
6. The Delegated Entity will measure/remeasure overall effectiveness of the DM process using three measures. For each measure, the Delegated Entity will:
 - A. Analyze results
 - B. Clearly identify measure specifications
 - C. Develop a plan for intervention, if applicable, and perform a remeasurement
 - D. Identify a relevant process or outcome
 - E. Identify opportunities for improvement, if applicable
 - F. Set a performance goal(s)
 - G. Use a valid method that provides quantitative results
7. The Delegated Entity will provide practitioners with written information about the DM program that includes instructions on how to use the DM services and how the Delegated Entity will work with patients participating in the program
8. The Delegated Entity will contact the company when members are identified who would potentially benefit from the company's DM programs
9. The Delegated Entity will notify the company when there is a need for coordination and integration between medical and behavioral health services
10. The Delegated Entity will notify the company when a member's DM plans are discontinued.

Case management and disease management reporting requirements

Complex case management

The company agrees to monitor and evaluate case management (CM) reports from the Delegated Entity on a regular basis. The Delegated Entity agrees to provide the company with CM information, including but not limited to the following:

1. CM program description or the CM description in the patient management program description and any updates or revisions, as applicable
2. Annual written evaluation of the CM program
3. Utilization management committee minutes describing CM activity
4. A quarterly report of total membership and the CM enrollment rate, and an aggregate summary of DM and behavioral health referrals
5. An annual report containing data that, at a minimum, includes three identified CM measures and CM member satisfaction analyses
6. Other reports, data and information requested from time to time by the company and in a format acceptable to the company, including but not limited to timely, accurate and appropriate data and information (including demographics) to enable the company to fulfill NCQA, accrediting organizations, and federal and state regulatory filing requirements, and meet the HEDIS standards
7. Complete and accurate encounter data by type of primary care service rendered to members in the form and manner as specified by the company (the provider certifies that such encounter data is truthful and complete)

Disease management

The company agrees to monitor and evaluate disease management (DM) reports from the Delegated Entity on a regular basis. The Delegated Entity agrees to provide the company with DM information, including but not limited to the following:

1. A DM program description or a copy of the DM description from the patient management program description and any updates or revisions, as applicable, including but not limited to the following:
 - A. An annual written evaluation of the DM program

- B. Utilization management committee minutes describing DM activity
 - C. A quarterly report of total membership and the DM enrollment rate, and an aggregate summary of DM and behavioral health referrals
2. An annual report containing data that, at a minimum, includes three identified DM measures and results of member satisfaction analyses
3. An annual report of eligible member active participation
4. Other reports, data, and information requested from time to time by the company and in a format acceptable to the company, including but not limited to timely, accurate, and appropriate data, information, and demographics to enable the company to fulfill NCQA, accrediting organizations, and federal and state regulatory filing requirements, and meet the HEDIS standards
5. Complete and accurate encounter data by type of primary care service rendered to members in the form and manner as specified by the company (the provider certifies that such encounter data is truthful and complete)

Contact person for members

The Delegated Entity agrees to provide the members with access to an individual in the Delegated Entity's organization who is available to receive communications from and provide necessary services to members about the Delegated Entity's responsibilities under this Agreement.

Sharing clinical information

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

Notification of complaints

The Delegated Entity agrees to notify the company within 24 hours of receipt of complaints, either oral or written, received by the Delegated Entity from participating providers as well as all attorney contact involving members.

Subdelegation audit

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.

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, as Aetna's 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
Your 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 Aetna's **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 1/1/19, CMS no longer requires 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.

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 finalized its regulatory changes to business continuity plan requirements for Medicare Advantage (MA) and Prescription Drug Benefit programs.

As a result, 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, 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

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.

- **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

Health care reform and Delegated Entities

Signed into law in March 2010, 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.

Some provisions of the ACA, including insurance market reforms such as increased access for dependents and the prohibition of lifetime limits on coverage, have impacted health care benefits since soon after adoption of the law. Other provisions, such as requiring all Americans to obtain health care coverage and the implementation of insurance exchanges, took effect in 2014.

In addition, 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 Aetna's 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.

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. 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

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

Case 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 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 physician'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 Aetna's benefit 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 physician (PCP) — A physician 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 primary physician 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-92 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.

