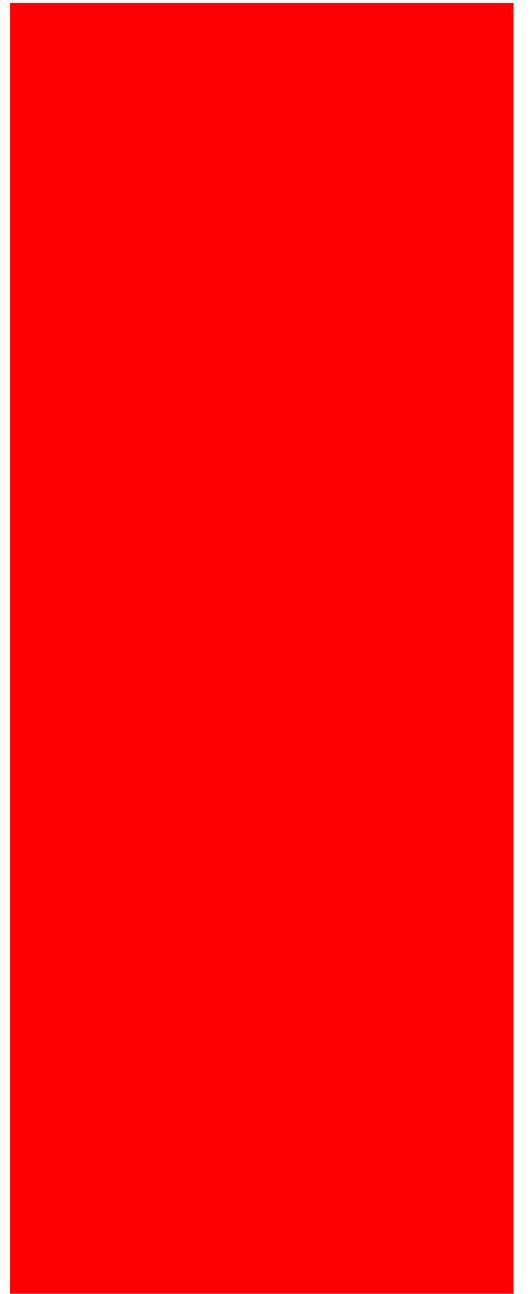




117 SECTION R –
INFORMATION SYSTEMS

118 R.1



Section R: Information Systems (Section §16 of RFP)

R.1 Describe your approach for implementing information systems in support of this RFP, including:

- Capability and capacity assessment to determine if new or upgraded systems, enhanced systems functionality and/or additional systems capacity are required to meet contract requirements;
- Configuration of systems (e.g., business rules, valid values for critical data, data exchanges/interfaces) to accommodate contract requirements;
- System setup for intake, processing and acceptance of one-time data feeds from the State and other sources, e.g., initial set of CCN enrollees, claims/service utilization history for the initial set of CCN enrollees, active/open service authorizations for the initial set CCN enrollees, etc.; and
- Internal and joint (CCN and DHH) testing of one-time and ongoing exchanges of eligibility/enrollment, provider network, claims/encounters and other data.
- Provide a Louisiana Medicaid CCN-Program-specific work plan that captures:
 - Key activities and timeframes and
 - Projected resource requirements from your organization for implementing information systems in support of this contract.
- Describe your historical data process including but not limited to:
 - Number of years retained;
 - How the data is stored; and
 - How accessible is it.

The work plan should cover activities from contract award to the start date of operations.

Aetna Better Health[®] and its affiliates have been implementing Medicaid managed care information systems for over 25 years. We recently implemented three new encounter systems for Medicaid managed care programs in Florida, Pennsylvania and Illinois and expanded our Missouri Medicaid managed care program into two large regions. Today, Aetna Better Health administers or manages Medicaid health plans providing coverage to over 1.3 million members in 10 states. Our implementations leverage a proven methodology that is rigorous, yet accommodating to the unique needs of any given contract. We initiate certain preliminary implementation activities prior to contract award, creating an infrastructure that expedites subsequent implementation activities. Foremost among these preliminary activities is formation of a Lead Team comprising personnel from every operating division, including any division involved in information systems implementation. Twenty (20) staff members in the following roles/departments will coordinate implementation of the Coordinated Care Network (CCN) Program, providing the direction and prompt, consensus-based, decision-making necessary to keep implementation on task and on schedule. The Lead Team is chaired by the Aetna Better Health Chief Operations Officer (COO).

Louisiana Lead Team

Regional Vice President
Finance – CFO
Information Management and Systems Director
Compliance Officer
Encounter Management
Provider Payment & Reimbursement
Information Technology (IT)
Member Services
OPKM/Claims Audit/BAM/Claims
Provider Services
Training

VP of Business Development
Medical Director
Implementation Director
Enrollment/Disenrollment Manager
Finance – TPL & COB
Human Resources
Reporting
Network Management
Provider Data Services
Appeals/Grievance

Capability and Capacity Assessment

Aetna Better Health's IT solution is provided by its affiliate, Aetna Medicaid, an Aetna company. Aetna Medicaid's IT systems have evolved along with the Medicaid managed care environment, and thus currently exhibit the functionality necessary to accommodate the diverse requirements of Medicaid in 10 states. Expert in legacy and state-of-the art MMIS systems alike, Aetna Medicaid's IT personnel have a proven record of assisting state agencies in transitioning from Medicaid fee-for-service to Medicaid managed care. We have efficiently implemented required HIPAA transactions with every Medicaid single-state agency where we have contracts. All implementations and expansions have come up on-time and in accordance with each Medicaid single-state agency's expectations and requirements.

Aetna Better Health and Aetna Medicaid have reviewed every systems requirement in the CCN-P RFP, its appendices, attachments and systems guide and determined that our systems currently possess the functionality to support them all; not one information system upgrade, functionality enhancement or capacity expansion will be required to meet the needs of the CCN Program. The design phase of our systems implementation will not require any new development, but merely configuration of existing systems functionality to the specific needs of this Contract. Our Lead Team will see to it that the core business applications responsible for provider enrollment and data management, member eligibility and enrollment, claims processing and service authorization are configured per Contract requirements, then coordinate and conduct the rigorous and exhaustive unit and end-to-end testing necessary to verify and validate implementation of the desired functionality. In keeping with requirement 16.3.10 of this RFP, Aetna Better Health and Aetna Medicaid personnel will complete and return to the Department of Health and Hospitals (DHH) an Information Systems Capabilities Assessment (ISCA) documenting our systems functionality no later than thirty (30) days from the date Aetna Better Health signs the Contract with DHH.

Systems Configuration

Aetna Better Health's implementation methodology leverages our Implementation Team's knowledge and experience to see to it that our information system solutions support the most secure, effective and efficient workflow possible. Our Lead Team consolidates and coordinates the identified needs of cross-functional workgroups within a work plan supporting the configuration, testing and deployment of all required information systems functionality.

Aetna Better Health's core information system, QNXT™, stands unmatched as a health care delivery and support solution. Designed to encompass an "n-tier" environment and service-oriented architecture, the rules-driven, user-configurable system and its advanced .NET architecture integrate readily with Aetna Medicaid's other key production systems. Aetna Better Health and Aetna Medicaid have jointly played an active role in QNXT™ development since the system's infancy, merging our 25 years experience in Medicaid managed care with, first, QSCI's and, subsequently, Trizetto's, programming expertise to produce a flexible, scalable information system readily configurable to the unique needs of our individual health plans.

Upon contract award, Aetna Better Health will work with the appropriate DHH personnel and contractors (e.g., MMIS, PBM, behavioral health vendor) to capture detailed systems and process requirements. We will create detailed file specifications for all data exchanges including; Input/Output (I/O), purpose, sender, receiver, secure transmission method, update or full file content, frequency, dependencies, business rules, file naming, file layouts, and the accounts and control system that will serve to systematically certify data and balances. Data exchange specifications will include file transmission validation and verification procedures. Other documentation will include a benefit matrix defining covered and non-covered services, a prior authorization grid, eligibility requirements and rate code information compiled by the Implementation Team. All systems-related requirements and specifications, as well as a copy of the CCN Program Contract itself, will be forwarded to Aetna Medicaid's Business Application Management (BAM) department, which will use the information to draft a solution document, or blue-print, of the required systems configuration. That document will then be forwarded to the VP of Business Application Management for approval and distribution to the Lead Team to facilitate compatibility with concurrent activities.

Once the systems blue-print is approved, BAM analysts will configure QNXT™ accordingly, seeing to it that the system's respective components, including Carrier and Program Setup, Benefit Plans and Benefits, Employer/Policy, Provider Contracts, Medical Policy and basic financial information like category of expense, adjudication rules and messages (remit and explanation of benefits) reflect the associated requirements. Applicable fee tables and other associated information, including base reference data such as CPT/HCPCS codes, diagnosis codes, modifiers, CPT/modifier combinations, revenue codes, etc., are also configured by BAM.

Business Rules / Valid Values

Aetna Better Health's QNXT™ system is a relational database that already conforms to the data and document management standards and standard transaction code sets required by DHH. Data structures within and between systems are maintained through data mapping protocols and business rules that support Louisiana's CCN program requirements and promote heightened data integrity. QNXT™, supports the configuration of multiple edits (business rules) to test claim validity, enforce valid values/formats for critical data (e.g. Medicaid ID, NPI and SSN numbers and DOB) and conduct claim determination accordingly. Applied edits include, but are not limited to: a) member eligibility; b) covered/non-covered services; c) required documentation; d) services within the scope of the providers practice; e) duplication of services; f) prior authorization; and g) invalid procedure codes.

Two applications compliment QNXT™'s applied logic. The first, iHealth, enforces select payment policies from one of the industry's most comprehensive correct coding and medical

policy content libraries, thereby promoting improved coding accuracy. The second, McKesson's ClaimCheck[®], expedites and sees to the accuracy of claim payments, auditing correct coding combinations based upon the following criteria:

- CPT-4 and ICD-9-CM coding definitions
- AMA and CMS guidelines and industry standards
- Medical policy and literature research
- Input from academic affiliations

External Data Exchanges/Interfaces

Aetna Better Health's management information system is currently capable of supporting DHH's required technical interfaces and complies with all applicable requirements of the Health Insurance Portability and Accountability Act (HIPAA). Detailed version migration plans provide for continued compliance with current and future HIPAA mandates, including 5010 compliance. Two systems assist us in this regard:

- Microsoft's BizTalk with HIPAA Accelerator[™] processes HIPAA-compliant transactions easily and efficiently, enabling Aetna Better Health to accept information electronically from almost any HIPAA-compliant contractor or provider. Accelerator has the Washington Publishing Company (WPC) Implementation Guide schemas for each HIPAA ANSI X12 transaction embedded directly into its application engine, including a facility to update these schemas automatically as the transaction sets are updated over time.
- Foresight's HIPAA Validator[™] InStream[™] is a fully functional HIPAA editing and validation application. It validates HIPAA transactions through all seven levels of edits as defined by the Workgroup for Electronic Data Interchange and Strategic National Implementation Process (WEDI/SNIP), has all standard HIPAA code sets embedded, and can support custom, trading partner- specific companion guides and validation requirements. The application also provides descriptive error reports to submitters to facilitate quick error resolution.

Internal Data Exchange/Interfaces

One aspect of application deployment particularly relevant when discussing systems implementation is Aetna Medicaid's systemic use of one relational database technology for all core business applications. Key production systems, including QNXT[™], our web-based care management business application (Dynamo[™]), ActiveHealth, AboveHealth[®], our Actuarial Services Database (ASDB) and proprietary Encounter Management (EMS) and General Risk Model (predictive modeling) systems use Microsoft's SQL Server 2000 Relational Database Management System (RDBMS), allowing for the virtual integration of data from physically disparate systems. This provides for consistent naming, formatting, definition and usage of data across applications. It allows us to maintain transaction and information integrity across core applications while maintaining the specialized, robust functionality each application provides. BAM, in addition to configuring QNXT[™] itself, sees to it that all supported interfaces are configured and tested accordingly. Three examples of how such interoperability promotes data consistency and integrity follow:

Provider Information from QNXT™ to our web-based care management business application (Dynamo™): Aetna Better Health’s network administration personnel use QNXT™ to build and maintain provider network information, including demographics, specialty/sub-specialty, affiliations, fee schedule and contractual arrangements. An extract of this information is automatically fed to our web-based care management business application (Dynamo™), on a nightly basis, reflecting any changes in provider network composition (additions, changes and terminations). No provider network data is input into the web-based care management business application (Dynamo™), the system of record for this information is QNXT™.

Eligibility Information from QNXT™ to our web-based care management business application (Dynamo™): Eligibility information received by Aetna Better Health is housed and maintained in QNXT™. An extract from QNXT™ is automatically created and loaded into the web-based care management business application (Dynamo™), on a regularly scheduled basis. If there is a change in a member’s demographic or eligibility data, the change is updated in QNXT™ and uploaded to the web-based care management business application (Dynamo™), during the next scheduled interface.

- QNXT™ to AboveHealth®: AboveHealth®, Aetna Better Health’s secure web portal allows authorized users to perform a number of functions, all dependent on the regularly scheduled import of data from QNXT™. These include:
- Claim/Encounter Status Inquiry — To support this operation, a periodic claims status file is exported from QNXT™ and populates AboveHealth’s® database.
- Checking authorization Status – For services requiring pre-authorization. This too, is based on data extracted daily from QNXT™.
- Member eligibility and provider directory look-up — To support these operations, a periodic extract of eligibility and provider information from QNXT™ is created and loaded into the AboveHealth® database.

The table below lists the external sources of QNXT™ data, while the chart that follows maps the exchange of data between QNXT™ and other key production systems, including:

- How each data exchange is triggered
- Direction of each data exchange
- Frequency of each data exchange
- A summary of the data exchanged



Part Two: Technical Proposal
Section R: Information Systems

Data Exchange Between Key Production Systems							
	Dynamo1	EMS2	General Risk Model (GRM)	ASDB3	Grievance & Appeals	ActiveHealth® Care Engine™	AboveHealth®
QNXT™	Automated QNXT™ ▲ Dynamo Daily - Member - Provider	Automated QNXT™ ▲ EMS Weekly - Claims - Provider (PRN)		Automated QNXT™ ▲ ASDB Monthly - Enrollment - Member - Provider - Medical claims - Rx claims	Manual QNXT™ ▲ G&A PRN - Claims - Member - Provider	Automated QNXT™ ▲ ActiveHealth® Weekly - Claims - Enrollment - Provider	Automated QNXT™ ▲ AboveHealth® Daily - Authorizations - Claims - Enrollment - Member - Provider - EPSDT Status - Remittance Advices AboveHealth® ▲ QNXT™ Twice Daily - Authorizations
Dynamo			Automated Dynamo ▲ PM Daily - Member case management. Assignment				
ASDB	Automated ASDB ▲ Dynamo Monthly - Member - Provider		Automated ASDB ▲ PM Monthly - Enrollment - Member - Provider - Medical claims - Rx claims				

¹ Aetna Better Health's web-based care management business application

² Encounter Management System

³ Actuarial Services Database

System setup for intake, processing and acceptance

Aetna Better Health, after receipt and analysis of the two years of historic claims data for members enrolled in Aetna Better Health, effective the start date of operations, will employ a stratification process that will facilitate participants' assignment to the appropriate risk level; allowing Member Services personnel, Care and Case managers to appropriately target members with the most significant need. The Medical Management Coordinator in collaboration with the Chief Medical Officer (CMO) will be responsible for overseeing the stratification process. Information we will concentrate on includes members:

- With prior authorizations that indicate hospitalization admissions
- Who based on their claims pattern may have a chronic disease (e.g., asthma, diabetes, Congestive Heart Failure [CHF], Chronic Obstructive Pulmonary Disease [COPD])
- That are receiving or have recently (past 60 days) received home health care services
- Members with Special Health Care Needs (MSHCNs) and Children with Special Health Care Needs (CSHCNs)
- Who are recent NICU graduates
- Who have had three (3) or more ED visits in the last six (6) months
- Who have had three (3) or more inpatient admissions in six (6) months
- With five (5) or more prescriptions from different therapeutic classes
- With a recent (last 60 days) hospital admission and readmission within fifteen (15) days

Key to our stratification process is our *General Risk Model (GRM)*. We successfully use *GRM* in each of our Medicaid care management programs and it is a standard tool for our care management system solution. Through the utilization of *GRM* will be able to assign a Total Risk Score to each participant and determine the appropriate risk level into which the participant falls. Unlike some identification methods which are solely dependent on retrospective claims review or referrals, this tool uses innovative data-driven identification and stratification methods that includes looking at gaps in medical care and problematic participant behavior. *GRM* is an effective tool to accurately identify a member's future high-cost utilization and/or those at risk of developing a serious chronic condition for whom enrollment in care management programs would result in improvements in both clinical and financial outcomes.

The analysis of the two years of historic claims data will also facilitate the identification of providers the member has frequently had encounters. We will use this data to determine:

- 1) The member's Primary Care Provider (PCP)
- 2) The specialists the member frequently visits
- 3) If the member's PCP or specialists participate with Aetna Better Health

We will use the results of this analysis to outreach to providers that we currently do have under contract and begin outreaching to those providers. This analysis will be a key tool for our network expansion efforts, we will fine tune our network to meet the needs of our members. If we are unable to reach a contractual agreement with a provider we will use our single case agreement process so that the member may continue in the provider's care. We will be

especially sensitive to providers used by MSHCN and CSHCN to secure continuity of care for these members. A report of any gaps in providers will be provided to the Chief Operating Officer (COO) and the Provider Services Manager as a planning tool. The Quality Management Coordinator and Grievance System Manager will also be copied on this report and be involved in any planning sessions.

Testing of One-Time and Ongoing Data Exchanges

Aetna Better Health's Lead Team bears responsibility for leading and coordinating the testing and issue/defect management of all business applications associated with any implementation. With regard to Louisiana, this includes appointing a Technology Lead to manage execution of the DHH-provided test plan and associated activities prior to Contract's Go-Live Date. Aetna Better Health will initiate regular meetings with DHH personnel upon contract award to collaborate on a test approach that best aligns unit, end-to-end and DHH's Readiness Review testing. Should DHH provide specific test scripts or scenarios, we will include these into our unit and/or end-to-end testing. Should the timing of DHH's request preclude that option, DHH's test scripts or scenarios will be executed independently. Aetna Better Health's implementation tests comprise IT-facilitated end-to-end testing of all business and technology functions, daily status meetings, and policies and procedures providing for the prompt resolution and/or escalation of any issue. All testing issues are comprehensively tracked, managed and resolved, allowing anyone from Aetna Better Health or Aetna Medicaid's IT or related business function to see all issues and participate in and validate their resolution. Critical and potentially show-stopping issues are escalated to Lead Team for discussion and resolution. Daily meetings see that any roadblock, issue or defect is resolved as quickly as possible.

Joint Testing

Aetna Better Health-DHH Testing

Upon contract award, Aetna Better Health will work with the appropriate DHH personnel to capture detailed systems and process requirements. We will create detailed file specifications for all data exchanges including; Input/Output (I/O), purpose, sender, receiver, secure transmission method, update or full file content, frequency, dependencies, business rules, file naming, file layouts, and the accounts and control system that will serve to systematically certify data and balances. Data exchange specifications will include file transmission validation and verification procedures. Our Technology Lead will coordinate the internal testing necessary to support the one-time and ongoing exchange of eligibility/enrollment, provider network, claims/encounters and other data with DHH, then work with DHH to coordinate joint testing accordingly. Should any issues arise in the course of the joint testing, Aetna Better Health will work with DHH to resolve them within allotted timeframes.

Aetna Better Health-FI EDI Testing

Upon Contract award, Aetna Better Health will submit to DHH and its MMIS vendor a plan for testing the ASC X12N 837 COB in accordance with the required three (3) tiered methodology. The plan will include the following activities:

Prior to testing, Aetna Better Health will supply DHH with documentation of provider information publicly available through the Freedom of Information Act (FOIA) from the National Provider and Plan Enumeration System (NPPES). The documentation will map each provider to the corresponding provider types and specialties provided by DHH.

Tier I

Aetna Better Health will request, complete and submit to MMIS an EDI application and approval forms necessary to obtain a Trading Partner ID .

The Technology Lead will contact the MMIS' EDI Department to obtain EDI specifications relative to data and format requirements for EDI claims. We will use these specifications to confirm compliance with required data and format requirements prior to any testing.

Concurrent with EDI enrollment, Aetna Better Health will begin testing – at our own expense – with EDIFECS, the MMIS' third-party vendor, to certify HIPAA compliance prior to submission of any test files through the MMIS Electronic Data Interchange (EDI). Upon successful certification by EDIFECS, we will begin submitting test encounters to MMIS' EDI Coordinator for data and format validation, seeing to it that the following information is included in each encounter file:

- All test files will be submitted with the required 4509999 identifier
- 'RP' is present in X12 field TX-TYPE-CODE field
- Aetna Better Health's Medicaid IDs is in loop 2330B segment NM1 in 'Other Payer Primary Identification Number
- If line item CCN paid amount is submitted, 'Other Payer Primary Identifier' in loop 2430 segment SVD is populated with their Medicaid provider number
- If a contracted provider has a valid NPI and taxonomy code, Aetna Better Health will submit those values in the 837. If the provider is an atypical provider, we will adhere to 837 atypical provider guidelines

Aetna Better Health's Technology Lead will work with the EDI Coordinator to resolve any submission related issues

Tier II

Once more than 50% of Aetna Better Health's encounter claims data has successfully passed the MMIS pre-processor edits, the MMIS will process the encounters through the MMIS Adjudication cycle and the Payment cycle. The Payment cycle will create an 835 transaction, which Aetna Better Health will retrieve via IDEX. Encounter analysts will examine the returned 835s, comparing them to the encounter data claims (837s) submitted to see that all claims submitted are accounted for. Should any issues arise, Aetna Better Health will use the MMIS' new edit code reports, as well as the MMIS edit code explanation document provided, to help determine the nature of the problem. We will reach out to MMIS for assistance if necessary.

Tier III

Once satisfactory test results are documented, and the MMIS moves Aetna Better Health into production, Aetna Better Health will submit encounter files on a monthly basis. We will have established procedures for recouping post-payments available for DHH's review during the Readiness Review process. These require that we void encounters for any claim recouped in full. For recoupments that result in an adjusted claim value, we submit replacement encounters accordingly.

Internal Testing

Aetna Better Health follows the Strategic National Implementation Project's (SNIP) recommendations for testing created by the Workgroup for Electronic Data Interchange (WEDI), providing for our continued compliance with current and future federal IT mandates. These recommendations include the seven distinct types of testing described below:

Type 1: Integrity Testing involves testing for valid segments, segment order, element attributes, testing for numeric values in numeric data elements, validation of X12 syntax and compliance with X12 rules.

Type 2: Requirement Testing involves testing for HIPAA Implementation Guide-specific requirements, such as repeat counts, used and not used codes, elements and segments, required or intra-segment situational data elements (non-medical code sets as laid out in the Implementation Guide) and values noted via an X12 code list or table.

Type 3: Balancing Testing involves testing the transaction for balanced field totals, record or segment counts, financial balancing of claims or remittance advice, and balancing of summary fields.

Type 4: Situation Testing is the testing of specific inter-segment situations described in the HIPAA Implementation Guides such that: If A occurs, then B must be populated. This is considered to include the validation of situational fields given values or situations present elsewhere in the file. As an example, if the transaction is an inpatient claim, a date of admission must be present.

Type 5: Code Set Testing is testing for valid Implementation Guide-specific code set values. Examples are CPT, CDT3, NDC, and ICD-9-CM.

Type 6: Product Types/Types of Service Testing (also known as line-of-business testing) is specialized testing required by certain healthcare specialties, such as chiropractic, ambulance, durable medical equipment, etc.

Type 7: Trading Partner-Specific Testing involves edits in the HIPAA Implementation Guides that are unique and specific to a payer. Examples are edits for Medicare, Medicaid, or Indian Health Services.

In addition to the recommended testing above, Aetna Better Health utilizes two applications to validate the HIPAA compliance of any in/outbound HIPAA transaction prior to import/export.

- Foresight's HIPAA Validator™ InStream™ is a fully functional HIPAA editing and validation application. It validates HIPAA transactions through all seven levels of edits as defined by the Workgroup for Electronic Data Interchange and Strategic National Implementation Process (WEDI/SNIP), has all standard HIPAA code sets embedded, and can support custom, trading partner- specific companion guides and validation requirements. The application also provides descriptive error reports to submitters to facilitate quick error resolution.
- Microsoft's BizTalk with HIPAA Accelerator™ processes HIPAA-compliant transactions easily and efficiently, enabling Aetna Better Health to accept information electronically from almost any HIPAA-compliant contractor or provider. Accelerator has the Washington

Publishing Company (WPC) Implementation Guide schemas for each HIPAA ANSI X12 transaction embedded directly into its application engine, including a facility to update these schemas automatically as the transaction sets are updated over time.

Aetna Better Health currently complies with the following federally mandated HIPAA transactions:

- ASC X12N 834 Benefit Enrollment and Maintenance
- ASC X12N 835 Claims Payment Remittance Advice Transaction
- ASC X12N 837I Institutional Claim/Encounter Transaction
- ASC X12N 837P Professional Claim/Encounter Transaction
- ASC X12N 276 Claims Status Inquiry
- ASC X12N 277 Claims Status Response
- ASC X12N 278 Utilization Review Inquiry/Response
- ASC X12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products

Aetna Better Health continuously monitors the technical interfaces supporting our HIPAA transactions. Our NOC and Operation Command Centers in Windsor, Connecticut monitor systems performance 24/7/365 via state-of-the-art applications and tools. IBM's Tivoli Monitoring (ITM) products, for example, interface with other enterprise monitoring tools to provide a comprehensive yet consolidated view of problems across the enterprise. Production outages and system issues are managed by the Production Services Department, which assembles and coordinates teams and vendors to facilitate quick resolution and provide escalation when needed. Finally, the System Platform Performance (SPP) Department provides enterprise-wide performance monitoring, tuning, trend analysis and reporting for large-scale and midrange systems/platforms and mainframe systems and applications in support of business operations. SPP aims to promote optimum throughput and efficient use of resources to meet established service level agreements and availability goals.

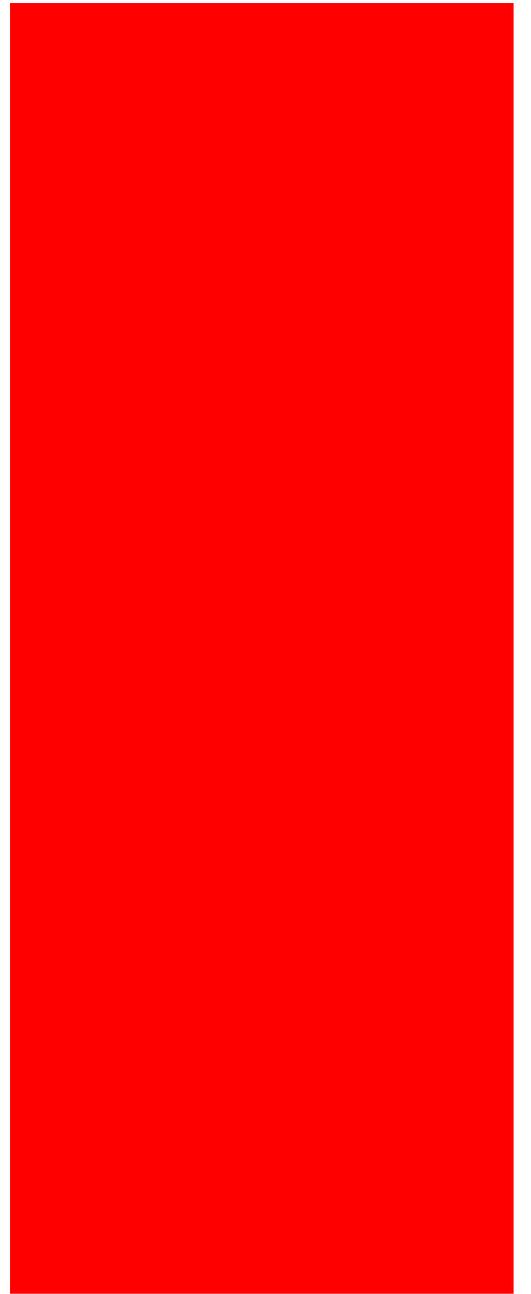
Louisiana Medicaid CCN Work Plan

Please see Appendix X for the work plan which identifies key activities, timeframes and projected resource requirements related to systems implementation of the Louisiana CCN contract.

Historical Data Processes

QNXT™, Aetna Better Health's core information processing system, maintains a complete transaction history; no data is archived, and all data is available real-time in an online accessible format.

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R.2 Describe your processes, including procedural and systems-based internal controls, for ensuring the integrity, validity and completeness of all information you provide to DHH (to their fiscal intermediary and the Enrollment Broker.) In your description, address separately the encounter data-specific requirements in, Encounter Data Section of the RFP as well as how you will reconcile encounter data to payments according to your payment cycle, including but not limited to reconciliation of gross and net amounts and handling of payment adjustments, denials and pend processes. Additionally, describe how you will accommodate DHH-initiated data integrity, validity and provide independent completeness audits.

Aetna Better Health and its affiliates have been implementing Medicaid managed care information systems for over 25 years. Today, Aetna Better Health administers or manages Medicaid health plans providing coverage to over 1.3 million members in 10 states. Well aware of the role sound, reliable information plays in effective healthcare administration, Aetna Better Health maintains robust processes safeguarding the integrity, validity and completeness of the information we provide to DHH, its Fiscal Intermediary and Enrollment Broker.

Integrity, Validity and Completeness of Information

Encounter Transactions

We have efficiently implemented required HIPAA transactions with every state agency with which we have contracted since the Act’s inception. We currently maintain HIPAA compliant technical interfaces supporting the information needs of 10 state agencies, their Fiscal Intermediaries and Enrollment Brokers. The following table describes the procedural and systems-based controls we have implemented to safeguard the integrity, validity and completeness of the information we provide to DHH and its Fiscal Intermediary:

17.5.4 Encounter Data-Specific Requirement	
Procedural Control	Systems-based Control
17.5.4.1 - The CCN's system shall be able to transmit to and receive encounter data from the DHH FI's system as required for the appropriate submission of encounter data.	
We have developed encounter implementation strategies and approaches that facilitate the timely, accurate and complete submission and receipt of encounter information. These strategies and approaches support the efficient and effective identification, categorization and accounting for encounter specifications to design, test and implement the encounter management system.	Aetna Better Health’s proprietary Encounter Management System (EMS) provides for the accurate, timely and complete submission and receipt of encounter data –including all billed and paid units and charges, as well as the National Provider Identifier (NPI) – in HIPAA compliant 837(I/P) format. Developed with the functionality to manage encounter data across the encounter submission continuum – including preparation, review, verification, certification, submission, and reporting – the system consolidates required claims data from multiple sources (e.g. QNXT™ and contracted service providers) for all services eligible for processing.

17.5.4 Encounter Data-Specific Requirement	
Procedural Control	Systems-based Control
<p>17.5.4.2 - Within sixty (60) days of operation in the applicable geographic service area, the CCN's system shall be ready to submit encounter data to the FI in a provider-to-payer-to-payer COB format. The CCN must incur all costs associated with certifying HIPAA transactions readiness through a third-party, EDIFECS, prior to submitting encounter data to the FI. Data elements and reporting requirements are provided in the CCN-P Systems Companion Guide.</p> <p>• All encounters shall be submitted electronically in the standard HIPAA transaction formats, specifically the ANSI X12N 837 provider-to-payer-to-payer COB Transaction formats (P - Professional, and I - Institutional). Compliance with all applicable HIPAA, federal and state mandates, both current and future is required.</p>	
<p>We have developed encounter implementation strategies and approaches that facilitate the timely implementation of our encounter reporting capabilities. These strategies and approaches support the efficient and effective identification, categorization and accounting for encounter specifications to design, test and implement the encounter management system. In fact we have recently implemented three new encounter systems for Medicaid managed care programs (Florida, Pennsylvania and Illinois), meeting each state's requirements and specifications for the development and submission of encounters. One of our encounter system implementation best practices is the early, frequent and consistent meetings with the state's encounter management agent to establish a sound working relationship. This sound working relationship is a method to avoid unnecessary and costly errors often caused by misunderstandings or miscommunication.</p> <p>We will incur all costs associated with this activity. We have met the testing protocols for each of our ten states; including the most recent implementations of Illinois, Pennsylvania and Florida.</p>	<p>We have reviewed the data elements and reporting requirements in the CCN-P Systems Companion Guide and will meet all specifications and requirements, including but not limited to:</p> <ol style="list-style-type: none"> 1. Submitting encounters electronically in the standard HIPAA transaction formats, specifically ANSI X12N 837. 2. We will comply with all HIPAA, federal and state mandates – current and future – as such requirements/specifications are implemented; provided that there is adequate time to test transmission protocols with DHH and its FI.
<p>17.5.4.3 - The CCN shall provide the FI with complete and accurate encounter data for all levels of healthcare services provided.</p>	
<p>Aetna Better Health has encounter system implementation and submission best practices to validate data validity for all levels of healthcare services provided (ancillary, acute, and institutional services) prior to submitting encounter data to DHH.</p>	<p>Aetna Better Health has encounter system implementation and submission best practices to validate data validity for all levels of healthcare services provided (ancillary, acute, and institutional services) prior to submitting encounter data to DHH:</p> <ol style="list-style-type: none"> 1. The QNXT™ system verifies that all necessary claims fields are populated with values of the appropriate range and type prior to the encounter information being loaded onto the EMS.

17.5.4 Encounter Data-Specific Requirement	
Procedural Control	Systems-based Control
	<p>2 .Encounter data files from vendor sources go through a staging process. The staging process consists of automated and manual verification, to validate that files have the proper layout and the appropriate fields populated. In this staging process, correct files are allowed to pass; pending files are corrected if there are correctable errors, or are rejected if the errors cannot be corrected. This staging process results in only the cleanest files being imported into the EMS.</p> <p>3. After data from QNXT™ and vendor sources are loaded into the EMS, they must pass the EMS Scrub Edits, which are customized based on DHH’s requirements for clean encounters. Files that are unlikely to pass the DHH’s edits are not submitted until they are corrected. Encounter Unit analysts take responsibility for the correction. This proactive approach to identifying and correcting errors prior to the submission of data to the Commonwealth expedites review and adjudication.</p>
<p>17.5.4.4 - The CCN shall have the ability to update CPT/HCPCS, ICD-9-CM, and other codes based on HIPAA standards and move to future versions as required.</p>	
We have protocols to thoroughly test these modifications to see to transitional accuracy.	Aetna Better Health has updated CPT/HCPCS, ICD-9-CM and other codes in accordance with HIPAA standards and the Medicaid agencies’ requirements and specifications. In addition, we continually meet the requirements of these Medicaid agencies’ to update fee schedules and other system modifications. We have designed our controls, processes and standards to modify CPT/HCPCS, ICD-9-CM, including protocols to thoroughly test these modifications to verify transitional accuracy.
<p>17.5.4.5 - In addition to CPT, ICD-9-CM and other national coding standards, the use of applicable HCPCS Level II and Category II CPT codes are mandatory, aiding both the CCN and DHH to evaluate performance measures.</p>	
Aetna Better Health has uniform written policies and procedures and system protocols that we apply to maintain compliance with these encounter reporting requirements. We also have written policies and procedures that require informing our provider network of CPT/HCPCS coding modifications that are effective as of a date-of-service to avoid unnecessary delays, confusion or problems in submitting complete, accurate and timely encounters to DHH and other Medicaid agencies.	Aetna Better Health maintains strict compliance with updates regarding <i>Current Procedural Terminology</i> (CPT), the <i>Healthcare Procedural Coding System</i> (HCPCS) (CPT/HCPCS), and ICD-9-CM and other codes in accordance with HIPAA standards so that claims and resulting encounters are processed in an orderly and consistent manner

17.5.4 Encounter Data-Specific Requirement	
Procedural Control	Systems-based Control
17.5.4.6 - The CCN shall have the capability to convert all information that enters its claims system via hard copy paper claims to electronic encounter data, to be submitted in the appropriate HIPAA compliant formats to DHH's FI.	
	<p>All paper claims are converted to electronic images we have the capability and capacity to convert all the claim information received via hard copy "paper" claims to electronic claims using Optical Character Recognition (OCR) technology. All paper claims are converted to electronic images by our vendor (EMDEON – using their Alchemy program). If the claim cannot be translated into an electronic data record by the OCR process, then the paper claims is sent directly to our claims department for data entry. Each claim is assigned a unique claim number and an electronic file of the claim is created. This file is uploaded into QNXT™ to be accessed by the claims team. The paper claim is in the QNXT™ system within 1 to 3 business days from its receipt. Additionally, the scanned image of the paper claim is stored in an image repository and is viewable to Aetna Better Health personnel, as needed.</p> <p>Aetna Better Health uses Microsoft BizTalk with HIPAA Accelerator™ (a data transformation application) to translate data to and from the full spectrum of HIPAA Transactions sets in a highly customizable, flexible, and robust server-based environment. Moreover, Accelerator has the Washington Publishing Company (WPC) Implementation Guide schemas for each HIPAA ANSI X12 transaction embedded directly into its application engine, including a facility to update these schemas automatically as the Transactions sets are updated over time.</p>
17.5.4.7 - The FI encounter process shall utilize a DHH-approved version of the claims processing system (edits and adjudication) to identify valid and invalid encounter records from a batch submission by the CCN. Any submission which contains fatal errors that prevent processing, or that does not satisfy defined threshold error rates, will be rejected and returned to the CCN for immediate correction.	
	<p>Encounter system implementation and submission best practices validate data validity for all levels of healthcare services provided (ancillary, acute, and institutional services) prior to submitting encounter data to DHH:</p> <ol style="list-style-type: none"> 1. The QNXT™ system verifies that all necessary claims fields are populated with values of the appropriate range and type prior to the encounter information being loaded onto the Encounter Management System. 2. Encounter data files from vendor sources go through a staging process. The staging process consists of automated and manual verification, to validate that files have the proper

17.5.4 Encounter Data-Specific Requirement	
Procedural Control	Systems-based Control
	<p>layout and the appropriate fields populated. In this staging process, correct files are allowed to pass; pended files are corrected if there are correctable errors, or are rejected if the errors cannot be corrected. This staging process results in only the cleanest files being imported into the EMS.</p> <p>3. After data from QNXT™ and vendor sources are loaded into the EMS, they must pass the EMS Scrub Edits, which are customized based on DHH’s requirements for clean encounters. Files that are unlikely to pass the DHH’s edits are not submitted until they are corrected. Encounter Unit analysts take responsibility for the correction. This proactive approach to identifying and correcting errors prior to the submission of data to the Commonwealth expedites review and adjudication</p>
<p>17.5.4.8 - DHH and its FI shall determine which claims processing edits are appropriate for encounters and shall set encounter edits to “pay” or “deny”. Encounter denial codes shall be deemed “repairable” or “non-repairable”. An example of a repairable encounter is “provider invalid for date of service”. An example of a non-repairable encounter is “exact duplicate”. The CCN is required to be familiar with the FI exception codes and dispositions for the purpose of repairing denied encounters.</p>	
<p>Aetna Better Health will obtain documentation from the FI regarding the approved processing edits and specifically design our encounter submission process to transmit timely, accurate and complete encounters consistent with these requirements to avoid confusion and unnecessary cost. Our best practice is to meet frequently with the Medicaid agency and the FI to fully understand design, intent and application of these edits and the adjudication process during the system design and testing phase. We will validate our compliance during readiness review and system testing activities.</p>	<p>Aetna Better Health will configure our Encounter Management System (EMS) to differentiate between “repairable” and “non-repairable” encounters. The systems workflow management functionality provides for the routing and disposition of encounters based upon the associated exception code.</p>
<p>17.5.4.9 - As specified in the CCN-P Systems Companion Guide, denials for the following reasons will be of particular interest to DHH:</p> <ul style="list-style-type: none"> • Denied for Medical Necessity including lack of documentation to support necessity; • Member has other insurance that must be billed first; • Prior authorization not on file; • Claim submitted after filing deadline; and • Service not covered by CCN. 	
<p>Aetna Better Health monitors denial reasons as a tool to determine if our training, processes, protocols or operations require performance improvement. We also monitor denial reasons to determine if a provider may need with assistance with filing claims appropriately or in following our established protocols.</p>	

17.5.4 Encounter Data-Specific Requirement	
Procedural Control	Systems-based Control
<p>We train and inform providers of our claims requirements and specification in the Provider Manual, Provider Newsletters and initial/on-going provider training events. We use the PDSA approach to monitor and adjust our processes and procedures. Establishing a positive working relationship with participating and non-participating providers is a priority. Aetna Better Health has never, nor will we ever, use deliberate claims mishandling or claim denials as a method to delay or avoid payment of claims.</p>	
<p>17.5.4.10 - The CCN shall utilize DHH provider billing manuals and become familiar with the claims data elements that must be included in encounters. The CCN shall retain all required data elements in claims history for the purpose of creating encounters that are compatible with DHH and its FI's billing requirements.</p>	
<p>Aetna Better Health's expert team of claims system developers and encounter system design specialists have already reviewed DHH's system guide and compared it to similar guides from other Medicaid agencies.</p>	<p>Aetna Better Health has standard operating procedures related to the retention and storage of claims and encounter history and data. Our expert team of claims system developers and encounter system design specialists have already reviewed DHH's system guide and compared it to similar guides from other Medicaid agencies. .</p>
<p>17.5.4.11 - Due to the need for timely data and to maintain integrity of processing sequence, the CCN shall address any issues that prevent processing of an encounter; acceptable standards shall be ninety percent (90%) of reported repairable errors are addressed within thirty (30) calendar days and ninety-nine percent (99%) of reported repairable errors within sixty (60) calendar days or within a negotiated timeframe approved by DHH. Failure to promptly research and address reported errors, including submission of and compliance with an acceptable corrective action plan may result in monetary penalties.</p>	
<p>Aetna Better Health currently meets DHH's requirements in each of the ten states in which we do business. We will apply the management principles and administrative discipline that support our record of excellence in this area to the Louisiana CCN program.</p>	
<p>17.5.4.12 - For encounter data submissions, the CCN shall submit ninety-five (95%) of its encounter data at least monthly due no later than the twenty-fifth (25th) calendar day of the month following the month in which they were processed and approved/paid, including encounters reflecting a zero dollar amount (\$0.00) and encounters in which the CCN has a capitation arrangement with a provider. The CCN CEO or CFO shall attest to the truthfulness, accuracy, and completeness of all encounter data submitted.</p>	
<p>Aetna Better Health currently meets DHH's requirements in each of the ten states in which we do business. We will apply the management principles and administrative discipline that support our record of excellence in this area to the Louisiana CCN program.</p>	

17.5.4 Encounter Data-Specific Requirement	
Procedural Control	Systems-based Control
17.5.4.13 - The CCN shall ensure that all encounter data from a contractor is incorporated into a single file from the CCN. The CCN shall not submit separate encounter files from CCN contractors.	
	Business Application Management (BAM) personnel will configure EMS such that all encounter data attributable to a given contractor is incorporated within a single file prior to submission.
17.5.4.14 - The CCN shall ensure that files contain settled claims and claim adjustments or voids, including but not limited to, adjustments necessitated by payment errors, processed during that payment cycle, as well as encounters processed during that payment cycle from providers with whom the CCN has a capitation arrangement.	
Aetna Better Health's written policies and procedures and operating manuals are specifically designed to support this requirement. Furthermore, we require each capitated or delegated provider to meet these requirements and will test compliance during readiness review. We recommend that DHH develop encounter testing protocols to include examples of these requirements to assure itself that Aetna Better Health meets this stipulation.	
17.5.4.15 - The CCN shall ensure the level of detail associated with encounters from providers with whom the CCN has a capitation arrangement shall be equivalent to the level of detail associated with encounters for which the CCN received and settled a fee-for-service claim.	
Aetna Better Health's written policies and procedures and operating manuals are specifically designed to support this requirement. Furthermore, we require each capitated or delegated provider to meet these requirements and will test compliance during readiness review. We recommend that DHH develop encounter testing protocols to include examples of these requirements to assure itself that Aetna Better Health meets this stipulation.	
17.5.4.16 - The CCN shall adhere to federal and/or department payment rules in the definition and treatment of certain data elements, such as units of service that are a standard field in the encounter data submissions and will be treated similarly by DHH across all CCNs.	
	Business Application Management (BAM) personnel will configure EMS in accordance with all federal and/or department payment rules pertaining to the definition and treatment of certain data elements.
17.5.4.17 - Encounter records shall be submitted such that payment for discrete services which may have been submitted in a single claim can be ascertained in accordance with the CCNs applicable reimbursement methodology for that service.	
	Business Application Management (BAM) personnel will configure EMS such that encounter records display the level of detail necessary to differentiate between discrete services

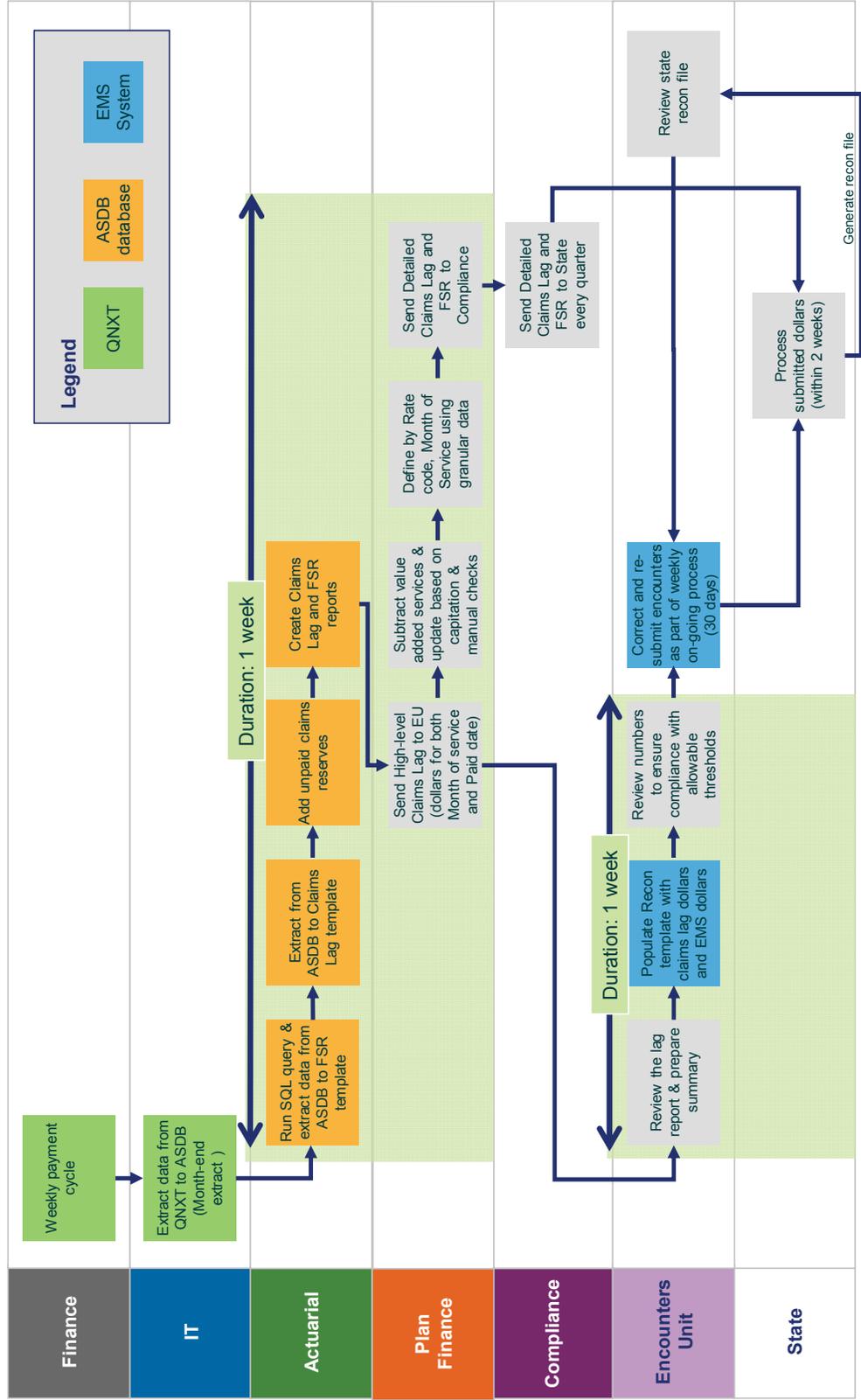
Provider Data

Aetna Better Health will provide the Enrollment Broker a Provider Directory in two formats: an electronic file and a hard copy, abbreviated version. To expedite such activities, we maintain data on all contracted providers and all non-participating providers having filed a claim within QNXT™, our core information processing system. For participating, contracted providers, we establish a provider record during the credentialing process or through data received from our vendor relationships. For non-participating providers, we input demographic information in the provider management system when we receive notification that a claim has been filed and there are no records for the billing provider anywhere in the system. Provider records are updated continually as new information is received. The majority of provider information, however, comes from network providers who submit updated demographic information by contacting our provider call centers and network representatives or access our secure Website for physicians, hospitals and other healthcare professionals. To see to it that the provider data we submit to the Enrollment Broker is as sound, valid and complete as possible, we have implemented automated processes that coordinate Aetna Better Health's provider enrollment records with the published list of Louisiana Medicaid provider types, specialty, and sub-specialty codes at www.lamedicaid.com on a regular basis. Policies and procedures provide for the prompt reconciliation of any inconsistencies. Should circumstances ever necessitate a member's disenrollment, these same processes see to it that the documentation submitted is as sound, valid and complete as possible.

Reconciliation of Encounter Data to Payments

Aetna Better Health provides for the integrity, validity and completeness of our encounter data through the regular reconciliation of claims payments to submitted encounters, seeing to it that the dollars paid in any given payment cycle match the corresponding dollars submitted via the encounter file. As illustrated in the following diagram, encounter unit analysts reconcile encounter data to financial expenditures on a weekly basis. In addition, monthly and quarterly processes reconcile encounters to our claims lag report.

Financial to Encounters Reconciliation



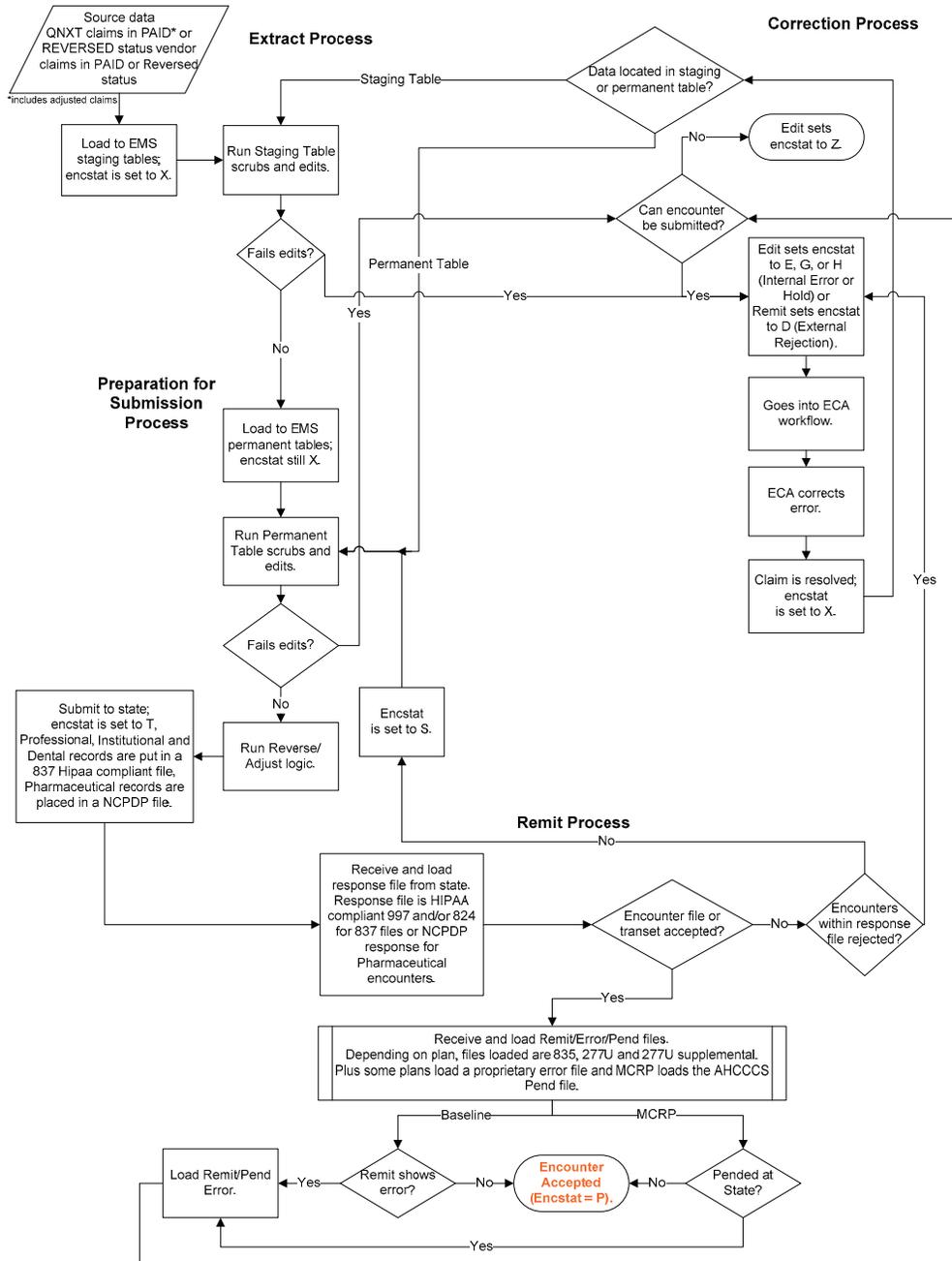
Handling of Payment Adjustments, Denials and Pends

As illustrated by the flow chart on the following page, Aetna Better Health has a clearly defined process for handling encounters relative to claims payment adjustments, denials or pends. Beginning in the upper left corner, source data comprising Aetna Better Health or Aetna Better Health vendor claims in PAID or REVERSED status is pulled from QNXT™, Aetna Better Health's core information processing system. That data is loaded into our proprietary Encounter Management System, where each encounter must pass a series of "scrubs" and edits en route from intermediate (or staging) to permanent data tables. EMS next applies reversal/adjustment logic specific to the requirements of the given state to each encounter having passed these internal edits. These encounters are then flagged, (T= Sent; waiting for Remit/Error/Pend file(s)), formatted and submitted to the state via HIPAA compliant 837 or NCPDP files. The states' response files are handled as indicated.

ENCSTAT Definitions

- D - Denied by State (Baseline)
- Deleted by State (MCRP).
- E - EMS Error or 997 response rejection.
- G - Hold, back-end (projects).
- H - Hold, system or user.
- N - Pended by State (MCRP only).
- P - Accepted.
- Q - Denied by State (MCRP only).
- S - Ready to send.
- T - Sent, waiting for Remit/Error/Pend file(s).
- U - Voided (previously pended MCRP only).
- V - Void (not sent).
- W - Voided (previously accepted).
- X - Extracted, waiting for void adjustment logic.
- Y - Voided Previously Denied (MCRP only).
- Z - Dead.

Encounter Department High Level Overview



DHH-initiated Data Integrity and Validity Studies

Aetna Better Health maintains a Quality Improvement Program whereby we continually evaluate opportunities to adopt and implement procedural and systems-based controls providing improved data integrity, validity and completeness. As part of our ongoing quality improvement efforts, claims and EDI experts, clinical quality assurance and reporting and data analytics personnel will cooperate with DHH's own Continuous Quality Improvement Program initiatives. We will use quality improvement tools, such as root cause analysis, to investigate and evaluate data quality issues identified by DHH, then present those findings during a quarterly site visit (or as needed). As data issues are discussed, Aetna Better Health quality assurance personnel will incorporate corrective action steps into a quality improvement report, and then implement corrective measures accordingly. If for any reason an issue is not resolved in a timely manner, we will provide DHH a Corrective Action Plan (CAP) listing issues, responsible parties, and projected resolution dates.

Provision of Independent Audit Results

QNXT™ maintains audit trails facilitating the auditing of individual claims in accordance with, at a minimum, the guidelines and objectives of the American Institute of Certified Public Accountants (AICPA) Audit and Account Guide, The Auditor's Study and Evaluation of Internal Control in Electronic Data Processing (EDP) Systems. Aetna Better Health will maintain an internal EDP Policy and Procedures (P&P) manual mirroring AICPA guidelines and will make the manual available to DHH and both state and independent auditors upon request. The manual will, at a minimum, describe all accessible screens used throughout the system and attest to the system's adherence to not only the same Graphical User Interface (GUI) standards, but programmers' adherence to the highest industry standards for the coding, testing, execution and documentation of all system activities.

Aetna Better Health has engaged KPMG, LLC since 2000 to perform SOC I Type II audits of our claims processing and related general computer controls. These have consistently indicated positive, unqualified opinions. We will contract with KPMG – or a similar independent firm subject to the written approval of DHH – to perform audits in full compliance with AICPA Professional Standards for Reporting on the Processing of Transactions by Service Organizations. These will include:

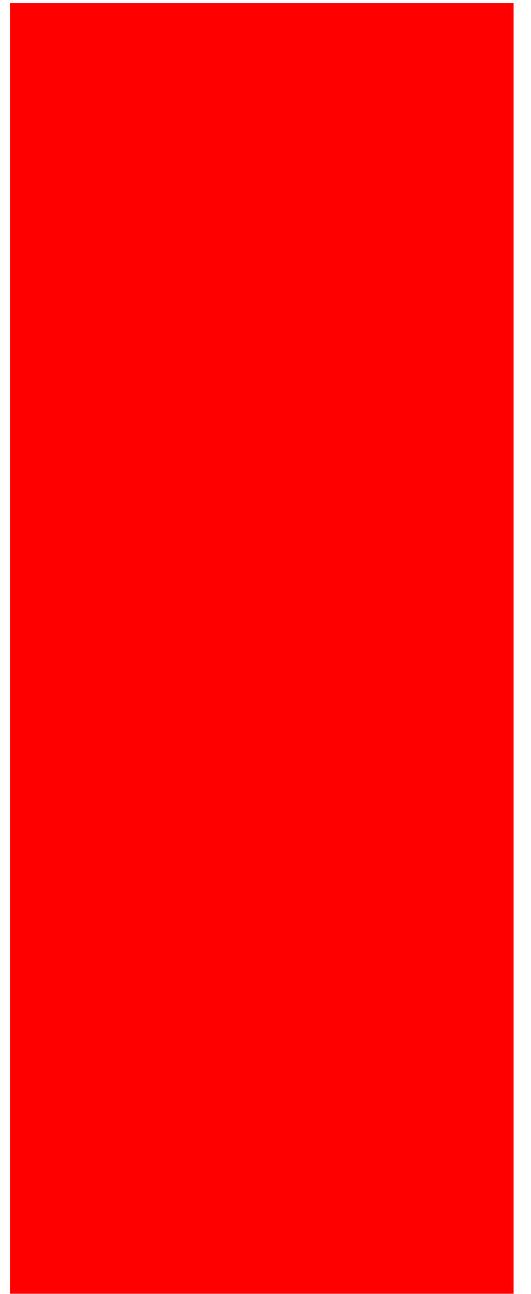
- 1) Conduct limited scope EDP audits on an ongoing and annual basis using DHH's audit program specifications at the conclusion of the first twelve (12) month operation period and each twelve (12) month period thereafter, while the Contract is in force with DHH and at the conclusion of the Contract; and
- 2) Conduct a comprehensive audit on an annual basis to determine the CCN's compliance with the obligations specified in the Contract and the Systems Guide.

The auditing firm will deliver to the Aetna Better Health and to DHH a report, prepared in accordance with generally accepted auditing standards for EDP application reviews, of findings and recommendations within thirty (30) calendar days of the close of each audit. In addition, an exit interview will be conducted at the conclusion of the audit and a yearly written report of all findings and recommendations submitted to Aetna Better Health and DHH by the independent auditing firm. These finding will be incorporated within our EDP manual following DHH's



review. Aetna Better Health will deliver to DHH a corrective action plan addressing any deficiencies identified during the audit within ten (10) business days of receipt of the audit report.

120 R.3





R.3 Describe in detail how your organization will ensure that the availability of its systems will, at a minimum, be equal to the standards set forth in the RFP. At a minimum your description should encompass: information and telecommunications systems architecture; business continuity/disaster recovery strategies; availability and/or recovery time objectives by major system; monitoring tools and resources; continuous testing of all applicable system functions, and periodic and ad-hoc testing of your business continuity/disaster recovery plan.

Identify the timing of implementation of the mix of technologies and management strategies (policies and procedures) described in your response to previous paragraph or indicate whether these technologies and management strategies are already in place.

Elaborate, if applicable, on how you have successfully implemented the aforementioned mix of technologies and management strategies with other clients.

Aetna Better Health and its affiliates have been implementing Medicaid managed care information systems for over 25 years. As a result, we are aware of the importance state agencies, network providers and members place on uninterrupted access to our information and telecommunication systems. Our information and telecommunication systems are configured accordingly, incorporating the multiple levels of redundancy necessary to provide members' and providers' access to internet and/or telephone-based and information functions 24 hours a day, seven days a week (except during periods of scheduled system unavailability mutually agreed upon with DHH). All other system functions and information are available to applicable system users between, at a minimum, the hours of 7 a.m. and 7 p.m. (CST), Monday through Friday. Redundant technical interfaces provide for the uninterrupted exchange of data, such as that which will be required between Aetna Better Health and DHH's FI and/or Enrollment Broker.

Information and Telecommunications Systems Architecture

Aetna Better Health's key production and telecommunication system include the following Aetna Better Health-owned and outsourced system/applications. All key information system are housed at Aetna Medicaid's primary and secondary (DR/BC) data centers in Windsor and Middleton, Connecticut (respectively), while telecommunications services (Avaya) are based out of Blue Bell, Pennsylvania¹. Technical support is provided through an agreement between Aetna Better Health and the Aetna Medicaid Business Unit, affording Aetna Better Health access to Aetna Medicaid's expansive technical support. Disaster Recovery and Business Continuity (DR/BC) Plans are maintained at three levels: Aetna Medicaid manages and maintains DR/BC Plans providing for uninterrupted access to corporate resources. Individual health plans, in turn, are required to maintain detailed DR/BC Plans relative to their respective geographic location and associated risks. Finally, all outsourced system/application vendors are required to maintain their own DR/BC plans, which they are contractually required to validate on an annual basis.

¹ An Avaya switch will also be installed on-site in Louisiana.

**Owned systems/Applications:**

- QNXT™ – Core information processing system responsible for:
 - Claims data, adjudication and COB/TPL processes
 - Demographic, eligibility and enrollment data
 - Provider contract configuration,
 - EDI processes
 - QM/UM, Prior Authorizations and concurrent reviews
- EMS – Encounter Management system
- *General Risk Model (GRM)* – Risk stratification system
- ASDB – Actuarial Database
- Grievance and Appeals Database – Issue management tracking
- Avaya – Communications (telecommunications) management platform

Outsourced systems/Applications:

- Dynamo™ - Web -based care management business application
- ActiveHealth® Care Engine - Clinical support/messaging
- AboveHealth® – Secure Web portal (member/provider)

Business Continuity/Disaster Recovery Strategies

Aetna Medicaid's disaster backup and recovery strategy is to provide and maintain an internal disaster recovery capability. This strategy leverages the internal computer processing capacity of two state-of-the-art, hardened computer centers located in Middletown and Windsor, Connecticut. Both facilities have extensive fire suppression systems, dual incoming power feeds, UPS, and backup diesel generators supporting 24/7/365 operation. Physical access is strictly controlled and monitored, and access to vital areas is segregated by floor and business function as appropriate. The two data centers house Aetna Medicaid's computer processing capabilities on three major platforms, mainframe (Z/OS), mid-range (Various UNIX versions), and LAN (Windows on X86 processors). The data centers are load balanced and supplemented by quick-ship and capacity-on-demand contracts, permitting each center to back the other up in the event of disaster. We maintain contracts with national vendors providing for replacement equipment and supplemental capacity as needed, further promoting compliance with Recovery Time Objectives (RTO).

In the event of a data center disaster, the RTO to resume most production processing is four days from disaster declaration for all mainframe and mid-range system and five days for LAN systems. Portfolios of highly available applications, such as web and pharmacy, have RTO's of four hours or less. These applications utilize mirroring and/or load balancing technologies between the data centers to make certain that the reduced RTOs can be met. Aetna Medicaid's voice and data network backbones are fully redundant using SONET ring technology and are recovered within 1-4 hrs hours of a data center outage. In short, Aetna Medicaid's data center recovery strategy and its application RTO's are consistent with or better than industry standards.

***Data Backup***

Infrastructure and application data is secured and stored offsite on a daily basis. Backed-up data is cross vaulted between the two computer centers, with mainframe backups stored primarily on disk media and mid-range/LAN backups stored primarily on tape. Additionally, all mainframe disk data is mirrored to the alternate data center providing a simplified and timelier recovery for that piece of the environment. Any customer data lost as a result of a data center catastrophe will be recovered through re-submittals by service providers and/or recovery reconciliation teams. To provide for ready access to off-site storage, Aetna Better Health maintains remote back-ups of operating instructions, procedures, reference files, system documentation, and operational files. These include:

- Descriptions of the controls for back-up processing, including how frequently back-ups occur
- Documented back-up procedures
- The location of data that has been backed up (off-site and on-site, as applicable)
- Identification and description of what is being backed up as part of the back-up plan; and
- Any change in back-up procedures in relation to a change(s) in technology

Aetna Better Health will provide DHH with a list of all back-up files to be stored at remote locations and the frequency with which these files will be updated upon request.

Contingency Plans

Aetna Better Health maintains, and is continually ready to invoke, contingency plans protecting the availability, integrity, and security of data during unexpected failures or disasters, providing for the continued function of essential application or system functions. In keeping with best practice, our contingency plans include both a Disaster Recovery Plan (DRP) and a Business Continuity Plan (BCP). The following scenarios are addressed:

- The central computer installation and resident software are destroyed or damaged;
- The system interruption or failure resulting from network, operating hardware, software, or operations errors that compromise the integrity of transaction that are active in a live system at the time of the outage;
- System interruption or failure resulting from network, operating hardware, software or operations errors that compromise the integrity of data maintained in a live or archival system;
- System interruption or failure resulting from network, operating hardware, software or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system, but does prevent access to the system, such as it causes unscheduled system unavailability; and

For each instance, our contingency plans specify projected recovery times and anticipated data loss for mission-critical system in the event of a declared disaster.

Disaster Recovery Plan

The Aetna Medicaid's Disaster Recovery Plan is the high level plan for recovery of a data center and its critical components. The plan is derived from over 50 detailed IT infrastructure plans which are maintained by each critical support area. The plans contain processes and procedures



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to recover all functions, services, and equipment which are needed to recover either data center. These plans are centrally maintained by our disaster recovery group, are stored both locally and offsite and are updated semi-annually or as needed by the respective infrastructure area.

Application recovery (DBAR) plans document technical and management contacts, application recovery specifics, application dependencies, integrated system synchronization, and checkout procedures. The plans are maintained routinely and utilize automated recovery processes to insure appropriate data resilience. These DBAR plans are validated annually with the application owners and business users with periodic integrated tabletop simulations.

Escalation and notification procedures are contained within disaster recovery plans to verify recovery team members, affected partners and business unit owners are activated in a timely manner. AIS's role during a disaster is to lead, manage, and staff the various recovery teams, which will also be augmented by additional vendor specialists under contract for certain supplemental recovery technologies, which AIS will coordinate.

Each one of Aetna Better Health's health plans is responsible for maintaining its own DR Plan, as each local plan must contain detailed instructions relative to its geographic location and associated risks.

Business Continuity Plan

Aetna Medicaid maintains and implements a detailed business continuity program, with over 300 plans to address its critical business work group operations. In the event of an office outage, processing is transferred to surviving offices within Aetna Better Health's network with little or no disruption to service levels. The detailed business continuity plans are maintained on a quarterly basis and in-depth tests, including CMP and BCP simulations, building evacuations, or call tree tests, are conducted periodically.

The Aetna Medicaid is responsible for the coordination of Aetna Medicaid's DR/BC activities. Similarly, each Aetna Better Health's plan maintains a local version of the Disaster Recovery/Business Continuity Plan specific to its respective operations and local resources. The Plan contains a listing of key customer priorities, key factors that could cause disruption, and the timelines within which each anticipates resumption of critical customer services (e.g. providers' receipt of prior authorization approvals and denials), including the percentage of recovery at certain hours, as well as key activities required to meet those timelines. Recovery Time Objectives (RTOs) for key information and telecommunication systems are provided below:

Availability and/or Recovery Time Objectives (RTOs) by Major System

Aetna Medicaid Business Unit's Chief Operating Officer (COO) bears responsibility for maintaining the continuity of Aetna Better Health's information system, seeing to our continued compliance with required RTOs. As demonstrated in the table below, Aetna Better Health's RTOs provide for the recovery of required Tier 1 functionality (eligibility/enrollment and claims processing) within zero to four hours, exceeding DHH's RTO of seventy-two (72) hours.

The COO will notify designated DHH personnel via phone, fax and/or electronic mail within sixty (60) minutes upon discovery of any problem within or outside Aetna Better Health's span of control that may jeopardize or is jeopardizing availability and performance of critical system functions and the availability of critical information, including any problems impacting scheduled exchanges of data with DHH or DHH's FI. The notification will provide details as to



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the related impact to critical path processes such as enrollment management and encounter submission processes. Similarly, should Aetna Better Health discover a problem that results in delays in report distribution or problems in on-line access to critical system functions and information during a business day, we will notify designated DHH personnel via phone, fax, and/or electronic mail within fifteen (15) minutes, in order for the applicable work activities to be rescheduled or handled based on system unavailability protocol. In either case, we will provide DHH, at a minimum, hourly updates (via phone and/or electronic mail) regarding the nature of the event(s), as well as a status on its resolution.

Aetna Better Health will resolve and implement system restoration within sixty (60) minutes of any official declaration of unscheduled system unavailability of critical functions caused by the failure of system and telecommunications technologies within our span of control. Unscheduled system unavailability to all other system functions caused by system and telecommunications technologies within our span of control will be resolved, and the restoration of services implemented, within eight (8) hours. Cumulative system unavailability caused by system and/or IS infrastructure technologies within our span of control will not exceed twelve (12) hours during any continuous twenty (20) business day period.

Within five (5) business days of the occurrence of a problem with system availability, Aetna Better Health will provide DHH with full written documentation including a corrective action plan describing what measure we will implement to prevent a recurrence.

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Key Information and Telecommunication Systems' Recovery Time Objectives (RTOs)		
Application	Description	DBAR Priority*
QNX TM	Core information processing system - Claims data, adjudication and COB/TPL processes - Demographic, eligibility and enrollment data - Provider contract configuration, - EDI processes - QM/UM, Prior Authorizations and concurrent reviews	Tier 1
Dynamo ^{TM2}	Web-based care management application	Tier 1
Avaya	Call management system	Tier 1
EMS	Encounter Management system	Tier 2
Predictive Modeling	Risk stratification	Tier 2
Actuarial Service Database (ASDB)	Predictive modeling / Statistical outlier analysis	Tier 2
ActiveHealth Care Engine	Clinical support / messaging	Tier 2
Grievances and Appeals	Issue management	Tier 2
AboveHealth [®]	Secure Web Portal (Member/Provider)	Tier 2

*Recovery time objectives for tier-one applications are 0-4 hrs; RTO for remaining applications is 1-4 weeks.

² Our web-based care management business Application (Dynamo^{TM2})



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Monitoring Tools and Resources

Aetna Medicaid's core business system maintained a 99.99 percent uptime through the 2010 calendar year, due largely to the combined efforts of personnel at our Network Operation Center (NOC), Operation Command Center and Production Services and System Platform Performance Departments. The four share one common goal: the optimization of our core business systems' performance. Our NOC and Operation Command Centers, for example, monitor system performance 24/7/365 via state-of-the-art applications and tools, such as IBM Tivoli Monitoring (ITM) products. ITM is an event management/problem detection tool that can monitor Windows Server system attributes and system Event logs, as well as ASCII logs. It interfaces with other enterprise monitoring tools to provide a comprehensive yet consolidated view of problems across the enterprise. Production outages and system issues are managed by the Production Services Department which assembles and coordinates teams and vendors to facilitate quick resolution and provide escalation when needed. And finally, the system Platform Performance (SPP) Department provides enterprise-wide performance monitoring, tuning, trend analysis and reporting for large-scale and midrange system/platforms and mainframe system and applications in support of business operations. SPP aims to promote optimum throughput and efficient use of resources to meet established service level agreements and availability goals

Continuous Testing of All Applicable System Functions

Aetna Better Health, in conjunction with Aetna Medicaid, continuously monitors all information system functions. As described above, personnel in each of the four departments at Aetna Medicaid's corporate data center work in concert to monitor system performance, using various quality control measures to anticipate and mitigate any potential system issue. IT personnel at the health plan level monitor performance as well and work with corporate IT personnel to resolve issues as they arise.

Business Continuity/Disaster Recovery Plan Testing

Aetna Better Health and Aetna Medicaid update disaster recovery plans and procedures as necessary. Annual testing of corporate and local disaster recovery plans, employing simulated disasters and lower level failures, affords corporate and local IT personnel alike the opportunity to demonstrate and validate system recovery capabilities for DHH. Should these tests ever fail to demonstrate our ability to restore system functions, Aetna Better Health will submit a corrective action plan to DHH describing how the failure will be resolved within ten (10) business days of the conclusion of the test.

Identify the timing of implementation of the mix of technologies and management strategies (policies and procedures) described in your response to (a), or indicate whether these technologies and management strategies are already in place.

Aetna Better Health's information system currently supports the diverse needs of Medicaid health plans in 10 states. Our Information system personnel has reviewed every system requirement in the CCN-P RFP, its appendices, attachments and system guide and determined that our system already possess the functionality to support them all. The design phase of our system implementation will not include any development, but merely clarification and configuration of existing system functionality to the specific needs of this Contract. Our COO will see to it that the core business applications responsible for provider enrollment and data



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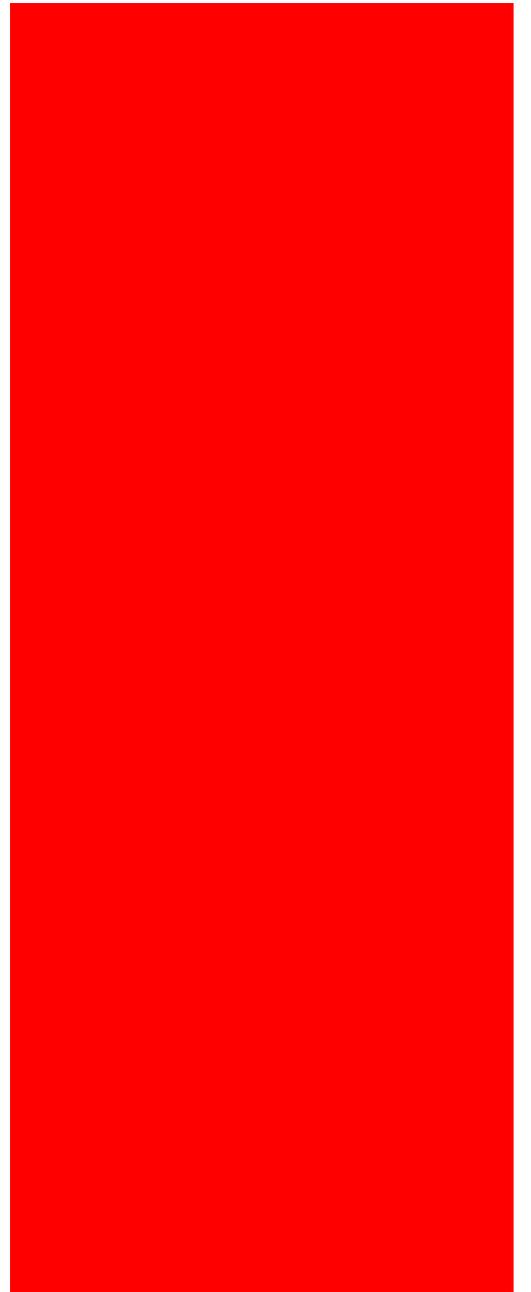
management, member eligibility and enrollment, claims processing and service authorization are configured accordingly, then unit and end-to-end testing conducted to verify and validate implementation of the desired functionality.

Elaborate, if applicable, on how you have successfully implemented the aforementioned mix of technologies and management strategies with other clients.

Aetna Better Health has been implementing Medicaid managed care information system for over 25 years. Today, Aetna Better Health administers or manages Medicaid health plans providing coverage to over 1.3 million members in 10 states, and each has implemented its own DR/BC Plans accordingly. All Aetna Better Health's plan maintains their own DR/BC Plans, though each has access to Aetna Medicaid's deep pool of DR/BC resources.

In compliance with DHH's System Readiness Review Requirements, Aetna Better Health will submit a contingency plan comprising Disaster Recovery and Business Continuity Plans no later than 120 days prior to the Contract's Operational Start Date.

121 R.4



R.4 Describe in detail:

- How your *key production systems* are designed to *interoperate*. In your response address all of the following:
 - How identical or closely related data elements in different systems are named, formatted and maintained:
 - Are the data elements named consistently;
 - Are the data elements formatted similarly (# of characters, type-text, numeric, etc.);
 - Are the data elements updated/refreshed with the same frequency or in similar cycles; and
 - Are the data elements updated/refreshed in the same manner (manual input, data exchange, automated function, etc.).
 - All exchanges of data between key production systems.
 - How each data exchange is triggered: a manually initiated process, an automated process, etc.
 - The frequency/periodicity of each data exchange: “real-time” (through a live point to-point interface or an interface “engine”), daily/nightly as triggered by a system processing job, biweekly, monthly, etc.
- As part of your response, provide diagrams that illustrate:
 - point-to-point interfaces,
 - information flows,
 - internal controls and
 - the networking arrangement (AKA “network diagram”) associated with the information systems profiled.

These diagrams should provide insight into how your Systems will be organized and interact with DHH systems for the purposes of exchanging Information and automating and/or facilitating specific functions associated with the Louisiana Medicaid CCN Program.

Aetna Better Health through its affiliate Aetna Medicaid has access to a state-of-the-art core production system: QNXT™. QNXT™ integrates the following four primary production functions within one core application.

- Claims processing
- Eligibility and enrollment processing
- Service authorization management
- Provider enrollment and data management

This integration provides for the consistent naming and formatting of all related data elements. Data is not stored in disparate systems where it is subject to the naming and formatting conventions of each respective system, but rather within a single integrated application. QNXT™ data may be refreshed automatically (e.g. intake of HIPAA transaction code sets from our automated claims clearinghouse) or manually (e.g. daily updates by personnel), with the refresh

rate of any particular data element dependent on the timeliness of the data. QNXT's™ robust interoperability provides for the mapping of “source” data elements within QNXT™ to corresponding fields in related systems. As a result, any change or edit made to a data element within QNXT™ is automatically propagated across related fields anytime it is refreshed, providing for increased data validity, integrity and accuracy. As with QNXT's™ internal refresh rates, the refresh rate of any given data interface is determined by the nature of the respective data exchange. Refresh of claims data between QNXT™ and EMS, for example, need only occur after Aetna Better Health's weekly check run, whereas member and provider data accessible via AboveHealth®, Aetna Better Health's secure web portal, is refreshed daily. The process is expedited through the use of shared relational database technology, described below, that supports seamless systems interoperability.

Systems Interoperability

Data Exchange between Key Production Systems

One aspect of application deployment particularly relevant when discussing these data interfaces is Aetna Better Health's systemic use of one relational database technology for all core business applications. Key production systems, including QNXT™, our web-based business application (Dynamo™), ActiveHealth, AboveHealth®, our Actuarial Services Database (ASDB) and proprietary Encounter Management System (EMS) and predictive modeling systems use Microsoft's SQL Server 2000 Relational Database Management System (RDBMS), allowing for the virtual integration of data from physically disparate systems. This provides for consistent naming, formatting, definition and usage of data across applications. It allows us to maintain transaction and information integrity across core applications while maintaining the specialized, robust functionality each application provides. Three examples of how such interoperability promotes data consistency and integrity follow:

Provider Information from QNXT™ to our Web-based Care Management Business Application (Dynamo™)

Aetna Better Health network administration personnel use QNXT™ to build and maintain provider network information, including demographics, specialty/sub-specialty, affiliations, fee schedule and contractual arrangements. An extract of this information is automatically fed to our web-based care management business application (Dynamo™) on a nightly basis, reflecting any changes in provider network composition (additions, changes and terminations). No provider network data is input into our web-based care management business application (Dynamo™); the system of record for this information is QNXT™.

Eligibility Information from QNXT™ to our web-based care management business application (Dynamo™)

Eligibility information received by Aetna Better Health is housed and maintained in QNXT™. An extract from QNXT™ is automatically created and loaded into our web-based care management business application (Dynamo™) on a regularly scheduled basis. If there is a change in a member's demographic or eligibility data, the change is updated in QNXT™ and uploaded to our web-based care management business application (Dynamo™) during the next scheduled interface.

QNXT™ to AboveHealth®

AboveHealth®, Aetna Better Health’s secure web portal allows authorized users to perform a number of functions, all dependent on the regularly scheduled import of data from QNXT™. These include:

- Claim/Encounter Status Inquiry — To support this operation, a periodic claims status file is exported from QNXT™ and populates AboveHealth’s® database.
- Checking authorization Status – For services requiring pre-authorization. This too, is based on data extracted daily from QNXT™.
- Member eligibility and provider directory look-up — To support these operations, a periodic extract of eligibility and provider information from QNXT™ is created and loaded into the AboveHealth® database.

The following table summarizes the data exchange between QNXT™ and other key production systems, including:

- How each data exchange is triggered
- Whether each data exchange is one or two-way
- The frequency of each data exchange

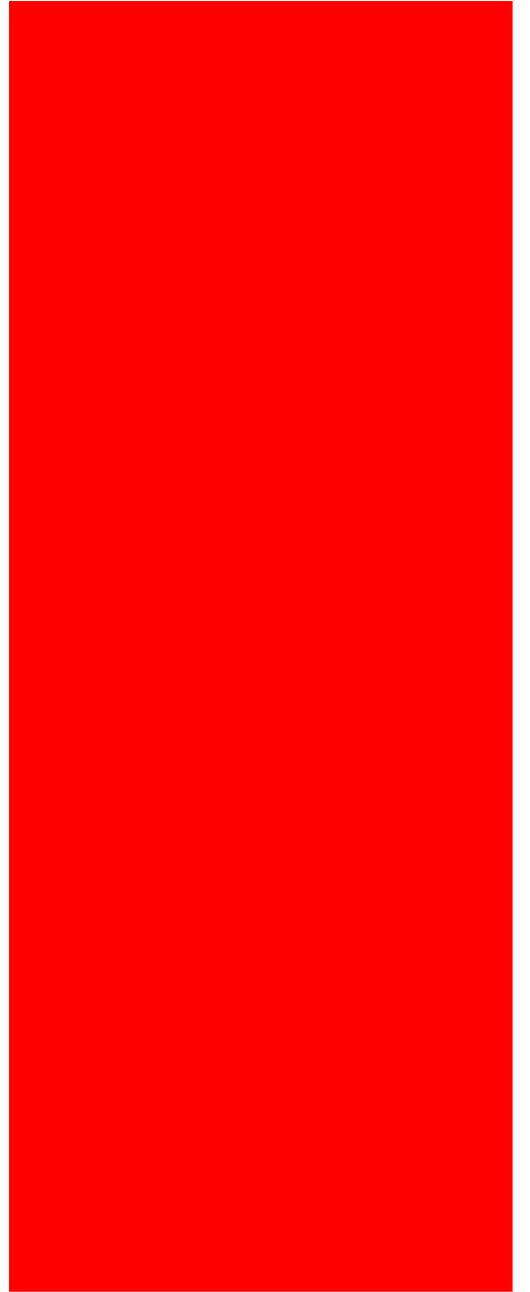
A summary of the Data Exchange Between QNXT™ and Other Key Production Systems			
	Dynamo ¹	EMS ²	AboveHealth®
QNXT™	Automated	Automated	Automated
	QNXT™ ► Dynamo	QNXT™ ► EMS	QNXT™ ► AboveHealth®
	Daily	Weekly	Daily
	- Member - Provider	- Claims - Provider (PRN)	- Authorizations - Claims - Enrollment - Member - Provider - EPSDT Status - Remittance Advices
			AboveHealth® ► QNXT™ Twice Daily - Authorizations

¹Aetna Better Health’s web-based care management business application

²Encounter Management System

The following network diagram illustrates the manner in which Aetna Better Health’s systems are organized and interact with one another, DHH and our respective trading partners for the purposes of exchanging Information and automating and/or facilitating specific functions associated with the Louisiana Medicaid Coordinated Care Network (CCN) Program. This diagram shows all systems that interact with QNXT™, including minor systems that provide editing and other features that fail to meet the overall qualification to be included in this response.

122 R.5



R.5 Describe your ability to provide and store encounter data in accordance with the requirements in this RFP. In your response:

- Explain whether and how your systems meet (or exceed) each of these requirements.
- Cite at least three currently-live instances where you are successfully providing encounter data in accordance with DHH coding, data exchange format and transmission standards and specifications or similar standards and specifications, with at least two of these instances involving the provision of encounter information from providers with whom you have capitation arrangements. In elaborating on these instances, address all of the requirements in Section 17. Also, explain how that experience will apply to the Louisiana Medicaid CCN Program.
- If you are not able at present to meet a particular requirement contained in the aforementioned section, identify the applicable requirement and discuss the effort and time you will need to meet said requirement.
- Identify challenges and “lessons learned” from your implementation and operations experience in other states and describe how you will apply these lessons to this contract.

Provide and Storage of Encounter Data

Aetna Better Health’s expert team of claims system developers and encounter system design specialists have reviewed DHH’s system guide and compared it to similar guides from other Medicaid agencies. Based on this review and our recent experience implementing three new encounter systems for Medicaid managed care programs in Florida, Pennsylvania and Illinois we will meet DHH’s encounter system requirements, specifications and program elements. We also recently expanded our Missouri Medicaid managed care program into two large regions and successfully transitioned providers (PCP, hospital, ancillary, specialist and others) from fee-for-service to managed care. We have the knowledge, experience and skill to support providers during this transition. We have successfully converted providers from submitting paper claims to electronic claims in each of these instances. Our relational database design is an efficient and optimal method to store claims and encounter data. Each claim and corresponding encounter has a unique number that supports seamless extraction of data to support claim and encounter adjustments, voiding, or modification. We have sufficient storage capacity to support the Louisiana Coordinated Care Network (CCN) Program during the term of this contract. Our storage capacity can be easily expanded to meet the needs of this program.

Capacity of our Encounter System to Meet DHH’s Requirements – Applying our Experience

In the table below we have specifically addressed each of the encounter specifications and requirements in RFP sections 17.5.4.1 to 17.5.4.17. We have selected three example states (Delaware, Florida, and Maryland) in accordance with the instructions of this question. These states were selected because they are representative of the range of encounter requirements from the other seven states. We are aware that encounters are important to DHH for several reasons. We also value claim and encounter data because these data provide the source of information to understand our members, providers and the communities we serve. We constantly use claim and

encounter data in performing critical activities related to predictive modeling, improving health outcomes, increasing the quality of life, determine compliance with HEDIS^{®3} measures and measure our performance.

Please see a detailed flow chart at the end on this section for a description of the encounter process.

³ HEDIS[®] is a registered trademark of the National Committee for Quality Assurance.



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Requirement	Delaware	Florida	Maryland	Explanation
17.5.4.1 The CCN's system shall be able to transmit to and receive encounter data from the DHH FI's system as required for the appropriate submission of encounter data.	Meets	Meets	Meets	In Delaware, Florida and Maryland we meet each Medicaid agencies encounter data submission requirements. We also receive encounter data responses from each Medicaid agency in accordance with the protocols of that Medicaid agency. Aetna Better Health's proprietary Encounter Management System (EMS) provides for the accurate, timely and complete submission of encounter data –including all billed and paid units and charges ⁴ , as well as the National Provider Identifier (NPI) – in HIPAA compliant 837 (I/P) format. Developed with the functionality to manage encounter data across the encounter submission continuum – including preparation, review, verification, certification, submission, and reporting – the system consolidates required claims data from multiple sources (e.g. QNXT™ and contracted service providers) for all services eligible for processing.
How we will apply this experience to the Louisiana CCN program?	We have developed encounter implementation strategies and approaches that facilitate the timely, accurate and complete encounters. These strategies and approaches support the efficient and effective identification, categorization and accounting for encounter specifications to design, test and implement the encounter management system. In each of these sample instances (Delaware, Florida and Maryland) and in our other seven (7) Medicaid managed care we met the criteria for submitting encounters to the state or its agent. In fact we have recently implemented three new encounter systems for Medicaid managed care programs (Florida, Pennsylvania and Illinois) and met each of these states requirements and specifications for the development and submission of encounters. We have experience supporting providers transitioning from fee-for-service to Medicaid managed care and in shifting providers from submitting paper claims to electronic claims. We will apply this experience to the Louisiana CCN program. We expect that initially we may experience a			

⁴ We are not required to submit denied encounters for these Medicaid programs. However, we do submit administrative denial to the Pennsylvania Medicaid agency. We also submit denials to the Medicaid county regulatory organization in California, but this is a different process than in Pennsylvania.



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Section R: Information Systems

Requirement	Delaware	Florida	Maryland	Explanation
<p>17.5.4.2 Within sixty (60) days of operation in the applicable geographic service area, the CCN's system shall be ready to submit encounter data to the FI in a provider-to-payer-to-payer COB format.</p> <p>The CCN must incur all costs associated with certifying HIPAA transactions readiness through a third-party, EDIFICS, prior to submitting encounter data to the FI.</p> <p>Data elements and reporting requirements are provided in the CCN-P Systems Companion Guide.</p> <ul style="list-style-type: none"> All encounters shall be submitted electronically in the standard HIPAA transaction formats, specifically the ANSI X12N 837 provider-to-payer-to-payer COB Transaction formats (P - Professional, and I - Institutional). Compliance with all applicable HIPAA, federal and state mandates, both current and future is required. 	<p>Meets</p>	<p>Meets</p>	<p>Meets</p>	<p>In each of the States we are using as an example we met the required encounter submission in accordance with the Medicaid agencies requirements. We successfully met the requirements in each State and have the experience, capability, and technical expertise to meet the expectations in Louisiana.</p> <p>We will incur all costs associated with this activity. We have met the testing protocols for each of our ten states; including the most recent implementations of Illinois, Pennsylvania and Florida.</p> <p>We have reviewed the data elements and reporting requirements in the CCN-P Systems Companion Guide and will meet all specifications and requirements, including but not limited to:</p> <ol style="list-style-type: none"> Submitting encounters electronically in the standard HIPAA transaction formats, specifically ANSI X12N 837. We will comply with all HIPAA, federal and state mandates – current and future – as such requirements/specifications are implemented; provided that there is adequate time to test transmission protocols with DHH and its FI.

Requirement	Delaware	Florida	Maryland	Explanation
<p>How we will apply this experience to the Louisiana CCN program?</p>	<p>Weeet</p>	<p>Weeet</p>	<p>Weeet</p>	<p>We have developed encounter implementation strategies and approaches that facilitate the timely, accurate and complete encounters. These strategies and approaches support the efficient and effective identification, categorization and accounting for encounter specifications to design, test and implement the encounter management system. In each of these sample instances (Delaware, Florida and Maryland) and in our other seven (7) Medicaid managed care we met the criteria for submitting encounters to the state or its agent. In fact we have recently implemented three new encounter systems for Medicaid managed care programs (Florida, Pennsylvania and Illinois) and met each of these states requirements and specifications for the development and submission of encounters. One of our encounter system implementation best practices is the early, frequent and consistent meetings with the state's encounter management agent to establish a sound working relationship. This sound working relationship is a method to avoid unnecessary and costly errors often caused by misunderstandings or miscommunication.</p>
<p>17.5.4.3 The CCN shall provide the FI with complete and accurate encounter data for all levels of healthcare services provided.</p>	<p>Weeet</p>	<p>Weeet</p>	<p>Weeet</p>	<p>We meet this requirement in each of these states. We have the experience, expertise and system capabilities to submit timely, accurate and complete encounters for all levels of services.</p>
<p>How we will apply this experience to the Louisiana CCN program?</p>	<p>Today we meet this requirement in the three example states and in our other seven Medicaid managed care states. We have encounter system implementation and submission best practices to validate data validity for all levels of healthcare services provided (ancillary, acute, and institutional services) prior to submitting encounter data to DHH:</p> <ol style="list-style-type: none"> 1. The QNXT™ system verifies that all necessary claims fields are populated with values of the appropriate range and type prior to the encounter information being loaded onto the EMS. 2. Encounter data files from vendor sources go through a staging process. The staging process consists of automated and manual verification, to validate that files have the proper layout and the appropriate fields populated. In this staging process, correct files are allowed to pass; pending files are corrected if there are correctable errors, or are rejected if the errors cannot be corrected. This staging process results in only the cleanest files being imported into the EMS. 3. After data from QNXT™ and vendor sources are loaded into the EMS, they must pass the EMS Scrub Edits, which are customized based on DHH's requirements for clean encounters. Files that are unlikely to pass the DHH's edits are not submitted until they are corrected. Encounter Unit analysts take responsibility for the correction. This proactive approach to identifying and correcting errors 			



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Requirement	Delaware	Florida	Maryland	Explanation
<p>17.5.4.4 The CCN shall have the ability to update CPT/HCPCS, ICD-9-CM, and other codes based on HIPAA standards and move to future versions as required.</p>	Meets	Meets	Meets	<p>We have in each of these states updated CPT/HCPCS, ICD-9-CM and other codes in accordance with HIPAA standards and the Medicaid agencies' requirements and specifications. In addition, we continually meet the requirements of these Medicaid agencies' to update fee schedules and other system modifications. We have designed our controls, processes and standards to modify CPT/HCPCS, ICD-9-CM, include protocols to thoroughly test these modifications to confirm transitional accuracy.</p>
<p>How we will apply this experience to the Louisiana CCN program?</p>	<p>Each of the states Aetna Better Health provides Medicaid managed care have different nuisances in the capture and reporting of encounter data. We have uniform written policies and procedures and system protocols that we apply to maintain compliance with, but separation on a state-by-state basis, these encounter reporting requirements. Aetna Better Health maintains strict compliance with updates regarding <i>Current Procedural Terminology (CPT)</i>, the <i>Healthcare Procedural Coding System (HCPCS)</i> (CPT/HCPCS), and ICD-9-CM and other codes in accordance with HIPAA standards so that claims and resulting encounters are processed in an orderly and consistent manner. CPT procedural codes are published by the American Medical Association (AMA). Updated annually on January 1, CPT is a proprietary terminology created and maintained by the AMA. Its purpose is to provide a uniform language for describing and reporting the professional services provided by physicians.</p> <p>HCPCS is maintained by the Centers for Medicare and Medicaid Services (CMS). Its purpose is to provide a system for reporting the medical services provided to Medicaid/Medicare members. HCPCS is made up of two parts: Level I is composed entirely of the current version of CPT; HCPCS Level II provides codes to represent medical services that are not covered by the CPT system, for example, medical supplies and services performed by healthcare professionals who are not physicians. The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other healthcare professionals. Healthcare professionals use the CPT to identify services and procedures they bill to Aetna Better Health for covered and medically necessary services. We understand that decisions regarding the addition, deletion, or revision of CPT codes are made by the</p>			

Requirement	Delaware	Florida	Maryland	Explanation
				<p>AMA. The CPT codes are republished and updated annually by the AMA. Level I of the HCPCS, the CPT codes, does not include codes needed to separately report medical items or services that are regularly billed by suppliers other than physicians. We are aware that HCPCS Level II is a standardized coding system to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DME) when used outside a physician's office. Because most Medicaid agencies, including DHH, require mandatory coverage of a variety of services, supplies, and equipment that are not identified by CPT codes, the level II HCPCS codes were established by CMS for submitting claims for these items. Currently, there are national HCPCS codes representing over 4,000 separate categories of like items or services that encompass millions of products from different manufacturers. When submitting claims, we require our provider to use one of these codes to identify the items they are billing. The descriptor that is assigned to a code represents the definition of the items and services that can be billed using that code. For these reasons and to provide timely, accurate and complete encounters to the Medicaid agencies we provide managed care service to, we closely monitor and maintain compliance with the most current CPT/HCPCS coding requirements and stipulations. We also have written policies and procedures that require informing our provider network of CPT/HCPCS coding modifications that are effective as of a date-of-service to avoid unnecessary delays, confusion or problems in submitting complete, accurate and timely encounters to DHH and other Medicaid agencies.</p> <p>In addition to the above we also closely monitor and remain compliant with the following requirements:</p> <ul style="list-style-type: none"> • <u>Permanent National Codes</u> - National permanent HCPCS level II codes are maintained by the CMS HCPCS Workgroup • <u>Miscellaneous Codes</u> - National codes also include "miscellaneous/not otherwise classified" codes. These codes are used when a supplier is submitting a bill for an item or service and there is no existing national code that adequately describes the item or service being billed. • <u>Temporary National Codes</u> - Temporary codes are for the purpose of meeting, within a short time frame, the national program operational needs that are not addressed by an already existing national code. We are aware that and monitor the CMS HCPCS Workgroup has set aside certain sections of the HCPCS code set to allow the Workgroup to develop temporary codes.

Requirement	Delaware	Florida	Maryland	Explanation
	<ul style="list-style-type: none"> • <u>Types of temporary HCPCS codes:</u> <ul style="list-style-type: none"> ○ The C codes were established to permit implementation of section 201 of the Balanced Budget Refinement Act of 1999. ○ The Q codes are used to identify services that would not be given a CPT-4 code, such as drugs, biologicals, and other types of medical equipment or services, and which are not identified by national level II codes but for which codes are needed for claims processing purposes. ○ The G codes are used to identify professional healthcare procedures and services that would otherwise be coded in CPT-4 but for which there are no CPT-4 codes. ○ The K codes were established for use by the DME MACs when the currently existing permanent national codes do not include the codes needed to implement a DME MAC medical review policy. ○ The S codes are used by private insurers to report drugs, services, and supplies for which there are no national codes but for which codes are needed by the private sector to implement policies, programs, or claims processing. ○ Certain H codes are used by those State Medicaid agencies that are mandated by State law to establish separate codes for identifying mental health services such as alcohol and drug treatment services. ○ The T codes are designated for use by Medicaid State agencies to establish codes for items for which there are no permanent national codes and for which codes are necessary to meet a national Medicaid program operating need. • <u>Code Modifiers</u> - In some instances, Medicaid agencies instruct Aetna Better Health to require its providers to require a <i>code modifier</i> to a HCPCS code to provide additional information regarding the service or item identified by the HCPCS code. Modifiers are used when the information provided by a HCPCS code descriptor needs to be supplemented to identify specific circumstances that may apply to an item or service. For example, a UE modifier is often used when the item identified by a HCPCS code is "used equipment," a NU modifier is used for "new equipment." The level II HCPCS modifiers are either alpha-numeric or two letters. • <u>HCPCS Updates to Permanent National Codes</u> – We are aware that the national codes are updated annually 	<p>CPT Category II Codes - We are aware that CPT Category II codes are supplemental tracking codes used for performance measurement. These tracking codes for performance measurement decrease the need for record abstraction and chart review, and thereby minimize administrative burdens on</p>		



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Requirement	Delaware	Florida	Maryland	Explanation
				<p>physicians and other healthcare professionals. These codes are intended to facilitate data collection about quality of care by coding certain services and/or test results that support performance measures and that have been agreed upon as contributing to good patient care. CPT II codes are maintained and updated by the Performance Measures Advisory Group (PMAG), an advisory body to the CPT Editorial Panel. The PMAG comprises performance measurement experts representing the Agency of Healthcare Research and Quality (AHRQ), the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Committee for Quality Assurance (NCQA) and the Physician Consortium for Performance Improvement.</p> <p>The <i>International Classification of Diseases, Clinical Modification</i>, currently in its ninth revision (ICD-9-CM), is used to describe and report the illnesses, conditions, and injuries of patients who require medical services. ICD-9-CM is made up of a series of numerical and alphanumeric codes and code descriptions that represent very specific illnesses and injuries. Similarly, the services provided by physicians and other healthcare professionals are described and reported by using terminologies and classification systems. The <i>International Classification of Diseases, Clinical Modification</i>, provides a system for coding medical procedures performed in the inpatient departments of hospitals, but two other systems apply to the services provided by physicians and other medical providers in hospital-based outpatient departments, physicians' offices, and other ambulatory settings: the <i>Current Procedural Terminology</i> and the <i>Healthcare Common Procedure Coding System</i>.</p>
<p>17.5.4.5 In addition to CPT, ICD-9-CM and other national coding standards, the use of applicable HCPCS Level II and Category II CPT codes are mandatory, aiding both the CCN and DHH to evaluate performance measures.</p>	Meets	Meets	Meets	<p>We use HCPCS Level II and Category II CPT codes in each of the example states. Our encounter system is fully capable of supporting these and other national coding standards to meet DHH's requirements.</p>
<p>How we will apply this experience to the Louisiana CCN program?</p>	<p>Each of the states Aetna Better Health provides Medicaid managed care have different nuisances in the capture and reporting of encounter data. We have uniform written policies and procedures and system protocols that we apply to maintain compliance with, but separation on a state-by-state basis, these encounter reporting requirements. Aetna Better Health maintains strict compliance with updates regarding <i>Current Procedural Terminology (CPT)</i>, the <i>Healthcare Procedural Coding System (HCPCS) (CPT/HCPCS)</i>, and ICD-9-CM and other codes in accordance with HIPAA standards so that claims and resulting encounters are processed in an orderly and consistent manner. CPT procedural codes are published by the American Medical Association (AMA). Updated annually on</p>			

Requirement	Delaware	Florida	Maryland	Explanation
				<p>January 1, CPT is a proprietary terminology created and maintained by the AMA. Its purpose is to provide a uniform language for describing and reporting the professional services provided by physicians. HCPCS is maintained by the Centers for Medicare and Medicaid Services (CMS). Its purpose is to provide a system for reporting the medical services provided to Medicaid/Medicare members. HCPCS is made up of two parts: Level I is composed entirely of the current version of CPT; HCPCS Level II provides codes to represent medical services that are not covered by the CPT system, for example, medical supplies and services performed by healthcare professionals who are not physicians. The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other healthcare professionals. Healthcare professionals use the CPT to identify services and procedures they bill to Aetna Better Health for covered and medically necessary services. We understand that decisions regarding the addition, deletion, or revision of CPT codes are made by the AMA. The CPT codes are republished and updated annually by the AMA. Level I of the HCPCS, the CPT codes, does not include codes needed to separately report medical items or services that are regularly billed by suppliers other than physicians. We are aware that HCPCS Level II is a standardized coding system to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DME) when used outside a physician's office. Because most Medicaid agencies, including DHH, require mandatory coverage of a variety of services, supplies, and equipment that are not identified by CPT codes, the level II HCPCS codes were established by CMS for submitting claims for these items. Currently, there are national HCPCS codes representing over 4,000 separate categories of like items or services that encompass millions of products from different manufacturers. When submitting claims, we require our provider to use one of these codes to identify the items they are billing. The descriptor that is assigned to a code represents the definition of the items and services that can be billed using that code. For these reasons and to provide timely, accurate and complete encounters to the Medicaid agencies we provide managed care service to, we closely monitor and maintain compliance with the most current CPT/HCPCS coding requirements and stipulations. We also have written policies and procedures that require informing our provider network of CPT/HCPCS coding modifications that are effective as of a date-of-service to avoid unnecessary delays, confusion or problems in submitting complete, accurate and timely encounters to DHH and other Medicaid agencies.</p> <p>In addition to the above we also closely monitor and remain compliant with the following requirements:</p>

Requirement	Delaware	Florida	Maryland	Explanation
				<ul style="list-style-type: none"> • Permanent National Codes - National permanent HCPCS level II codes are maintained by the CMS HCPCS Workgroup • <u>Miscellaneous Codes</u> - National codes also include "miscellaneous/not otherwise classified" codes. These codes are used when a supplier is submitting a bill for an item or service and there is no existing national code that adequately describes the item or service being billed. • <u>Temporary National Codes</u> - Temporary codes are for the purpose of meeting, within a short time frame, the national program operational needs that are not addressed by an already existing national code. We are aware that and monitor the CMS HCPCS Workgroup has set aside certain sections of the HCPCS code set to allow the Workgroup to develop temporary codes. • <u>Types of temporary HCPCS codes:</u> <ul style="list-style-type: none"> ○ The C codes were established to permit implementation of section 201 of the Balanced Budget Refinement Act of 1999. ○ The Q codes are used to identify services that would not be given a CPT-4 code, such as drugs, biologicals, and other types of medical equipment or services, and which are not identified by national level II codes but for which codes are needed for claims processing purposes. ○ The G codes are used to identify professional healthcare procedures and services that would otherwise be coded in CPT-4 but for which there are no CPT-4 codes. ○ The K codes were established for use by the DME MACs when the currently existing permanent national codes do not include the codes needed to implement a DME MAC medical review policy. ○ The S codes are used by private insurers to report drugs, services, and supplies for which there are no national codes but for which codes are needed by the private sector to implement policies, programs, or claims processing. ○ Certain H codes are used by those State Medicaid agencies that are mandated by State law to establish separate codes for identifying mental health services such as alcohol and drug treatment services. ○ The T codes are designated for use by Medicaid State agencies to establish codes for items for which there are no permanent national codes and for which codes are necessary to meet a national Medicaid program operating need. • <u>Code Modifiers</u> - In some instances, Medicaid agencies instruct Aetna Better Health to require its providers to require a <i>code modifier</i> to a HCPCS code to provide additional information regarding the service or item identified by the HCPCS code. Modifiers are used when the information provided by a HCPCS code descriptor needs to be supplemented to identify specific

Requirement	Delaware	Florida	Maryland	Explanation
17.5.4.6 The CCN shall have the capability to convert all information that enters its claims system via hard copy paper claims to electronic encounter data, to be submitted in the appropriate HIPAA compliant formats to DHH's FI.	Meets	Meets	Meets	<p>circumstances that may apply to an item or service. For example, a UE modifier is often used when the item identified by a HCPCS code is "used equipment," a NU modifier is used for "new equipment." The level II HCPCS modifiers are either alpha-numeric or two letters.</p> <ul style="list-style-type: none"> • <u>HCPCS Updates to Permanent National Codes</u> – We are aware that the national codes are updated annually <p>CPT Category II Codes - We are aware that CPT Category II codes are supplemental tracking codes used for performance measurement. These tracking codes for performance measurement decrease the need for record abstraction and chart review, and thereby minimize administrative burdens on physicians and other healthcare professionals. These codes are intended to facilitate data collection about quality of care by coding certain services and/or test results that support performance measures and that have been agreed upon as contributing to good patient care. CPT II codes are maintained and updated by the Performance Measures Advisory Group (PMAG), an advisory body to the CPT Editorial Panel. The PMAG comprises performance measurement experts representing the Agency of Healthcare Research and Quality (AHRQ), the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Committee for Quality Assurance (NCQA) and the Physician Consortium for Performance Improvement.</p> <p>The <i>International Classification of Diseases, Clinical Modification</i>, currently in its ninth revision (ICD-9-CM), is used to describe and report the illnesses, conditions, and injuries of patients who require medical services. ICD-9-CM is made up of a series of numerical and alphanumeric codes and code descriptions that represent very specific illnesses and injuries. Similarly, the services provided by physicians and other healthcare professionals are described and reported by using terminologies and classification systems. The <i>International Classification of Diseases, Clinical Modification</i>, provides a system for coding medical procedures performed in the inpatient departments of hospitals, but two other systems apply to the services provided by physicians and other medical providers in hospital-based outpatient departments, physicians' offices, and other ambulatory settings: the <i>Current Procedural Terminology</i> and the <i>Healthcare Common Procedure Coding System</i>.</p>
	Meets	Meets	Meets	<p>In each of the three states we selected (in fact in each of our states) we have the capability and capacity to convert all the claim information received via hard copy "paper" claims to electronic claims using Optical Character Recognition (OCR) technology. All paper claims are</p>



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Requirement	Delaware	Florida	Maryland	Explanation
				<p>converted to electronic images by our vendor (EMDEON- using their Alchemy program). If the claim cannot be translated into an electronic data record by the OCR process, then the paper claims is sent directly to our claims department for data entry. Each claim is assigned a unique claim number and an electronic file of the claim is created. This file is uploaded into QNXT™ to be accessed by the claims team. The paper claim is in the QNXT™ system within 1 to 3 business days from its receipt. Additionally, the scanned image of the paper claim is stored in an image repository and is viewable to Aetna Better Health personnel, as needed.</p> <p>In addition, Microsoft BizTalk with HIPAA Accelerator™ processes HIPAA-compliant transactions easily and efficiently, allowing Aetna Better Health to accept information electronically from almost any HIPAA-compliant contractor or provider. Microsoft BizTalk with HIPAA Accelerator™ is a data transformation application that translates data to and from the full spectrum of HIPAA Transactions sets in a highly customizable, flexible, and robust server-based environment. Moreover, Accelerator has the Washington Publishing Company (WPC) Implementation Guide schemas for each HIPAA ANSI X12 transaction embedded directly into its application engine, including a facility to update these schemas automatically as the Transactions sets are updated over time.</p> <p>Also, Foresight HIPAA Validator™ InStream™ a fully functional HIPAA editing and validation application. It can validate HIPAA transactions through all seven levels of edits as defined by the Workgroup for Electronic Data Interchange and Strategic National Implementation Process (WEDI/SNIP), has all standard HIPAA code sets embedded, and can support custom, trading-partner-</p>



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<p>How we will apply this experience to the Louisiana CCN program?</p>				<p>specific companion guides and validation requirements. In addition, it supports validation at the individual edit level, allowing Aetna Better Health to accept all compliant records that pass at a lower level of edit, rather than requiring all seven levels of edits. The application also provides descriptive error reports to submitters to facilitate quick error resolution.</p>
<p>17.5.4.7 The FI encounter process shall utilize a DHH-approved version of the claims processing system (edits and adjudication) to identify valid and invalid encounter records from a batch submission by the CCN. Any submission which contains fatal errors that prevent processing, or that does not satisfy defined threshold error rates, will be rejected and returned to the CCN for immediate correction.</p>	Meets	Meets	Meets	<p>The procedures described above are uniformly and consistently applied in our other 10 Medicaid managed care operations. These processes will be applied to the Louisiana CCN program. We have experience supporting providers transitioning from fee-for-service to Medicaid managed care and in shifting providers from submitting paper claims to electronic claims. We will apply this experience to the Louisiana CCN program. We expect that initially we may experience a high volume of paper claim submission, but we will systematically target and reduce this practice.</p> <p>We understand and agree that the FI encounter process will use a DHH approved version of system edits to identify valid and invalid encounter records. Every state Medicaid agency, including the three selected as our sample, has similar requirements. Our approach is to get documentation from the FI regarding the approved edits and adjudication requirements and specifically design our encounter submission process to transmit timely, accurate and complete encounters consistent with these requirements to avoid confusion and unnecessary cost. Our best practice is to meet frequently with the Medicaid agency and the FI to provide full understanding of design, intent and application of these edits and adjudication process during the system design and testing phase. We will validate our compliance during readiness review and system testing activities.</p> <p>We understand and agree to this stipulation. The state Medicaid agencies regulating the three health plans we selected as an example have similar requirements; in fact,</p>



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Requirement	Delaware	Florida	Maryland	Explanation
<p>How we will apply this experience to the Louisiana CCN program?</p>				<p>it is our experience that this is a common stipulation.</p>
<p>17.5.4.8 DHH and its FI shall determine which claims processing edits are appropriate for encounters and shall set encounter edits to "pay" or "deny". Encounter denial codes shall be deemed "repairable" or "non-repairable". An example of a repairable encounter is "provider invalid for date of service". An example of a non-repairable encounter is "exact duplicate". The CCN is required to be familiar with the FI exception</p>	<p>Meets</p>	<p>Meets</p>	<p>Meets</p>	<p>Today we meet these requirements in the three example states and in our other seven Medicaid managed care states. We have encounter system implementation and submission best practices to validate data validity for all levels of healthcare services provided (ancillary, acute, and institutional services) prior to submitting encounter data to DHH:</p> <ol style="list-style-type: none"> 1. The QNXT™ system verifies that all necessary claims fields are populated with values of the appropriate range and type prior to the encounter information being loaded onto the Encounter Management System. 2. Encounter data files from vendor sources go through a staging process. The staging process consists of automated and manual verification, to validate that files have the proper layout and the appropriate fields populated. In this staging process, correct files are allowed to pass; pending files are corrected if there are correctable errors, or are rejected if the errors cannot be corrected. This staging process results in only the cleanest files being imported into the EMS. 3. After data from QNXT™ and vendor sources are loaded into the EMS, they must pass the EMS Scrub Edits, which are customized based on DHH's requirements for clean encounters. Files that are unlikely to pass the DHH's edits are not submitted until they are corrected. Encounter Unit analysts take responsibility for the correction. This proactive approach to identifying and correcting errors prior to the submission of data to the Commonwealth expedites review and adjudication

Requirement	Delaware	Florida	Maryland	Explanation
<p>codes and dispositions for the purpose of repairing denied encounters.</p>				<p>consistent with these requirements to avoid confusion and unnecessary cost. Our best practice is to meet frequently with the Medicaid agency and the FI to provide full understanding of design, intent and application of these edits and adjudication process during the system design and testing phase. We will validate our compliance during readiness review and system testing activities.</p> <p>We understand and agree to this stipulation. The state Medicaid agencies regulating the three health plans we selected as an example have similar requirements; in fact, it is our experience that this is a common stipulation. We have protocols to effectively and efficiently respond to these features.</p> <p>We understand and agree to this stipulation. Our expert team of encounter specialists have already reviewed DHH's system guide and compared it to similar guides from other Medicaid agencies. Each of the states selected to represent our universe of encounter systems have similar requirements.</p>
<p>How we will apply this experience to the Louisiana CCN program?</p>	<p>Today we meet this requirement in the three example states and in our other seven Medicaid managed care states. We have encounter system implementation and submission best practices to validate data validity for all levels of healthcare services provided (ancillary, acute, and institutional services) prior to submitting encounter data to DHH:</p> <ol style="list-style-type: none"> 1. The QNXT™ system verifies that all necessary claims fields are populated with values of the appropriate range and type prior to the encounter information being loaded onto the EMS. 2. Encounter data files from vendor sources go through a staging process. The staging process consists of automated and manual verification, to validate that files have the proper layout and the appropriate fields populated. In this staging process, correct files are allowed to pass; pending files are corrected if there are correctable errors, or are rejected if the errors cannot be corrected. This staging process results in only the cleanest files being imported into the EMS. 3. After data from QNXT™ and vendor sources are loaded into the EMS, they must pass the EMS 			

Requirement	Delaware	Florida	Maryland	Explanation
<p>17.5.4.9 As specified in the CCN-P Systems Companion Guide, denials for the following reasons will be of particular interest to DHH:</p> <ul style="list-style-type: none"> • Denied for Medical Necessity including lack of documentation to support necessity; • Member has other insurance that must be billed first; • Prior authorization not on file; • Claim submitted after filing deadline; and • Service not covered by CCN. 	Meets	Meets	Meets	<p>We share DHH's interest in these denial reasons. Each of these denial reasons indicates an issue with our provider documentation, communication and training protocols. Especially if there are participating providers with a pattern of these denials and we fail to take corrective action. Aetna Better Health uses the results of claims adjudication – especially denial – to assess our performance and responsiveness to minimal provider service protocols.</p>
<p>How we will apply this experience to the Louisiana CCN program?</p>	Meets	Meets	Meets	<p>We monitor denial reasons in our three example states in our other seven dates as a tool to determine if our training, processes, protocols or operations require performance improvement. We also monitor denial reasons to determine if a provider may need with assistance with filing claims appropriately or in following our established protocols. We train and inform providers of our claims requirements and specification in the Provider Manual, Provider Newsletters and initial/on-going provider training events. We use the PDSA approach to monitor and adjust our processes and procedures. Establishing a positive working relationship with participating and non-participating providers is a priority. Aetna Better Health has never, nor will we ever, use deliberate claims mishandling or claim denials as a method to delay or avoid payment of claims.</p>
<p>17.5.4.10 The CCN shall utilize DHH provider billing manuals and become familiar with the claims data elements that must be included in encounters. The CCN shall retain all required data elements in claims history for the purpose of creating encounters that are</p>	Meets	Meets	Meets	<p>We understand and agree to this stipulation. Our expert team of claims system developers and encounter system design specialists have already reviewed DHH's system guide and compared it to similar guides from other Medicaid agencies. Each of the states selected to represent our universe of encounter systems have similar</p>



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Requirement	Delaware	Florida	Maryland	Explanation
compatible with DHH and its FI's billing requirements.				requirements. We understand and agree to this stipulation. We have standard operating procedures related to the retaining and storage of claims and encounter history and data. Our expert team of claims system developers and encounter system design specialists have already reviewed DHH's system guide and compared it to similar guides from other Medicaid agencies. . .
How we will apply this experience to the Louisiana CCN program?	Aetna Better Health applies the state Medicaid agency's billing and encounter specific requirements to our internal processes in the three example states and in each of our other states. We understand that processing and data errors create unnecessary and administrative burdensome problems and additional administrative costs for both DHH and ourselves. Therefore, we adhere to performance standards to reduce (goal is to eliminate) issues related to failing to adhere to DHH's stipulations and requirements.			
17.5.4.11 Due to the need for timely data and to maintain integrity of processing sequence, the CCN shall address any issues that prevent processing of an encounter; acceptable standards shall be ninety percent (90%) of reported repairable errors are addressed within thirty (30) calendar days and ninety-nine percent (99%) of reported repairable errors within sixty (60) calendar days or within a negotiated timeframe approved by DHH. Failure to promptly research and address reported errors, including submission of and compliance with an acceptable corrective action plan may result in monetary penalties.	Meets	Meets	Meets	We understand and agree to this stipulation. The state Medicaid agencies regulating the three health plans we selected as an example have similar requirements; in fact, it is our experience that this is a common stipulation. For the period ending May 1, 2011, our encounter acceptance rates are as follows: Delaware: Professional 98.13% - Institutional 99.97 Florida: Professional 99.00% - Institutional 98.72 - NCPDP 98.00% Maryland: Professional 98.62% - Institutional 98.72%
How we will apply this experience to the Louisiana CCN program?	Based on the performance statistics provided above it is apparent that Aetna Better Health meets DHH's requirements in the three example states and in each of the other seven states. We will apply the management principles and administrative discipline that supports our record of excellence in this area to the Louisiana CCN program.			



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Requirement	Delaware	Florida	Maryland	Explanation
17.5.4.12 For encounter data submissions, the CCN shall submit ninety-five (95%) of its encounter data at least monthly due no later than the twenty-fifth (25th) calendar day of the month following the month in which they were processed and approved/paid, including encounters reflecting a zero dollar amount (\$0.00) and encounters in which the CCN has a capitation arrangement with a provider. The CCN CEO or CFO shall attest to the truthfulness, accuracy, and completeness of all encounter data submitted.	Meets	Meets	Meets	We understand and agree to this stipulation. The state Medicaid agencies regulating the three health plans we selected as an example have similar requirements; in fact, it is our experience that this is a common stipulation. For the period ending May 1, 2011, our encounter acceptance rates are as follows: Delaware: Professional 98.13% - Institutional 99.97 Florida: Professional 99.00% - Institutional 98.72 - NCPDP 98.00% Maryland: Professional 98.62% - Institutional 98.72%
How we will apply this experience to the Louisiana CCN program?	Based on the performance statistics provided above it is apparent that Aetna Better Health meets DHH's requirements in the three example states and in each of the other seven states. We will apply the management principles and administrative discipline that supports our record of excellence in this area to the Louisiana CCN program.			
17.5.4.13 The CCN shall ensure that all encounter data from a contractor is incorporated into a single file from the CCN. The CCN shall not submit separate encounter files from CCN contractors.	Meets	Meets	Meets	We understand and agree to this stipulation. The state Medicaid agencies regulating the three health plans we selected as an example have similar requirements; in fact, it is our experience that this is a common stipulation.
How we will apply this experience to the Louisiana CCN program?	In each of our example states and in our seven other states we have capitated providers or we receive encounters from a provider we delegate claims processing authority and responsibility. Generally (depending on the state's schedule of carved out services and/or specific service limitations or benefit restrictions) we limited capitation to dental and vision providers. We also may capitate a transportation vendor with an outstanding record of meeting service standards and specifications. We also delegate claims adjudication authority to our pharmacy benefit manager. However, in the Louisiana CCN instance both dental and pharmacy are carved out services. Regardless, our standard operating procedure is to require any provider that submits encounters must meet strict testing guidance and requirements. As part of our testing protocols with DHH we will adequately test the validity of our vision provider's encounter processing at the same time we test our own compliance.			

Requirement	Delaware	Florida	Maryland	Explanation
<p>17.5.4.14 The CCN shall ensure that files contain settled claims and claim adjustments or voids, including but not limited to, adjustments necessitated by payment errors, processed during that payment cycle, as well as encounters processed during that payment cycle from providers with whom the CCN has a capitation arrangement.</p> <p>How we will apply this experience to the Louisiana CCN program?</p>	Meets	Meets	Meets	<p>We understand and agree to this stipulation. The state Medicaid agencies regulating the three health plans we selected as an example have similar requirements; in fact, it is our experience that this is a common stipulation.</p>
<p>How we will apply this experience to the Louisiana CCN program?</p>	<p>Aetna Better Health's standard operating procedure is to submit an adjusted, in accordance with DHH's requirements, encounter in these circumstances. We will adopt, apply and adhere to DHH's administrative and encounter coding and submission requirements related to this requirement. Our written policy and procedures and operating manuals are specifically designed to meet this requirement. Furthermore, we require each capitated or delegated provider to meet these requirements and will test compliance during readiness review. We recommend that DHH develop encounter testing protocols to include examples of these requirements to assure its self that Aetna Better Health meets this stipulation.</p>			
<p>17.5.4.15 The CCN shall ensure the level of detail associated with encounters from providers with whom the CCN has a capitation arrangement shall be equivalent to the level of detail associated with encounters for which the CCN received and settled a fee-for-service claim.</p> <p>How we will apply this experience to the Louisiana CCN program?</p>	Meets	Meets	Meets	<p>We understand and agree to this stipulation. The state Medicaid agencies regulating the three health plans we selected as an example have similar requirements; in fact, it is our experience that this is a common stipulation.</p>
<p>How we will apply this experience to the Louisiana CCN program?</p>	<p>Aetna Better Health's standard operating procedure is to submit an adjusted, in accordance with DHH's requirements, encounter in these circumstances. We will adopt, apply and adhere to DHH's administrative and encounter coding and submission requirements related to this requirement. Our written policy and procedures and operating manuals are specifically designed to meet this requirement. Furthermore, we require each capitated or delegated provider to meet these requirements and will test compliance during readiness review. We recommend that DHH develop encounter testing protocols to include examples of these requirements to assure itself that Aetna Better Health meets this stipulation.</p>			



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Requirement	Delaware	Florida	Maryland	Explanation
<p>17.5.4.16 The CCN shall adhere to federal and/or department payment rules in the definition and treatment of certain data elements, such as units of service that are a standard field in the encounter data submissions and will be treated similarly by DHH across all CCNs.</p> <p>How we will apply this experience to the Louisiana CCN program?</p>	Meets	Meets	Meets	<p>We understand and agree to this stipulation. The state Medicaid agencies regulating the three health plans we selected as an example have similar requirements; in fact, it is our experience that this is a common stipulation.</p>
<p>17.5.4.17 Encounter records shall be submitted such that payment for discrete services which may have been submitted in a single claim can be ascertained in accordance with the CCNs applicable reimbursement methodology for that service.</p> <p>How we will apply this experience to the Louisiana CCN program?</p>	Meets	Meets	Meets	<p>Aetna Better Health meets a similar requirement in each of the three example states. The procedures described above are uniformly and consistently applied in our other 10 Medicaid managed care operations. These processes will be applied to the Louisiana CCN program. We have experience supporting providers transitioning from fee-for-service to Medicaid managed care and in shifting providers from submitting paper claims to electronic claims. Our expert team of claims system developers and encounter system design specialists have already reviewed DHH's system guide and compared it to similar guides from other Medicaid agencies</p> <p>We understand and agree to this stipulation. The state Medicaid agencies regulating the three health plans we selected as an example have similar requirements; in fact, it is our experience that this is a common stipulation.</p>
<p>17.5.4.17 Encounter records shall be submitted such that payment for discrete services which may have been submitted in a single claim can be ascertained in accordance with the CCNs applicable reimbursement methodology for that service.</p> <p>How we will apply this experience to the Louisiana CCN program?</p>	Meets	Meets	Meets	<p>Aetna Better Health meets a similar requirement in each of the three example states. The procedures described above are uniformly and consistently applied in our other 10 Medicaid managed care operations. These processes will be applied to the Louisiana CCN program. We have experience supporting providers transitioning from fee-for-service to Medicaid managed care and in shifting providers from submitting paper claims to electronic claims. Our expert team of claims system developers and encounter system design specialists have already reviewed DHH's system guide and compared it to similar guides from other Medicaid agencies</p>

Challenges and Lessons Learned

Implementing a new encounter system, especially with a State Medicaid State Agency that is new to managed care, can be a challenge. There are three primary lessons we have learned as a result of the last three Medicaid managed care implementations. These are:

There must be open communication between DHH's FI and Aetna Better Health on the implementation. The old cliché is "if you've seen one Medicaid program, you've seen one Medicaid program" also applies to Medicaid managed care health plans and their encounter systems. Aetna Better Health is fully committed to aligning its encounter program to meet the needs of DHH and its FI. However, due to the complexity of encounter systems we recommend there be frequent and meaningful communication regarding design, development, implementation, and testing. We have discovered that regularly scheduled meeting between with the Medicaid agency and their agent (FI) and the CCN is one of the most meaningful communication methods. This way both parties can ask questions, review incremental test results and provide insight and direction. To facilitate these meetings and support communication we further recommend that DHH's FI assign a project manager or equivalent level professional to work with each CCN. This will help avoid unnecessary confusion or errors.

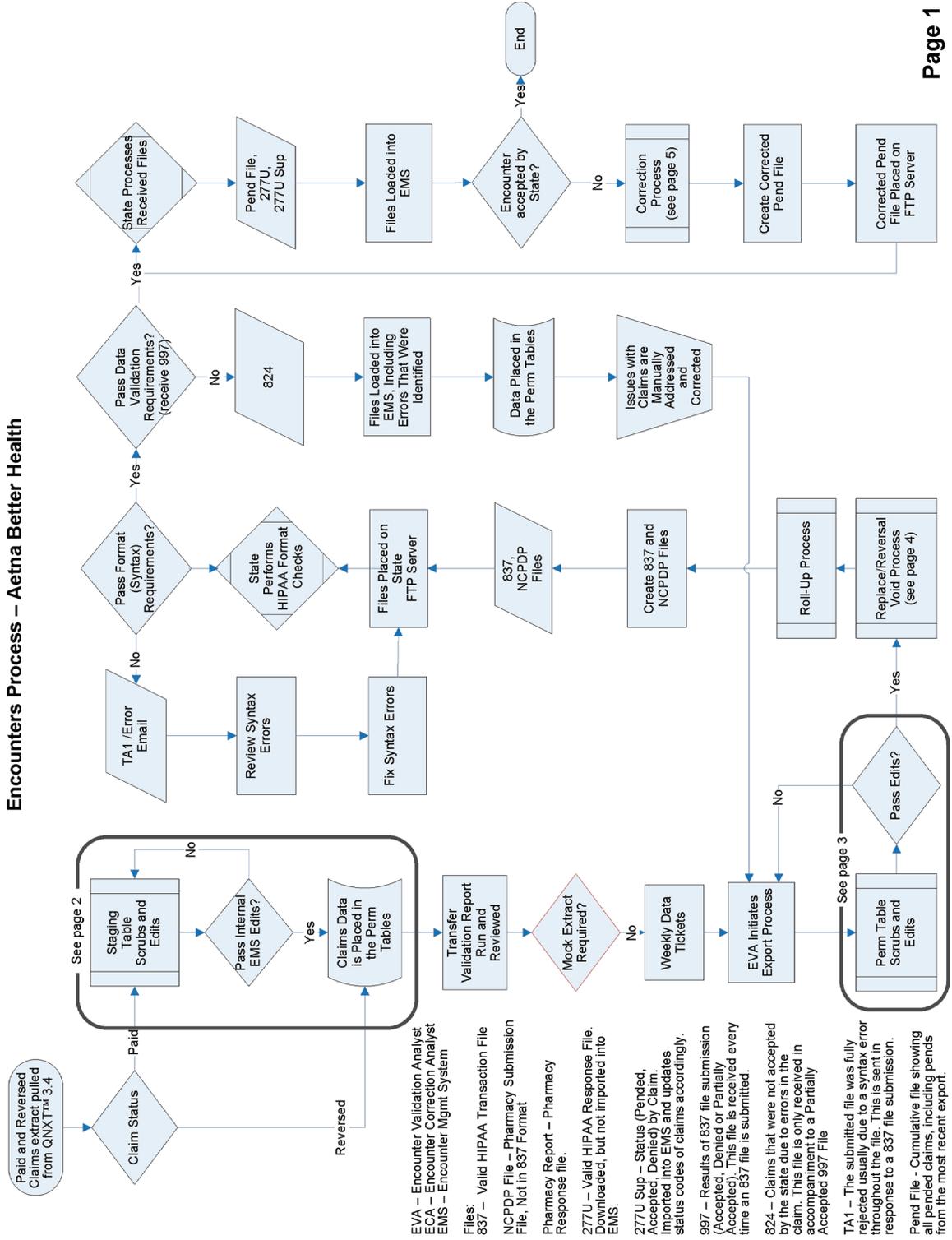
DHH and its FI should set realistic encounter system development and testing timeline and goals. These timelines and goals should be as stable as possible once the development and testing process begins.

DHH and its FI should, once the development and testing process begins, avoid adjusting encounter system requirements, program design elements, reports and coding specifications. Stability in the design environment is critical to remain on target for quality and timeliness of development and testing.

Aetna Better Health is aware that changes in the timeline, requirements, design, reporting and coding are inevitable in a project of this size and complexity. The impact on the quality, timeframe and cost can be mitigated by working together and through close communication. Our QNXT™ and Encounter Management System (EMS) are responsive and flexible to meet DHH's needs and requirements. These systems provide a state-of-the-art platform that can keep pace with the multiple enhancements that are expected as healthcare reform is implemented.

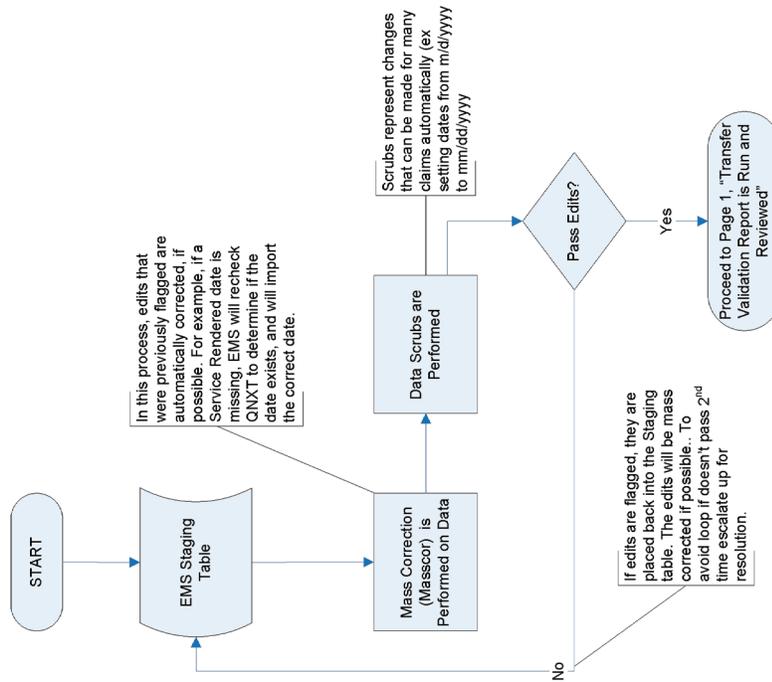
Aetna Better Health will assign an encounter development team to the Louisiana CCN implementation. This development team will be led by a senior manager of our organization and include representatives of our key operational units responsible for encounter management. Included on this team will be veterans from our last three implementations that will offer insight, knowledge and experience to DHH and its FI. DHH and its FI will have a highly dedicated and responsible encounter development team to manage this encounter system implementation.

Encounters Process – Aetna Better Health

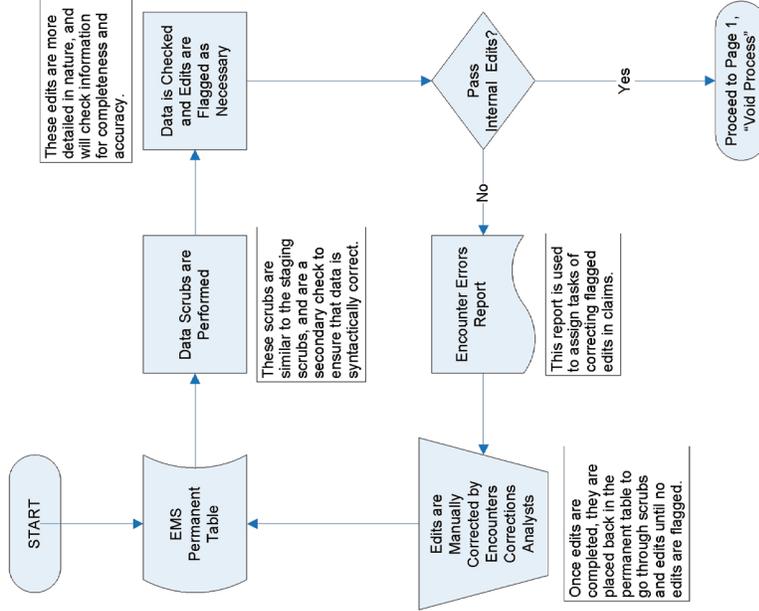


EVA – Encounter Validation Analyst
 ECA – Encounter Correction Analyst
 EMS – Encounter Mgmt System
 Files:
 837 – Valid HIPAA Transaction File
 NCPDP File – Pharmacy Submission File, Not in 837 Format
 Pharmacy Report – Pharmacy Response file.
 277U – Valid HIPAA Response File. Downloaded, but not imported into EMS.
 277U Sup – Status (Pended, Accepted, Denied) by Claim. Imported into EMS and updates status codes of claims accordingly.
 997 – Results of 837 file submission (Accepted, Denied or Partially Accepted). This file is received every time an 837 file is submitted.
 824 – Claims that were not accepted by the state due to errors in the claim. This file is only received in accompaniment to a Partially Accepted 997 File
 TA1 – The submitted file was fully rejected usually due to a syntax error throughout the file. This is sent in response to a 837 file submission.
 Pend File - Cumulative file showing all pended claims, including pends from the most recent export.

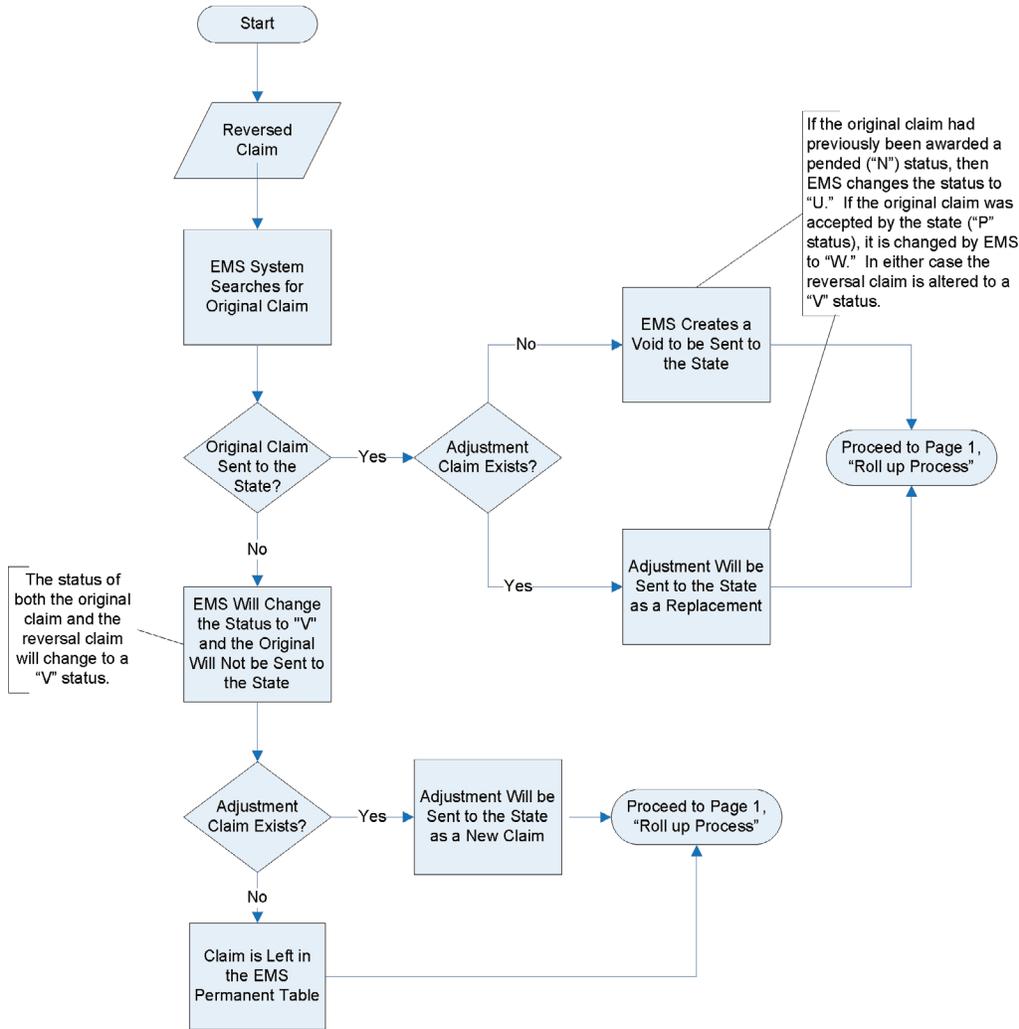
Staging Table Scrubs and Edits Process



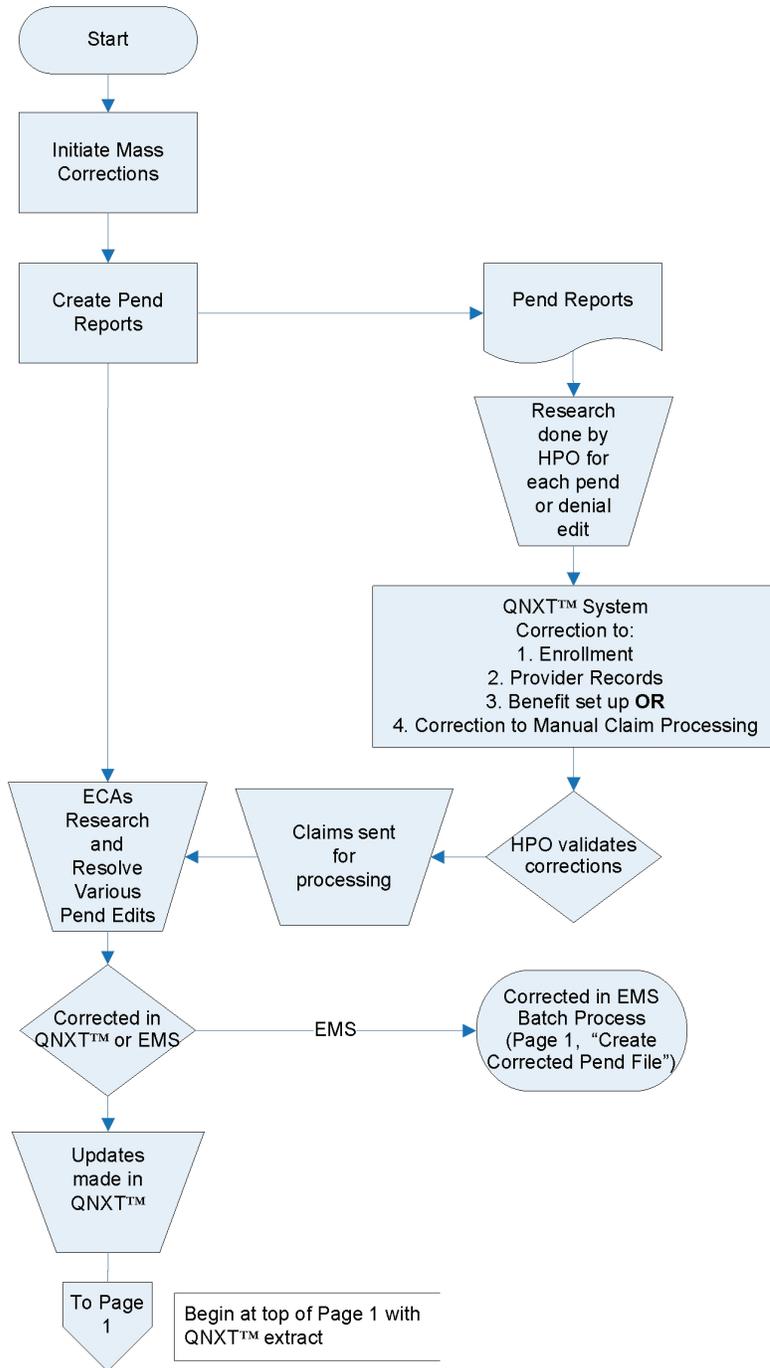
Permanent Table Scrubs and Edits Process



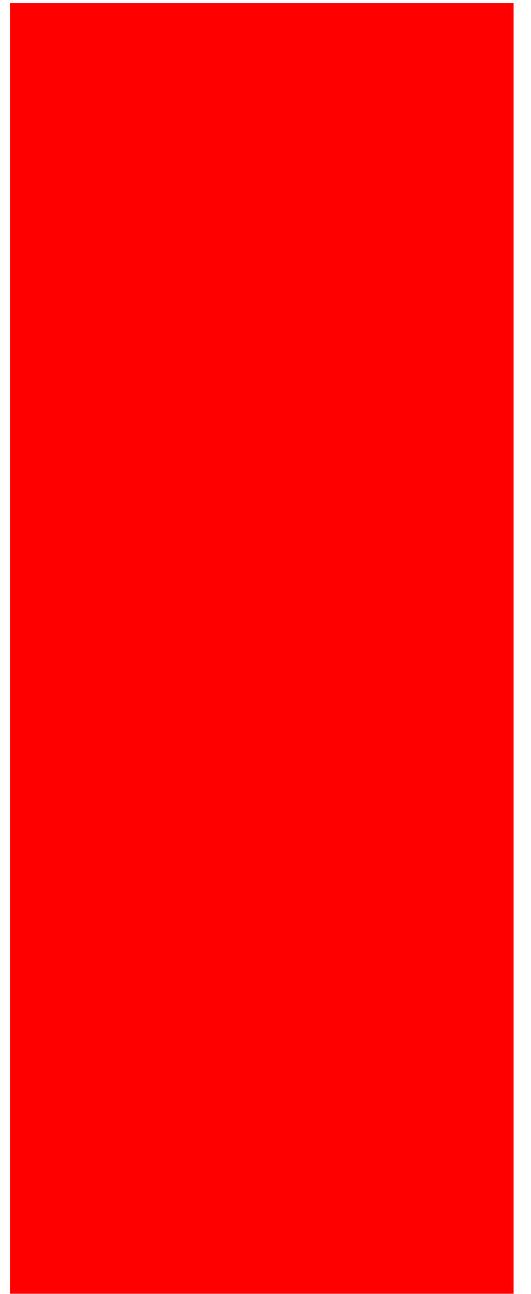
Reversal/Replace (Void Process)



Correction Process



123 R.6



R.6 Describe your ability to receive, process, and update eligibility/enrollment, provider data, and encounter data to and from the Department and its agents. In your response:

- Explain whether and how your systems meet (or exceed) each of these requirements.
- Cite at least three currently-live instances where you are successfully receiving, processing and updating eligibility/enrollment data in accordance with DHH coding, data exchange format and transmission standards and specifications or similar standards and specifications. In elaborating on these instances, address all of the requirements in Section 16 and 17, and CCN-P systems companion guide. Also, explain how that experience will apply to the Louisiana Medicaid CCN Program.
- If you are not able at present to meet a particular requirement contained in the aforementioned sections, identify the applicable requirement and discuss the effort and time you will need to meet said requirement.

Identify challenges and “lessons learned” from implementation in other states and describe how you will apply these lessons to this contract.

Aetna Better Health, as described below, meets each of DHH’s requirements and has the ability and capacity to receive, process and update eligibility/enrollment, provider data, and encounter data from DHH and its agents. We have selected Delaware, Florida and Maryland as representative states. We discuss challenges and lessons learned following the tables.

Eligibility Data Functionality/Requirement	Delaware	Florida	Maryland
Maintain “real time” data connectivity to data source	We maintain “real time” data connectivity to the data source for the purpose of receiving, processing, updating and exchanging data with the State.	We maintain “real time” data connectivity to the data source for the purpose of receiving, processing, updating and exchanging data with the State	We maintain “real time” data connectivity to the data source for the purpose of receiving, processing, updating and exchanging data with the State
Data Source(s)	The source for eligibility data is the State.	The source for eligibility data is the State	The source for eligibility data is the State
Frequency of receipt	Daily receipt of adds, deletes (terms) and changes. Month end reconciliation. -- File Transfer: Aetna Better Health prefers to have the state push the files to us. Aetna Better Health can accommodate a "pull"	Daily receipt of adds, deletes (terms) and changes. Month end reconciliation. -- File Transfer: Aetna Better Health prefers to have the state push the files to us. Aetna Better Health can accommodate a "pull"	Daily receipt of adds, deletes (terms) and changes. Month end reconciliation. -- File Transfer: Aetna Better Health prefers to have the state push the files to us. Aetna Better Health can accommodate a "pull"

Eligibility Data Functionality/Requirement	Delaware	Florida	Maryland
	<p>strategy in which we go out and retrieve the files. However, the preference is to have the files sent (aka - pushed) to us. We can also perform manual daily website retrievals (once again, not our preference).</p> <p>--Frequency: We prefer Mon - Fri daily add/change files. We can accommodate daily changes 7 days a week. We prefer to reconcile once a month, but we can accommodate a more frequent reconciliation.</p> <p>--Loading: We load eligibility files daily Mon - Fri. Usually, files received over the weekend are loaded on Monday. We load files in sequential order. If we received a file out of sequence, we will hold the file until the sequence issue is resolved.</p> <p>--Timing: Our preference for eligibility processing is between 5:30 - 8:00 am (AZ time).</p> <p>--Processing: We process adds, changes, and terminations on a daily basis.</p>	<p>strategy in which we go out and retrieve the files. However, the preference is to have the files sent (aka - pushed) to us. We can also perform manual daily website retrievals (once again, not our preference).</p> <p>--Frequency: We prefer Mon - Fri daily add/change files. We can accommodate daily changes 7 days a week. We prefer to reconcile once a month, but we can accommodate a more frequent reconciliation.</p> <p>--Loading: We load eligibility files daily Mon - Fri. Usually, files received over the weekend are loaded on Monday. We load files in sequential order. If we received a file out of sequence, we will hold the file until the sequence issue is resolved.</p> <p>--Timing: Our preference for eligibility processing is between 5:30 - 8:00 am (AZ time).</p> <p>--Processing: We process adds, changes, and terminations on a daily basis.</p>	<p>strategy in which we go out and retrieve the files. However, the preference is to have the files sent (aka - pushed) to us. We can also perform manual daily website retrievals (once again, not our preference).</p> <p>--Frequency: We prefer Mon - Fri daily add/change files. We can accommodate daily changes 7 days a week. We prefer to reconcile once a month, but we can accommodate a more frequent reconciliation.</p> <p>--Loading: We load eligibility files daily Mon - Fri. Usually, files received over the weekend are loaded on Monday. We load files in sequential order. If we received a file out of sequence, we will hold the file until the sequence issue is resolved.</p> <p>--Timing: Our preference for eligibility processing is between 5:30 - 8:00 am (AZ time).</p> <p>--Processing: We process adds, changes, and terminations on a daily basis.</p>

Eligibility Data Functionality/Requirement	Delaware	Florida	Maryland
Transmission method	Electronic data transmission from the State to a secure FTP site	Electronic data transmission from the State to a secure FTP site	Electronic data transmission from the State to a secure FTP site
Transmission standard* *Please see a detailed EDI eligibility flow chart at the end of this section.	Aetna Better Health meets this State's transmission standards – both incoming and outgoing standards are met. Aetna Better Health can accommodate DHH's transmission standards, file formats, compression techniques, data formats and transmission protocols. Aetna Better Health will work with DHH's MMIS vendor during testing to meet transmission standards.	Aetna Better Health meets this State's transmission standards – both incoming and outgoing standards are met. Aetna Better Health can accommodate DHH's transmission standards, file formats, compression techniques, data formats and transmission protocols. Aetna Better Health will work with DHH's MMIS vendor during testing to meet transmission standards.	Aetna Better Health meets this State's transmission standards – both incoming and outgoing standards are met. Aetna Better Health can accommodate DHH's transmission standards, file formats, compression techniques, data formats and transmission protocols. Aetna Better Health will work with DHH's MMIS vendor during testing to meet transmission standards.
HIPPA standard code set (specify)	ASC X12N 834 Benefit Enrollment and Maintenance	ASC X12N 834 Benefit Enrollment and Maintenance	ASC X12N 834 Benefit Enrollment and Maintenance
Account for and track: <ul style="list-style-type: none"> Member ID Number Mailing Address Telephone number Head of household Rate code Age (Date of Birth) Sex PCP assignment Primary language (if other than English) 	<ul style="list-style-type: none"> Yes Yes Yes Yes Yes Yes Yes Yes <p>These data are identified, retained and tracked in the QNXT™ system. We maintain integrity of these data through data mapping procedures.</p>	<ul style="list-style-type: none"> Yes Yes Yes Yes Yes Yes Yes Yes <p>These data are identified, retained and tracked in the QNXT™ system. We maintain integrity of these data through data mapping procedures.</p>	<ul style="list-style-type: none"> Yes Yes Yes Yes Yes Yes Yes Yes <p>These data are identified, retained and tracked in the QNXT™ system. We maintain integrity of these data through data mapping procedures.</p>

Eligibility Data Functionality/Requirement	Delaware	Florida	Maryland
Update eligibility record in QNXT™ within 24 hours?	Yes	Yes	Yes
Inform State/Agent of member changes (Addresses, Telephone Number, Household adjustment)	Yes	Yes	Yes
Identify possible duplicate eligibility records <ul style="list-style-type: none"> o Correct records if required 	A standard routine is applied to each eligibility file to determine if there are duplicate records. If we identify a potential duplicate record we reconcile the duplicate by validating 5 data points [1. Name; 2. ID Number; 3. Address; 4) Date of Birth; 5) Sex.]. If 3 or more of these data points match we will consider the eligibility a match.	A standard routine is applied to each eligibility file to determine if there are duplicate records. If we identify a potential duplicate record we reconcile the duplicate by validating 5 data points [1. Name; 2. ID Number; 3. Address; 4) Date of Birth; 5) Sex.]. If 3 or more of these data points match we will consider the eligibility a match.	A standard routine is applied to each eligibility file to determine if there are duplicate records. If we identify a potential duplicate record we reconcile the duplicate by validating 5 data points [1. Name; 2. ID Number; 3. Address; 4) Date of Birth; 5) Sex.]. If 3 or more of these data points match we will consider the eligibility a match.
Maintain spans of eligibility periods	The QNXT™ system maintains each member's span of eligibility and updates the eligibility continuously. Breaks in eligibility periods are defined by date spans [begin and end dates]. Eligibility spans are system accessible for eligibility feeds to providers, prior authorization, and claims adjudication.	The QNXT™ system maintains each member's span of eligibility and updates the eligibility continuously. Breaks in eligibility periods are defined by date spans [begin and end dates]. Eligibility spans are system accessible for eligibility feeds to providers, prior authorization, and claims adjudication.	The QNXT™ system maintains each member's span of eligibility and updates the eligibility continuously. Breaks in eligibility periods are defined by date spans [begin and end dates]. Eligibility spans are system accessible for eligibility feeds to providers, prior authorization, and claims adjudication.
Maintain Audit trail of eligibility record changes	The QNXT™ system performs the following major functions: <ul style="list-style-type: none"> • Adds, updates, closes and voids eligibility spans • Produces an audit trail detailing all changes made to the database 	The QNXT™ system performs the following major functions: <ul style="list-style-type: none"> • Adds, updates, closes and voids eligibility spans • Produces an audit trail detailing all changes made to the database 	The QNXT™ system performs the following major functions: <ul style="list-style-type: none"> • Adds, updates, closes and voids eligibility spans • Produces an audit trail detailing all changes made to the database

Eligibility Data Functionality/Requirement	Delaware	Florida	Maryland
	<ul style="list-style-type: none"> • Produces member database update error report • Produces possible duplicate member reports • Monthly Reconciliation <p>Audit report exceptions are research to determine the cause and resolved in accordance with standard operating procedures. QNXT™ maintain a detailed record of all changes made to eligibility records for tracking, auditing and reconciliation.</p>	<ul style="list-style-type: none"> • Produces member database update error report • Produces possible duplicate member reports • Monthly Reconciliation <p>Audit report exceptions are research to determine the cause and resolved in accordance with standard operating procedures. QNXT™ maintain a detailed record of all changes made to eligibility records for tracking, auditing and reconciliation.</p>	<ul style="list-style-type: none"> • Produces member database update error report • Produces possible duplicate member reports • Monthly Reconciliation <p>Audit report exceptions are research to determine the cause and resolved in accordance with standard operating procedures. QNXT™ maintain a detailed record of all changes made to eligibility records for tracking, auditing and reconciliation.</p>
Protect confidentiality of records	<p>Aetna Better Health's management information system currently supports DHH's required technical interfaces and complies with all applicable requirements of the Health Insurance Portability and Accountability Act (HIPAA). We are, and will continue to be, responsive, within a reasonable timeframe, to any and all adjustments or modifications to future HIPAA procedures, policies, rules and statutes that may be required during the term of our contract. Our management information system configuration supports</p>	<p>Aetna Better Health's management information system currently supports DHH's required technical interfaces and complies with all applicable requirements of the Health Insurance Portability and Accountability Act (HIPAA). We are, and will continue to be, responsive, within a reasonable timeframe, to any and all adjustments or modifications to future HIPAA procedures, policies, rules and statutes that may be required during the term of our contract. Our management information system configuration supports</p>	<p>Aetna Better Health's management information system currently supports DHH's required technical interfaces and complies with all applicable requirements of the Health Insurance Portability and Accountability Act (HIPAA). We are, and will continue to be, responsive, within a reasonable timeframe, to any and all adjustments or modifications to future HIPAA procedures, policies, rules and statutes that may be required during the term of our contract. Our management information system configuration supports</p>

Eligibility Data Functionality/Requirement	Delaware	Florida	Maryland
	<p>migration from one HIPAA version to another in the following ways:</p> <ul style="list-style-type: none"> • Microsoft BizTalk with HIPAA Accelerator™ processes HIPAA-compliant transactions easily and efficiently, enabling Aetna Better Health to accept information electronically from almost any HIPAA-compliant contractor or provider. Accelerator has the Washington Publishing Company (WPC) Implementation Guide schemas for each HIPAA ANSI X12 transaction embedded directly into its application engine, including a facility to update these schemas automatically as the transaction sets are updated over time. • Foresight HIPAA Validator™ InStream™ is a fully functional HIPAA editing and validation application. It validates HIPAA transactions through all seven levels of edits as defined by the Workgroup for Electronic Data Interchange and Strategic National 	<p>migration from one HIPAA version to another in the following ways:</p> <ul style="list-style-type: none"> • Microsoft BizTalk with HIPAA Accelerator™ processes HIPAA-compliant transactions easily and efficiently, enabling Aetna Better Health to accept information electronically from almost any HIPAA-compliant contractor or provider. Accelerator has the Washington Publishing Company (WPC) Implementation Guide schemas for each HIPAA ANSI X12 transaction embedded directly into its application engine, including a facility to update these schemas automatically as the transaction sets are updated over time. • Foresight HIPAA Validator™ InStream™ is a fully functional HIPAA editing and validation application. It validates HIPAA transactions through all seven levels of edits as defined by the Workgroup for Electronic Data Interchange and Strategic National 	<p>migration from one HIPAA version to another in the following ways:</p> <ul style="list-style-type: none"> • Microsoft BizTalk with HIPAA Accelerator™ processes HIPAA-compliant transactions easily and efficiently, enabling Aetna Better Health to accept information electronically from almost any HIPAA-compliant contractor or provider. Accelerator has the Washington Publishing Company (WPC) Implementation Guide schemas for each HIPAA ANSI X12 transaction embedded directly into its application engine, including a facility to update these schemas automatically as the transaction sets are updated over time. • Foresight HIPAA Validator™ InStream™ is a fully functional HIPAA editing and validation application. It validates HIPAA transactions through all seven levels of edits as defined by the Workgroup for Electronic Data Interchange and Strategic National

Eligibility Data Functionality/Requirement	Delaware	Florida	Maryland
	<p>Implementation Process (WEDI/SNIP), has all standard HIPAA code sets embedded, and can support custom, trading-partner-specific companion guides and validation requirements. The application also provides descriptive error reports to submitters to facilitate quick error resolution.</p> <p>Aetna Better Health follows the Strategic National Implementation Project (SNIP) recommendations for testing created by the Workgroup for Electronic Data Interchange (WEDI), further promoting system compliance with federal IT mandates.</p>	<p>Implementation Process (WEDI/SNIP), has all standard HIPAA code sets embedded, and can support custom, trading-partner-specific companion guides and validation requirements. The application also provides descriptive error reports to submitters to facilitate quick error resolution.</p> <p>Aetna Better Health follows the Strategic National Implementation Project (SNIP) recommendations for testing created by the Workgroup for Electronic Data Interchange (WEDI), further promoting system compliance with federal IT mandates.</p>	<p>Implementation Process (WEDI/SNIP), has all standard HIPAA code sets embedded, and can support custom, trading-partner-specific companion guides and validation requirements. The application also provides descriptive error reports to submitters to facilitate quick error resolution.</p> <p>Aetna Better Health follows the Strategic National Implementation Project (SNIP) recommendations for testing created by the Workgroup for Electronic Data Interchange (WEDI), further promoting system compliance with federal IT mandates.</p>
Reconcile eligibility records each month - process	<p>Meet</p> <p>Member eligibility is reconciled in two different ways on a monthly basis. The first is a comparison between the Monthly 834 file and the membership listed in QNXT™ to identify any exceptions. All exceptions are researched, validated, and appropriately updated in QNXT™. The second reconciliation is a comparison of the membership in QNXT™ to the Capitation File.</p>	<p>Meet</p> <p>Member eligibility is reconciled in two different ways on a monthly basis. The first is a comparison between the Monthly 834 file and the membership listed in QNXT™ to identify any exceptions. All exceptions are researched, validated, and appropriately updated in QNXT™. The second reconciliation is a comparison of the membership in QNXT™ to the Capitation File.</p>	<p>Meet</p> <p>Member eligibility is reconciled in two different ways on a monthly basis. The first is a comparison between the Monthly 834 file and the membership listed in QNXT™ to identify any exceptions. All exceptions are researched, validated, and appropriately updated in QNXT™. The second reconciliation is a comparison of the membership in QNXT™ to the Capitation File.</p>

Eligibility Data Functionality/Requirement	Delaware	Florida	Maryland
	All exceptions are identified, researched, validated, and appropriately updated in QNXT™.	All exceptions are identified, researched, validated, and appropriately updated in QNXT™.	All exceptions are identified, researched, validated, and appropriately updated in QNXT™.
Web based system to validate eligibility information for providers	<p>Above Health is a secure HIPAA-compliant web portal for our members and providers. Designed to foster open communication and facilitate access to a variety of data in a multitude of ways, this secure, ASP-based application synchronizes data on a daily basis with QNXT™ through data extract and load processes, allowing members to check eligibility status, review benefits and prior authorization status, and send secure emails to our Member Services personnel. Providers are afforded additional functionalities, including:</p> <ul style="list-style-type: none"> • Member eligibility verification • Panel roster review • Searchable provider list • Claim status search • Remittance advice search • Submit authorizations • Search authorizations <p>We configure the portal to provide HEDIS® scorecard data, as well</p>	<p>Above Health is a secure HIPAA-compliant web portal for our members and providers. Designed to foster open communication and facilitate access to a variety of data in a multitude of ways, this secure, ASP-based application synchronizes data on a daily basis with QNXT™ through data extract and load processes, allowing members to check eligibility status, review benefits and prior authorization status, and send secure emails to our Member Services personnel. Providers are afforded additional functionalities, including:</p> <ul style="list-style-type: none"> • Member eligibility verification • Panel roster review • Searchable provider list • Claim status search • Remittance advice search • Submit authorizations • Search authorizations <p>We configure the portal to provide HEDIS® scorecard data, as well</p>	<p>Above Health is a secure HIPAA-compliant web portal for our members and providers. Designed to foster open communication and facilitate access to a variety of data in a multitude of ways, this secure, ASP-based application synchronizes data on a daily basis with QNXT™ through data extract and load processes, allowing members to check eligibility status, review benefits and prior authorization status, and send secure emails to our Member Services personnel. Providers are afforded additional functionalities, including:</p> <ul style="list-style-type: none"> • Member eligibility verification • Panel roster review • Searchable provider list • Claim status search • Remittance advice search • Submit authorizations • Search authorizations <p>We configure the portal to provide HEDIS® scorecard data, as well</p>

Eligibility Data Functionality/Requirement	Delaware	Florida	Maryland
	<p>as alerts indicating when a member is due or past due for a HEDIS®-related service (e.g., well-child check-up, need for asthma controller medication, immunizations). This information is integrated within the application's provider panels/rosters. If a member is due or past due for a service, a "flag" appears next to the member's name, which, when clicked, permits providers to view a description of the needed service(s).</p>	<p>as alerts indicating when a member is due or past due for a HEDIS®-related service (e.g., well-child check-up, need for asthma controller medication, immunizations). This information is integrated within the application's provider panels/rosters. If a member is due or past due for a service, a "flag" appears next to the member's name, which, when clicked, permits providers to view a description of the needed service(s).</p>	<p>as alerts indicating when a member is due or past due for a HEDIS®-related service (e.g., well-child check-up, need for asthma controller medication, immunizations). This information is integrated within the application's provider panels/rosters. If a member is due or past due for a service, a "flag" appears next to the member's name, which, when clicked, permits providers to view a description of the needed service(s).</p>
<p>Apply eligibility records during prior authorization decision making</p>	<p>Meet</p> <p>This is a standard operating and processing process for all States. Eligibility records are applied during prior authorization requests by a routine in QNXT™. This routine applies the member's span of eligibility to the prior authorization request. If the member's eligibility record does not support the eligibility request the requestor is notified and a notice of action is issued in accordance with the State's specific guidance. Each State has different criteria and specifications (including time lines) for issuing a Notice of Action.</p>	<p>Meet</p> <p>This is a standard operating and processing process for all States. Eligibility records are applied during prior authorization requests by a routine in QNXT™. This routine applies the member's span of eligibility to the prior authorization request. If the member's eligibility record does not support the eligibility request the requestor is notified and a notice of action is issued in accordance with the State's specific guidance. Each State has different criteria and specifications (including time lines) for issuing a Notice of Action.</p>	<p>Meet</p> <p>This is a standard operating and processing process for all States. Eligibility records are applied during prior authorization requests by a routine in QNXT™. This routine applies the member's span of eligibility to the prior authorization request. If the member's eligibility record does not support the eligibility request the requestor is notified and a notice of action is issued in accordance with the State's specific guidance. Each State has different criteria and specifications (including time lines) for issuing a Notice of Action.</p>

Eligibility Data Functionality/Requirement	Delaware	Florida	Maryland
<p>System edits to:</p> <p>a) Confirming eligibility on each member as claims are submitted on the basis of the eligibility information provided by DHH and the Enrollment Broker that applies to the period during which the charges were incurred</p> <p>b) Perform system edits for valid dates of service, and assure that dates of services are valid dates such as not in the future or outside of a member's Medicaid eligibility span</p>	<p>QNXT™ Data Edits QNXT™ has over 400 business rules that Aetna Better Health configures to support enforcement of our claims Policies and Procedures (P&Ps). The application of specific conditions, restrictions, and validation criteria promote the accuracy of claim processing against DHH standards. The edits can result in claims pending or denying depending on the editing logic. For example, if the member is not eligible on the date of service, QNXT™ will automatically deny the claim. In the event that the category of service of the provider of record does not match the procedure code billed the claim will pend for manual review to validate accuracy of provider set-up.</p> <p>Examples of data edits specific to QNXT™ include the following:</p> <p>Benefits Package Variations QNXT™ automatically analyzes CPT, REV, and HCPC codes to determine whether specific services are covered under the contract or benefit rules. If services are not covered, the system will</p>	<p>QNXT™ Data Edits QNXT™ has over 400 business rules that Aetna Better Health configures to support enforcement of our claims Policies and Procedures (P&Ps). The application of specific conditions, restrictions, and validation criteria promote the accuracy of claim processing against DHH standards. The edits can result in claims pending or denying depending on the editing logic. For example, if the member is not eligible on the date of service, QNXT™ will automatically deny the claim. In the event that the category of service of the provider of record does not match the procedure code billed the claim will pend for manual review to validate accuracy of provider set-up.</p> <p>Examples of data edits specific to QNXT™ include the following:</p> <p>Benefits Package Variations QNXT™ automatically analyzes CPT, REV, and HCPC codes to determine whether specific services are covered under the contract or benefit rules. If services are not covered, the system will</p>	<p>QNXT™ Data Edits QNXT™ has over 400 business rules that Aetna Better Health configures to support enforcement of our claims Policies and Procedures (P&Ps). The application of specific conditions, restrictions, and validation criteria promote the accuracy of claim processing against DHH standards. The edits can result in claims pending or denying depending on the editing logic. For example, if the member is not eligible on the date of service, QNXT™ will automatically deny the claim. In the event that the category of service of the provider of record does not match the procedure code billed the claim will pend for manual review to validate accuracy of provider set-up.</p> <p>Examples of data edits specific to QNXT™ include the following:</p> <p>Benefits Package Variations QNXT™ automatically analyzes CPT, REV, and HCPC codes to determine whether specific services are covered under the contract or benefit rules. If services are not covered, the system will</p>

Eligibility Data Functionality/Requirement	Delaware	Florida	Maryland
	<p>automatically deny the respective claim line. The claim line will deny with the appropriate HIPAA remittance remark on the EOB.</p> <p>Data Accuracy QNXT™ is continually updated based on the most current code sets available (HCPCS, REV, CPT codes) by year. As new codes are added, terminated, or changed, we update the codes in QNXT™ so the system is always in compliance with HIPAA standards. If a network provider bills a code that has been terminated, QNXT™ will deny the claim line and advise the provider the code is invalid via remittance advice.</p> <p>Adherence to Prior Authorization Requirements QNXT™ is configured to enforce the supporting documentation requirements of certain services. In addition, QNXT™ has the ability to configure Prior Authorization (PA) by code, provider type, and place of service. QNXT™ is configured to automatically identify certain types of authorizations for medical director review. Claim edit rules are set to validate the claim</p>	<p>automatically deny the respective claim line. The claim line will deny with the appropriate HIPAA remittance remark on the EOB.</p> <p>Data Accuracy QNXT™ is continually updated based on the most current code sets available (HCPCS, REV, CPT codes) by year. As new codes are added, terminated, or changed, we update the codes in QNXT™ so the system is always in compliance with HIPAA standards. If a network provider bills a code that has been terminated, QNXT™ will deny the claim line and advise the provider the code is invalid via remittance advice.</p> <p>Adherence to Prior Authorization Requirements QNXT™ is configured to enforce the supporting documentation requirements of certain services. In addition, QNXT™ has the ability to configure Prior Authorization (PA) by code, provider type, and place of service. QNXT™ is configured to automatically identify certain types of authorizations for medical director review. Claim edit rules are set to validate the claim</p>	<p>automatically deny the respective claim line. The claim line will deny with the appropriate HIPAA remittance remark on the EOB.</p> <p>Data Accuracy QNXT™ is continually updated based on the most current code sets available (HCPCS, REV, CPT codes) by year. As new codes are added, terminated, or changed, we update the codes in QNXT™ so the system is always in compliance with HIPAA standards. If a network provider bills a code that has been terminated, QNXT™ will deny the claim line and advise the provider the code is invalid via remittance advice.</p> <p>Adherence to Prior Authorization Requirements QNXT™ is configured to enforce the supporting documentation requirements of certain services. In addition, QNXT™ has the ability to configure Prior Authorization (PA) by code, provider type, and place of service. QNXT™ is configured to automatically identify certain types of authorizations for medical director review. Claim edit rules are set to validate the claim</p>

Eligibility Data Functionality/Requirement	Delaware	Florida	Maryland
	<p>against the network provider, member, dates of service, services rendered, and units authorized.</p> <p>Provider Qualifications QNXT™ provider files are configured by specialty and category of service. This allows for the enforcement of categories of service and provider type on claims validation. Certain procedures can only be performed by select network provider types. For example, QNXT™ will not permit the processing of a claim for in-office heart surgery by a podiatrist. iHealth lends additional support in this regard, reviewing any claim line set to “Pay” for billing appropriateness by specialty. QNXT™ checks other provider-specific items as well, verifying, for example, that each provider has obtained the requisite National Provider Identifier (NPI) or its equivalent and included the identifier on all claims submissions.</p> <p>Member Eligibility and Enrollment QNXT™ validates the date of service against the member’s enrollment segment to determine if the member was eligible</p>	<p>against the network provider, member, dates of service, services rendered, and units authorized.</p> <p>Provider Qualifications QNXT™ provider files are configured by specialty and category of service. This allows for the enforcement of categories of service and provider type on claims validation. Certain procedures can only be performed by select network provider types. For example, QNXT™ will not permit the processing of a claim for in-office heart surgery by a podiatrist. iHealth lends additional support in this regard, reviewing any claim line set to “Pay” for billing appropriateness by specialty. QNXT™ checks other provider-specific items as well, verifying, for example, that each provider has obtained the requisite National Provider Identifier (NPI) or its equivalent and included the identifier on all claims submissions.</p> <p>Member Eligibility and Enrollment QNXT™ validates the date of service against the member’s enrollment segment to determine if the member was eligible</p>	<p>against the network provider, member, dates of service, services rendered, and units authorized.</p> <p>Provider Qualifications QNXT™ provider files are configured by specialty and category of service. This allows for the enforcement of categories of service and provider type on claims validation. Certain procedures can only be performed by select network provider types. For example, QNXT™ will not permit the processing of a claim for in-office heart surgery by a podiatrist. iHealth lends additional support in this regard, reviewing any claim line set to “Pay” for billing appropriateness by specialty. QNXT™ checks other provider-specific items as well, verifying, for example, that each provider has obtained the requisite National Provider Identifier (NPI) or its equivalent and included the identifier on all claims submissions.</p> <p>Member Eligibility and Enrollment QNXT™ validates the date of service against the member’s enrollment segment to determine if the member was eligible</p>

Eligibility Data Functionality/Requirement	Delaware	Florida	Maryland
	<p>on the date of service. If the member was not eligible on the date of service, the system will automatically deny the claim using the appropriate HIPAA approved remittance comment.</p> <p>Duplicate Billing Logic QNXT™ uses a robust set of edits to determine duplication of services. Examples are same member, same date, same network provider, same service, or any combination of these criteria. In addition, claim lines set to “Pay” are subjected to iHealth’s duplicate logic. This logic protects against our paying for services rendered by the same physician or other physicians within the same provider group</p> <p>ClaimCheck® Edits ClaimCheck® is a comprehensive code auditing solution that supports QNXT™ by applying expert industry edits from a provider recognized knowledge base to analyze claims for accuracy and consistency with our P&Ps. ClaimCheck® clinical editing software identifies coding errors in the following categories:</p> <ul style="list-style-type: none"> • Procedure 	<p>on the date of service. If the member was not eligible on the date of service, the system will automatically deny the claim using the appropriate HIPAA approved remittance comment.</p> <p>Duplicate Billing Logic QNXT™ uses a robust set of edits to determine duplication of services. Examples are same member, same date, same network provider, same service, or any combination of these criteria. In addition, claim lines set to “Pay” are subjected to iHealth’s duplicate logic. This logic protects against our paying for services rendered by the same physician or other physicians within the same provider group</p> <p>ClaimCheck® Edits ClaimCheck® is a comprehensive code auditing solution that supports QNXT™ by applying expert industry edits from a provider recognized knowledge base to analyze claims for accuracy and consistency with our P&Ps. ClaimCheck® clinical editing software identifies coding errors in the following categories:</p> <ul style="list-style-type: none"> • Procedure 	<p>on the date of service. If the member was not eligible on the date of service, the system will automatically deny the claim using the appropriate HIPAA approved remittance comment.</p> <p>Duplicate Billing Logic QNXT™ uses a robust set of edits to determine duplication of services. Examples are same member, same date, same network provider, same service, or any combination of these criteria. In addition, claim lines set to “Pay” are subjected to iHealth’s duplicate logic. This logic protects against our paying for services rendered by the same physician or other physicians within the same provider group</p> <p>ClaimCheck® Edits ClaimCheck® is a comprehensive code auditing solution that supports QNXT™ by applying expert industry edits from a provider recognized knowledge base to analyze claims for accuracy and consistency with our P&Ps. ClaimCheck® clinical editing software identifies coding errors in the following categories:</p> <ul style="list-style-type: none"> • Procedure

Eligibility Data Functionality/Requirement	Delaware	Florida	Maryland
	<ul style="list-style-type: none"> unbundling • Mutually exclusive procedures • Incidental procedures • Medical visits, same date of service • Bilateral and duplicate procedures • Pre and Post-operative care • Assistant Surgeon • Modifier Auditing • Medically Unlikely <p>Aetna Better Health offers network providers access to Clear Claim Connection®, a provider reference tool that helps providers optimize their claims submission accuracy. Currently there are 2300 provider groups registered to use this web-based tool that providers can use to understand our clinical editing logic. This allows them to better understand the rules and clinical rationale affecting adjudication. Providers access Clear Claim Connection® through our web portal via secure login. Various coding combinations can then be entered to determine why, for example, a particular coding combination resulted in a denial. The provider may also review coding</p>	<ul style="list-style-type: none"> unbundling • Mutually exclusive procedures • Incidental procedures • Medical visits, same date of service • Bilateral and duplicate procedures • Pre and Post-operative care • Assistant Surgeon • Modifier Auditing • Medically Unlikely <p>Aetna Better Health offers network providers access to Clear Claim Connection®, a provider reference tool that helps providers optimize their claims submission accuracy. Currently there are 2300 provider groups registered to use this web-based tool that providers can use to understand our clinical editing logic. This allows them to better understand the rules and clinical rationale affecting adjudication. Providers access Clear Claim Connection® through our web portal via secure login. Various coding combinations can then be entered to determine why, for example, a particular coding combination resulted in a denial. The provider may also review coding</p>	<ul style="list-style-type: none"> unbundling • Mutually exclusive procedures • Incidental procedures • Medical visits, same date of service • Bilateral and duplicate procedures • Pre and Post-operative care • Assistant Surgeon • Modifier Auditing • Medically Unlikely <p>Aetna Better Health offers network providers access to Clear Claim Connection®, a provider reference tool that helps providers optimize their claims submission accuracy. Currently there are 2300 provider groups registered to use this web-based tool that providers can use to understand our clinical editing logic. This allows them to better understand the rules and clinical rationale affecting adjudication. Providers access Clear Claim Connection® through our web portal via secure login. Various coding combinations can then be entered to determine why, for example, a particular coding combination resulted in a denial. The provider may also review coding</p>

Eligibility Data Functionality/Requirement	Delaware	Florida	Maryland
	<p>combinations prior to claim submission, to determine if applicable auditing rules and clinical rationale will deny the claim before it is submitted.</p> <p>iHealth Edits iHealth clinically edits claims to assist in promoting the proper and fair payment of professional DME and outpatient claims.</p> <p>Coding Accuracy If the services are up-coded, or unbundled, iHealth will alert the Claims Department to deny the claim line along with the specific clinical editing policy justification for the denial. The claim line will deny with the appropriate HIPAA remittance remark on the Explanation of Benefits (EOB).</p> <p>Duplicate Billing Logic In addition, claim lines set to “Pay” are subjected to iHealth’s duplicate logic. This logic protects against Aetna Better Health paying for services rendered by the same physician or other physicians within the same provider group</p>	<p>combinations prior to claim submission, to determine if applicable auditing rules and clinical rationale will deny the claim before it is submitted.</p> <p>iHealth Edits iHealth clinically edits claims to assist in promoting the proper and fair payment of professional DME and outpatient claims.</p> <p>Coding Accuracy If the services are up-coded, or unbundled, iHealth will alert the Claims Department to deny the claim line along with the specific clinical editing policy justification for the denial. The claim line will deny with the appropriate HIPAA remittance remark on the Explanation of Benefits (EOB).</p> <p>Duplicate Billing Logic In addition, claim lines set to “Pay” are subjected to iHealth’s duplicate logic. This logic protects against Aetna Better Health paying for services rendered by the same physician or other physicians within the same provider group</p>	<p>combinations prior to claim submission, to determine if applicable auditing rules and clinical rationale will deny the claim before it is submitted.</p> <p>iHealth Edits iHealth clinically edits claims to assist in promoting the proper and fair payment of professional DME and outpatient claims.</p> <p>Coding Accuracy If the services are up-coded, or unbundled, iHealth will alert the Claims Department to deny the claim line along with the specific clinical editing policy justification for the denial. The claim line will deny with the appropriate HIPAA remittance remark on the Explanation of Benefits (EOB).</p> <p>Duplicate Billing Logic In addition, claim lines set to “Pay” are subjected to iHealth’s duplicate logic. This logic protects against Aetna Better Health paying for services rendered by the same physician or other physicians within the same provider group</p>

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	<p>Durable Medical Equipment (DME) Editing iHealth Technologies' (iHT) performs edits related to select DME payment policies that align with DHH covered service policies. These DME edits include but are not limited to; DME rentals, oxygen and oxygen systems, hospital beds and accessories, external infusion pumps and anatomic/functional modifiers required for DME services.</p> <p>Procedure Code Guidelines - iHealth Aetna Better Health follows the AMA CPT-4 Book and CMS HCPCS Book, which both provide instructions regarding code usage. iHT has developed these guidelines into edits. For example, if a vaccine administration code is billed without the correct vaccine/toxoid codes, Aetna Better Health would then deny the code as inappropriate coding based on industry standards. According to the AMA CPT Book, this vaccination must be reported in addition to the vaccine and toxoid code(s).</p>	<p>Durable Medical Equipment (DME) Editing iHealth Technologies' (iHT) performs edits related to select DME payment policies that align with DHH covered service policies. These DME edits include but are not limited to; DME rentals, oxygen and oxygen systems, hospital beds and accessories, external infusion pumps and anatomic/functional modifiers required for DME services.</p> <p>Procedure Code Guidelines - iHealth Aetna Better Health follows the AMA CPT-4 Book and CMS HCPCS Book, which both provide instructions regarding code usage. iHT has developed these guidelines into edits. For example, if a vaccine administration code is billed without the correct vaccine/toxoid codes, Aetna Better Health would then deny the code as inappropriate coding based on industry standards. According to the AMA CPT Book, this vaccination must be reported in addition to the vaccine and toxoid code(s).</p>	<p>Durable Medical Equipment (DME) Editing iHealth Technologies' (iHT) performs edits related to select DME payment policies that align with DHH covered service policies. These DME edits include but are not limited to; DME rentals, oxygen and oxygen systems, hospital beds and accessories, external infusion pumps and anatomic/functional modifiers required for DME services.</p> <p>Procedure Code Guidelines - iHealth Aetna Better Health follows the AMA CPT-4 Book and CMS HCPCS Book, which both provide instructions regarding code usage. iHT has developed these guidelines into edits. For example, if a vaccine administration code is billed without the correct vaccine/toxoid codes, Aetna Better Health would then deny the code as inappropriate coding based on industry standards. According to the AMA CPT Book, this vaccination must be reported in addition to the vaccine and toxoid code(s).</p>

Eligibility Data Functionality/Requirement	Delaware	Florida	Maryland
	<p>Procedure Code Definition Policies - iHealth iHT supports correct coding based on the definition or nature of a procedure code or combination of procedure codes. These editing policies will either bundle or re-code procedures based on the appropriateness of the code selection. For example, if a provider attempts to unbundle procedures, iHT will apply editing logic that will bundle all of the procedures billed into the most appropriate code. For example, if a provider bills an office visit and also bills separately for heart monitoring with a stethoscope at the same visit, iHT will rebundle the service into the appropriate E&M or office code.</p> <p>Fraud & Abuse Aetna Better Health's Fraud and Abuse Department utilizes claims payment tracking and trending reports, claims edits, audits and provider billing patterns as indicators of potential fraud and abuse. The Fraud and Abuse Department uses this information to detect aberrant provider billing behavior, prompting</p>	<p>Procedure Code Definition Policies - iHealth iHT supports correct coding based on the definition or nature of a procedure code or combination of procedure codes. These editing policies will either bundle or re-code procedures based on the appropriateness of the code selection. For example, if a provider attempts to unbundle procedures, iHT will apply editing logic that will bundle all of the procedures billed into the most appropriate code. For example, if a provider bills an office visit and also bills separately for heart monitoring with a stethoscope at the same visit, iHT will rebundle the service into the appropriate E&M or office code.</p> <p>Fraud & Abuse Aetna Better Health's Fraud and Abuse Department utilizes claims payment tracking and trending reports, claims edits, audits and provider billing patterns as indicators of potential fraud and abuse. The Fraud and Abuse Department uses this information to detect aberrant provider billing behavior, prompting</p>	<p>Procedure Code Definition Policies - iHealth iHT supports correct coding based on the definition or nature of a procedure code or combination of procedure codes. These editing policies will either bundle or re-code procedures based on the appropriateness of the code selection. For example, if a provider attempts to unbundle procedures, iHT will apply editing logic that will bundle all of the procedures billed into the most appropriate code. For example, if a provider bills an office visit and also bills separately for heart monitoring with a stethoscope at the same visit, iHT will rebundle the service into the appropriate E&M or office code.</p> <p>Fraud & Abuse Aetna Better Health's Fraud and Abuse Department utilizes claims payment tracking and trending reports, claims edits, audits and provider billing patterns as indicators of potential fraud and abuse. The Fraud and Abuse Department uses this information to detect aberrant provider billing behavior, prompting</p>

Eligibility Data Functionality/Requirement	Delaware	Florida	Maryland
	<p>additional analysis and investigation. Our fraud and abuse personnel work in conjunction with Provider Services and Compliance Departments to address the questionable behavior(s) through provider education and outreach. If we discovers, or becomes aware, that an incident of potential/suspected fraud and abuse has occurred, internal P&Ps mandate that we report the incident to DHH in accordance with DHH's requirements.</p>	<p>additional analysis and investigation. Our fraud and abuse personnel work in conjunction with Provider Services and Compliance Departments to address the questionable behavior(s) through provider education and outreach. If we discovers, or becomes aware, that an incident of potential/suspected fraud and abuse has occurred, internal P&Ps mandate that we report the incident to DHH in accordance with DHH's requirements.</p>	<p>additional analysis and investigation. Our fraud and abuse personnel work in conjunction with Provider Services and Compliance Departments to address the questionable behavior(s) through provider education and outreach. If we discovers, or becomes aware, that an incident of potential/suspected fraud and abuse has occurred, internal P&Ps mandate that we report the incident to DHH in accordance with DHH's requirements.</p>
<p>Identify members and children with special healthcare needs for assignment of a PCP (if the member does not choose) to meet the member's/child's needs.</p>	<p>Members with special needs are assigned, when and where available, to PCPs or specialists who have the capacity to provide and coordinate the necessary care and serve as the PCMH. Providers with this capability are identified in QNXT™ to facilitate member assignment. Identification in the system permits us to evaluate the availability of these providers in the network so we may conduct specific provider training or enhance recruitment activities as necessary.</p>	<p>Members with special needs are assigned, when and where available, to PCPs or specialists who have the capacity to provide and coordinate the necessary care and serve as the PCMH. Providers with this capability are identified in QNXT™ to facilitate member assignment. Identification in the system permits us to evaluate the availability of these providers in the network so we may conduct specific provider training or enhance recruitment activities as necessary.</p>	<p>Members with special needs are assigned, when and where available, to PCPs or specialists who have the capacity to provide and coordinate the necessary care and serve as the PCMH. Providers with this capability are identified in QNXT™ to facilitate member assignment. Identification in the system permits us to evaluate the availability of these providers in the network so we may conduct specific provider training or enhance recruitment activities as necessary.</p>

Eligibility Data Functionality/Requirement	Delaware	Florida	Maryland
Identify providers with open access appointment system.	A system attribute identifies providers who have an open access or modified open access appointment system and increases member assignments if appropriate.	A system attribute identifies providers who have an open access or modified open access appointment system and increases member assignments if appropriate.	A system attribute identifies providers who have an open access or modified open access appointment system and increases member assignments if appropriate.
Identify members who have failed to adhere to EPSDT periodicity schedule, with a history of missed appointments (Provider Assistance Program) for special assistance when requesting PA or PCP change, or who have been hard to reach for Case Management follow-up.	If a member is considered non-compliant either with EPSDT periodicity schedule or has a history of missed appointments (Provider Assistance Program) a “flag” is entered into QNXT™ to alert Prior Authorization personnel, Member Services and Provider Services during administrative processes to either alert the provider of contact the member. Alerts are designed to notify the member’s PCP or attending physician specialist to encourage the member to complete EPSDT services or determine barriers to keeping appointments. Case managers (CM) document in QNXT™ when a member has been hard to reach (e.g., homelessness, etc) so that when the member contacts Aetna Better Health the Prior Authorization, Member Services, Grievance and Appeals or Quality Management personnel are aware of the	If a member is considered non-compliant either with EPSDT periodicity schedule or has a history of missed appointments (Provider Assistance Program) a “flag” is entered into QNXT™ to alert Prior Authorization personnel, Member Services and Provider Services during administrative processes to either alert the provider of contact the member. Alerts are designed to notify the member’s PCP or attending physician specialist to encourage the member to complete EPSDT services or determine barriers to keeping appointments. Case managers (CM) document in QNXT™ when a member has been hard to reach (e.g., homelessness, etc) so that when the member contacts Aetna Better Health the Prior Authorization, Member Services, Grievance and Appeals or Quality Management personnel are aware of the	If a member is considered non-compliant either with EPSDT periodicity schedule or has a history of missed appointments (Provider Assistance Program) a “flag” is entered into QNXT™ to alert Prior Authorization personnel, Member Services and Provider Services during administrative processes to either alert the provider of contact the member. Alerts are designed to notify the member’s PCP or attending physician specialist to encourage the member to complete EPSDT services or determine barriers to keeping appointments. Case managers (CM) document in QNXT™ when a member has been hard to reach (e.g., homelessness, etc) so that when the member contacts Aetna Better Health the Prior Authorization, Member Services, Grievance and Appeals or Quality Management personnel are aware of the

Eligibility Data Functionality/Requirement	Delaware	Florida	Maryland
	situation and can attempt to obtain current contact information (cell phone number, address, e-mail address) and alert the case manager.	situation and can attempt to obtain current contact information (cell phone number, address, e-mail address) and alert the case manager.	situation and can attempt to obtain current contact information (cell phone number, address, e-mail address) and alert the case manager.

Provider Data Functionality/Requirement	Delaware	Florida	Maryland
Maintain, track and report provider types, specialty, and sub-specialty codes	<p>Meet</p> <p>The specialty and sub-specialty are codes designated by the State. We design QNXT™ to meet the State’s coding structure.</p> <p>We load provider type as a attribute in QNXT™ to track.</p>	<p>Meet</p> <p>The specialty and sub-specialty are codes designated by the State. We design QNXT™ to meet the State’s coding structure.</p> <p>We load provider type as a attribute in QNXT™ to track</p>	<p>Meet</p> <p>The specialty and sub-specialty are codes designated by the State. We design QNXT™ to meet the State’s coding structure.</p> <p>We load provider type as a attribute in QNXT™ to track</p>
Coordinate our provider enrollment records with the Medicaid agency’s by provider type, specialty and subspecialty codes as those used by the Medicaid agency and/or the Enrollment Broker	<p>Meet</p> <p>The specialty and sub-specialty are codes designated by the State. We design QNXT™ to meet the State’s coding structure.</p> <p>We load provider type as a attribute in QNXT™ to track</p> <p>Provided by Medicaid agency, then mapped to the data field within QNXT™. Report that is written by IT – distinct reports.</p>	<p>Meet</p> <p>The specialty and sub-specialty are codes designated by the State. We design QNXT™ to meet the State’s coding structure.</p> <p>We load provider type as a attribute in QNXT™ to track</p> <p>Provided by Medicaid agency, then mapped to the data field within QNXT™. Report that is written by IT – distinct reports</p>	<p>Meet</p> <p>The specialty and sub-specialty are codes designated by the State. We design QNXT™ to meet the State’s coding structure.</p> <p>We load provider type as a attribute in QNXT™ to track</p> <p>Provided by Medicaid agency, then mapped to the data field within QNXT™. Report that is written by IT – distinct reports</p>
Track, account for and report key provider record information, including but not limited to: <ul style="list-style-type: none"> • Provider name, • Address, • licensing 	<p>Meet</p> <p>Tracking, accounting and reporting on provider record information is a standard process within</p>	<p>Meet</p> <p>Tracking, accounting and reporting on provider record information is a standard process within</p>	<p>Meet</p> <p>Tracking, accounting and reporting on provider record information is a standard process within</p>

Provider Data Functionality/Requirement	Delaware	Florida	Maryland
information, <ul style="list-style-type: none"> • Tax ID, • National Provider Identifier (NPI), • Taxonomy and • Payment information 	QNXT™. This is custom designed for each State based on State requirements and information to be included in the Provider Directory and provided to either the MMIS vendor, FI or enrollment broker.	QNXT™. This is custom designed for each State based on State requirements and information to be included in the Provider Directory and provided to either the MMIS vendor, FI or enrollment broker.	QNXT™. This is custom designed for each State based on State requirements and information to be included in the Provider Directory and provided to either the MMIS vendor, FI or enrollment broker.
Track, account for and report key provider functionality, including but not limited to: <ul style="list-style-type: none"> • Audit trail and history of changes made to the provider file; • Automated interfaces with all licensing and medical boards; • Automated alerts when provider licenses are nearing expiration; • Retention of NPI requirements; • System generated letters to providers when their licenses are nearing expiration; • Linkages of individual providers to groups; • Credentialing information; • Provider office hours; • After hours/weekend 	Meet There are two auditable trails for these functions. First, audit trail is through the Remedy Tracking System – System to account for all requests to add, change or modify a provider record. Second audit trail is tracked within QNXT™ itself. Historical record of all data changes are tracked by date, time and identification number of the individual making the addition, change or record modification. This is maintained in the provider management subsystem. Change request documentation is housed in the Provider Relations Department. Remedy also retains a copy of the change request for historical reference and auditing. Credentialing information is obtained from our affiliated NCQA® credentialing	Meet There are two auditable trails for these functions. First, audit trail is through the Remedy Tracking System – System to account for all requests to add, change or modify a provider record. Second audit trail is tracked within QNXT™ itself. Historical record of all data changes are tracked by date, time and identification number of the individual making the addition, change or record modification. This is maintained in the provider management subsystem. Change request documentation is housed in the Provider Relations Department. Remedy also retains a copy of the change request for historical reference and auditing. Credentialing information is obtained from our affiliated NCQA® credentialing	Meet There are two auditable trails for these functions. First, audit trail is through the Remedy Tracking System – System to account for all requests to add, change or modify a provider record. Second audit trail is tracked within QNXT™ itself. Historical record of all data changes are tracked by date, time and identification number of the individual making the addition, change or record modification. This is maintained in the provider management subsystem. Change request documentation is housed in the Provider Relations Department. Remedy also retains a copy of the change request for historical reference and auditing. Credentialing information is obtained from our affiliated NCQA® credentialing

Provider Data Functionality/Requirement	Delaware	Florida	Maryland
<p>availability</p> <ul style="list-style-type: none"> Provider languages spoken 	<p>vendor. Credentialing information is maintained in QNXT™ and with the affiliated credentialing vendor. Provider Relations runs a monthly report to identify providers with expiring licenses and mails a letter to the provider. A copy of the letter is sent to our NCQA® vendor for appropriate action. The vendor checks with the appropriate State authority to determine if license is maintained and the QNXT™ file is adjusted as appropriate.</p> <p>The linkage (record of assignment) of members to a provider is using an affiliation (tying two records together) in the provider's record.</p> <p>Housed in provider module. TTY and TTD will be built as needed for DHH. Languages spoken by provider office are maintained in the provider file and can be extracted for reporting purposes.</p>	<p>vendor. Credentialing information is maintained in QNXT™ and with the affiliated credentialing vendor. Provider Relations runs a monthly report to identify providers with expiring licenses and mails a letter to the provider. A copy of the letter is sent to our NCQA® vendor for appropriate action. The vendor checks with the appropriate State authority to determine if license is maintained and the QNXT™ file is adjusted as appropriate.</p> <p>The linkage (record of assignment) of members to a provider is using an affiliation (tying two records together) in the provider's record.</p> <p>Housed in provider module. TTY and TTD will be built as needed for DHH. Languages spoken by provider office are maintained in the provider file and can be extracted for reporting purposes.</p>	<p>vendor. Credentialing information is maintained in QNXT™ and with the affiliated credentialing vendor. Provider Relations runs a monthly report to identify providers with expiring licenses and mails a letter to the provider. A copy of the letter is sent to our NCQA® vendor for appropriate action. The vendor checks with the appropriate State authority to determine if license is maintained and the QNXT™ file is adjusted as appropriate.</p> <p>The linkage (record of assignment) of members to a provider is using an affiliation (tying two records together) in the provider's record.</p> <p>Housed in provider module. TTY and TTD will be built as needed for DHH. Languages spoken by provider office are maintained in the provider file and can be extracted for reporting purposes.</p>
<p>If a PCP, track member assignments (linkages)</p>	<p>Meet</p> <p>Aetna Better Health tracks and retains a history of member PCP assignments. Aetna Better Health can also track the members assigned to a PCP.</p>	<p>Meet</p> <p>Aetna Better Health does track and retain a history of member PCP assignments. Aetna Better Health can also track the members assigned to a PCP.</p>	<p>Meet</p> <p>Aetna Better Health does track and retain a history of member PCP assignments. Aetna Better Health can also track the members assigned to a PCP.</p>

Provider Data Functionality/Requirement	Delaware	Florida	Maryland
Track if PCP is open or closed to new members	We capture this in QNXT™ and can report at any time and monitor on a monthly basis to see that there are enough providers for auto-assignment	We capture this in QNXT™ and can report at any time and monitor on a monthly basis to see that there are enough providers for auto-assignment	We capture this in QNXT™ and can report at any time and monitor on a monthly basis to see that there are enough providers for auto-assignment
Track member grievances and appeals	Meet Aetna Better Health maintains a database for tracking member grievances and appeals. This database is customizable to meet the specific requirements of each State. Maintained by Aetna Better Health's Grievance and Appeals personnel, the data base can support reporting and tracking of individual grievance and appeal actions from initiation to final decision at the State authority.	Meet Aetna Better Health maintains a database for tracking member grievances and appeals. This database is customizable to meet the specific requirements of each State. Maintained by Aetna Better Health's Grievance and Appeals personnel, the data base can support reporting and tracking of individual grievance and appeal actions from initiation to final decision at the State authority.	Meet Aetna Better Health maintains a database for tracking member grievances and appeals. This database is customizable to meet the specific requirements of each State. Maintained by Aetna Better Health's Grievance and Appeals personnel, the data base can support reporting and tracking of individual grievance and appeal actions from initiation to final decision at the State authority.
Track quality of care investigations and reviews quality investigations	Meet Quality investigations are tracked in Aetna's Potential Quality of Care (PQoC) Database. The database is maintained by Aetna Better Health's Information System (AIS) Department. Quality investigations for all Aetna Better Health organizations, Medicaid, Medicare, Behavioral Health, and Commercial are tracked in the same database. It provides a global review and access to all providers with a quality	Meet Quality investigations are tracked in Aetna's Potential Quality of Care (PQoC) Database. The database is maintained by Aetna Better Health's Information System (AIS) Department. Quality investigations for all Aetna Better Health organizations, Medicaid, Medicare, Behavioral Health, and Commercial are tracked in the same database. It provides a global review and access to all providers with a quality	Meet Quality investigations are tracked in Aetna's Potential Quality of Care (PQoC) Database. The database is maintained by Aetna Better Health's Information System (AIS) Department. Quality investigations for all Aetna Better Health organizations, Medicaid, Medicare, Behavioral Health, and Commercial are tracked in the same database. It provides a global review and access to all providers with a quality

Provider Data Functionality/Requirement	Delaware	Florida	Maryland
	<p>investigation as part of their history.</p> <p>The PQoC is a VB.net frontend w/SQL server backend.</p>	<p>investigation as part of their history.</p> <p>The PQoC is a VB.net frontend w/SQL server backend.</p>	<p>investigation as part of their history.</p> <p>The PQoC is a VB.net frontend w/SQL server backend.</p>
Apply provider information when adjudicating claims	<p>Meet</p> <p>This is a standard operating and processing process for all States. Provider records are applied during claims adjudication processing to match against procedure performed, demographics of the member and other common edit criteria. Claims from providers without the appropriate provider types, specialty, and sub-specialty codes are denied, specific denial reason recorded on the remittance advice and a notice of action letter is issued. Each State has different criteria and specifications (including time lines) for issuing a Notice of Action.</p>	<p>Meet</p> <p>This is a standard operating and processing process for all States. Provider records are applied during claims adjudication processing to match against procedure performed, demographics of the member and other common edit criteria. Claims from providers without the appropriate provider types, specialty, and sub-specialty codes are denied, specific denial reason recorded on the remittance advice and a notice of action letter is issued. Each State has different criteria and specifications (including time lines) for issuing a Notice of Action.</p>	<p>Meet</p> <p>This is a standard operating and processing process for all States. Provider records are applied during claims adjudication processing to match against procedure performed, demographics of the member and other common edit criteria. Claims from providers without the appropriate provider types, specialty, and sub-specialty codes are denied, specific denial reason recorded on the remittance advice and a notice of action letter is issued. Each State has different criteria and specifications (including time lines) for issuing a Notice of Action.</p>
Update and maintain accurate provider information for Provider Directory	<p>Meet</p> <p>The appropriate fields to initially establish, update and maintain a provider directory is housed in our QNXT™ system.</p> <p>Our Network Provider Directory will be available for distribution to members and One Page Brochure (and the complete Provider</p>	<p>Meet</p> <p>The appropriate fields to initially establish, update and maintain a provider directory is housed in our QNXT™ system.</p> <p>Our Network Provider Directory will be available for distribution to members and One Page Brochure (and the complete Provider</p>	<p>Meet</p> <p>The appropriate fields to initially establish, update and maintain a provider directory is housed in our QNXT™ system.</p> <p>Our Network Provider Directory will be available for distribution to members and One Page Brochure (and the complete Provider</p>

Provider Data Functionality/Requirement	Delaware	Florida	Maryland
	<p>Directory) will be available for distribution and the Enrollment Broker in accordance with GSA A, B and C timelines.</p> <p>Provider Directory will be available:</p> <ul style="list-style-type: none"> • A hard copy directory for members and upon request, potential members; • Web-based, searchable, online directory for members and the public; and • Electronic file of the directory for the Enrollment Broker • Hard copy, abbreviated version for the Enrollment Broker <p>Our Provider Directory will be available in paper form and through our website. The web version of the Provider Directory is updated weekly, prior to distribution to the Enrollment Broker and posting on our website.</p>	<p>Directory) will be available for distribution and the Enrollment Broker in accordance with GSA A, B and C timelines.</p> <p>Provider Directory will be available:</p> <ul style="list-style-type: none"> • A hard copy directory for members and upon request, potential members; • Web-based, searchable, online directory for members and the public; and • Electronic file of the directory for the Enrollment Broker • Hard copy, abbreviated version for the Enrollment Broker <p>Our Provider Directory will be available in paper form and through our website. The web version of the Provider Directory is updated weekly, prior to distribution to the Enrollment Broker and posting on our website.</p>	<p>Directory) will be available for distribution and the Enrollment Broker in accordance with GSA A, B and C timelines.</p> <p>Provider Directory will be available:</p> <ul style="list-style-type: none"> • A hard copy directory for members and upon request, potential members; • Web-based, searchable, online directory for members and the public; and • Electronic file of the directory for the Enrollment Broker • Hard copy, abbreviated version for the Enrollment Broker <p>Our Provider Directory will be available in paper form and through our website. The web version of the Provider Directory is updated weekly, prior to distribution to the Enrollment Broker and posting on our website.</p>

Encounter Data Functionality/Requirement	Delaware	Florida	Maryland
Identify all data elements as required by DHH for encounter data submission as stipulated in this Section of the RFP and the Systems Guide	<p>Meet</p> <p>All data elements required by the Medicaid single-state agency for encounter data submission are tracked, reported and included on encounter transmissions to the Medicaid single-state agency, its MMIS vendor or its FI as appropriate</p>	<p>Meet</p> <p>All data elements required by the Medicaid single-state agency for encounter data submission are tracked, reported and included on encounter transmissions to the Medicaid single-state agency, its MMIS vendor or its FI as appropriate</p>	<p>Meet</p> <p>All data elements required by the Medicaid single-state agency for encounter data submission are tracked, reported and included on encounter transmissions to the Medicaid single-state agency, its MMIS vendor or its FI as appropriate</p>
The CCN's system shall be able to transmit to and receive encounter data from the DHH FI's system as required for the appropriate submission of encounter data	<p>Meet</p> <p>All data elements required by the Medicaid single-state agency for encounter data submission are tracked, reported and included on encounter transmissions to the Medicaid single-state agency, its MMIS vendor or its FI as appropriate</p>	<p>Meet</p> <p>All data elements required by the Medicaid single-state agency for encounter data submission are tracked, reported and included on encounter transmissions to the Medicaid single-state agency, its MMIS vendor or its FI as appropriate</p>	<p>Meet</p> <p>All data elements required by the Medicaid single-state agency for encounter data submission are tracked, reported and included on encounter transmissions to the Medicaid single-state agency, its MMIS vendor or its FI as appropriate</p>
17.5.4.3 The CCN shall provide the FI with complete and accurate encounter data for all levels of healthcare services provided.	<p>We meet this requirement in the three example states and in our other seven Medicaid managed care states. We have encounter system implementation and submission best practices to validate data validity for all levels of healthcare services provided (ancillary, acute, and institutional services) prior to submitting encounter data to DHH:</p> <p>1. The QNXT™ system verifies that all necessary claims fields</p>	<p>We meet this requirement in the three example states and in our other seven Medicaid managed care states. We have encounter system implementation and submission best practices to validate data validity for all levels of healthcare services provided (ancillary, acute, and institutional services) prior to submitting encounter data to DHH:</p> <p>1. The QNXT™ system verifies that all necessary claims fields</p>	<p>We meet this requirement in the three example states and in our other seven Medicaid managed care states. We have encounter system implementation and submission best practices to validate data validity for all levels of healthcare services provided (ancillary, acute, and institutional services) prior to submitting encounter data to DHH:</p> <p>1. The QNXT™ system verifies that all necessary claims fields</p>

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	<p>are populated with values of the appropriate range and type prior to the encounter information being loaded onto the EMS.</p> <p>2 .Encounter data files from vendor sources go through a staging process. The staging process consists of automated and manual verification, to validate that files have the proper layout and the appropriate fields populated. In this staging process, correct files are allowed to pass; pended files are corrected if there are correctable errors, or are rejected if the errors cannot be corrected. This staging process results in only the cleanest files being imported into the EMS.</p> <p>3. After data from QNXT™ and vendor sources are loaded into the EMS, they must pass the EMS Scrub Edits, which are customized based on DHH's requirements for clean encounters. Files that are unlikely to pass the DHH's edits are not submitted until they are corrected. Encounter Unit analysts take responsibility for the correction. This proactive approach to identifying and</p>	<p>are populated with values of the appropriate range and type prior to the encounter information being loaded onto the EMS.</p> <p>2 .Encounter data files from vendor sources go through a staging process. The staging process consists of automated and manual verification, to validate that files have the proper layout and the appropriate fields populated. In this staging process, correct files are allowed to pass; pended files are corrected if there are correctable errors, or are rejected if the errors cannot be corrected. This staging process results in only the cleanest files being imported into the EMS.</p> <p>3. After data from QNXT™ and vendor sources are loaded into the EMS, they must pass the EMS Scrub Edits, which are customized based on DHH's requirements for clean encounters. Files that are unlikely to pass the DHH's edits are not submitted until they are corrected. Encounter Unit analysts take responsibility for the correction. This proactive approach to identifying and</p>	<p>are populated with values of the appropriate range and type prior to the encounter information being loaded onto the EMS.</p> <p>2 .Encounter data files from vendor sources go through a staging process. The staging process consists of automated and manual verification, to validate that files have the proper layout and the appropriate fields populated. In this staging process, correct files are allowed to pass; pended files are corrected if there are correctable errors, or are rejected if the errors cannot be corrected. This staging process results in only the cleanest files being imported into the EMS.</p> <p>3. After data from QNXT™ and vendor sources are loaded into the EMS, they must pass the EMS Scrub Edits, which are customized based on DHH's requirements for clean encounters. Files that are unlikely to pass the DHH's edits are not submitted until they are corrected. Encounter Unit analysts take responsibility for the correction. This proactive approach to identifying and</p>

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	correcting errors prior to the submission of data to the Commonwealth expedites review and adjudication.	correcting errors prior to the submission of data to the Commonwealth expedites review and adjudication.	correcting errors prior to the submission of data to the Commonwealth expedites review and adjudication.
17.5.4.4 The CCN shall have the ability to update CPT/HCPCS, ICD-9-CM, and other codes based on HIPAA standards and move to future versions as required.	Each of the states Aetna Better Health provides Medicaid managed care have different nuisances in the capture and reporting of encounter data. We have uniform written policies and procedures and system protocols that we apply to maintain compliance with, but separation on a state-by-state basis, these encounter reporting requirements. Aetna Better Health maintains strict compliance with updates regarding <i>Current Procedural Terminology (CPT)</i> , the <i>Healthcare Procedural Coding System (HCPCS)</i> (CPT/HCPCS), and ICD-9-CM and other codes in accordance with HIPAA standards so that claims and resulting encounters are processed in an orderly and consistent manner. CPT procedural codes are published by the American Medical Association (AMA). Updated annually on January 1, CPT is a proprietary terminology created and maintained by the AMA. Its purpose is to provide a uniform language for describing	Each of the states Aetna Better Health provides Medicaid managed care have different nuisances in the capture and reporting of encounter data. We have uniform written policies and procedures and system protocols that we apply to maintain compliance with, but separation on a state-by-state basis, these encounter reporting requirements. Aetna Better Health maintains strict compliance with updates regarding <i>Current Procedural Terminology (CPT)</i> , the <i>Healthcare Procedural Coding System (HCPCS)</i> (CPT/HCPCS), and ICD-9-CM and other codes in accordance with HIPAA standards so that claims and resulting encounters are processed in an orderly and consistent manner. CPT procedural codes are published by the American Medical Association (AMA). Updated annually on January 1, CPT is a proprietary terminology created and maintained by the AMA. Its purpose is to provide a uniform language for describing	Each of the states Aetna Better Health provides Medicaid managed care have different nuisances in the capture and reporting of encounter data. We have uniform written policies and procedures and system protocols that we apply to maintain compliance with, but separation on a state-by-state basis, these encounter reporting requirements. Aetna Better Health maintains strict compliance with updates regarding <i>Current Procedural Terminology (CPT)</i> , the <i>Healthcare Procedural Coding System (HCPCS)</i> (CPT/HCPCS), and ICD-9-CM and other codes in accordance with HIPAA standards so that claims and resulting encounters are processed in an orderly and consistent manner. CPT procedural codes are published by the American Medical Association (AMA). Updated annually on January 1, CPT is a proprietary terminology created and maintained by the AMA. Its purpose is to provide a uniform language for describing

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	<p>and reporting the professional services provided by physicians.</p> <p>HCPCS is maintained by the Centers for Medicare and Medicaid Services (CMS). Its purpose is to provide a system for reporting the medical services provided to Medicaid/Medicare members. HCPCS is made up of two parts: Level I is composed entirely of the current version of CPT; HCPCS Level II provides codes to represent medical services that are not covered by the CPT system, for example, medical supplies and services performed by healthcare professionals who are not physicians. The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. Healthcare professionals use the CPT to identify services and procedures they bill to Aetna Better Health for covered and medically necessary services. We understand that decisions regarding the addition, deletion, or</p>	<p>and reporting the professional services provided by physicians.</p> <p>HCPCS is maintained by the Centers for Medicare and Medicaid Services (CMS). Its purpose is to provide a system for reporting the medical services provided to Medicaid/Medicare members. HCPCS is made up of two parts: Level I is composed entirely of the current version of CPT; HCPCS Level II provides codes to represent medical services that are not covered by the CPT system, for example, medical supplies and services performed by healthcare professionals who are not physicians. The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. Healthcare professionals use the CPT to identify services and procedures they bill to Aetna Better Health for covered and medically necessary services. We understand that decisions regarding the addition, deletion, or</p>	<p>and reporting the professional services provided by physicians.</p> <p>HCPCS is maintained by the Centers for Medicare and Medicaid Services (CMS). Its purpose is to provide a system for reporting the medical services provided to Medicaid/Medicare members. HCPCS is made up of two parts: Level I is composed entirely of the current version of CPT; HCPCS Level II provides codes to represent medical services that are not covered by the CPT system, for example, medical supplies and services performed by healthcare professionals who are not physicians. The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. Healthcare professionals use the CPT to identify services and procedures they bill to Aetna Better Health for covered and medically necessary services. We understand that decisions regarding the addition, deletion, or</p>

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	<p>revision of CPT codes are made by the AMA. The CPT codes are republished and updated annually by the AMA. Level I of the HCPCS, the CPT codes, does not include codes needed to separately report medical items or services that are regularly billed by suppliers other than physicians. We are aware that HCPCS Level II is a standardized coding system to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DME) when used outside a physician's office. Because most Medicaid agencies, including DHH, require mandatory coverage of a variety of services, supplies, and equipment that are not identified by CPT codes, the level II HCPCS codes were established by CMS for submitting claims for these items. Currently, there are national HCPCS codes representing over 4,000 separate categories of like items or services that encompass millions of products from different manufacturers.</p>	<p>revision of CPT codes are made by the AMA. The CPT codes are republished and updated annually by the AMA. Level I of the HCPCS, the CPT codes, does not include codes needed to separately report medical items or services that are regularly billed by suppliers other than physicians. We are aware that HCPCS Level II is a standardized coding system to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DME) when used outside a physician's office. Because most Medicaid agencies, including DHH, require mandatory coverage of a variety of services, supplies, and equipment that are not identified by CPT codes, the level II HCPCS codes were established by CMS for submitting claims for these items. Currently, there are national HCPCS codes representing over 4,000 separate categories of like items or services that encompass millions of products from different manufacturers.</p>	<p>revision of CPT codes are made by the AMA. The CPT codes are republished and updated annually by the AMA. Level I of the HCPCS, the CPT codes, does not include codes needed to separately report medical items or services that are regularly billed by suppliers other than physicians. We are aware that HCPCS Level II is a standardized coding system to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DME) when used outside a physician's office. Because most Medicaid agencies, including DHH, require mandatory coverage of a variety of services, supplies, and equipment that are not identified by CPT codes, the level II HCPCS codes were established by CMS for submitting claims for these items. Currently, there are national HCPCS codes representing over 4,000 separate categories of like items or services that encompass millions of products from different manufacturers.</p>

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	<p>When submitting claims, we require our provider to use one of these codes to identify the items they are billing. The descriptor that is assigned to a code represents the definition of the items and services that can be billed using that code. For these reasons and to provide timely, accurate and complete encounters to the Medicaid agencies we provide managed care service to, we closely monitor and maintain compliance with the most current CPT/HCPCS coding requirements and stipulations. We also have written policies and procedures that require informing our provider network of CPT/HCPCS coding modifications that are effective as of a date-of-service to avoid unnecessary delays, confusion or problems in submitting complete, accurate and timely encounters to DHH and other Medicaid agencies.</p> <p>In addition to the above we also closely monitor and remain compliant with the following requirements:</p> <ul style="list-style-type: none"> • <u>Permanent National Codes - National</u> 	<p>When submitting claims, we require our provider to use one of these codes to identify the items they are billing. The descriptor that is assigned to a code represents the definition of the items and services that can be billed using that code. For these reasons and to provide timely, accurate and complete encounters to the Medicaid agencies we provide managed care service to, we closely monitor and maintain compliance with the most current CPT/HCPCS coding requirements and stipulations. We also have written policies and procedures that require informing our provider network of CPT/HCPCS coding modifications that are effective as of a date-of-service to avoid unnecessary delays, confusion or problems in submitting complete, accurate and timely encounters to DHH and other Medicaid agencies.</p> <p>In addition to the above we also closely monitor and remain compliant with the following requirements:</p> <ul style="list-style-type: none"> • <u>Permanent National Codes - National</u> 	<p>When submitting claims, we require our provider to use one of these codes to identify the items they are billing. The descriptor that is assigned to a code represents the definition of the items and services that can be billed using that code. For these reasons and to provide timely, accurate and complete encounters to the Medicaid agencies we provide managed care service to, we closely monitor and maintain compliance with the most current CPT/HCPCS coding requirements and stipulations. We also have written policies and procedures that require informing our provider network of CPT/HCPCS coding modifications that are effective as of a date-of-service to avoid unnecessary delays, confusion or problems in submitting complete, accurate and timely encounters to DHH and other Medicaid agencies.</p> <p>In addition to the above we also closely monitor and remain compliant with the following requirements:</p> <ul style="list-style-type: none"> • <u>Permanent National Codes - National</u>

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	<p>permanent HCPCS level II codes are maintained by the CMS HCPCS Workgroup</p> <ul style="list-style-type: none"> • <u>Miscellaneous Codes</u> - National codes also include "miscellaneous/not otherwise classified" codes. These codes are used when a supplier is submitting a bill for an item or service and there is no existing national code that adequately describes the item or service being billed. • <u>Temporary National Codes</u> - Temporary codes are for the purpose of meeting, within a short time frame, the national program operational needs that are not addressed by an already existing national code. We are aware that and monitor the CMS HCPCS Workgroup has set aside certain sections of the HCPCS code set to allow the Workgroup to develop temporary codes. • Types of temporary HCPCS codes: <ul style="list-style-type: none"> ○ The C codes were established to permit implementation of section 201 of the 	<p>permanent HCPCS level II codes are maintained by the CMS HCPCS Workgroup</p> <ul style="list-style-type: none"> • <u>Miscellaneous Codes</u> - National codes also include "miscellaneous/not otherwise classified" codes. These codes are used when a supplier is submitting a bill for an item or service and there is no existing national code that adequately describes the item or service being billed. • <u>Temporary National Codes</u> - Temporary codes are for the purpose of meeting, within a short time frame, the national program operational needs that are not addressed by an already existing national code. We are aware that and monitor the CMS HCPCS Workgroup has set aside certain sections of the HCPCS code set to allow the Workgroup to develop temporary codes. • Types of temporary HCPCS codes: <ul style="list-style-type: none"> ○ The C codes were established to permit implementation of section 201 of the 	<p>permanent HCPCS level II codes are maintained by the CMS HCPCS Workgroup</p> <ul style="list-style-type: none"> • <u>Miscellaneous Codes</u> - National codes also include "miscellaneous/not otherwise classified" codes. These codes are used when a supplier is submitting a bill for an item or service and there is no existing national code that adequately describes the item or service being billed. • <u>Temporary National Codes</u> - Temporary codes are for the purpose of meeting, within a short time frame, the national program operational needs that are not addressed by an already existing national code. We are aware that and monitor the CMS HCPCS Workgroup has set aside certain sections of the HCPCS code set to allow the Workgroup to develop temporary codes. • Types of temporary HCPCS codes: <ul style="list-style-type: none"> ○ The C codes were established to permit implementation of section 201 of the

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	<p>Balanced Budget Refinement Act of 1999.</p> <ul style="list-style-type: none"> ○ The Q codes are used to identify services that would not be given a CPT-4 code, such as drugs, biologicals, and other types of medical equipment or services, and which are not identified by national level II codes but for which codes are needed for claims processing purposes. ○ The G codes are used to identify professional health care procedures and services that would otherwise be coded in CPT-4 but for which there are no CPT-4 codes. ○ The K codes were established for use by the DME MACs when the currently existing permanent national codes do not include the codes needed to implement a DME MAC medical review policy. ○ The S codes are 	<p>Balanced Budget Refinement Act of 1999.</p> <ul style="list-style-type: none"> ○ The Q codes are used to identify services that would not be given a CPT-4 code, such as drugs, biologicals, and other types of medical equipment or services, and which are not identified by national level II codes but for which codes are needed for claims processing purposes. ○ The G codes are used to identify professional health care procedures and services that would otherwise be coded in CPT-4 but for which there are no CPT-4 codes. ○ The K codes were established for use by the DME MACs when the currently existing permanent national codes do not include the codes needed to implement a DME MAC medical review policy. ○ The S codes are 	<p>Balanced Budget Refinement Act of 1999.</p> <ul style="list-style-type: none"> ○ The Q codes are used to identify services that would not be given a CPT-4 code, such as drugs, biologicals, and other types of medical equipment or services, and which are not identified by national level II codes but for which codes are needed for claims processing purposes. ○ The G codes are used to identify professional health care procedures and services that would otherwise be coded in CPT-4 but for which there are no CPT-4 codes. ○ The K codes were established for use by the DME MACs when the currently existing permanent national codes do not include the codes needed to implement a DME MAC medical review policy. ○ The S codes are

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	<p>used by private insurers to report drugs, services, and supplies for which there are no national codes but for which codes are needed by the private sector to implement policies, programs, or claims processing.</p> <ul style="list-style-type: none"> ○ Certain H codes are used by those State Medicaid agencies that are mandated by State law to establish separate codes for identifying mental health services such as alcohol and drug treatment services. ○ The T codes are designated for use by Medicaid State agencies to establish codes for items for which there are no permanent national codes and for which codes are necessary to meet a national Medicaid program operating need. 	<p>used by private insurers to report drugs, services, and supplies for which there are no national codes but for which codes are needed by the private sector to implement policies, programs, or claims processing.</p> <ul style="list-style-type: none"> ○ Certain H codes are used by those State Medicaid agencies that are mandated by State law to establish separate codes for identifying mental health services such as alcohol and drug treatment services. ○ The T codes are designated for use by Medicaid State agencies to establish codes for items for which there are no permanent national codes and for which codes are necessary to meet a national Medicaid program operating need. 	<p>used by private insurers to report drugs, services, and supplies for which there are no national codes but for which codes are needed by the private sector to implement policies, programs, or claims processing.</p> <ul style="list-style-type: none"> ○ Certain H codes are used by those State Medicaid agencies that are mandated by State law to establish separate codes for identifying mental health services such as alcohol and drug treatment services. ○ The T codes are designated for use by Medicaid State agencies to establish codes for items for which there are no permanent national codes and for which codes are necessary to meet a national Medicaid program operating need.

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	<ul style="list-style-type: none"> Code Modifiers - In some instances, Medicaid agencies instruct Aetna Better Health to require its providers to require a <i>code modifier</i> to a HCPCS code to provide additional information regarding the service or item identified by the HCPCS code. Modifiers are used when the information provided by a HCPCS code descriptor needs to be supplemented to identify specific circumstances that may apply to an item or service. For example, a UE modifier is often used when the item identified by a HCPCS code is "used equipment," a NU modifier is used for "new equipment." The level II HCPCS modifiers are either alpha-numeric or two letters. HCPCS Updates to Permanent National Codes – We are aware that the national codes are updated annually <p>CPT Category II Codes - We are aware that CPT Category II codes are supplemental tracking codes used for</p>	<ul style="list-style-type: none"> Code Modifiers - In some instances, Medicaid agencies instruct Aetna Better Health to require its providers to require a <i>code modifier</i> to a HCPCS code to provide additional information regarding the service or item identified by the HCPCS code. Modifiers are used when the information provided by a HCPCS code descriptor needs to be supplemented to identify specific circumstances that may apply to an item or service. For example, a UE modifier is often used when the item identified by a HCPCS code is "used equipment," a NU modifier is used for "new equipment." The level II HCPCS modifiers are either alpha-numeric or two letters. HCPCS Updates to Permanent National Codes – We are aware that the national codes are updated annually <p>CPT Category II Codes - We are aware that CPT Category II codes are supplemental tracking codes used for</p>	<ul style="list-style-type: none"> Code Modifiers - In some instances, Medicaid agencies instruct Aetna Better Health to require its providers to require a <i>code modifier</i> to a HCPCS code to provide additional information regarding the service or item identified by the HCPCS code. Modifiers are used when the information provided by a HCPCS code descriptor needs to be supplemented to identify specific circumstances that may apply to an item or service. For example, a UE modifier is often used when the item identified by a HCPCS code is "used equipment," a NU modifier is used for "new equipment." The level II HCPCS modifiers are either alpha-numeric or two letters. HCPCS Updates to Permanent National Codes – We are aware that the national codes are updated annually <p>CPT Category II Codes - We are aware that CPT Category II codes are supplemental tracking codes used for</p>

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	<p>performance measurement. These tracking codes for performance measurement decrease the need for record abstraction and chart review, and thereby minimize administrative burdens on physicians and other health care professionals. These codes are intended to facilitate data collection about quality of care by coding certain services and/or test results that support performance measures and that have been agreed upon as contributing to good patient care. CPT II codes are maintained and updated by the Performance Measures Advisory Group (PMAG), an advisory body to the CPT Editorial Panel. The PMAG comprises performance measurement experts representing the Agency of Healthcare Research and Quality (AHRQ), the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Committee for Quality Assurance (NCQA) and the</p>	<p>performance measurement. These tracking codes for performance measurement decrease the need for record abstraction and chart review, and thereby minimize administrative burdens on physicians and other health care professionals. These codes are intended to facilitate data collection about quality of care by coding certain services and/or test results that support performance measures and that have been agreed upon as contributing to good patient care. CPT II codes are maintained and updated by the Performance Measures Advisory Group (PMAG), an advisory body to the CPT Editorial Panel. The PMAG comprises performance measurement experts representing the Agency of Healthcare Research and Quality (AHRQ), the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Committee for Quality Assurance (NCQA) and the</p>	<p>performance measurement. These tracking codes for performance measurement decrease the need for record abstraction and chart review, and thereby minimize administrative burdens on physicians and other health care professionals. These codes are intended to facilitate data collection about quality of care by coding certain services and/or test results that support performance measures and that have been agreed upon as contributing to good patient care. CPT II codes are maintained and updated by the Performance Measures Advisory Group (PMAG), an advisory body to the CPT Editorial Panel. The PMAG comprises performance measurement experts representing the Agency of Healthcare Research and Quality (AHRQ), the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Committee for Quality Assurance (NCQA) and the</p>

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	<p>Physician Consortium for Performance Improvement.</p> <p>The <i>International Classification of Diseases, Clinical Modification</i>, currently in its ninth revision (ICD-9-CM), is used to describe and report the illnesses, conditions, and injuries of patients who require medical services. ICD-9-CM is made up of a series of numerical and alphanumeric codes and code descriptions that represent very specific illnesses and injuries. Similarly, the services provided by physicians and other healthcare professionals are described and reported by using terminologies and classification systems. The <i>International Classification of Diseases, Clinical Modification</i>, provides a system for coding medical procedures performed in the inpatient departments of hospitals, but two other systems apply to the services provided by physicians and other medical providers in hospital-based outpatient departments, physicians' offices, and other ambulatory settings: the <i>Current Procedural Terminology</i></p>	<p>Physician Consortium for Performance Improvement.</p> <p>The <i>International Classification of Diseases, Clinical Modification</i>, currently in its ninth revision (ICD-9-CM), is used to describe and report the illnesses, conditions, and injuries of patients who require medical services. ICD-9-CM is made up of a series of numerical and alphanumeric codes and code descriptions that represent very specific illnesses and injuries. Similarly, the services provided by physicians and other healthcare professionals are described and reported by using terminologies and classification systems. The <i>International Classification of Diseases, Clinical Modification</i>, provides a system for coding medical procedures performed in the inpatient departments of hospitals, but two other systems apply to the services provided by physicians and other medical providers in hospital-based outpatient departments, physicians' offices, and other ambulatory settings: the <i>Current Procedural Terminology</i></p>	<p>Physician Consortium for Performance Improvement.</p> <p>The <i>International Classification of Diseases, Clinical Modification</i>, currently in its ninth revision (ICD-9-CM), is used to describe and report the illnesses, conditions, and injuries of patients who require medical services. ICD-9-CM is made up of a series of numerical and alphanumeric codes and code descriptions that represent very specific illnesses and injuries. Similarly, the services provided by physicians and other healthcare professionals are described and reported by using terminologies and classification systems. The <i>International Classification of Diseases, Clinical Modification</i>, provides a system for coding medical procedures performed in the inpatient departments of hospitals, but two other systems apply to the services provided by physicians and other medical providers in hospital-based outpatient departments, physicians' offices, and other ambulatory settings: the <i>Current Procedural Terminology</i></p>

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	and the <i>Healthcare Common Procedure Coding System</i> .	and the <i>Healthcare Common Procedure Coding System</i> .	and the <i>Healthcare Common Procedure Coding System</i> .
<p>17.5.4.5 In addition to CPT, ICD-9-CM and other national coding standards, the use of applicable HCPCS Level II and Category II CPT codes are mandatory, aiding both the CCN and DHH to evaluate performance measures.</p>	<p>Each of the states Aetna Better Health provides Medicaid managed care have different nuances in the capture and reporting of encounter data. We have uniform written policies and procedures and system protocols that we apply to maintain compliance with, but separation on a state-by-state basis, these encounter reporting requirements. Aetna Better Health maintains strict compliance with updates regarding <i>Current Procedural Terminology (CPT)</i>, the <i>Healthcare Procedural Coding System (HCPCS)</i> (CPT/HCPCS), and ICD-9-CM and other codes in accordance with HIPAA standards so that claims and resulting encounters are processed in an orderly and consistent manner. CPT procedural codes are published by the American Medical Association (AMA). Updated annually on January 1, CPT is a proprietary terminology created and maintained by the AMA. Its purpose is to provide a uniform language for describing and reporting the professional services</p>	<p>Each of the states Aetna Better Health provides Medicaid managed care have different nuances in the capture and reporting of encounter data. We have uniform written policies and procedures and system protocols that we apply to maintain compliance with, but separation on a state-by-state basis, these encounter reporting requirements. Aetna Better Health maintains strict compliance with updates regarding <i>Current Procedural Terminology (CPT)</i>, the <i>Healthcare Procedural Coding System (HCPCS)</i> (CPT/HCPCS), and ICD-9-CM and other codes in accordance with HIPAA standards so that claims and resulting encounters are processed in an orderly and consistent manner. CPT procedural codes are published by the American Medical Association (AMA). Updated annually on January 1, CPT is a proprietary terminology created and maintained by the AMA. Its purpose is to provide a uniform language for describing and reporting the professional services</p>	<p>Each of the states Aetna Better Health provides Medicaid managed care have different nuances in the capture and reporting of encounter data. We have uniform written policies and procedures and system protocols that we apply to maintain compliance with, but separation on a state-by-state basis, these encounter reporting requirements. Aetna Better Health maintains strict compliance with updates regarding <i>Current Procedural Terminology (CPT)</i>, the <i>Healthcare Procedural Coding System (HCPCS)</i> (CPT/HCPCS), and ICD-9-CM and other codes in accordance with HIPAA standards so that claims and resulting encounters are processed in an orderly and consistent manner. CPT procedural codes are published by the American Medical Association (AMA). Updated annually on January 1, CPT is a proprietary terminology created and maintained by the AMA. Its purpose is to provide a uniform language for describing and reporting the professional services</p>

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	<p>provided by physicians. HCPCS is maintained by the Centers for Medicare and Medicaid Services (CMS). Its purpose is to provide a system for reporting the medical services provided to Medicaid/Medicare members. HCPCS is made up of two parts: Level I is composed entirely of the current version of CPT; HCPCS Level II provides codes to represent medical services that are not covered by the CPT system, for example, medical supplies and services performed by healthcare professionals who are not physicians. The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. Health care professionals use the CPT to identify services and procedures they bill to Aetna Better Health for covered and medically necessary services. We understand that decisions regarding the addition, deletion, or revision of CPT codes are made by the AMA. The CPT codes are</p>	<p>provided by physicians. HCPCS is maintained by the Centers for Medicare and Medicaid Services (CMS). Its purpose is to provide a system for reporting the medical services provided to Medicaid/Medicare members. HCPCS is made up of two parts: Level I is composed entirely of the current version of CPT; HCPCS Level II provides codes to represent medical services that are not covered by the CPT system, for example, medical supplies and services performed by healthcare professionals who are not physicians. The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other healthcare professionals. Healthcare professionals use the CPT to identify services and procedures they bill to Aetna Better Health for covered and medically necessary services. We understand that decisions regarding the addition, deletion, or revision of CPT codes are made by the AMA. The CPT codes are</p>	<p>provided by physicians. HCPCS is maintained by the Centers for Medicare and Medicaid Services (CMS). Its purpose is to provide a system for reporting the medical services provided to Medicaid/Medicare members. HCPCS is made up of two parts: Level I is composed entirely of the current version of CPT; HCPCS Level II provides codes to represent medical services that are not covered by the CPT system, for example, medical supplies and services performed by healthcare professionals who are not physicians. The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. Healthcare professionals use the CPT to identify services and procedures they bill to Aetna Better Health for covered and medically necessary services. We understand that decisions regarding the addition, deletion, or revision of CPT codes are made by the AMA. The CPT codes are</p>

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	<p>republished and updated annually by the AMA. Level I of the HCPCS, the CPT codes, does not include codes needed to separately report medical items or services that are regularly billed by suppliers other than physicians. We are aware that HCPCS Level II is a standardized coding system to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DME) when used outside a physician's office. Because most Medicaid agencies, including DHH, require mandatory coverage of a variety of services, supplies, and equipment that are not identified by CPT codes, the level II HCPCS codes were established by CMS for submitting claims for these items. Currently, there are national HCPCS codes representing over 4,000 separate categories of like items or services that encompass millions of products from different manufacturers. When submitting claims, we require our provider to use one of these</p>	<p>republished and updated annually by the AMA. Level I of the HCPCS, the CPT codes, does not include codes needed to separately report medical items or services that are regularly billed by suppliers other than physicians. We are aware that HCPCS Level II is a standardized coding system to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DME) when used outside a physician's office. Because most Medicaid agencies, including DHH, require mandatory coverage of a variety of services, supplies, and equipment that are not identified by CPT codes, the level II HCPCS codes were established by CMS for submitting claims for these items. Currently, there are national HCPCS codes representing over 4,000 separate categories of like items or services that encompass millions of products from different manufacturers. When submitting claims, we require our provider to use one of these</p>	<p>republished and updated annually by the AMA. Level I of the HCPCS, the CPT codes, does not include codes needed to separately report medical items or services that are regularly billed by suppliers other than physicians. We are aware that HCPCS Level II is a standardized coding system to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DME) when used outside a physician's office. Because most Medicaid agencies, including DHH, require mandatory coverage of a variety of services, supplies, and equipment that are not identified by CPT codes, the level II HCPCS codes were established by CMS for submitting claims for these items. Currently, there are national HCPCS codes representing over 4,000 separate categories of like items or services that encompass millions of products from different manufacturers. When submitting claims, we require our provider to use one of these</p>

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	<p>codes to identify the items they are billing. The descriptor that is assigned to a code represents the definition of the items and services that can be billed using that code. For these reasons and to provide timely, accurate and complete encounters to the Medicaid agencies we provide managed care service to, we closely monitor and maintain compliance with the most current CPT/HCPCS coding requirements and stipulations. We also have written policies and procedures that require informing our provider network of CPT/HCPCS coding modifications that are effective as of a date-of-service to avoid unnecessary delays, confusion or problems in submitting complete, accurate and timely encounters to DHH and other Medicaid agencies.</p> <p>In addition to the above we also closely monitor and remain compliant with the following requirements:</p> <ul style="list-style-type: none"> • <u>Permanent National Codes</u> - National permanent HCPCS level II codes are maintained by the CMS HCPCS 	<p>codes to identify the items they are billing. The descriptor that is assigned to a code represents the definition of the items and services that can be billed using that code. For these reasons and to provide timely, accurate and complete encounters to the Medicaid agencies we provide managed care service to, we closely monitor and maintain compliance with the most current CPT/HCPCS coding requirements and stipulations. We also have written policies and procedures that require informing our provider network of CPT/HCPCS coding modifications that are effective as of a date-of-service to avoid unnecessary delays, confusion or problems in submitting complete, accurate and timely encounters to DHH and other Medicaid agencies.</p> <p>In addition to the above we also closely monitor and remain compliant with the following requirements:</p> <ul style="list-style-type: none"> • <u>Permanent National Codes</u> - National permanent HCPCS level II codes are maintained by the CMS HCPCS 	<p>codes to identify the items they are billing. The descriptor that is assigned to a code represents the definition of the items and services that can be billed using that code. For these reasons and to provide timely, accurate and complete encounters to the Medicaid agencies we provide managed care service to, we closely monitor and maintain compliance with the most current CPT/HCPCS coding requirements and stipulations. We also have written policies and procedures that require informing our provider network of CPT/HCPCS coding modifications that are effective as of a date-of-service to avoid unnecessary delays, confusion or problems in submitting complete, accurate and timely encounters to DHH and other Medicaid agencies.</p> <p>In addition to the above we also closely monitor and remain compliant with the following requirements:</p> <ul style="list-style-type: none"> • <u>Permanent National Codes</u> - National permanent HCPCS level II codes are maintained by the CMS HCPCS

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	<p>Workgroup</p> <ul style="list-style-type: none"> • <u>Miscellaneous Codes</u> - National codes also include "miscellaneous/not otherwise classified" codes. These codes are used when a supplier is submitting a bill for an item or service and there is no existing national code that adequately describes the item or service being billed. • <u>Temporary National Codes</u> - Temporary codes are for the purpose of meeting, within a short time frame, the national program operational needs that are not addressed by an already existing national code. We are aware that and monitor the CMS HCPCS Workgroup has set aside certain sections of the HCPCS code set to allow the Workgroup to develop temporary codes. • Types of temporary HCPCS codes: <ul style="list-style-type: none"> ○ The C codes were established to permit implementation of section 201 of the Balanced Budget Refinement Act of 1999. ○ The Q codes are 	<p>Workgroup</p> <ul style="list-style-type: none"> • <u>Miscellaneous Codes</u> - National codes also include "miscellaneous/not otherwise classified" codes. These codes are used when a supplier is submitting a bill for an item or service and there is no existing national code that adequately describes the item or service being billed. • <u>Temporary National Codes</u> - Temporary codes are for the purpose of meeting, within a short time frame, the national program operational needs that are not addressed by an already existing national code. We are aware that and monitor the CMS HCPCS Workgroup has set aside certain sections of the HCPCS code set to allow the Workgroup to develop temporary codes. • Types of temporary HCPCS codes: <ul style="list-style-type: none"> ○ The C codes were established to permit implementation of section 201 of the Balanced Budget Refinement Act of 1999. ○ The Q codes are 	<p>Workgroup</p> <ul style="list-style-type: none"> • <u>Miscellaneous Codes</u> - National codes also include "miscellaneous/not otherwise classified" codes. These codes are used when a supplier is submitting a bill for an item or service and there is no existing national code that adequately describes the item or service being billed. • <u>Temporary National Codes</u> - Temporary codes are for the purpose of meeting, within a short time frame, the national program operational needs that are not addressed by an already existing national code. We are aware that and monitor the CMS HCPCS Workgroup has set aside certain sections of the HCPCS code set to allow the Workgroup to develop temporary codes. • Types of temporary HCPCS codes: <ul style="list-style-type: none"> ○ The C codes were established to permit implementation of section 201 of the Balanced Budget Refinement Act of 1999. ○ The Q codes are

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	<p>used to identify services that would not be given a CPT-4 code, such as drugs, biologicals, and other types of medical equipment or services, and which are not identified by national level II codes but for which codes are needed for claims processing purposes.</p> <ul style="list-style-type: none"> ○ The G codes are used to identify professional healthcare procedures and services that would otherwise be coded in CPT-4 but for which there are no CPT-4 codes. ○ The K codes were established for use by the DME MACs when the currently existing permanent national codes do not include the codes needed to implement a DME MAC medical review policy. ○ The S codes are used by private insurers to report drugs, services, and supplies for which there are no national codes but for which codes are needed by the 	<p>used to identify services that would not be given a CPT-4 code, such as drugs, biologicals, and other types of medical equipment or services, and which are not identified by national level II codes but for which codes are needed for claims processing purposes.</p> <ul style="list-style-type: none"> ○ The G codes are used to identify professional health care procedures and services that would otherwise be coded in CPT-4 but for which there are no CPT-4 codes. ○ The K codes were established for use by the DME MACs when the currently existing permanent national codes do not include the codes needed to implement a DME MAC medical review policy. ○ The S codes are used by private insurers to report drugs, services, and supplies for which there are no national codes but for which codes are needed by the private sector to 	<p>used to identify services that would not be given a CPT-4 code, such as drugs, biologicals, and other types of medical equipment or services, and which are not identified by national level II codes but for which codes are needed for claims processing purposes.</p> <ul style="list-style-type: none"> ○ The G codes are used to identify professional health care procedures and services that would otherwise be coded in CPT-4 but for which there are no CPT-4 codes. ○ The K codes were established for use by the DME MACs when the currently existing permanent national codes do not include the codes needed to implement a DME MAC medical review policy. ○ The S codes are used by private insurers to report drugs, services, and supplies for which there are no national codes but for which codes are needed by the private sector to

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	<p>private sector to implement policies, programs, or claims processing.</p> <ul style="list-style-type: none"> ○ Certain H codes are used by those State Medicaid agencies that are mandated by State law to establish separate codes for identifying mental health services such as alcohol and drug treatment services. ○ The T codes are designated for use by Medicaid State agencies to establish codes for items for which there are no permanent national codes and for which codes are necessary to meet a national Medicaid program operating need. ● Code Modifiers - In some instances, Medicaid agencies instruct Aetna Better Health to require its providers to require a <i>code modifier</i> to a HCPCS code to provide additional information regarding the service or item identified by the HCPCS code. Modifiers are used when the information provided by a HCPCS 	<p>implement policies, programs, or claims processing.</p> <ul style="list-style-type: none"> ○ Certain H codes are used by those State Medicaid agencies that are mandated by State law to establish separate codes for identifying mental health services such as alcohol and drug treatment services. ○ The T codes are designated for use by Medicaid State agencies to establish codes for items for which there are no permanent national codes and for which codes are necessary to meet a national Medicaid program operating need. ● Code Modifiers - In some instances, Medicaid agencies instruct Aetna Better Health to require its providers to require a <i>code modifier</i> to a HCPCS code to provide additional information regarding the service or item identified by the HCPCS code. Modifiers are used when the information provided by a HCPCS code descriptor needs 	<p>implement policies, programs, or claims processing.</p> <ul style="list-style-type: none"> ○ Certain H codes are used by those State Medicaid agencies that are mandated by State law to establish separate codes for identifying mental health services such as alcohol and drug treatment services. ○ The T codes are designated for use by Medicaid State agencies to establish codes for items for which there are no permanent national codes and for which codes are necessary to meet a national Medicaid program operating need. ● Code Modifiers - In some instances, Medicaid agencies instruct Aetna Better Health to require its providers to require a <i>code modifier</i> to a HCPCS code to provide additional information regarding the service or item identified by the HCPCS code. Modifiers are used when the information provided by a HCPCS code descriptor needs

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	<p>code descriptor needs to be supplemented to identify specific circumstances that may apply to an item or service. For example, a UE modifier is often used when the item identified by a HCPCS code is "used equipment," a NU modifier is used for "new equipment." The level II HCPCS modifiers are either alpha-numeric or two letters.</p> <ul style="list-style-type: none"> • HCPCS Updates to Permanent National Codes – We are aware that the national codes are updated annually <p>CPT Category II Codes - We are aware that CPT Category II codes are supplemental tracking codes used for performance measurement. These tracking codes for performance measurement decrease the need for record abstraction and chart review, and thereby minimize administrative burdens on physicians and other healthcare professionals. These codes are intended to facilitate data collection about quality of care by coding certain services</p>	<p>to be supplemented to identify specific circumstances that may apply to an item or service. For example, a UE modifier is often used when the item identified by a HCPCS code is "used equipment," a NU modifier is used for "new equipment." The level II HCPCS modifiers are either alpha-numeric or two letters.</p> <ul style="list-style-type: none"> • HCPCS Updates to Permanent National Codes – We are aware that the national codes are updated annually <p>CPT Category II Codes - We are aware that CPT Category II codes are supplemental tracking codes used for performance measurement. These tracking codes for performance measurement decrease the need for record abstraction and chart review, and thereby minimize administrative burdens on physicians and other health care professionals. These codes are intended to facilitate data collection about quality of care by coding certain services and/or test results that</p>	<p>to be supplemented to identify specific circumstances that may apply to an item or service. For example, a UE modifier is often used when the item identified by a HCPCS code is "used equipment," a NU modifier is used for "new equipment." The level II HCPCS modifiers are either alpha-numeric or two letters.</p> <ul style="list-style-type: none"> • HCPCS Updates to Permanent National Codes – We are aware that the national codes are updated annually <p>CPT Category II Codes - We are aware that CPT Category II codes are supplemental tracking codes used for performance measurement. These tracking codes for performance measurement decrease the need for record abstraction and chart review, and thereby minimize administrative burdens on physicians and other health care professionals. These codes are intended to facilitate data collection about quality of care by coding certain services and/or test results that</p>

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	<p>and/or test results that support performance measures and that have been agreed upon as contributing to good patient care. CPT II codes are maintained and updated by the Performance Measures Advisory Group (PMAG), an advisory body to the CPT Editorial Panel. The PMAG comprises performance measurement experts representing the Agency of Healthcare Research and Quality (AHRQ), the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Committee for Quality Assurance (NCQA) and the Physician Consortium for Performance Improvement.</p> <p>The <i>International Classification of Diseases, Clinical Modification</i>, currently in its ninth revision (ICD-9-CM), is used to describe and report the illnesses, conditions, and injuries of patients who require medical services. ICD-9-CM is made up of a series of numerical and</p>	<p>support performance measures and that have been agreed upon as contributing to good patient care. CPT II codes are maintained and updated by the Performance Measures Advisory Group (PMAG), an advisory body to the CPT Editorial Panel. The PMAG comprises performance measurement experts representing the Agency of Healthcare Research and Quality (AHRQ), the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Committee for Quality Assurance (NCQA) and the Physician Consortium for Performance Improvement.</p> <p>The <i>International Classification of Diseases, Clinical Modification</i>, currently in its ninth revision (ICD-9-CM), is used to describe and report the illnesses, conditions, and injuries of patients who require medical services. ICD-9-CM is made up of a series of numerical and alphanumeric codes</p>	<p>support performance measures and that have been agreed upon as contributing to good patient care. CPT II codes are maintained and updated by the Performance Measures Advisory Group (PMAG), an advisory body to the CPT Editorial Panel. The PMAG comprises performance measurement experts representing the Agency of Healthcare Research and Quality (AHRQ), the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Committee for Quality Assurance (NCQA) and the Physician Consortium for Performance Improvement.</p> <p>The <i>International Classification of Diseases, Clinical Modification</i>, currently in its ninth revision (ICD-9-CM), is used to describe and report the illnesses, conditions, and injuries of patients who require medical services. ICD-9-CM is made up of a series of numerical and alphanumeric codes</p>

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	<p>alphanumeric codes and code descriptions that represent very specific illnesses and injuries. Similarly, the services provided by physicians and other healthcare professionals are described and reported by using terminologies and classification systems. The <i>International Classification of Diseases, Clinical Modification</i>, provides a system for coding medical procedures performed in the inpatient departments of hospitals, but two other systems apply to the services provided by physicians and other medical providers in hospital-based outpatient departments, physicians' offices, and other ambulatory settings: the <i>Current Procedural Terminology</i> and the <i>Healthcare Common Procedure Coding System</i>.</p>	<p>and code descriptions that represent very specific illnesses and injuries. Similarly, the services provided by physicians and other healthcare professionals are described and reported by using terminologies and classification systems. The <i>International Classification of Diseases, Clinical Modification</i>, provides a system for coding medical procedures performed in the inpatient departments of hospitals, but two other systems apply to the services provided by physicians and other medical providers in hospital-based outpatient departments, physicians' offices, and other ambulatory settings: the <i>Current Procedural Terminology</i> and the <i>Healthcare Common Procedure Coding System</i>.</p>	<p>and code descriptions that represent very specific illnesses and injuries. Similarly, the services provided by physicians and other healthcare professionals are described and reported by using terminologies and classification systems. The <i>International Classification of Diseases, Clinical Modification</i>, provides a system for coding medical procedures performed in the inpatient departments of hospitals, but two other systems apply to the services provided by physicians and other medical providers in hospital-based outpatient departments, physicians' offices, and other ambulatory settings: the <i>Current Procedural Terminology</i> and the <i>Healthcare Common Procedure Coding System</i>.</p>
<p>17.5.4.6 The CCN shall have the capability to convert all information that enters its claims system via hard copy paper claims to electronic encounter data, to be submitted in the appropriate HIPAA compliant formats to DHH's FI.</p>	<p>In each of the three states we selected (in fact in each of our states) we have the capability and capacity to convert all the claim information received via hard copy "paper" claims to electronic claims using Optical Character Recognition (OCR) technology. All paper</p>	<p>In each of the three states we selected (in fact in each of our states) we have the capability and capacity to convert all the claim information received via hard copy "paper" claims to electronic claims using Optical Character Recognition (OCR) technology. All paper</p>	<p>In each of the three states we selected (in fact in each of our states) we have the capability and capacity to convert all the claim information received via hard copy "paper" claims to electronic claims using Optical Character Recognition (OCR) technology. All paper</p>

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	<p>claims are converted to electronic images by our vendor (EMDEON–using their Alchemy program). If the claim cannot be translated into an electronic data record by the OCR process, then the paper claims is sent directly to our claims department for data entry. Each claim is assigned a unique claim number and an electronic file of the claim is created. This file is uploaded into QNXT™ to be accessed by the claims team. The paper claim is in the QNXT™ system within 1 to 3 business days from its receipt. Additionally, the scanned image of the paper claim is stored in an image repository and is viewable to Aetna Better Health personnel, as needed.</p> <p>In addition, Microsoft BizTalk with HIPAA Accelerator™ processes HIPAA-compliant transactions easily and efficiently, allowing Aetna Better Health to accept information electronically from almost any HIPAA-compliant contractor or provider. Microsoft BizTalk with HIPAA Accelerator™ is a data transformation application that translates data to and</p>	<p>claims are converted to electronic images by our vendor (EMDEON–using their Alchemy program). If the claim cannot be translated into an electronic data record by the OCR process, then the paper claims is sent directly to our claims department for data entry. Each claim is assigned a unique claim number and an electronic file of the claim is created. This file is uploaded into QNXT™ to be accessed by the claims team. The paper claim is in the QNXT™ system within 1 to 3 business days from its receipt. Additionally, the scanned image of the paper claim is stored in an image repository and is viewable to Aetna Better Health personnel, as needed.</p> <p>In addition, Microsoft BizTalk with HIPAA Accelerator™ processes HIPAA-compliant transactions easily and efficiently, allowing Aetna Better Health to accept information electronically from almost any HIPAA-compliant contractor or provider. Microsoft BizTalk with HIPAA Accelerator™ is a data transformation application that translates data to and</p>	<p>claims are converted to electronic images by our vendor (EMDEON–using their Alchemy program). If the claim cannot be translated into an electronic data record by the OCR process, then the paper claims is sent directly to our claims department for data entry. Each claim is assigned a unique claim number and an electronic file of the claim is created. This file is uploaded into QNXT™ to be accessed by the claims team. The paper claim is in the QNXT™ system within 1 to 3 business days from its receipt. Additionally, the scanned image of the paper claim is stored in an image repository and is viewable to Aetna Better Health personnel, as needed.</p> <p>In addition, Microsoft BizTalk with HIPAA Accelerator™ processes HIPAA-compliant transactions easily and efficiently, allowing Aetna Better Health to accept information electronically from almost any HIPAA-compliant contractor or provider. Microsoft BizTalk with HIPAA Accelerator™ is a data transformation application that translates data to and</p>

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	<p>from the full spectrum of HIPAA Transactions sets in a highly customizable, flexible, and robust server-based environment. Moreover, Accelerator has the Washington Publishing Company (WPC) Implementation Guide schemas for each HIPAA ANSI X12 transaction embedded directly into its application engine, including a facility to update these schemas automatically as the Transactions sets are updated over time. Also, Foresight HIPAA Validator™ InStream™ a fully functional HIPAA editing and validation application. It can validate HIPAA transactions through all seven levels of edits as defined by the Workgroup for Electronic Data Interchange and Strategic National Implementation Process (WEDI/SNIP), has all standard HIPAA code sets embedded, and can support custom, trading-partner-specific companion guides and validation requirements. In addition, it supports validation at the individual edit level, allowing Aetna Better Health to accept all compliant records that pass at a lower level of</p>	<p>from the full spectrum of HIPAA Transactions sets in a highly customizable, flexible, and robust server-based environment. Moreover, Accelerator has the Washington Publishing Company (WPC) Implementation Guide schemas for each HIPAA ANSI X12 transaction embedded directly into its application engine, including a facility to update these schemas automatically as the Transactions sets are updated over time. Also, Foresight HIPAA Validator™ InStream™ a fully functional HIPAA editing and validation application. It can validate HIPAA transactions through all seven levels of edits as defined by the Workgroup for Electronic Data Interchange and Strategic National Implementation Process (WEDI/SNIP), has all standard HIPAA code sets embedded, and can support custom, trading-partner-specific companion guides and validation requirements. In addition, it supports validation at the individual edit level, allowing Aetna Better Health to accept all compliant records that pass at a lower level of</p>	<p>from the full spectrum of HIPAA Transactions sets in a highly customizable, flexible, and robust server-based environment. Moreover, Accelerator has the Washington Publishing Company (WPC) Implementation Guide schemas for each HIPAA ANSI X12 transaction embedded directly into its application engine, including a facility to update these schemas automatically as the Transactions sets are updated over time. Also, Foresight HIPAA Validator™ InStream™ a fully functional HIPAA editing and validation application. It can validate HIPAA transactions through all seven levels of edits as defined by the Workgroup for Electronic Data Interchange and Strategic National Implementation Process (WEDI/SNIP), has all standard HIPAA code sets embedded, and can support custom, trading-partner-specific companion guides and validation requirements. In addition, it supports validation at the individual edit level, allowing Aetna Better Health to accept all compliant records that pass at a lower level of</p>

Encounter Data Functionality/Requirement	Delaware	Florida	Maryland
	edit, rather than requiring all seven levels of edits. The application also provides descriptive error reports to submitters to facilitate quick error resolution.	edit, rather than requiring all seven levels of edits. The application also provides descriptive error reports to submitters to facilitate quick error resolution.	edit, rather than requiring all seven levels of edits. The application also provides descriptive error reports to submitters to facilitate quick error resolution.
<p>17.5.4.11 Due to the need for timely data and to maintain integrity of processing sequence, the CCN shall address any issues that prevent processing of an encounter; acceptable standards shall be ninety percent (90%) of reported repairable errors are addressed within thirty (30) calendar days and ninety-nine percent (99%) of reported repairable errors within sixty (60) calendar days or within a negotiated timeframe approved by DHH. Failure to promptly research and address reported errors, including submission of and compliance with an acceptable corrective action plan may result in monetary penalties.</p>	<p>We understand and agree to this stipulation. The state Medicaid agencies regulating the three health plans we selected as an example have similar requirements; in fact, it is our experience that this is a common stipulation.</p> <p>For the twelve months ending May 1, 2011, our encounter acceptance rates are as follows:</p> <p>Delaware: Professional 98.13% - Institutional 99.97</p> <p>Florida: Professional 99.00% - Institutional 98.72 - NCPDP 98.00%</p> <p>Maryland: Professional 98.62% - Institutional 98.72%</p>	<p>We understand and agree to this stipulation. The state Medicaid agencies regulating the three health plans we selected as an example have similar requirements; in fact, it is our experience that this is a common stipulation.</p> <p>For the twelve months ending May 1, 2011, our encounter acceptance rates are as follows:</p> <p>Delaware: Professional 98.13% - Institutional 99.97</p> <p>Florida: Professional 99.00% - Institutional 98.72 - NCPDP 98.00%</p> <p>Maryland: Professional 98.62% - Institutional 98.72%</p>	<p>We understand and agree to this stipulation. The state Medicaid agencies regulating the three health plans we selected as an example have similar requirements; in fact, it is our experience that this is a common stipulation.</p> <p>For the twelve months ending May 1, 2011, our encounter acceptance rates are as follows:</p> <p>Delaware: Professional 98.13% - Institutional 99.97</p> <p>Florida: Professional 99.00% - Institutional 98.72 - NCPDP 98.00%</p> <p>Maryland: Professional 98.62% - Institutional 98.72%</p>
<p>17.5.4.12 For encounter data submissions, the CCN shall submit ninety-five (95%) of its encounter data at least monthly due no later than the twenty-fifth (25th) calendar day of the month following the month in which they were processed and approved/paid, including encounters reflecting a zero dollar amount (\$0.00) and encounters in which the CCN</p>	<p>We understand and agree to this stipulation. The state Medicaid agencies regulating the three health plans we selected as an example have similar requirements; in fact, it is our experience that this is a common stipulation.</p>	<p>We understand and agree to this stipulation. The state Medicaid agencies regulating the three health plans we selected as an example have similar requirements; in fact, it is our experience that this is a common stipulation.</p>	<p>We understand and agree to this stipulation. The state Medicaid agencies regulating the three health plans we selected as an example have similar requirements; in fact, it is our experience that this is a common stipulation.</p>

Encounter Data Functionality/Requirement	Delaware	Florida	Maryland
<p>has a capitation arrangement with a provider. The CCN CEO or CFO shall attest to the truthfulness, accuracy, and completeness of all encounter data submitted.</p>	<p>For the twelve months ending May 1, 2011, our encounter acceptance rates are as follows: Delaware: Professional 98.13% - Institutional 99.97 Florida: Professional 99.00% - Institutional 98.72 - NCPDP 98.00% Maryland: Professional 98.62% - Institutional 98.72%</p>	<p>For the twelve months ending May 1, 2011, our encounter acceptance rates are as follows: Delaware: Professional 98.13% - Institutional 99.97 Florida: Professional 99.00% - Institutional 98.72 - NCPDP 98.00% Maryland: Professional 98.62% - Institutional 98.72%</p>	<p>For the twelve months ending May 1, 2011, our encounter acceptance rates are as follows: Delaware: Professional 98.13% - Institutional 99.97 Florida: Professional 99.00% - Institutional 98.72 - NCPDP 98.00% Maryland: Professional 98.62% - Institutional 98.72%</p>
<p>17.5.4.13 The CCN shall ensure that all encounter data from a contractor is incorporated into a single file from the CCN. The CCN shall not submit separate encounter files from CCN contractors.</p>	<p>We understand and agree to this stipulation. The state Medicaid agencies regulating the three health plans we selected as an example have similar requirements; in fact, it is our experience that this is a common stipulation.</p>	<p>We understand and agree to this stipulation. The state Medicaid agencies regulating the three health plans we selected as an example have similar requirements; in fact, it is our experience that this is a common stipulation.</p>	<p>We understand and agree to this stipulation. The state Medicaid agencies regulating the three health plans we selected as an example have similar requirements; in fact, it is our experience that this is a common stipulation.</p>
<p>17.5.4.14 The CCN shall ensure that files contain settled claims and claim adjustments or voids, including but not limited to, adjustments necessitated by payment errors, processed during that payment cycle, as well as encounters processed during that payment cycle from providers with whom the CCN has a capitation arrangement.</p>	<p>We understand and agree to this stipulation. The state Medicaid agencies regulating the three health plans we selected as an example have similar requirements; in fact, it is our experience that this is a common stipulation.</p>	<p>We understand and agree to this stipulation. The state Medicaid agencies regulating the three health plans we selected as an example have similar requirements; in fact, it is our experience that this is a common stipulation.</p>	<p>We understand and agree to this stipulation. The state Medicaid agencies regulating the three health plans we selected as an example have similar requirements; in fact, it is our experience that this is a common stipulation.</p>

Connectivity Functionality/Requirement	Delaware	Florida	Maryland
16.3.1. DHH is requiring that the CCN interface with DHH, the Medicaid Fiscal Intermediary (FI), the Enrollment Broker (EB) and its trading partners. The CCN must have capacity for real time connectivity to all DHH approved systems.	Meet Aetna Better Health maintains interface with the Medicaid single-state agency, its MMIS vendor, FI and EB as required. This connectivity is real time and meets the specifications of the Medicaid single-state agency.	Meet Aetna Better Health maintains interface with the Medicaid single-state agency, its MMIS vendor, FI and EB as required. This connectivity is real time and meets the specifications of the Medicaid single-state agency.	Meet Aetna Better Health maintains interface with the Medicaid single-state agency, its MMIS vendor, FI and EB as required. This connectivity is real time and meets the specifications of the Medicaid single-state agency.
16.3.2. The System shall conform and adhere to the data and document management standards of DHH and its FI, inclusive of standard transaction code sets.	Our QNXT™ system conforms to the data and document management standards of the Medicaid single-state agency, its MMIS vendor, FI and EB.	Our QNXT™ system conforms to the data and document management standards of the Medicaid single-state agency, its MMIS vendor, FI and EB.	Our QNXT™ system conforms to the data and document management standards of the Medicaid single-state agency, its MMIS vendor, FI and EB.
16.3.3. The CCN's Systems shall utilize mailing address standards in accordance with the United States Postal Service.	Aetna Better Health fulfillment house uses U.S. Postal approved software for mailing address standardization in accordance with U.S. Postal regulations.	Aetna Better Health fulfillment house uses U.S. Postal approved software for mailing address standardization in accordance with U.S. Postal regulations.	Aetna Better Health fulfillment house uses U.S. Postal approved software for mailing address standardization in accordance with U.S. Postal regulations.
16.3.4. At such time that DHH requires, the CCN shall participate and cooperate with DHH to implement, within a reasonable timeframe, a secure, web-accessible health record for members, such as Personal Health Record (PHR) or Electronic Health Records (EHR).	Aetna Better Health understands, acknowledges and agrees to this requirement. We will participate and cooperate as required. We have experience in these areas and are interested in supporting DHH in its efforts.	Aetna Better Health understands, acknowledges and agrees to this requirement. We will participate and cooperate as required. We have experience in these areas and are interested in supporting DHH in its efforts.	Aetna Better Health understands, acknowledges and agrees to this requirement. We will participate and cooperate as required. We have experience in these areas and are interested in supporting DHH in its efforts.
16.3.5. At such time that DHH requires, the CCN shall participate in statewide efforts to incorporate all hospital, physician, and other provider information into a statewide health information exchange.	Aetna Better Health understands, acknowledges and agrees to this requirement. We will participate and cooperate as required.	Aetna Better Health understands, acknowledges and agrees to this requirement. We will participate and cooperate as required.	Aetna Better Health understands, acknowledges and agrees to this requirement. We will participate and cooperate as required.
16.3.6. The CCN shall meet, as requested by DHH, with work groups or committees to coordinate activities and develop system strategies that actively reinforce the healthcare reform initiative.	Aetna Better Health understands, acknowledges and agrees to this requirement. We will participate and cooperate as required.	Aetna Better Health understands, acknowledges and agrees to this requirement. We will participate and cooperate as required.	Aetna Better Health understands, acknowledges and agrees to this requirement. We will participate and cooperate as required.

Connectivity Functionality/Requirement	Delaware	Florida	Maryland
<p>16.3.7. All information, whether data or documentation and reports that contain or references to that information involving or arising out of the Contract is owned by DHH. The CCN is expressly prohibited from sharing or publishing DHH’s information and reports without the prior written consent of DHH. In the event of a dispute regarding the sharing or publishing of information and reports, DHH’s decision on this matter shall be final.</p>	<p>We have experience in these areas and are interested in supporting DHH in its efforts.</p> <p>Aetna Better Health understands, acknowledges and agrees to this requirement. We will participate and cooperate as required. We have experience in these areas and are interested in supporting DHH in its efforts.</p>	<p>We have experience in these areas and are interested in supporting DHH in its efforts.</p> <p>Aetna Better Health understands, acknowledges and agrees to this requirement. We will participate and cooperate as required. We have experience in these areas and are interested in supporting DHH in its efforts.</p>	<p>We have experience in these areas and are interested in supporting DHH in its efforts.</p> <p>Aetna Better Health understands, acknowledges and agrees to this requirement. We will participate and cooperate as required. We have experience in these areas and are interested in supporting DHH in its efforts.</p>
<p>16.3.9. The CCN shall be responsible for all initial and recurring costs required for access to DHH system(s), as well as DHH access to the CCN’s system(s). These costs include, but are not limited to, hardware, software, licensing, and authority/permission to utilize any patents, annual maintenance, support, and connectivity with DHH, the Fiscal Intermediary (FI) and the Enrollment Broker.</p>	<p>Aetna Better Health understands, acknowledges and agrees to this requirement.</p> <p>Aetna Better Health understands, acknowledges and agrees to this requirement.</p> <p>Aetna Better Health understands, acknowledges and agrees to this requirement.</p>	<p>Aetna Better Health understands, acknowledges and agrees to this requirement.</p> <p>Aetna Better Health understands, acknowledges and agrees to this requirement.</p> <p>Aetna Better Health understands, acknowledges and agrees to this requirement.</p>	<p>Aetna Better Health understands, acknowledges and agrees to this requirement.</p> <p>Aetna Better Health understands, acknowledges and agrees to this requirement.</p> <p>Aetna Better Health understands, acknowledges and agrees to this requirement.</p>
<p>16.3.10. The CCN shall complete an Information Systems Capabilities Assessment (ISCA), which will be provided by DHH. The ISCA shall be completed and returned to DHH no later than thirty (30) days from the date the CCN signs the Contract with DHH.</p>	<p>Aetna Better Health understands, acknowledges and agrees to this requirement.</p>	<p>Aetna Better Health understands, acknowledges and agrees to this requirement.</p>	<p>Aetna Better Health understands, acknowledges and agrees to this requirement.</p>

Challenges and Lessons Learned

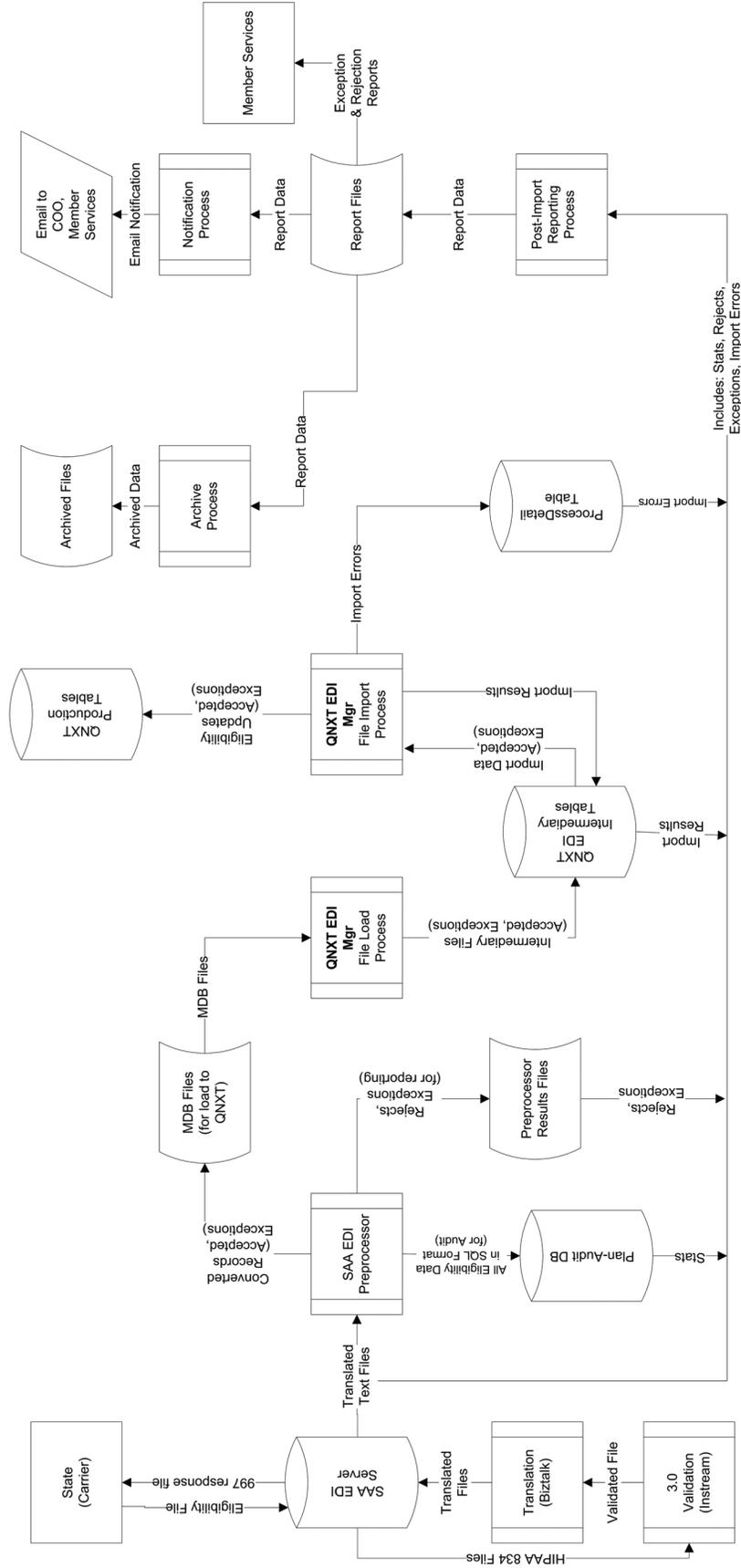
Implementing a new IT and data management system, including establishing connectivity for the exchange of information between a Medicaid single-state agency and its MMIS vendor, FI and EB especially with a Medicaid State Agency that is new to managed care, can be a challenge. There are three primary lessons we have learned as a result of the last three Medicaid managed care implementations. These are:

- 1) There must be open communication between DHH's FI and Aetna Better Health on the implementation. The old cliché is "if you've seen one Medicaid program, you've seen one Medicaid program" also applies to Medicaid managed care health plans and their encounter systems. Aetna Better Health is fully committed to aligning its IT and data management system, including establishing connectivity for the exchange of information to meet the needs of DHH, its FI and EB. However, due to the complexity of IT and data management system, including processes to establish connectivity for the exchange of information between systems we recommend there be frequent and meaningful communication regarding design, development, implementation, and testing. We have discovered that regularly scheduled meeting between with the Medicaid agency and their agent (FI) and the CCN is one of the most meaningful communication methods. This way both parties can ask questions, review incremental test results and provide insight and direction. To facilitate these meetings and support communication we further recommend that DHH's FI assign a project manager or equivalent level professional to work with each CCN. This will help avoid unnecessary confusion or errors.
- 2) DHH and its FI should set realistic IT and data management system, including connectivity for the exchange of information system development and testing timeline and goals. These timelines and goals should be as stable as possible once the development and testing process begins.
- 3) DHH and its FI should, once the development and testing process begins, avoid adjusting IT and data management system, including data exchange connectivity requirements, program design elements, reports and coding specifications. Stability in the design environment is critical to remain on target for quality and timeliness of development and testing.

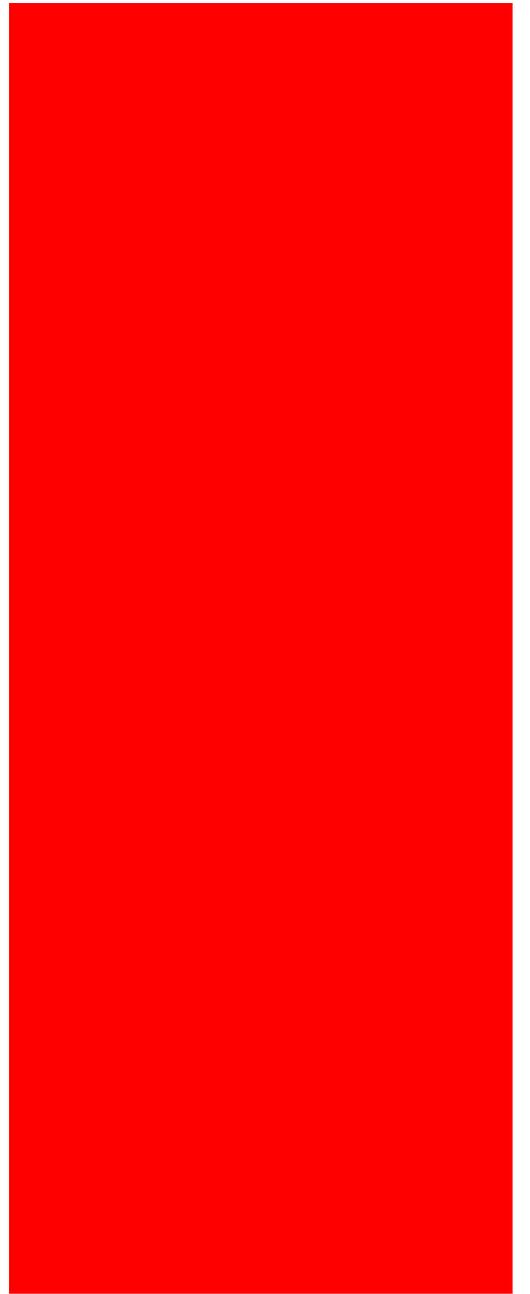
Aetna Better Health is aware that changes in the timeline, requirements, design, reporting and coding are inevitable in a project of this size and complexity. The impact on the quality, timeframe and cost can be mitigated by working together and through close communication. Our QNXT™ system is responsive and flexible to meet DHH's needs and requirements. This system provides a state-of-the-art platform that can keep pace with the multiple enhancements that are expected as healthcare reform is implemented.

Aetna Better Health will assign an IT and data management system, including expertise to establish connectivity for the exchange of information development team to the Louisiana CCN implementation. This development team will be led by a senior manager of our organization and include representatives of our key operational units responsible for IT and data management system and connectivity for the exchange of information. Included on this team will be veterans from our last three implementations that will offer insight, knowledge and experience to DHH and its FI.

EDI Eligibility Process Flow Summary



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R.7 Describe the ability within your systems to meet (or exceed) each of the requirements in Section §16. Address each requirement. If you are not able at present to meet a particular requirement contained in the aforementioned section, identify the applicable requirement and discuss the effort and time you will need to meet said requirement.

Aetna Better Health and its affiliates have been implementing Medicaid managed care information systems for over 25 years. Today, Aetna Better Health administers or manages Medicaid health plans providing coverage to over 1.3 million members in 10 states. Well aware of the role sound, reliable information plays in effective healthcare administration, Aetna Better Health maintains robust processes safeguarding the integrity, validity and completeness of the information we provide to DHH, its Fiscal Intermediary and Enrollment Broker.

Aetna Better Health meets the requirements as specified in § 16 and shall continue to meet these requirements.

Requirement	Meets or Exceeds	Explanation
16 Systems and Technical Requirements		
16.1 General Requirements		
<p>16.1.1 The CCN shall maintain an automated Management Information System (MIS), hereafter referred to as System, which accepts and processes provider claims, verifies eligibility, collects and reports encounter data and validates prior authorization and pre-certification that complies with DHH and federal reporting requirements. The CCN shall ensure that its System meets the requirements of the Contract, state issued Guides (See CCN-P Systems Guide) and all applicable state and federal laws, rules and regulations, including Medicaid confidentiality and HIPAA and American Recovery and Reinvestment Act (ARRA) privacy and security requirements.</p>	Meets	<p>The design goal for Aetna Better Health's information system is to use powerful, reliable, and expandable data processing systems. The foundation of this platform is a redundant, high speed Local Area Network (LAN) and Wide Area Network (WAN) and clustering of servers to build-in redundancy. This approach provides 100 percent uptime for all core business systems in 2010. Aetna Better Health's network infrastructure consists entirely of Cisco routers, switches, and firewalls. Cisco standardization provides maximum latitude in equipment configurations. Cisco routers support our MPLS network, external traffic to the Internet, and connections to other private networks. Core business applications run on Hewlett Packard BL 460 servers. Each server is equipped with a minimum of two quad-core Intel processors and 8GB of RAM. Applications loaded on the server pools access data on high-end database servers running on the Hewlett Packard's BL685 platform and are configured with 24 cores and 96 gigabytes of RAM. These 64-bit database servers attach to Hitachi storage arrays via Brocade switches. This server configuration will provide all necessary computing power, redundancy, and scalability to meet both enrollment growth and an increase in requirements. Aetna Better Health is able to add servers to the cluster to increase performance vertically, and servers can accept increases in RAM and processing power to grow horizontally. This scalability allows systems to match any escalation in demand associated with DHH's/Aetna Better Health's performance requirements, while at the same time maintaining system uptime and performance. Network traffic and users accesses to the core application are load balanced</p>
<p>16.1.2 The CCN's application systems foundation shall employ the relational data model in its database architecture, which would entail the utilization of a relational database management system (RDBMS) such as Oracle®, DB2®, or SQL Server®. It is important that the CCN's application systems support query access using Structured Query Language (SQL). Other standard connector technologies, such as Open Database Connectivity (ODBC) and/or Object Linking and Embedding (OLE), are desirable.</p>	Meets	
<p>16.1.3 All the CCN's applications, operating software, middleware, and networking hardware and software shall be able to interoperate as needed with DHH's systems and shall conform to applicable standards and specifications set by DHH.</p>	Meets	



Part Two: Technical Proposal
Section R: Information Systems

Requirement	Meets or Exceeds	Explanation
<p>16.1.4 The CCN's System shall have, and maintain, capacity sufficient to handle the workload projected for the begin date of operations and shall be scalable and flexible so that it can be adapted as needed, within negotiated timeframes, in response to changes in the Contract requirements.</p>	<p>Meets</p>	<p>by f5 Global Load Balancing services. Aetna Better Health's member services call center runs on an Aetna Medicaid-supplied Avaya S8500 IP switch, which maintains 20 percent extra capacity to cover any spikes and growth spurts.</p> <p>Applications loaded on the server pool access data from high-end database servers. These 64-bit, Itanium class database servers attach to EMC and HP storage arrays via Brocade switches. This server configuration will provide all necessary computing power, redundancy, and scalability to meet both enrollment growth and an increase in requirements Aetna Better Health is able to add servers to the cluster to increase performance vertically, and servers can accept increases in RAM and processing power to grow horizontally. This scalability allows systems to match any escalation in demand associated with DHH/ Aetna Better Health's performance requirements, while at the same time maintaining system uptime and performance. Network traffic and users accesses to the core application are load balanced by f5 Global Load Balancing services. Aetna Better Health's Member Services call center runs on an Aetna Medicaid-supplied Avaya S8500 IP switch, which maintains 20 percent extra capacity to cover any spikes and growth spurts.</p> <p>Aetna Medicaid's management works with Aetna Better Health's Information Management and Systems Director to develop and maintain written policies, procedures, and job descriptions necessary to "lock in" system and operational improvements. Annual reviews then verify policy and procedures' (P&Ps) continued agreement with current practices.</p> <p>Aetna Medicaid has engaged KPMG since 2000 to perform SAS 70 audits, including Operating Effectiveness for Claims Processing Controls and Related General Computer Controls. All audit reports have reflected unbiased opinions.</p>



Part Two: Technical Proposal
Section R: Information Systems

Requirement	Meets or Exceeds	Explanation
		<p>System description:</p> <p>QNXT™ - At the core of Aetna Medicaid's application architecture is QNXT™, a rules-based information processing system comprising 28 integrated modules that maintain the following:</p> <ul style="list-style-type: none"> • Claims data, including associated adjudication, COB and TPL processes • Demographic, eligibility and enrollment data, including prior coverage • Provider contract configuration, including network and services • EDI processes • QM/JUM including, but not limited to Prior Authorizations and concurrent reviews <p>QNXT™ leverages Microsoft's .NET architecture, providing for flexible, scalable, and seamless systems integration. In addition, the system's foundational database is Microsoft's SQL Server, permitting a wide variety of applications to analyze the data, display results, and print standardized and customized reports.</p> <p>The cornerstone of Aetna Medicaid's claims adjudication process, QNXT™ accepts – via the supporting technical interfaces – DHH' Daily Enrollment and Manual Payment Transaction files', and then updates our member records accordingly. Automated processes reconcile QNXT™'s resident member files with DHH' monthly update recording the results for DHH' review should it be necessary. Aetna Better Health's enrollment team then validates the data for accuracy, auditing relevant files and reviewing any resultant fallout reports. Should the process bring any errors to light, enrollment personnel promptly notify DHH' Information Services Division and work the issue to resolution. Enrollment personnel then resume posting of daily updates, beginning with the last two days of the month.</p>



Part Two: Technical Proposal
Section R: Information Systems

Requirement	Meets or Exceeds	Explanation
		<p>QNXT™ uses weekly downloads of provider data from DHH's secure FTP server to update Aetna Better Health's provider files. Enrollment personnel then use unassigned enrollment reports to verify each member's assignment to an individual PCP/PCMH, our PCP/PCMH assignment file is as current and complete as possible. System queries identify new enrollments and generate welcome letters accordingly. These are added to new member welcome packets, which are delivered by members' assigned Case Manager (CM). Updated date-sensitive PCP assignment information is available to DHH in electronic format upon request.</p> <p>QNXT™ supports automation of routing processes, thus introducing improved efficiencies and accuracy to the adjudication process. For example, three-tier logic matches claims and authorizations based on criteria such as member, provider, service code, and dates of service. The system automatically deducts claimed services from authorized units, thus reducing the need for manual affiliation by claims analysts.</p> <p>Several applications compliment QNXT™'s claims processing functionality. The first, iHealth, enforces select payment policies from one of the industry's most comprehensive correct coding and medical policy content libraries. The second, McKesson's ClaimCheck®, expands upon those capabilities by allowing claims leadership to define and combine specific claims data criteria, such as provider or diagnosis, to set up unique edits that deliver enhanced auditing power. Finally, Medical Data Express' (MDE) Outpatient Facility Services Pricer supports the pricing and correction of outpatient hospital claims.</p> <p>As the system of record for our members' demographic, capitation, PCP/PCMH, and eligibility and enrollment data, QNXT™ serves as the primary source of data for multiple applications, including our web-based care management business application (Dynamo™) our</p>

Requirement	Meets or Exceeds	Explanation
16.2 HIPAA Standards and Code Sets		principal member and Medical Management application, VisionPro and EMS. Our systems data flow, provided at the end of this section, illustrates how the exchange of data between these systems, and throughout our organization, addresses the needs of our DHH members.
16.2.1 The System shall be able to transmit, receive and process data in current HIPAA-compliant or DHH specific formats and/or methods, including, but not limited to, secure File Transfer Protocol (FTP) over a secure connection such as a Virtual Private Network (VPN), that are in use at the start of Systems readiness review activities. Data elements and file format requirements may be found in the CCN-P Systems Companion Guide.	Meets	Aetna Better Health's management information system currently supports DHH's required technical interfaces and complies with all applicable requirements of the Health Insurance Portability and Accountability Act (HIPAA). We are, and will continue to be, responsive, within a reasonable timeframe, to any and all adjustments or modifications to future HIPAA procedures, policies, rules and statutes that may be required during the term of our contract. Our management information system configuration supports migration from one HIPAA version to another in the following ways:
16.2.2 All HIPAA-conforming exchanges of data between DHH and the CCN shall be subjected to the highest level of compliance as measured using an industry-standard HIPAA compliance checker. The HIPAA Business Associate Agreement (Appendix C) shall become a part of the Contract.	Meets	<ul style="list-style-type: none"> Microsoft BizTalk with HIPAA Accelerator™ processes HIPAA-compliant transactions easily and efficiently, enabling Aetna Better Health to accept information electronically from almost any HIPAA-compliant contractor or provider. Accelerator has the Washington Publishing Company (WPC) Implementation Guide schemas for each HIPAA ANSI X12 transaction embedded directly into its application engine, including a facility to update these schemas automatically as the transaction sets are updated over time. Foresight HIPAA Validator™ InStream™ is a fully functional HIPAA editing and validation application. It validates HIPAA transactions through all seven levels of edits as defined by the
16.2.3 The System shall conform to the following HIPAA-compliant standards for information exchange. Batch transaction types include, but are not limited to, the following:	Meets	
16.2.3.1. ASC X12N 834 Benefit Enrollment and Maintenance	Meets	
16.2.3.2. ASC X12N 835 Claims Payment Remittance Advice Transaction	Meets	
16.2.3.3. ASC X12N 837I Institutional Claim/Encounter Transaction	Meets	



Part Two: Technical Proposal
Section R: Information Systems

Requirement	Meets or Exceeds	Explanation
16.2.3.4. ASC X12N 837P Professional Claim/Encounter Transaction	Meets	<p>Workgroup for Electronic Data Interchange and Strategic National Implementation Process (WEDI/SNIP), has all standard HIPAA code sets embedded, and can support custom, trading-partner-specific companion guides and validation requirements. The application also provides descriptive error reports to submitters to facilitate quick error resolution.</p> <p>Aetna Better Health follows the Strategic National Implementation Project (SNIP) recommendations for testing created by the Workgroup for Electronic Data Interchange (WEDI), further promoting system compliance with federal IT mandates.</p> <p>To date none of our Medicaid single-state agencies where we hold contracts has required ASC X12N 270/271 Eligibility/Benefit Inquiry/Response so this HIPAA information exchange process is unavailable until the fourth quarter of 2011. Aetna Better Health does not expect meeting this requirement to be a significant effort and will be ready to test transactions using HIPAA process by or before system readiness review.</p>
16.2.3.5. ASC X12N 270/271 Eligibility/Benefit Inquiry/Response;	Will Meet	
16.2.3.6. ASC X12N 276 Claims Status Inquiry	Meets	
16.2.3.7. ASC X12N 277 Claims Status Response	Meets	
16.2.3.8. ASC X12N 278 Utilization Review Inquiry/Response	Meets	
16.2.3.9. ASC X12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products.	Meets	
16.2.4 The CCN shall not revise or modify the standardized forms or formats.	Meets	
16.2.5 Transaction types are subject to change and the CCN shall comply with applicable federal and HIPAA standards and regulations as they occur.	Meets	
16.2.6 The CCN shall adhere to national standards and standardized instructions and definitions that are consistent with industry norms that are developed jointly with DHH. These shall include, but not be limited to, HIPAA based standards, federal safeguard requirements including signature requirements described in the CMS State Medicaid Manual.	Meets	
16.3 Connectivity		
16.3.1 DHH is requiring that the CCN interface with DHH, the Medicaid Fiscal Intermediary (FI), the Enrollment Broker (EB) and its trading partners. The CCN must have capacity for real time connectivity to all DHH approved systems.	Meets	<p>Aetna Better Health acknowledges and understands these requirements. Aetna Better Health will meet Aetna Better Health's specifications and comply with each of the requirements in this section.</p>



Part Two: Technical Proposal
Section R: Information Systems

Requirement	Meets or Exceeds	Explanation
16.3.2 The System shall conform and adhere to the data and document management standards of DHH and its FI, inclusive of standard transaction code sets.	Meets	Aetna Better Health understands that DHH has the right and responsibility to change MMIS vendors at any time. Aetna Better Health is experienced in working with an Medicaid single-state agency during a change in MMIS vendors. Aetna Better Health has experienced communication and other issues during these changes and recommends close and consistent meetings and exchange of information to avoid potentially costly situations.
16.3.3 The CCN's Systems shall utilize mailing address standards in accordance with the United States Postal Service.	Meets	Aetna Better Health understands this requirement and shall fully comply.
16.3.4 At such time that DHH requires, the CCN shall participate and cooperate with DHH to implement, within a reasonable timeframe, a secure, web-accessible health record for members, such as Personal Health Record (PHR) or Electronic Health Records (EHR).	Meets	Aetna Better Health understands this requirement and shall fully comply.
16.3.5 At such time that DHH requires, the CCN shall participate in statewide efforts to incorporate all hospital, physician, and other provider information into a statewide health information exchange.	Meets	Aetna Better Health understands this requirement and shall fully comply.
16.3.6 The CCN shall meet, as requested by DHH, with work groups or committees to coordinate activities and develop system strategies that actively reinforce the healthcare reform initiative.	Meets	Aetna Better Health understands this requirement and shall fully comply.
16.3.7 All information, whether data or documentation and reports that contain or references to that information involving or arising out of the Contract is owned by DHH. The CCN is expressly prohibited from sharing or publishing DHH's information and reports without the prior written consent of DHH. In the event of a dispute regarding the sharing or publishing of information and reports, DHH's decision on this matter shall be final.	Meets	



Requirement	Meets or Exceeds	Explanation
<p>16.3.8 The Medicaid Management Information System (MMIS) processes claims and payments for covered Medicaid services. DHH's current MMIS contract expired December 31, 2010. DHH exercised its right to extend all or part of a five (5) year extension to its current FI. DHH shall require the CCN to comply with transitional requirements as necessary should DHH contract with a new FI during the Contract at no cost to DHH or its FI.</p>	<p>Meets</p>	
<p>16.3.9 The CCN shall be responsible for all initial and recurring costs required for access to DHH system(s), as well as DHH access to the CCN's system(s). These costs include, but are not limited to, hardware, software, licensing, and authority/permission to utilize any patents, annual maintenance, support, and connectivity with DHH, the Fiscal Intermediary (FI) and the Enrollment Broker.</p>	<p>Meet</p>	
<p>16.3.10 The CCN shall complete an Information Systems Capabilities Assessment (ISCA), which will be provided by DHH. The ISCA shall be completed and returned to DHH no later than thirty (30) days from the date the CCN signs the Contract with DHH.</p>	<p>Meets</p>	
<p>16.3.11 Hardware and Software The CCN must maintain hardware and software compatible with current DHH requirements which are as follows:</p>	<p>Meets</p>	

Requirement	Meets or Exceeds	Explanation
<p>16.3.11.1 Desktop Workstation Hardware:</p> <ul style="list-style-type: none"> • IBM-compatible PC using at least a Dual Core Processor (2.66 GHz, 6 MB cache, 1333 MHz FSB); • At least 4 GB (gigabytes) of RAM; • At least 250 GB HDD; • 256 MB discrete video memory; • A color monitor or LCD capable of at least 800 x 640 screen resolution; • A DVD +/-RW and CD-ROM drive capable of reading and writing to both media; • 1 gigabyte Ethernet card; • Enough spare USB ports to accommodate thumb drives, etc.; and • Printer compatible with hardware and software required. 	Meets	
<p>16.3.11.2 Desktop Workstation Software:</p> <ul style="list-style-type: none"> • Operating system should be Microsoft Windows XP SP3 or later, • Web browser that is equal to or surpasses Microsoft Internet Explorer v7.0 and is capable of resolving JavaScript and ActiveX scripts; • An e-mail application that is compatible with Microsoft Outlook; • An office productivity suite such as Microsoft Office that is compatible with Microsoft Office 2007 or later; • Each workstation should have access to high speed 	Meets	

Requirement	Meets or Exceeds	Explanation
<p>Internet;</p> <ul style="list-style-type: none"> Each workstation connected to the Internet should have anti-virus, anti-spam, and anti-malware software. Regular and frequent updates of the virus definitions and security parameters of these software applications should be established and administered; A desktop compression/encryption application that is compatible with WinZIP v11.0; All workstations, laptops and portable communication devices shall be installed with full disk encryption software; and Compliant with industry-standard physical and procedural safeguards for confidential information (NIST 800-53A, ISO 17788, etc.). 		
<p>16.3.11.3 Network and Back-up Capabilities</p> <ul style="list-style-type: none"> Establish a local area network or networks as needed to connect all appropriate workstation personal desktop computers (PCs); Establish appropriate hardware firewalls, routers, and other security measures so that the CCN's computer network is not able to be breached by an external entity; Establish appropriate back-up processes that ensure the back-up, archival, and ready retrieval of network server data and desktop workstation data; Ensure that network hardware is protected from electrical surges, power fluctuations, and power outages by using the appropriate uninterruptible power system (UPS) and surge protection devices; and 	Meets	



Requirement	Meets or Exceeds	Explanation
<ul style="list-style-type: none"> The CCN shall establish independent generator back-up power capable of supplying necessary power for four (4) days. 		
16.4 Resource Availability and Systems Changes		



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Requirement	Meets or Exceeds	Explanation
<p>16.4.1 Resource Availability The CCN shall provide Systems Help Desk services to DHH, its FI, and Enrollment Broker personnel that have direct access to the data in the CCN's Systems.</p>	<p>Meet</p>	<p>Aetna Better Health takes the security of our members' data very seriously and so maintains significant protocols and controls with regard its external use. Per our standard operating procedure regarding requests for system access by an external agency, we will configure a DHH-supplied PC or laptop such that authorized external users have access – via Citrix – to a secure, inquiry-only environment wherein they may create and/or generate reports on an ad-hoc basis. We will reach mutual agreement with DHH on the number of personnel members that need a NID number granting them role-based access as a non-Aetna Better Health user. Authorized users will have access to SPOC, Aetna's Single Point of Contact Help Desk, providing toll-free system and technical support 24/7/365. SPOC personnel will answer questions regarding Aetna Better Health's System functions and capabilities; report recurring programmatic and operation problems to appropriate personnel for follow-up; redirect problems or queries that are not supported by the Systems Help Desk, as appropriate, via a telephone transfer or other agreed upon methodology; and redirect problems or queries specific to data access authorization to the appropriate DHH personnel. Recurring problems not specific to Systems unavailability identified by the Systems Help Desk will be documented and reported to Aetna Better Health management within one (1) business day of recognition so that</p>

Requirement	Meets or Exceeds	Explanation
<p>16.4.1.1 The Systems Help Desk shall:</p> <ul style="list-style-type: none"> • Be available via local and toll-free telephone service, and via e-mail from 7a.m. to 7p.m., Central Time, Monday through Friday, with the exception of DHH designated holidays. Upon request by DHH, the CCN shall be required to staff the Systems Help Desk on a state holiday, Saturday, or Sunday; • Answer questions regarding the CCN's System functions and capabilities; report recurring programmatic and operation problems to appropriate personnel for follow-up; redirect problems or queries that are not supported by the Systems Help Desk, as appropriate, via a telephone transfer or other agreed upon methodology; and redirect problems or queries specific to data access authorization to the appropriate DHH personnel; • Ensure individuals who place calls after hours have the option to leave a message. The CCN's personnel shall respond to messages left between the hours of 7p.m. and 7a.m. by noon that next business day; • Ensure recurring problems not specific to Systems unavailability identified by the Systems Help Desk shall be documented and reported to CCN management within one (1) business day of recognition so that deficiencies are promptly corrected; and • Have an IS service management system that provides an automated method to record, track and report all questions and/or problems reported to the Systems Help Desk. 	<p>Meet</p>	<p>deficiencies can be promptly corrected. An issue management system will assist in that regard, providing SPOC personnel an automated means to record, track and report all questions and/or problems reported to the Systems Help Desk.</p>
<p>16.4.2 Information Systems Documentation Requirements</p>		

Requirement	Meets or Exceeds	Explanation
16.4.2.1 The CCN shall ensure that written Systems process and procedure manuals document and describe all manual and automated system procedures for its information management processes and information systems.	Meets	Aetna Better Health and Aetna Medicaid has system and user manuals that document its system and applications. In some instances we use system and user manuals provided by the system owner [e.g., QNXT™], in these instances there may be certain restrictions or limits regarding access to these manuals as required by the system owner and our licensing agreement. System design, management manuals, user manuals and quick reference guides available to Aetna Medicaid or Aetna Better Health shall also be available to DHH.
16.4.2.2 The CCN shall develop, prepare, print, maintain, produce, and distribute to DHH distinct Systems design and management manuals, user manuals and quick reference Guides, and any updates.	Meets	Aetna Better Health will submit revisions to appropriate manuals following system changes that are subject to DHH prior approval.
16.4.2.3 The CCN shall ensure the Systems user manuals contain information about, and instruction for, using applicable Systems functions and accessing applicable system data.	Meets	Aetna Better Health system design, management manuals, user manuals and quick reference guides will be available to DHH in printed form and on-line.
16.4.2.4 The CCN shall ensure when a System change is subject to DHH prior written approval, the CCN will submit revision to the appropriate manuals before implementing said Systems changes.	Meets	
16.4.2.5 The CCN shall ensure all aforementioned manuals and reference Guides are available in printed form and on-line; and	Meet	
16.4.2.6 The CCN shall update the electronic version of these manuals immediately, and update printed versions within ten (10) business days of the update taking effect.	Meets	
16.4.2.7 The CCN shall provide to DHH documentation describing its Systems Quality Assurance Plan.	Meets	
16.4.3 Systems Changes		
16.4.3.1 The CCN's Systems shall conform to future federal and/or DHH specific standards for encounter data exchange within one hundred twenty (120) calendar days prior to the standard's effective date or	Meets	As part of our change order management process, we define a system change as any modification that impacts the shared network, computing environment, or business applications by altering its

Requirement	Meets or Exceeds	Explanation
<p>earlier, as directed by CMS or DHH.</p> <p>16.4.3.2 If a system update and/or change are necessary, the CCN shall draft appropriate revisions for the documentation or manuals, and present to DHH thirty (30) days prior to implementation, for DHH review and approval. Documentation revisions shall be accomplished electronically and shall be made available for Department review in an easily accessible, near real-time method. Printed manual revisions shall occur within ten (10) business days of the actual revision.</p>	Meets	<p>existing state. This includes, but is not limited to:</p> <ul style="list-style-type: none"> • System Hardware: Servers or server components, power conditioners, etc. • System Software: Operating systems, antivirus, core business applications, etc. • Databases: Microsoft SQL Server, Microsoft Access, etc. • Network Hardware: Routers, switches, firewalls, VPN, security appliances, etc. • Desktop Management: Hardware, operating systems, Citrix client, antivirus, etc.
<p>16.4.3.3 The CCN shall notify DHH personnel of the following changes to its System within its span of control at least ninety (90) calendar days prior to the projected date of the change:</p>	Meets	<p>We assign system changes to one of three categories: (1) Full Cycle: by default all changes fall into this category. These changes are discussed and may be approved at the weekly IT COP meeting; (2) Expedited: change needs to occur prior to the next IT COP meeting. These changes require approval of Aetna Better Health's COO or designee and a Aetna Medicaid's IT Director; and (3) Routine: a minor change (e.g. changing a web page document) using an accepted process.</p>
<p>16.4.3.4 Major changes, upgrades, modification or updates to application or operating software associated with the following core production System:</p> <ul style="list-style-type: none"> • Claims processing; • Eligibility and enrollment processing; • Service authorization management; • Provider enrollment and data management; and • Conversions of core transaction management Systems. 	Meets	<p>We recognize that other activities, deemed to be comparatively minor, low-risk tasks, are routinely performed in the interest of system security and stability. It is our experience that the likelihood of these</p>

Requirement	Meets or Exceeds	Explanation
<p>16.4.3.5 The CCN shall respond to DHH notification of System problems not resulting in System unavailability according to the following timeframes:</p> <ul style="list-style-type: none"> • Within five (5) calendar days of receiving notification from DHH, the CCN shall respond in writing to notices of system problems. • Within fifteen (15) calendar days, the correction shall be made or a requirements analysis and specifications document will be due. • The CCN shall correct the deficiency by an effective date to be determined by DHH. • The CCN's Systems shall have a system-inherent mechanism for recording any change to a software module or subsystem. • The CCN shall put in place procedures and measures for safeguarding against unauthorized modification to the CCN's Systems. 	<p>Meets</p>	<p>activities having an impact on system stability is extremely rare, as they are not changes to a processing environment. Therefore, our IT management team identifies, tracks, manages, and reports on these activities. Examples of these administrative changes include, but are not limited to the following:</p> <ul style="list-style-type: none"> • Account administration (i.e., user profiles, password resets, user desktop application setup) • Adding share points • Restoring files (individual PC's) • Changing backup tapes and job schedules • File system adjustments • Work management (output queues) • Managing storage pools <p>We require our IT team to mitigate the risk associated with any upgrade by: (1) releasing any upgrade in a secure Aetna Medicaid's "back office" environment to test its impact prior to promoting it to the "production" environment; (2) backing up the entire system prior to the upgrade so Aetna Medicaid can reverse the process and return the system to its pre-upgrade state if necessary; (3) requiring the hardware/software vendor to have its personnel on-site to facilitate and monitor the COP; and (4) training our employees/end users on the conversion/upgrade. Standard operating procedure mandates that</p>
<p>16.4.3.6 Unless otherwise agreed to in advance by DHH, the CCN shall not schedule Systems unavailability to perform system maintenance, repair and/or upgrade activities to take place during hours that can compromise or prevent critical business operations.</p>	<p>Meets</p>	

Requirement	Meets or Exceeds	Explanation
<p>16.4.3.7 The CCN shall work with DHH pertaining to any testing initiative as required by DHH and shall provide sufficient system access to allow testing by DHH and/or its FI of the CCN's System.</p>	<p>Meets</p>	<p>we provide DHH with the following information prior to any system conversion or upgrade:</p> <ul style="list-style-type: none"> • System (hardware/software) to be upgraded and the nature of the upgrade • Timeframe for the upgrade • How PHI will be secured and protected during the upgrade • How the upgrade will be tested prior to final promotion • A plan to revert to the original system if there's a problem <p>Aetna Better Health will provide system access to DHH and/or FI for system testing purposes. Such access will be as agreed to by Aetna Better Health and DHH and limited to the purposes included in this agreement.</p>
16.5 Systems Refresh Plan		
<p>16.5.1 The CCN shall provide to DHH an annual Systems Refresh Plan. The plan shall outline how Systems within the CCN's span of control will be systematically assessed to determine the need to modify, upgrade and/or replace application software, operating hardware and software, telecommunications capabilities, information management policies and procedures, and/or systems management policies and procedures in response to changes in business requirements, technology obsolescence, personnel turnover and other relevant factors.</p>	<p>Meets</p>	<p>Aetna Better Health acknowledges and understands these requirements. Aetna Better Health will meet Aetna Better Health's specifications and comply with each of the requirements in this section.</p> <p>Aetna Better Health shall provide DHH a System Refresh Plan that will meet the specification as required herein.</p>



Requirement	Meets or Exceeds	Explanation
<p>16.5.2 The systems refresh plan shall also indicate how the CCN will ensure that the version and/or release level of all of its Systems components (application software, operating hardware, operating software) are always formally supported by the original equipment manufacturer (OEM), software development firm (SDF), or a third party authorized by the OEM and/or SDF to support the Systems component.</p>	<p>Meets</p>	
<p>16.6 Other Electronic Data Exchange</p>		
<p>16.6.1 The CCN's system shall house indexed electronic images of documents to be used by members and providers to transact with the CCN and that are reposed in appropriate database(s) and document management systems (i.e., Master Patient Index) as to maintain the logical relationships to certain key data such as member identification, provider identification numbers and claim identification numbers. The CCN shall ensure that records associated with a common event, transaction or customer service issue have a common index that will facilitate search, retrieval and analysis of related activities, such as interactions with a particular member about a reported problem.</p>	<p>Meet</p>	<p>Aetna Better Health acknowledges and understands these requirements. Aetna Better Health will meet Aetna Better Health's specifications and comply with each of the requirements in this section</p>
<p>16.6.2 The CCN shall implement Optical Character Recognition (OCR) technology that minimizes manual indexing and automates the retrieval of scanned documents.</p>	<p>Meet</p>	



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Requirement	Meets or Exceeds	Explanation
16.7 Electronic Messaging		
16.7.1 The CCN shall provide a continuously available electronic mail communication link (e-mail system) to facilitate communication with DHH. This e-mail system shall be capable of attaching and sending documents created using software compatible with DHH's installed version of Microsoft Office (currently 2007) and any subsequent upgrades as adopted.	Meets	Aetna Better Health acknowledges and understands these requirements. Aetna Better Health will meet Aetna Better Health's specifications and comply with each of the requirements in this section.
16.7.2 As needed, the CCN shall be able to communicate with DHH over a secure Virtual Private Network (VPN).	Meets	
16.7.3 The CCN shall comply with national standards for submitting public health information (PHI) electronically and shall set up a secure emailing system with that is password protected for both sending and receiving any personal health information.	Meets	
16.8 Eligibility and Enrollment Data Exchange		
The CCN shall:		
16.8.1 Receive, process and update enrollment files sent daily by the Enrollment Broker;	Meets	Aetna Better Health acknowledges and understands these requirements. Aetna Better Health will meet Aetna Better Health's specifications and comply with each of the requirements in this section.
16.8.2 Update its eligibility and enrollment databases within twenty-four (24) hours of receipt of said files;	Meets	Aetna Better Health currently processes eligibility and enrollment data in ten (10) states. In each of these instances the Medicaid single-state agency and its MMIS vendor and/or enrollment broker has unique requirements and specifications regarding these transactions. Aetna Better Health has standard operating procedures to apply eligibility and enrollment data from each of these states, track spans of eligibility, account for eligibility add, deletes and rate code changes
16.8.3 Transmit to DHH, in the formats and methods specified by DHH, member address changes and telephone number changes;	Meets	
16.8.4 Be capable of uniquely identifying (i.e., Master Patient Index) a distinct Medicaid member across multiple populations and Systems within its span of control; and	Meet	



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<p>16.8.5 Be able to identify potential duplicate records for a single member and, upon confirmation of said duplicate record by DHH, resolve the duplication such that the enrollment, service utilization, and customer interaction histories of the duplicate records are linked or merged.</p>	<p>Meet</p>	<p>and to identify duplicate enrollment records and “near duplicate” enrollment records. Duplicate and near duplicate enrollment records are researched with the Medicaid single-state agency, or it MMIS vendor, or its enrollment broker, as applicable. We have never been sanctioned nor have processing errors been detected during any state review or audit of our transactions.</p> <p>Since QNXT™ is the single system for retaining eligibility information and is the source of member identification and tracking within and across the system we meet these requirements.</p>
<p>16.9 Provider Enrollment At the onset of the CCN Contract and periodically as changes are necessary, DHH shall publish at the uri: www.lamedicaid.com the list of Louisiana Medicaid provider types, specialty, and sub-specialty codes. In order to coordinate provider enrollment records, the CCN shall utilize the published list of Louisiana Medicaid provider types, specialty, and sub-specialty codes in all provider data communications with DHH and the Enrollment Broker. The CCN shall provide the following:</p>		
<p>16.9.1 Provider name, address, licensing information, Tax ID, National Provider Identifier (NPI), taxonomy and payment information;</p>	<p>Meets</p>	<p>Provider records are configured to meet the specifications and requirements of DHH. Protocols exist for the development and quality review of documents used to convert the provider’s contract for loading into our system. Key data elements captured for member information and enrollment period are: office hours; specialty; languages spoken; handicap access and if TTY/TTD or interpreter services are available. These data are part of the provider’s record and available for review by the member service worker when assisting a member in selecting a PCP/PCMH, included in our</p>
<p>16.9.2 All relevant provider ownership information as prescribed by DHH, federal or state laws; and</p>	<p>Meets</p>	
<p>16.9.3 Performance of all federal or state mandated exclusion background checks on all providers (owners and managers). The providers shall perform the same for all their employees at least annually.</p>	<p>Meets</p>	

Requirement	Meets or Exceeds	Explanation
<p>16.9.4 Provider enrollment systems shall include, at minimum, the following functionality:</p> <ul style="list-style-type: none"> • Audit trail and history of changes made to the provider file; • Automated interfaces with all licensing and medical boards; • Automated alerts when provider licenses are nearing expiration; • Retention of NPI requirements; • System generated letters to providers when their licenses are nearing expiration; • Linkages of individual providers to groups; • Credentialing information; • Provider office hours; and • Provider languages spoken. 	<p>Meets</p>	<p>provider manual and made available to the enrollment broker.</p> <p>Aetna Better Health understands and agrees to the requirements regarding provider ownership information, including, but not limited to, provider ownership of Aetna Better Health. But in particular to referrals from a provider to an entity that the provider has an ownership interest.</p> <p>Key components of the initial credentialing process include:</p> <ul style="list-style-type: none"> • Submittal of an initial application and attestation that is signed and dated by the provider • Primary source verification by Aetna Better Health's contracted National Committee for Quality Assurance (NCQA)-accredited credentialing verification organization (CVO). The CVO verifies with independent sources: valid licensure; valid DEA or CDS certificate; education and training, including board certification, if applicable; any history of professional liability settlements or judgments; and the applicant's work history. • Verification of sanction or limitations on licensure, or felony convictions, utilizing NPDB, healthcare integrity protection data bank, state agencies etc. • On-site visits to verify that PCP and OB/GYN providers meet our office and medical record keeping standards. (This process is waived if the applicant is joining a provider group that is already a part of the Aetna Better Health provider network). <p>The re-credentialing process ascertains the continued qualifications of the healthcare professional and involves: 1) attestation and updating of initial application information by the provider; 2) primary source verifications by the CVO and 3) a review of the provider's performance (e.g., member complaints, utilization issues, results of ambulatory medical record reviews, provider profile results and quality of care concerns).</p>

Requirement	Meets or Exceeds	Explanation
		<p>Changes to provider configuration in the system of record [QNX™] are maintained in the system. The states where we currently have Medicaid managed care contracts generally do not support automated linkages to their provider licensure data bases; however, we do require re-credentialing of providers every 3 years. At this point we valid all the information in the credentialing file. We do have capabilities of researching State and Federal provider data bases on a regular and routine basis to valid credentialing and re-credentialing requirements. Credentialing and re-credentialing are performed by an NCQA certified affiliated vendor.</p>
<p>16.10 Information Systems Availability The CCN shall:</p>		
<p>16.10.1 Not be responsible for the availability and performance of systems and IT infrastructure technologies outside of the CCN's span of control;</p>	Meets	Aetna Better Health takes the security of our members' data very seriously and so maintains significant protocols and controls with regard its external use. Per our standard operating procedure regarding requests for system access by an external agency, we will configure a DHH-supplied PC or laptop such that authorized external users have access – via Citrix – to a secure, inquiry-only environment wherein they may create and/or generate reports on an ad-hoc basis. We will reach mutual agreement with DHH on the number of staff members that need a NID number granting them role-based access as a non-Aetna Better Health user. Authorized users will have access to SPOC, Aetna's Single Point of Contact Help Desk, providing toll-free system and technical support 24/7/365. SPOC personnel will answer questions regarding Aetna Better Health's System functions and capabilities; report recurring programmatic and operation
<p>16.10.2 Allow DHH personnel, agents of the Louisiana Attorney General's Office or individuals authorized by DHH or the Louisiana Attorney General's Office direct access to its data for the purpose of data mining and review;</p>	Meets	
<p>16.10.3 Ensure that critical member and provider Internet and/or telephone-based IVR functions and information functions are available to the applicable System users twenty-four (24) hours a day, seven (7) days a week except during periods of scheduled System unavailability agreed upon by DHH and the CCN. Unavailability caused by events outside of the CCN's span of control is outside of the scope of this requirement;</p>	Meets	

Requirement	Meets or Exceeds	Explanation
16.10.4 Ensure that at a minimum all other System functions and information are available to the applicable system users between the hours of 7a.m. and 7p.m., Central Time, Monday through Friday;	Meets	problems to appropriate personnel for follow-up; redirect problems or queries that are not supported by the Systems Help Desk, as appropriate, via a telephone transfer or other agreed upon methodology; and redirect problems or queries specific to data access authorization to the appropriate DHH personnel. Recurring problems not specific to Systems unavailability identified by the Systems Help Desk will be documented and reported to Aetna Better Health management within one (1) business day of recognition so that deficiencies can be promptly corrected. An issue management system will assist in that regard, providing SPOC personnel an automated means to record, track and report all questions and/or problems reported to the Systems Help Desk.
16.10.5 Ensure that the systems and processes within its span of control associated with its data exchanges with DHH's FI and/or Enrollment Broker and its contractors are available and operational;	Meets	Aetna Better Health has standard operating procedures regarding notification to our Medicaid single-state agencies should our system or any component of our system fail. Our Information Management and Systems Director will be DHH's point of contact regarding this information. We will develop protocols with DHH regarding such notification during readiness review and annually thereafter.
16.10.6 Ensure that in the event of a declared major failure or disaster, the CCN's core eligibility/enrollment and claims processing system shall be back on line within seventy-two (72) hours of the failure's or disaster's occurrence;	Meets	
16.10.7 Notify designated DHH staff via phone, fax and/or electronic mail within sixty (60) minutes upon discovery of a problem within or outside the CCN's span of control that may jeopardize or is jeopardizing availability and performance of critical systems functions and the availability of critical information as defined in this Section, including any problems impacting scheduled exchanges of data between the CCN and DHH or DHH's FI. In its notification, the CCN shall explain in detail the impact to critical path processes such as enrollment management and encounter submission processes;	Meets	
16.10.8 Notify designated DHH staff via phone, fax, and/or electronic mail within fifteen (15) minutes upon discovery of a problem that results in delays in report distribution or problems in on-line access to critical systems functions and information during a business day, in order for the applicable work activities to be rescheduled or handled based on System unavailability protocol;	Meets	
16.10.9 Provide information on System unavailability events, as well as status updates on problem resolution, to appropriate DHH staff. At a minimum these updates shall be provided on an hourly basis and made available via phone and/or electronic mail, and;	Meets	



Requirement	Meets or Exceeds	Explanation
<p>16.10.10 Resolve and implement system restoration within sixty (60) minutes of official declaration of unscheduled System unavailability of critical functions caused by the failure of system and telecommunications technologies within the CCN's span of control. Unscheduled System unavailability to all other System functions caused by system and telecommunications technologies within the CCN's span of control shall be resolved, and the restoration of services implemented, within eight (8) hours of the official declaration of System unavailability.</p>	<p>Meets</p>	
<p>16.10.10.1 Cumulative Systems unavailability caused by systems and/or IS infrastructure technologies within the CCN's span of control shall not exceed twelve (12) hours during any continuous twenty (20) business day period; and</p>	<p>Meets</p>	
<p>16.10.11 Within five (5) business days of the occurrence of a problem with system availability, the CCN shall provide DHH with full written documentation that includes a corrective action plan describing how the CCN will prevent the problem from reoccurring.</p>	<p>Meets</p>	
<p>16.11 Contingency Plan</p>		
<p>16.11.1 The CCN, regardless of the architecture of its Systems, shall develop and be continually ready to invoke, a contingency plan to protect the availability, integrity, and security of data during unexpected failures or disasters, (either natural or man-made) to continue essential application or system functions during or immediately following failures or disasters.</p>	<p>Meets</p>	<p>Disaster Recovery and Business Continuity Aetna Better Health's disaster backup and recovery strategy is to provide and maintain an internal disaster recovery capability. This strategy leverages the internal computer processing capacity of two state of the art, hardened computer centers located in both</p>

Requirement	Meets or Exceeds	Explanation
<p>16.11.2 Contingency plans shall include a disaster recovery plan (DRP) and a business continuity plan (BCP). A DRP is designed to recover systems, networks, workstations, applications, etc. in the event of a disaster. A BCP shall focus on restoring the operational function of the organization in the event of a disaster and includes items related to IT, as well as operational items such as employee notification processes and the procurement of office supplies needed to do business in the emergency mode operation environment. The practice of including both the DRP and the BCP in the contingency planning process is a best practice.</p>	Meets	<p>Middletown and Windsor, Connecticut. Both facilities have extensive fire suppression systems, dual incoming power feeds, UPS, and backup diesel generators supporting 24/7/365 operation. Physical access is strictly controlled and monitored, and access to vital areas is segregated by floor and business function as appropriate. The two data centers house Aetna Better Health's computer processing capabilities on three major platforms, mainframe (Z/OS), mid-range (Various UNIX versions), and LAN (Windows on X86 processors). The data centers are load balanced and supplemented by quick-ship and capacity-on-demand contracts, permitting each center to back the other up in the event of disaster. We maintain contracts with national vendors providing for replacement equipment and supplemental capacity as needed, further promoting compliance with recovery time objectives (RTO).</p>
<p>16.11.3 The CCN shall have a Contingency Plan that must be submitted to DHH for approval no later than thirty (30) days from the date the Contract is signed.</p>	Meets	
<p>16.11.4 At a minimum, the Contingency Plan shall address the following scenarios:</p>	Meets	
<p>16.11.4.1 The central computer installation and resident software are destroyed or damaged;</p>	Meets	<p>In the event of a data center disaster, the RTO to resume most production processing is four days from disaster declaration for all mainframe and mid-range systems and five days for LAN systems. Portfolios of highly available applications, such as web and pharmacy, have RTO's of six hours or less. These applications utilize mirroring and/or load balancing technologies between the datacenters to make certain that the reduced RTO's can be met. Aetna Better Health's voice and data network backbones are fully redundant using SONET ring technology and are recovered within 1 hour of a data center outage. In short, Aetna Better Health's data center recovery strategy and its application RTO's are consistent with or better than industry</p>
<p>16.11.4.2 The system interruption or failure resulting from network, operating hardware, software, or operations errors that compromise the integrity of transaction that are active in a live system at the time of the outage;</p>	Meets	
<p>16.11.4.3 System interruption or failure resulting from network, operating hardware, software or operations errors that compromise the integrity of data maintained in a live or archival system;</p>	Meets	

Requirement	Meets or Exceeds	Explanation
16.11.4 System interruption or failure resulting from network, operating hardware, software or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system, but does prevent access to the System, such as it causes unscheduled System unavailability; and	Meets	standards. Data Backup Infrastructure and application data is secured and stored offsite on a daily basis. Backed-up data is cross vaulted between the two computer centers, with mainframe backups stored primarily on disk media and mid-range/LAN backups stored primarily on tape. Additionally, all mainframe disk data is mirrored to the alternate data center providing a simplified and timelier recovery for that piece of the environment. Any customer data lost as a result of a data center catastrophe will be recovered through re-submittals by service providers and/or recovery reconciliation teams.
16.11.4.5 The Plan shall specify projected recovery times and data loss for mission-critical Systems in the event of a declared disaster.	Meets	
16.11.5 The CCN shall annually test its plan through simulated disasters and lower level failures in order to demonstrate to DHH that it can restore Systems functions.	Meets	
16.11.6 In the event the CCN fails to demonstrate through these tests that it can restore Systems functions, the CCN shall be required to submit a corrective action plan to DHH describing how the failure shall be resolved within ten (10) business days of the conclusion of the test.	Meets	
16.12 Off Site Storage and Remote Back-up		
16.12.1 The CCN shall provide for off-site storage and a remote back-up of operating instructions, procedures, reference files, system documentation, and operational files.	Meets	Disaster Recovery Plans The Aetna Information Services (AIS) Executive IT Disaster Recovery Plan is the high level plan for recovery of a data center and its critical components. The plan is derived from over 50 detailed IT infrastructure plans which are maintained by each critical support area. The plans contain processes and procedures to recover all functions, services, and equipment which are needed to recover either data center. These plans are centrally maintained by our disaster recovery group, are stored both locally and offsite and are updated semi-annually or as needed by the respective infrastructure area.
16.12.2 The data back-up policy and procedures shall include, but not be limited to:	Meets	
16.12.2.1 Descriptions of the controls for back-up processing, including how frequently back-ups occur;	Meets	Application recovery (DBAR) plans document technical and management contacts, application recovery specifics, application dependencies, integrated system synchronization, and checkout procedures. The plans are maintained routinely and utilize automated recovery processes to insure appropriate data resilience. These DBAR plans are validated annually with the application owners and business users with periodic integrated tabletop simulations.
16.12.2.2 Documented back-up procedures;	Meets	
16.12.2.3 The location of data that has been backed up (off-site and on-site, as applicable);	Meets	
16.12.2.4 Identification and description of what is being backed up as part of the back-up plan; and	Meets	

Requirement	Meets or Exceeds	Explanation
16.12.2.5 Any change in back-up procedures in relation to the CCN's technology changes.	Meets	Escalation and notification procedures are contained within disaster recovery plans to verify recovery team members, affected partners and business unit owners are activated in a timely manner. Our IT department's role during a disaster is to lead, manage, and staff the various recovery teams, which will also be augmented by additional vendor specialists under contract for certain supplemental recovery technologies, which our IT department will coordinate.
16.12.3 DHH shall be provided with a list of all back-up files to be stored at remote locations and the frequency with which these files are updated.	Meets	<p>Disaster Recovery Testing Aetna Better Health implements and maintains ongoing enhancements to disaster recovery plans and procedures. Testing is performed across a variety of applications and infrastructure components on a regular basis to promote ongoing disaster recovery readiness. Aetna Better Health routinely tests recovery elements of third party relationships including technology components, critical processes, and access points. These exercises can be initiated by either party and Aetna Better Health welcomes the opportunity to test these relationships as time and resources permit.</p> <p>Business Continuity Aetna Better Health maintains and implements a detailed business continuity program, with over 300 plans to address its critical business work group operations. In the event of an office outage, processing is transferred to surviving offices within Aetna Better Health's network with little or no disruption to service levels. The detailed business continuity plans are maintained on a quarterly basis and in-depth tests are conducted periodically. Business Continuity Plans are also designed to mitigate the effects of an extended system outage and loss of third party business associates; they also address severe staffing shortages.</p> <p>Aetna Better Health's Business Continuity Planning and Recovery Coordinator is responsible for coordination of Aetna Better Health's local DR/BC activities and works closely with Aetna Medicaid to</p>

Requirement	Meets or Exceeds	Explanation
		<p>support continuity of business operations. The Business Continuity Planning and Recovery Coordinator's contact information is also on file with DHH.</p> <p>Aetna Better Health and Aetna Medicaid maintain a local version of the Disaster Recovery/Business Continuity Plan specific to their respective operations and local resources. The Plan contains a listing of key customer priorities, key factors that could cause disruption, and the timelines within which each anticipates resumption of critical customer services (e.g. providers' receipt of prior authorization approvals and denials), including the percentage of recovery at certain hours, as well as key activities required to meet those timelines. Aetna Better Health's Business Continuity Planning Coordinator works in concert with our Training Department to see that both the Plan and our employee training program address the specific scenarios described in the ACOM (Section 104 – Business Continuity and Recovery Plan). Aetna Better Health will submit a summary of our Business Continuity and Recovery Plan – in accordance with ACOM requirements – to the Division of Health Care Management 15 days after the start of the contract year and annually thereafter.</p>
16.13 Records Retention		
<p>16.13.1 The CCN shall have online retrieval and access to documents and files for six (6) years in live systems for audit and reporting purposes, ten (10) years in archival systems. Services which have a once in a life-time indicator (i.e., appendix removal, hysterectomy) are denoted on DHH's procedure formulary file and claims shall remain in the current/active claims history that is used in claims editing and are not to be archived or purged. Online access to claims processing data shall be by the Medicaid recipient ID, provider ID and/or ICN (internal control number) to include pertinent claims data and claims status. The CCN shall provide forty-eight (48) hour turnaround or better on requests for</p>	Meets	<p>Aetna Better Health acknowledges and understands these requirements. Aetna Better Health will meet Aetna Better Health's specifications and comply with each of the requirements in this section.</p>



Requirement	Meets or Exceeds	Explanation
<p>access to information that is six (6) years old, and seventy-two (72) hour turnaround or better on requests for access to information in machine readable form, that is between six (6) to ten (10) years old. If an audit or administrative, civil or criminal investigation or prosecution is in progress or audit findings or administrative, civil or criminal investigations or prosecutions are unresolved, information shall be kept in electronic form until all tasks or proceedings are completed.</p>		
<p>16.13.2 The historical encounter data submission shall be retained for a period not less than six (6) years, following generally accepted retention guidelines.</p>	Meets	
<p>16.13.3 Audit Trails shall be maintained online for no less than six (6) years; additional history shall be retained for no less than ten (10) years and shall be provide forty-eight (48) hour turnaround or better on request for access to information in machine readable form, that is between six (6) to ten (10) years old.</p>	Meets	
<p>16.14 Information Security and Access Management The CCN's system shall:</p>		
<p>16.14.1 Employ an access management function that restricts access to varying hierarchical levels of system functionality and information. The access management function shall:</p>	Meets	<p>Our two state of the art, hardened computer centers located in both Middletown and Windsor, Connecticut. Both facilities have extensive fire suppression systems, dual incoming power feeds, UPS, and backup diesel generators supporting 24/7/365 operation. Physical access is strictly controlled and monitored, and access to vital areas is segregated by floor and business function as appropriate</p>
<p>16.14.1.1 Restrict access to information on a "least privilege" basis, such as users permitted inquiry privileges only, will not be permitted to modify information;</p>	Meets	<p>Aetna Better Health has a multi-layered and comprehensive system security process to safe guard and protect data in our system. For instance, Aetna Better Health's information system currently supports required technical interfaces and complies with all applicable requirements of the Health Insurance Portability and Accountability Act (HIPAA) as well as the procedures, policies, rules and statutes in</p>
<p>16.14.1.2 Restrict access to specific system functions and information based on an individual user profile, including inquiry only capabilities; global access to all functions shall be restricted to specified staff jointly agreed to by DHH and the CCN; and</p>	Meets	

Requirement	Meets or Exceeds	Explanation
16.14.1.3 Restrict unsuccessful attempts to access system functions to three (3), with a system function that automatically prevents further access attempts and records these occurrences.	Meets	effect during the term of our contract. Each data transmission is accompanied by an Aetna Better Health assigned security code, thereby enhancing data security, and system processes provide for the immediate identification of any data inconsistencies, allowing for their prompt resolution.
16.14.2 Make System information available to duly authorized representatives of DHH and other state and federal agencies to evaluate, through inspections or other means, the quality, appropriateness and timeliness of services performed.	Meets	Aetna Better Health recognizes that other activities, deemed to be comparatively minor, low-risk tasks, are routinely performed in the interest of system security and stability. It is our experience that the likelihood of these activities having an impact on system stability is extremely rare, as they are not changes to a processing environment. Therefore, Aetna Better Health leaves it to Aetna Medicaid's IT management team to identify, track, manage and report on these activities. Examples of these administrative changes include, but are not limited to the following:
16.14.3 Contain controls to maintain information integrity. These controls shall be in place at all appropriate points of processing. The controls shall be tested in periodic and spot audits following a methodology to be developed by the CCN and DHH.	Meets	<ul style="list-style-type: none"> • Account administration (i.e., user profiles, password resets, user desktop application setup) • Adding share points • Restoring files (individual PC's) • Changing backup tapes and job schedules • File system adjustments • Work management (output queues) • Managing storage pools
16.14.4 Ensure that audit trails be incorporated into all Systems to allow information on source data files and documents to be traced through the processing stages to the point where the information is finally recorded. The audit trails shall:	Meets	
16.14.4.1 Contain a unique log-on or terminal ID, the date, and time of any create/modify/delete action and, if applicable, the ID of the system job that effected the action;	Meets	
16.14.4.2 Have the date and identification "stamp" displayed on any on-line inquiry;	Meets	
16.14.4.3 Have the ability to trace data from the final place of recording back to its source data file and/or document;	Meets	We will create detailed file specifications for all data exchanges including; input/output (I/O), purpose, sender, receiver, secure transmission method, update or full file content, frequency, dependencies, business rules, file naming, file layouts, and the accounts and control system that will serve to systematically certify data and balances. Data exchange specifications will include file transmission validation and verification procedures.
16.14.4.4 Be supported by listings, transaction reports, update reports, transaction logs, or error logs; and	Meets	
16.14.4.5 Facilitate auditing of individual records as well as batch audits.	Meets	

Requirement	Meets or Exceeds	Explanation
16.14.5 Have inherent functionality that prevents the alteration of finalized records;	Meets	Aetna Better Health's and Aetna Medicaid's physical plants are secured and access limited through card readers and access levels determined by an individual's role and responsibility. Uniform guards are assigned to specific stations 24/7 to monitor access. Entry doors to our physical plants and server rooms are armed with badge readers that limit access except as permitted by building security and protocols. The security system records date and time of each door entry. Sensitive areas of our facility are monitored 24/7 by a video security system; CD back-up records are maintained for review.
16.14.6 Provide for the physical safeguarding of its data processing facilities and the systems and information housed therein. The CCN shall provide DHH with access to data facilities upon request. The physical security provisions shall be in effect for the life of the Contract;	Meets	Suspicious activity in or near secure doors must be reported to internal security. Our data systems include state-of-the-art fire and smoke detection systems and fire repression systems specifically designed for data processing centers. Employees receive initial and regular training regarding physical security and HIPAA requirements.
16.14.7 Restrict perimeter access to equipment sites, processing areas, and storage areas through a card key or other comparable system, as well as provide accountability control to record access attempts, including attempts of unauthorized access;	Meets	Per our standard operating procedure regarding requests for system access by an external agency, we will configure a DHH-supplied PC or laptop such that authorized external users have access – via Citrix – to a secure, inquiry-only environment wherein they may create and/or generate reports on an ad-hoc basis.
16.14.8 Include physical security features designed to safeguard processor sites through required provision of fire retardant capabilities, as well as smoke and electrical alarms, monitored by security personnel;	Meets	Remote users can only access our systems via VPN. Users must have both a valid identification number and password to gain entry to the system.
16.14.9 Put in place procedures, measures and technical security to prohibit unauthorized access to the regions of the data communications network inside of a CCN's span of control. This includes, but is not limited to, any provider or member service applications that are directly accessible over the Internet, shall be appropriately isolated to ensure appropriate access;	Meets	Each user has a unique user ID number. Users must have an seven (7) letter used identification number and an eight digit/letter password that must include a combination of letters, numbers and symbols. The system requires that a user's password by re-set on a regular basis and forbids a user repeating passwords. After three failed
16.14.10 Ensure that remote access users of its Systems can only access said Systems through two-factor user authentication and via methods such as Virtual Private Network (VPN), which must be prior approved by DHH no later than fifteen (15) calendar days after the Contract award; and	Meets	



Part Two: Technical Proposal
Section R: Information Systems

Requirement	Meets or Exceeds	Explanation
<p>16.14.11 Comply with recognized industry standards governing security of state and federal automated data processing systems and information processing. As a minimum, the CCN shall conduct a security risk assessment and communicate the results in an information security plan provided no later than fifteen (15) calendar days after the Contract award. The risk assessment shall also be made available to appropriate federal agencies.</p>	<p>Meets</p>	<p>attempts the system blocks entry and the user can only gain access through our System Administration team. Aetna Better Health has standard protocols to encrypt PHI. These protocols include a security feature that encrypts PHI on all e-mail and other transactions. We have a full suite of security and confidentiality policies and procedures. All employees receive training on HIPAA, security and confidentiality policies and procedures. Aetna Better Health will perform a security risk assessment and inform DHH of the results within 15 calendar after Contract award.</p>
<p>16.15 Audit Requirements</p>		
<p>16.15.1 The CCN shall ensure that their Systems facilitate the auditing of individual claims. Adequate audit trails shall be provided throughout the Systems. To facilitate claims auditing, the CCN shall ensure that the Systems follows, at a minimum, the guidelines and objectives of the American Institute of Certified Public Accountants (AICPA) Audit and Account Guide, The Auditor's Study and Evaluation of Internal Control in Electronic Data Processing (EDP) Systems.</p>	<p>Meets</p>	<p>Aetna Better Health acknowledges and understands these requirements. Aetna Better Health will meet Aetna Better Health's specifications and comply with each of the requirements in this section.</p>
<p>16.15.2 The CCN shall maintain and adhere to an internal EDP Policy and Procedures manual available for DHH review upon request, which at a minimum shall contain and assure all accessible screens used throughout the system adhere to the same Graphical User Interface (GUI) standards, and that all programmers shall adhere to the highest industry standards for coding, testing, executing and documenting all system activities. The manual is subject to yearly audit, by both state and independent auditors.</p>	<p>Meets</p>	

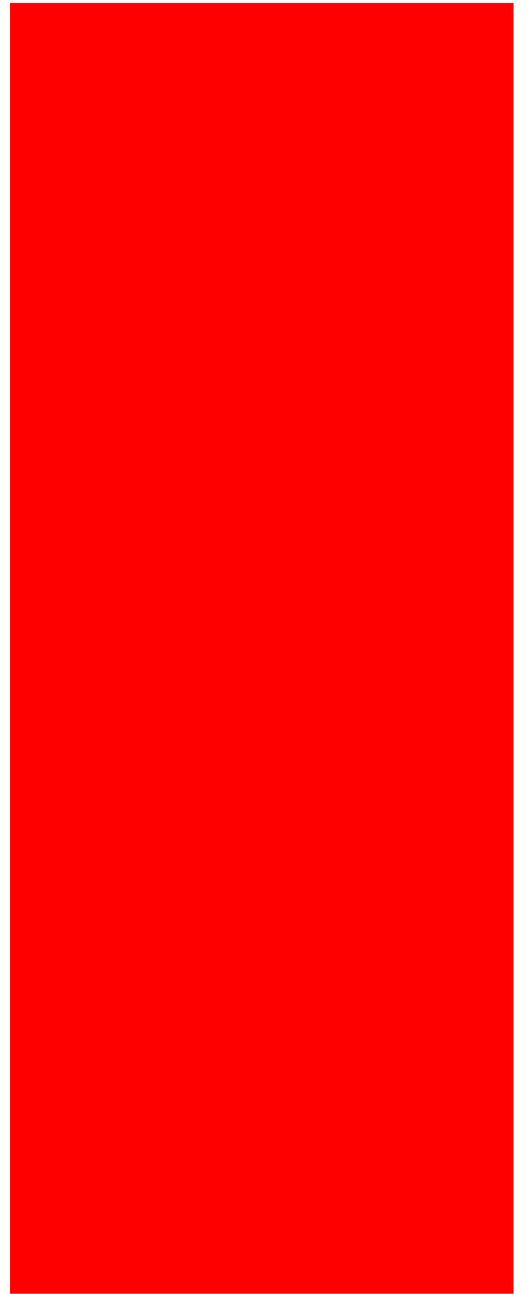


Requirement	Meets or Exceeds	Explanation
16.16 State Audits		
16.16.1 The CCN shall provide to state auditors (including legislative auditors), upon written request, files for any specified accounting period that a valid Contract exists in a file format or audit defined media, magnetic tapes, CD or other media compatible with DHH and/or state auditor's facilities. The CCN shall provide information necessary to assist the state auditor in processing or utilizing the files.	Meets	Aetna Better Health acknowledges and understands these requirements. Aetna Better Health will meet Aetna Better Health's specifications and comply with each of the requirements in this section.
16.16.2 If the auditor's findings point to discrepancies or errors, the CCN shall provide a written corrective action plan to DHH within ten (10) business days of receipt of the audit report.	Meets	
16.16.3 At the conclusion of the audit, an exit interview is conducted and a yearly written report of all findings and recommendations is provided by the state auditors. These findings shall be reviewed by DHH and integrated into the CCN's EDP manual.	Meets	
16.17 Independent Audit		
16.17.1 The CCN shall be required to contract with an independent firm, subject to the written approval of DHH, which has experience in conducting EDP and compliance audits in accordance with applicable federal and state auditing standards for applications comparable with the scope of the Contract's Systems application. The independent firm shall:	Meets	Aetna Better Health acknowledges and understands these requirements. Aetna Better Health will meet Aetna Better Health's specifications and comply with each of the requirements in this section.
16.17.1.1 Perform limited scope EDP audits on an ongoing and annual basis for contract compliance using DHH's audit program specifications at the conclusion of the first twelve (12) month operation period and each twelve (12) month period thereafter, while the Contract is in force with DHH and at the conclusion of the Contract; and	Meets	



Requirement	Meets or Exceeds	Explanation
16.17.1.2 Perform a comprehensive audit on an annual basis, for controls placed in operation and operation effectiveness, to determine the CCN's compliance with the obligations specified in the Contract and the Systems Guide.	Meets	
16.17.2 The auditing firm shall deliver to the CCN and to DHH a report of findings and recommendations within thirty (30) calendar days of the close of each audit. The report shall be prepared in accordance with generally accepted auditing standards for EDP application reviews.	Meets	
16.17.3 DHH shall use the findings and recommendations of each report as part of its monitoring process.	Meets	
16.17.4 The CCN shall deliver to DHH a corrective action plan to address deficiencies identified during the audit within ten (10) business days of receipt of the audit report. At the conclusion of the audit, an exit interview is conducted and a yearly written report of all findings and recommendations is provided by the independent auditing firm. These findings are reviewed by DHH and shall become a part of the CCN's EDP manual.	Meets	
16.17.5 Audits shall include a scope necessary to fully comply with AICPA Professional Standards for Reporting on the Processing of Transactions by Service Organizations (SAS-70 Report).	Meets	

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R.8 Describe your information systems change management and version control processes. In your description address your production control operations.

Aetna Better Health is aware that effective and efficient change order management of our hardware and software resources is a critical administrative process. Our Chief Operating Officer (COO) has authority and responsibility over our IT change order management. Aetna Better Health has a comprehensive IT program. Our IT organization is efficient and has effectively supported Medicaid managed care for over 25 years and today is the system managing the health information of 1.3 million Medicaid health plan members in 10 states. Aetna Medicaid's IT organization is flexible and responsive, led by a Vice President of Technology Support with over 15 years' related experience. Aetna Medicaid's IT organization includes 71 experienced and trained Phoenix-based FTEs responsible for the hardware and software change order processes. Aetna Better Health's COO manages the business continuity process and holds Aetna Medicaid accountable for the Change Order Process (COP). Aetna Medicaid's COP emphasizes detailed communication of business and associated technical requirements. It includes comprehensive planning and coordinating of project tasks, scheduling for minimum disruption, and change management quality control. Aetna Medicaid's process protects Aetna Better Health's core business applications and the systems from changes that may be disruptive or have an unacceptable level of risk. Our COP manages hardware/software changes through an approach based on technical and business evaluation, prioritization, coordination, and optimum use of resources. Aetna Medicaid uses Remedy Change Management system version 7.5 PS4 from BMC Software to manage system change requests.

As part of Aetna Better Health's change order management process, we define a system change as any modification that impacts the shared network, computing environment, or business application by altering its existing state. This includes, but is not limited to:

- System Hardware: Servers or server components, power conditioners, etc.
- System Software: Operating systems, antivirus, core business applications, etc.
- Databases: Microsoft SQL Server, Microsoft Access, etc.
- Network Hardware: Routers, switches, firewalls, VPN, security appliances, etc.
- Desktop Management: Hardware, operating systems, Citrix client, antivirus, etc.

Aetna Better Health assigns system changes to one of three categories:

- 1) Full Cycle: by default all changes fall into this category. These changes are discussed and may be approved at the weekly IT COP meeting
- 2) Expedited: change needs to occur prior to the next IT COP meeting. These changes require approval of Aetna Better Health's COO or designee and Aetna Medicaid's IT Director; and
- 3) Routine: a minor change (e.g. changing a web page document) using an accepted process

Aetna Better Health maintains strict policies and procedures safeguarding against unauthorized modifications to our systems. When an IT Change Control request is submitted, a new request is created in Remedy. Requests need to be approved by both the support group and the committee

members. If an IT Work Request or an IT Change Control is not approved, or requires prior approval, it is sent back to the requestor with reasons for the denial. A system change may be minor (changes to access for an employee) or major (system migration or changes that impact operations). Minor system changes are processed, sent through the committee for approval, then confirmation of the change is provided to the employee's manager. A major change is sent to Department of Health and Hospitals (DHH) for approval before receiving authorization from the Change Control Committee. With approval, development and testing complete, the change moves to production.

Aetna Better Health recognizes that other activities, deemed to be comparatively minor, low-risk tasks, are routinely performed in the interest of system security and stability. It is our experience that the likelihood of these activities having an impact on system stability is extremely rare, as they are not changes to a processing environment. Therefore, Aetna Better Health leaves it to Aetna Medicaid's IT management team to identify, track, manage and report on these activities. Examples of these administrative changes include, but are not limited to the following:

- Account administration (i.e., user profiles, password resets, user desktop application setup)
- Adding share points
- Restoring files (individual PC's)
- Changing backup tapes and job schedules
- File system adjustments
- Work management (output queues)
- Managing storage pools

Aetna Better Health mitigates the risk associated with any upgrade by: (1) releasing any upgrade in a secure "back office" environment to test its impact prior to promoting it to the "production" environment; (2) backing up the entire system prior to the upgrade so we can reverse the process and return the system to its pre-upgrade state if necessary; (3) requiring the hardware/software vendor to have its staff on-site to facilitate and monitor the COP; and (4) training Aetna Better Health employees/end users on the conversion/upgrade. Standard operating procedure mandates that Aetna Better Health provides DHH with the following information prior to any system conversion or upgrade:

- System (hardware/software) to be upgraded and the nature of the upgrade
- Timeframe for the upgrade
- How PHI will be secured and protected during the upgrade
- How the upgrade will be tested prior to final promotion
- A plan to revert to the original system if there's a problem

Although there is a standard Aetna Better Health committee that reviews conversion/upgrade requests; it is the standard operating procedure that Aetna Better Health forms a COP team to manage a major conversion/upgrade. This team is led by Aetna Better Health's COO or designee. Aetna Better Health upgraded QNXT™ to version 3.4 in July 2010. By adhering to our COP tools, this upgrade was executed without a disruption to system availability and zero deficits. The Aetna Better Health team responsible for this successful upgrade fully documented

the process. This documentation is a valuable resource for future system conversion/upgrades and will be a yardstick to guide future system conversion/upgrade activities.

Aetna Better Health's change management process provides a structured, fully recoverable framework in which to implement system changes in accordance and on schedule with federal, state and contract-specific requirements. Our implementation schedule for Louisiana will provide for full conformance with future federal and/or DHH specific standards for encounter data exchange in accordance with the readiness review schedule. The COO will notify DHH personnel of major changes, upgrades, modifications or updates to the following core production systems or associated operating software within our span of control at least ninety (90) calendar days prior to the projected effective date of the change:

- Claims processing
- Eligibility and enrollment processing
- Service authorization management
- Provider enrollment and data management
- Conversions of core transaction management Systems

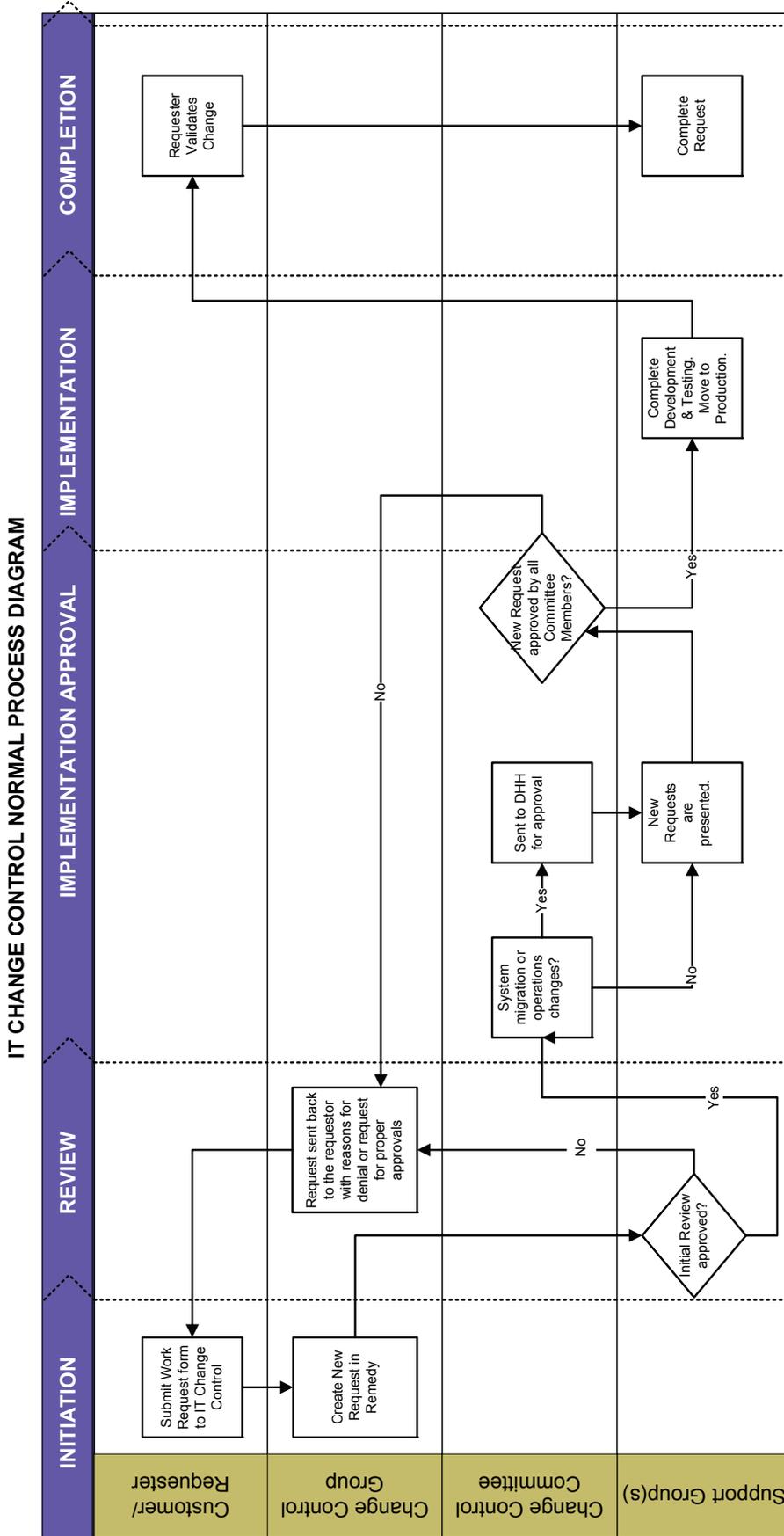
Associated documentation and/or manuals will be revised accordingly, and electronic versions of the drafts presented to DHH for review and approval no less than thirty (30) days prior to implementation in an easily accessible, near real-time format. Revisions to printed manuals will occur within ten (10) business days of DHH's approval of the electronic draft.

Standard policy will prohibit the scheduling of systems unavailability attributable to maintenance, repair and/or upgrade activities during hours that might compromise or prevent critical business operations without DHH's prior approval.

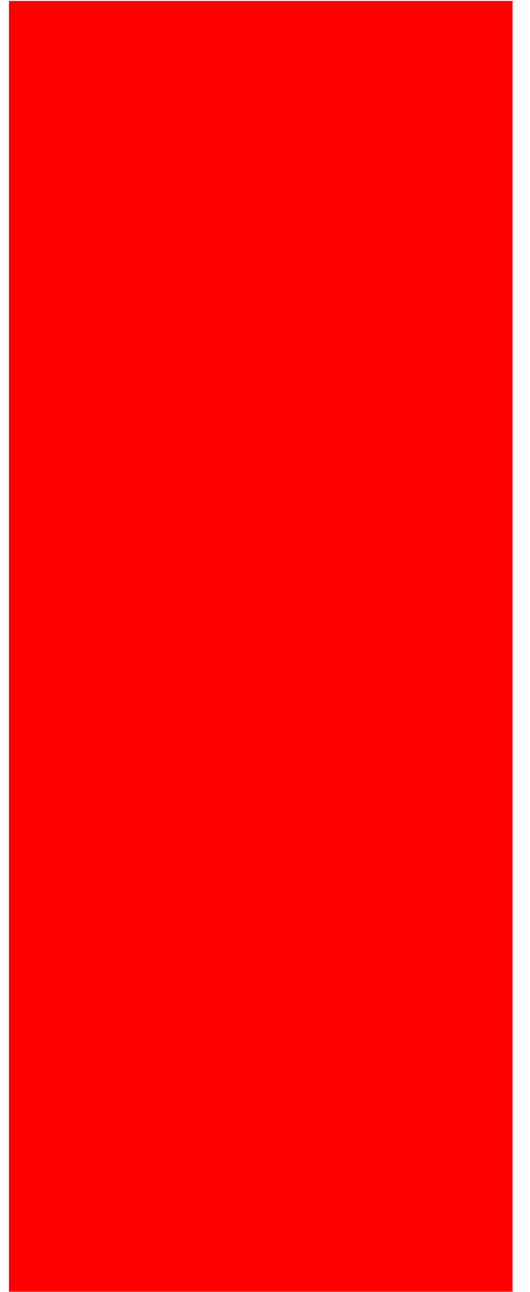
Additional policies will provide for the response to DHH notification of system problems not resulting in unavailability according to the following timeline:

- Within five (5) calendar days of receiving notification from DHH, Aetna Better Health will respond in writing to notices of system problems.
- Within fifteen (15) calendar days, the correction shall be made or a requirements analysis and specifications document will be due.
- Aetna Better Health will correct the deficiency by an effective date to be determined by DHH.

Please refer to the next page for a flowchart illustrating the IT Change Control Process that Aetna Better Health will use during this contract period.



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R.9 Describe your approach to demonstrating the readiness of your information systems to DHH prior to the start date of operations. At a minimum your description must address:

- provider contract loads and associated business rules;
- eligibility/enrollment data loads and associated business rules;
- claims processing and adjudication logic; and
- encounter generation and validation prior to submission to DHH.

Aetna Better Health and its affiliates have been implementing Medicaid managed care information systems for over 25 years. We recently implemented three new encounter systems for Medicaid managed care programs in Florida, Pennsylvania and Illinois and expanded our Missouri Medicaid managed care program into two large regions. Today, Aetna Better Health administers or manages Medicaid health plans providing coverage to over 1.3 million members in 10 states. Our implementations leverage a proven methodology that is rigorous, yet accommodating to the unique needs of any given contract. We initiate certain preliminary implementation activities prior to contract award, creating an infrastructure that expedites subsequent implementation activities. Foremost among these preliminary activities is formation of a Lead Team comprising personnel from every operating division, including any division involved in information systems implementation. Twenty (20) staff members in the following roles/departments will coordinate implementation of the Coordinated Care Network (CCN) Program, providing the direction and prompt, consensus-based, decision-making necessary to keep implementation on task and on schedule. The Lead Team is chaired by the Aetna Better Health Chief Operations Officer (COO).

Louisiana Lead Team

Regional Vice President	VP of Business Development
Finance – CFO	Medical Director
Information Management and Systems Director	Implementation Director
Compliance Officer	Enrollment/Disenrollment Manager
Encounter Management	Finance – TPL & COB
Provider Payment & Reimbursement	Human Resources
Information Technology (IT)	Reporting
Member Services	Network Management
OPKM/Claims Audit/BAM/Claims	Provider Data Services
Provider Services	Appeals/Grievance
Training	

Aetna Better Health’s Lead Team bears responsibility for leading and coordinating the testing and issue/defect management of all business applications associated with any implementation. With regard to Louisiana, this includes appointing a Technology Lead to manage execution of the DHH-provided test plan and associated activities prior to Contract’s Go-Live Date. Aetna Better Health will initiate regular meetings with DHH personnel upon contract award to

collaborate on a test approach that best aligns unit, end-to-end and DHH's Readiness Review testing. Should DHH provide specific test scripts or scenarios, we will endeavor to roll those into our unit and/or end-to-end testing whenever possible. Should the timing of DHH's request preclude that option, DHH's test scripts or scenarios will be executed independently. Aetna Better Health's implementation tests comprise IT-facilitated end-to-end testing of all business and technology functions, daily status meetings, and policies and procedures providing for the prompt resolution and/or escalation of any issue. All testing issues are comprehensively tracked, managed and resolved, allowing anyone from IT or related business function to see all issues and participate in and validate their resolution. Critical and potentially show-stopping issues are escalated to Lead Team for discussion and resolution. Daily meetings allow for any roadblock, issue or defect to be resolved as quickly as possible.

Provider Contract Loads and Associated Business Rules

Aetna Better Health's Business Application Management (BAM) Department is responsible for provider contract loads and the configuration of associated business rules. Business rules may be derived from multiple sources, including but not limited to benefit matrices (developed by Aetna Better Health's own implementation team) defining covered and non-covered services, DHH documentation and this RFP. Once configured, unit and end-to-end (each lasting 8 weeks) testing will validate the desired functionality. The validated contract will then be moved to the production environment, where Provider Data Services (PDS) staff affiliate providers to the contract accordingly. Related processes will coordinate provider enrollment records with the published list of Louisiana Medicaid provider types, specialty, and sub-specialty codes at www.lamedicaid.com prior to the submission of any provider data to DHH, its Fiscal Intermediary or the Enrollment Broker

Eligibility/Enrollment Data Loads and Associated Business Rules

Aetna Better Health's Information Technology department will be responsible for establishing the technical interfaces necessary to support the member eligibility/enrollment data loads associated with this contract. We currently receive, process and update enrollment files, via the required HIPAA transaction code sets, with ten other state agencies. As such, QNXT™, our core information processing system, will readily accept DHH's initial file containing twenty-four (24) month's eligibility and enrollment data, as well as subsequent daily, weekly and monthly transaction files once the necessary interface is established. Eligibility and enrollment files within QNXT™, our core information processing system, will be updated within twenty-four (24) hours of receipt. Business rules will identify, among other things, potential duplicate records for a single member such that, upon confirmation by DHH, Eligibility/Enrollment personnel can link or merge the enrollment, service utilization, and customer interaction histories of the duplicate records accordingly.

Systems-related sub-processes supporting Aetna Better Health's eligibility/enrollment import process include the following:

- File validation for HIPAA compliancy using Instream (a HIPAA transaction validation tool)
- File reformatting from an 834 (HIPAA eligibility format) into a QNXT™-acceptable format
- Pre-Processor execution to query file data against QNXT™ to identify new member record Adds, existing member record Updates, and existing member record Terminations

- Pre-Processor identification of member records meeting special-needs review to make available for manual handling by Member Services as opposed to import into QNXT™
- Load of membership data to intermediate tables in preparation for import into QNXT™
- Import of membership to from intermediate tables to QNXT™ production
- Reporting to Member Services which includes notification of successful import, statistics reconciling records received on file to records imported and records rejected for manual review, and detailed listings of each rejected record for manual review and handling
- Archiving of daily file from the State, Member Services reports and historical data for auditing and reporting purposes is performed

Claims Processing and Adjudication Logic

Aetna Better Health has a well-defined methodology for building, configuring and testing the claims processing capabilities and adjudication logic associated with any new contract. Prior to Contract award, Business Application Management (BAM) analysts will begin analyzing business requirements to design and configure an optimal and efficient system build that will minimize the need for manual processing. As mentioned earlier, OPKM personnel have already reviewed the claims processing requirements of this RFP, its appendices, attachments and systems guide and determined that our systems currently possess the functionality to support them.

Requirements analysis complete, BAM analysts will load the rules and requirements of the CCN Program, including eligibility file layout, provider contracts, fee schedules and member benefits and prior authorization requirements into QNXT™, our core claims adjudication application. Details of the configuration will be documented as the build progresses. A separate group of analyst(s) will then audit and validate the build based on the rules and requirements provided by the health plan and the implementation team. Once validated, the configuring analysts will jointly perform unit testing with the Operations Process Knowledge Management (OPKM) Testing team to validate that the system is operational and meets business requirements. Finally, they will participate in end-to-end testing to see that the system is operating as expected.

Aetna Better Health's claims processing activities include the application of comprehensive clinical and data related edits supporting the efficient, effective adjudication of claims. QNXT™ has data related edits configured within its software. These are supplemented by two clinical claims editing solutions. The first, iHealth Technologies' (iHT) Integrated Claims Management Services (ICM Services), maintains select payment policies from one of the industry's most comprehensive correct coding and Medical Policy content libraries and edits claims accordingly. The second, McKesson's ClaimCheck®, expands upon those capabilities by enabling our claims management team to define and combine specific claim criteria, such as provider or diagnosis, to deliver enhanced auditing power.

Inbound claims are initially checked for items such as member eligibility, covered services, excessive or unusual services for gender or age (e.g. "medically unlikely"), duplication of services, prior authorization, invalid procedure codes, and duplicate claims. Claims billed in excess of predetermined limits are automatically pended for review, as are any requiring additional documentation (e.g. medical records) in order to determine the appropriateness of the service provided. Professional claims (CMS 1500s) that reach an adjudicated status of "Pay" are

automatically reviewed against nationally recognized standards such as the Correct Coding Initiative (CCI), and medical policy requirements [e.g., American Medical Association (AMA)], with recommendations applied during an automatic re-adjudication process. Other methodologies utilized throughout the auto adjudication process include, but are not limited to, Multiple Surgical Reductions and Global Day E & M Bundling.

Encounter Generation and Validation Prior to Submission to DHH.

Upon Contract award, Aetna Better Health will submit to DHH and its FI a plan for testing the ASC X12N 837 COB in accordance with the Fiscal Intermediary's three (3) tiered methodology. The plan will include the following activities:

Prior to testing, Aetna Better Health will supply DHH with documentation of provider information publicly available through the Freedom of Information Act (FOIA) from the National Provider and Plan Enumeration System (NPPES). The documentation will map each provider to the corresponding provider types and specialties provided by DHH.

Tier 1

Aetna Better Health will request, complete and submit to the FI the EDI application and approval forms necessary to obtain a Trading Partner ID .

During the authorization process, the Chief Operating Officer (COO) will contact the FI's EDI Department to obtain EDI specifications relative to data and format requirements for EDI claims. We will use these specifications to confirm compliance with required data and format requirements prior to any testing.

Concurrent with EDI enrollment, Aetna Better Health will begin testing – at our own expense – with EDIFECS, Molina's third-party vendor, to certify HIPAA compliance prior to submission of any test files through the Molina Electronic Data Interchange (EDI). Upon successful certification by EDIFECS, we will begin submitting test encounters to the FI's EDI Coordinator for data and format validation, seeing to it that the following information is included in each encounter file:

- All test files will be submitted with the required 4509999 identifier.
- 'RP' is present in X12 field TX-TYPE-CODE field.
- Aetna Better Health's Medicaid IDs is in loop 2330B segment NM1 in 'Other Payer Primary Identification Number'
- If line item Coordinated Care Network (CCN) paid amount is submitted, 'Other Payer Primary Identifier' in loop 2430 segment SVD is populated with their Medicaid provider number.
- If a contracted provider has a valid NPI and taxonomy code, Aetna Better Health will submit those values in the 837. If the provider is an atypical provider, we will adhere to 837 atypical provider guidelines.

A representative of the lead team will work with the EDI Coordinator to resolve any submission related issues.

Tier II

Once more than 50% of Aetna Better Health's encounter claims data has successfully passed the FI's pre-processor edits, the FI will process the encounters through the MMIS Adjudication cycle and the Payment cycle. The Payment cycle will create an 835 transaction, which Aetna Better Health will retrieve via IDEX. The lead team will examine the returned 835s, comparing them to the encounter data claims (837s) submitted to verify that all claims submitted are accounted for. Should any issues arise, Aetna Better Health will use MMIS' new edit code reports, as well as the MMIS edit code explanation document provided, to help determine the nature of the problem. We will reach out to the FI for assistance if necessary.

Tier III

Once satisfactory test results are documented, and the FI moves Aetna Better Health into production, Aetna Better Health will submit encounter files on a monthly basis. We will have established procedures for recouping post-payments available for DHH's review during the Readiness Review process. These require that we void encounters for any claim recouped in full. For recoupments that result in an adjusted claim value, we submit replacement encounters accordingly.

Demonstration and Assessment of System Readiness

To assist DHH in further assessing our Information Systems readiness, Aetna Better Health will provide the following during System Reading Review:

- Our Global Testing Manger will coordinate and manage systems testing as prescribed by DHH's test plan and outlined in the CCN-P Systems Companion Guide, executing the test cycles necessary to demonstrate the ability of all external data interfaces - including those with Subcontractors - to transmit, receive and process data in HIPAA compliant or DHH specific formats and/or methods, including, but not limited to secure File Transfer Protocol (FTP) over a secure connection such as Virtual Private Network (VPN). We will provide DHH, or the designated contractor, with test data files for systems and interface testing for all external interfaces as necessary.
- We will either provide documentation, such as that described in our response to R16 (regarding protecting the confidentiality of member data), or demonstrate our systems' and facility's HIPAA compliance, as specified in the Information Security and Access Management section and as otherwise stated in the RFP.
- We will submit to DHH a description of the associated interface, data and process flow for each business processes described in the CCN-P Systems Companion Guide. These include, but are not limited to:
 - Encounter Correction Process
 - Resubmissions
 - Adjustment Process
- We will provide DHH with a summary of all recent external audit reports, including findings and corrective actions, relating to our proposed systems. Aetna Better Health has engaged KPMG, LLC since 2000 to perform SOC I Type II audits (formerly SAS 70). KPMG's most recent audit (Report on Controls Placed in Operation and Tests of Operating Effectiveness

for Claims Processing Controls and Related General Computer Controls of the Phoenix Service Center) included the period December 1, 2009 through November 30, 2010 and reflected an unqualified opinion. We will promptly make additional information on the detail of such system audits available to DHH upon request.

- We will provide the following deliverables required for Readiness Review

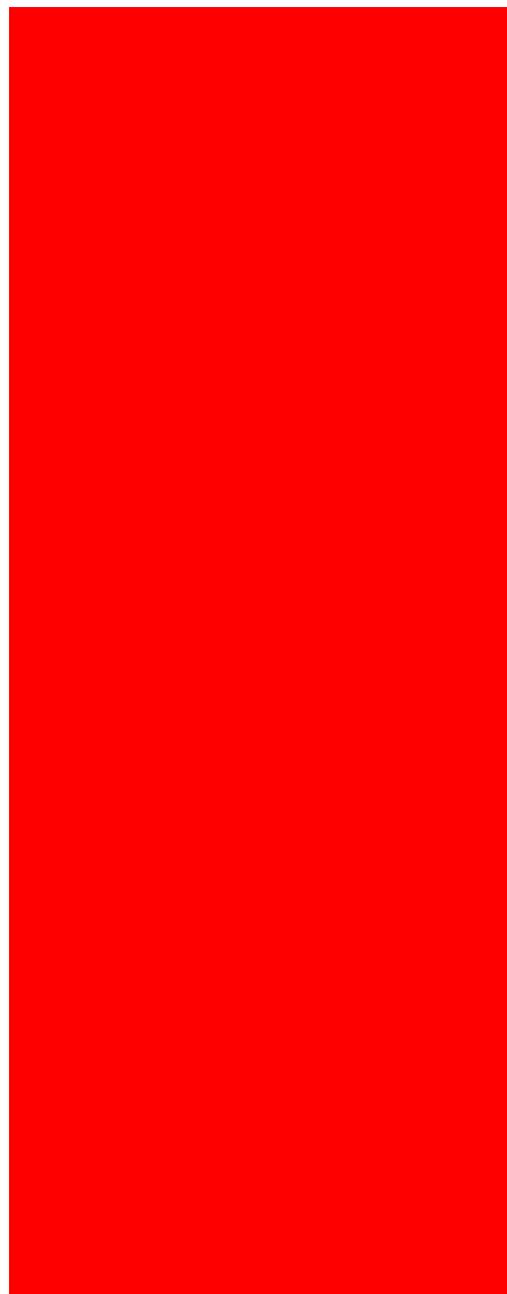
Systems-related Deliverables Required for Readiness Review
Network Provider and Subcontractor Registry
NCQA PCP-PCMH™ Recognition Report
Provider Directory Template
Predictive Modeling Specifications
Contingency Plan <ul style="list-style-type: none"> • Disaster Recovery Plan • Business Continuity Plan
Systems Quality Assurance Plan
Marketing Plan (relative to web-based member/provider communications)
Quality Assurance (QA) Report (including following early warning system performance measures) <ul style="list-style-type: none"> • Percentage of PCP Practices that provide verified 24/7 phone access with ability to speak with a PCP Practice clinician (MD, DO, NP, PA, RN, LPN) within 30 minutes of member contact. ≥95% • Percentage of regular and expedited service authorization request processed in timeframes in the contract ≥95% • Percentage of pre-processed claims that take more than two (2) business days to submit to the FI ≤ 5% • Rejected claims returned to provider with reason code within 15 days of receipt of claims submission ≥99% • Percentage of Call Center calls answered by a live person within 30 seconds

- We will demonstrate that personnel for the following systems-related functions have been hired and trained.

Systems-related Staff Functions
<p>Key Positions:</p> <ul style="list-style-type: none"> ● Information Management and Systems Director ● Business Continuity Planning and Emergency Coordinator ● Claims Administrator ● Provider Claims Educator
<p>Additional Required Personnel:</p> <ul style="list-style-type: none"> ● Claims Processing Personnel ● Encounter Processing Personnel

Aetna Better Health maintains a robust implementation process to see to it that we are able to demonstrate the required systems capabilities at Readiness Review. However, in the instance that a deficiency is identified in the course of Readiness Review, we will provide a Corrective Action Plan addressing the deficiency no later than ten (10) calendar days after notification of the deficiency by DHH.

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R.10 Describe your reporting and data analytic capabilities including:

- **generation and provision to the State of the management reports prescribed in the RFP;**
- **generation and provision to the State of reports on request;**
- **the ability in a secure, inquiry-only environment for authorized DHH staff to create and/or generate reports out of your systems on an *ad-hoc* basis; and**
- **Reporting back to providers within the network.**

Aetna Better Health administers, manages or owns Medicaid health plans in ten states, requiring an integrated reporting and data analytics technology infrastructure that supports responsive, accurate, complete and timely reporting and data analytics capabilities. Our care coordination and managed care programs rely on data analytics to see that we focus case and disease management on those members most at risk.

Informatics personnel work closely with other departments, including Actuarial Services and Medical Economics, and system vendors to integrate reporting data from Aetna Better Health's core information systems. These include QNXT™ and our web-based care management business application (Dynamo™), the principal stewards of Aetna Better Health's administrative and clinical data. QNXT™ handles claims, eligibility and enrollment processing, service authorization and provider enrollment and data management functions, while our web-based care management business application (Dynamo™), supports all clinical functions. This centralization of the reporting function supports improved data integrity while providing for the complete, accurate and timely submission of reports. Our Informatics team has worked diligently to consolidate the reporting requirements from each health plan that Aetna Better Health currently engages with to develop comprehensive reporting capabilities. The team has catalogued every statutory, regulatory and compliance based report across the organization, centralized those reports wherever possible, then standardized each report and associated metric. This results in improved data integrity and consistency. Informatics personnel use the report catalog to identify existing reports that may meet – or meet with minor modification - the needs of any new health plan, mitigating the effort required to develop report(s) from scratch whenever possible. A centralized production schedule and quality control process further support the accurate, complete and timely submission of required deliverables. Following is an overview of Aetna Better Health's reporting capabilities. Below that is a table listing the required system-based reports of this RFP and the Aetna Better Health systems responsible for them.

ASDB – Aetna Better Health's Actuarial Services Data Base (ASDB) supports reporting and analytical capabilities, such as our multidimensional predictive modeling and statistical outlier analysis. The application houses eligibility, provider, prior authorization and claims data and serves a diverse user base, including Medical Management, Finance and Operations. Analysts can use the proprietary Actuarial Analytics Web Portal (AAWeb), an interactive interface, as a point-and-click query tool to access reports, drill down into data and export information from ASDB. For instance, AAWeb can generate customized analyses to identify favorable and unfavorable cost and utilization trends, measure performance against key benchmarks, and

review summary information. It is a powerful tool that affords Medical Management personnel access to member and provider profiles, as well as current cost and utilization trends. This gives Aetna Better Health the ability to disseminate analysis results on treatment best practices to providers, who can then identify and prevent unnecessary migrations to higher levels of care and the development of chronic health conditions.

General Risk Model – Aetna Better Health’s *General Risk Model (GRM)* assimilates information from a variety of sources, including the Actuarial Services Data Base (ASDB) described above, and transforms it into a series of markers measuring both risk and opportunity. It then scores these markers and assigns a rank to every member, reflecting both the level of risk and potential opportunity for improvement, thereby helping Case Managers (CMs) provide the appropriate level of care coordination. In addition to its risk algorithms, the application identifies members who meet specific rules-based criteria for individual treatment interventions.

Consolidated Outreach and Risk Evaluation (CORE) – Aetna Better Health’s Consolidated Outreach and Risk Evaluation (CORE) tool identifies three key risk groups – high risk of ED, high risk of inpatient services and high health risk based on predictive modeling results. Case Managers then use the outcome of the risk stratification in determining the direction of additional assessments, targeting areas of concern identified through the risk stratification process.

ActiveHealth Care Engine – Aetna Better Health maintains an advantage in the integrated care coordination of our members as a result of our affiliate, ActiveHealth’s, CareEngine® System – a claims-based clinical support system combined with an automatic message generator called Care Considerations. The system integrates medical and pharmacy claims data and laboratory results within member-centered records that are then compared to over 1,500 evidence-based clinical rules and related algorithms developed by ActiveHealth’s team of board certified physicians and pharmacists. It then identifies member specific opportunities to optimize care and communicates evidence-based treatment recommendations – “Care Considerations” – to providers. At the same time, the system generates “Wellness Considerations” for members: communiqués focusing on prevention and wellness issues such as childhood immunizations, breast cancer screening, and disease appropriate screening and vaccinations. In addition to the provider messaging, Aetna Better Health receives a Care Considerations data file from Active Health that is uploaded into our care management business application (Dynamo™). Care coordinators and case managers can then address these recommendations (i.e., Care Considerations) with members during regular care planning meetings, as appropriate.

AboveHealth® – Aetna Better Health’s secure, HIPAA-compliant web portal for members and providers, this secure, ASP-based application synchronizes data on a daily basis with QNXT™ through data extract and load processes, allowing members to check eligibility status and review benefits and prior authorization status. Providers are afforded additional functionalities, including:

- Member eligibility verification
- Panel roster review
- Searchable provider list
- Claim status search

- Remittance advice search
- Authorization submittal
- Authorizations search

The portal is configured to provide HEDIS[®] scorecard data, as well as alerts indicating when a member is due or past due for a HEDIS[®]-related service (e.g., well-child check-up, need for asthma controller medication, immunizations). This information is integrated within the application's provider panels/rosters. If a member is due or past due for a service, a "flag" appears next to the member's name, which, when clicked, permits providers to view a description of the needed service(s).

a) generation and provision to the State of the management reports prescribed in the RFP:

Aetna Better Health's information system provides for the collection, analysis, integration and reporting of data in compliance with DHH and federal reporting requirements. The system provides information on areas including, but not limited to, utilization, grievances and appeals, and member disenrollment for reasons other than loss of Medicaid eligibility. Our core business and clinical management systems, QNXT[™] and our web-based care management business application (Dynamo[™]), collect data on member and provider characteristics, as well as services furnished to members. Our Informatics Department will create required reports using the electronic formats, instructions, and timeframes specified by DHH and at no cost to DHH. All reports submitted to DHH will be in a format accessible and modifiable by the standard Microsoft Office Suite of products, Version 2003 or later, or in a format accepted and approved by DHH. Any changes to report format will be submitted to DHH for approval prior to implementation. We will provide samples of all reports within forty-five (45) calendar days following the date the Contract is signed to confirm agreement on format and design.

Aetna Better Health will certify all submitted data, documents and reports including, but not limited to, enrollment information, financial reports, encounter data, and other information, as specified within the Contract and this RFP. The certification will attest, based on best knowledge, information, and belief as to the accuracy, completeness and truthfulness of the documents and data. Certifications will be submitted concurrently with the certified data and documents.

The data shall be certified by one of the following:

- CCN's Chief Executive Officer (CEO);
- CCN's Chief Financial Officer (CFO); or
- An individual who has the delegated authority to sign for, and who reports directly to the CEO or CFO.

Timeliness: Policies and procedures, aided by automated production schedules whenever possible, will provide that all required reports or files are submitted to DHH in a timely manner for review and approval. In the event that there are no instances to report, Aetna Better Health will submit a report so stating. Unless otherwise specified, deadlines for file and report submission will be as follows:

Schedule	Due Date
Daily	Within one (1) business day following the due date
Weekly	The Wednesday following the reporting week
Monthly	Within fifteen (15) calendar days of the end of each month
Quarterly	By April 30, July 30, October 30, and January 30, for the quarter immediately preceding the due date
Annual	Within thirty (30) calendar days following the twelfth (12th) month; and
Ad Hoc	Within three (3) business days from the agreed upon date of delivery

Designated health plan personnel will notify DHH via phone, fax, and/or electronic mail within fifteen (15) minutes upon discovery of any problem that results in delays in report distribution or problems in on-line access to critical systems functions and information during a business day, in order for the applicable work activities to be rescheduled or handled based on System unavailability protocol.

Accuracy and completeness: Aetna Better Health will adhere to DHH’s prescribed guidelines in determining whether a report is correct and complete prior to submission. These include:

- The report must contain 100% of the CCN’s data; and
- 99% of the required items for the report must be completed; and
- 99.5% of the data for the report must be accurate as determined by edit specifications/review guidelines set forth by DHH.

Errors: In the event that an error is discovered, either by Aetna Better Health or DHH, subsequent to a file or report’s submission, Aetna Better Health will correct the error(s) and submit accurate reports as follows:

- For encounters - In accordance with the timeframes specified in the Administrative Actions, Monetary Penalties and Sanctions Section of this RFP.
- For all reports – Fifteen (15) calendar days from the date of discovery by Aetna Better Health or date of written notification by DHH (whichever is earlier).

The following table lists the required system-based reports of this RFP and the Aetna Better Health systems responsible for them:



Part Two: Technical Proposal
Section R: Information Systems

Report or File Name	Frequency	Data Source
Member Services A. Unsuccessful new member contacts B. Member Services Call Center	A. Monthly B. Monthly with an Annual Summary	A. QNXT™ B. Avaya
Annual Medical Loss Ratio Report	Beginning second CY of implementation Due June 1 for previous CY	ASDB
Financial Reporting	A. Annual Audited Financial Statement B. Four Quarterly Unaudited Financial Statements and Financial Reporting Guide C. Monthly if requested by DHH	ASDB
CCMP A. Reports B. Predictive Modeling Specifications C. Program Evaluation	A. Quarterly with an Annual Summary B. Readiness review and Annually thereafter C. Annually	ASDB CORE Dynamo ⁵ Narrative
Quality Assurance (QA) A. QAPI Program description and QAPI Plan B. Impact and effectiveness of QAPI program evaluation C. Performance Improvement Project descriptions D. Performance Improvement Projects Outcomes E. Early Warning System Performance Measures F. Level I and Level II Performance Measures G. PCP Profile Reports	During readiness review, and Annually thereafter A. 30 days from the date of the Contract and Annually thereafter B. Annually C. Within 3 months of execution of Contract and at the beginning of each Contract year thereafter D. Annually E. Monthly F. Annually and upon DHH request G. Quarterly with an Annual Summary	ASDB Dynamo ⁵ above QNXT™ Narrative
Provider Call Center	Monthly with an Annual Summary	Avaya

⁵ Our web-based care management business application (Dynamo™)



Part Two: Technical Proposal
Section R: Information Systems

Report or File Name	Frequency	Data Source
Telephone and Internet Activity Report	Monthly	Avaya AboveHealth®
UM reports A. UM Committee Meeting minutes B. Medical Record Reviews	A. Within 5 working days of each meeting B. Quarterly with an Annual Summary	Committee meeting minutes
Case Management Reports	Quarterly with an Annual Summary	Dynamo ⁵ above
FQHC/RHC Encounter File	Monthly	Encounter Management System (EMS)
Encounter Submission File	Weekly	Encounter Management System (EMS)
Fraud and Abuse Activity Report	Quarterly with an Annual Summary	EXCEL
Grievance, Appeal and Fair Hearing Log Report	Monthly, and Quarterly Summary	Grievance & Appeals Database
Grievance, Appeal and Fair Hearing Log - Redacted	Monthly, and Quarterly Summary	Grievance & Appeals Database
Patient-Center Medical Home (PCMH) A. PCMH Implementation Plan B. NCQA PCP-PCMH™ recognition report	During Readiness Review and Annually thereafter	Internal Database
Service Area Review of Appointment Availability /Twenty-four (24) hour Access and Availability Survey	Annually	Internal Database
Abortion Consents	As appropriate	Internal Database
Member Satisfaction Survey Report	Annually	Internal Database
Provider Satisfaction Survey Report	Annually	Internal Database
Third Party Liability Collections	Annually	QNX™



Part Two: Technical Proposal
Section R: Information Systems

Report or File Name	Frequency	Data Source
CCN Disenrollment Report	Quarterly	QNX™
Network Provider and Subcontractor Registry	At Readiness Review and Monthly thereafter	QNX™
Claims Summary Report	Quarterly	QNX™
Denied Claims Report	Monthly	QNX™
Back-up File List	Quarterly	QNX™
Prior Authorization and Pre-Certification Summary	Annually	QNX™
Claims Processing Interest Payments	Quarterly	QNX™
Electronic Data Processing (EDP) Audit	Annually	QNX™
PCP Linkage File	Quarterly	QNX™
Non-Medicaid Enrolled Providers	Monthly	QNX™
Claims Payment Accuracy Report	Monthly	QNX™
EPSDT Report (CMS 416)	Quarterly and Annually, due March 31 (6 months after the end of the FFY)	QNX™
SAS 70 Report	Annually	QNX™
Provider Directory	Template due during Readiness Review	QNX™
Hysterectomy Consent Form	As appropriate	Narrative
Sterilization Consent Form	As appropriate	Narrative
System Refresh Plan	Annually	Narrative
Organizational Chart	Annually	Narrative



Part Two: Technical Proposal
Section R: Information Systems

Report or File Name	Frequency	Data Source
Functional Organizational Chart	Annually	Narrative
Referral Policies	During Readiness Review, Annually thereafter, and prior to any revisions	Narrative
Medical Record Review	Within 30 days from the date the Contract is signed, and Annually thereafter	Narrative
Model Attestation Letter	Attachment to all Reports	Narrative
Form CMS 1513 Ownership and Control Interest Statement	With proposal and Annually, by October 1st, thereafter	Narrative
Emergency Management Plan	During readiness review, 30 days prior to proposed changes, Annual certification	Narrative
Network Provider Development and Management Plan	During readiness review and Annually thereafter	Narrative
Marketing Activities A. Marketing Plan B. Updates C. Annual Review	A. Due at Readiness Review B. Monthly C. Annually	Narrative
Member Advisory Council Plan	Annually with Quarterly updates of meeting minutes and correspondence	Narrative

Reporting on behalf of Subcontractors: Aetna Better Health accepts responsibility for the oversight of subcontractors' performance and assumes accountability for functions and responsibilities delegated to subcontractors. Administrative oversight of subcontractors is performed through Aetna Better Health's delegation oversight function, whereby we monitor and enforce contractual performance and compliance by way of regular meetings, activity summary reports, and annual delegated entity audits. We maintain written agreements between Aetna Better Health and subcontractors specifying the activities and reporting responsibilities delegated to the subcontractor and providing for the revocation of delegated functions or imposing of other sanctions if the subcontractor's performance is inadequate. Should Aetna Better Health contract for the provision of any covered services during the course of this Contract, and we hold that contractor responsible for processing claims, Aetna Better Health will submit a claims payment accuracy percentage report for the claims processed by said contractor.

b) generation and provision to the State of reports on request;

Aetna Better Health's ability to meet the ad hoc report requests of state agencies, such as DHH, their designees and/or CMS is proven. All ad hoc requests are forwarded from the respective health plan to our Informatics Department, where they are time stamped and queued accordingly. Informatics analysts review the requirements, submitting any requests for clarification or additional direction to the originating health plan, which follows up with the appropriate – in this instance - DHH contact. Once the requirements are clearly understood, the analyst determines whether or not an existing report may be leveraged to satisfy the ad hoc request. If so, the necessary modifications are made, the deliverable validated by the Health Plan, and the finalized report submitted to the requestor. If not, the report is designed and developed from scratch, validated, and the finalized report submitted to the requestor. Production schedules are updated as necessary, proprietary information identified accordingly, and certifications attesting to the accuracy, completeness and truthfulness of the documents and data attached as required.

Policies and procedures provide the development of ad hoc reports within allotted timeframes; however, should the estimated time to complete a report fall beyond the allotted time, the Informatics department will notify the health plan, which will then work with DHH until the issue is resolved.

c) the ability in a secure, inquiry-only environment for authorized DHH staff to create and/or generate reports out of your systems on an *ad-hoc* basis; and

Aetna Better Health takes the security of our members' data very seriously and so maintains significant protocols and controls with regard its external use. Per our standard operating procedure regarding requests for system access by an external agency, we will configure an Aetna Better Health-supplied PC or laptop such that authorized external users have access – via Citrix – to a secure, inquiry-only environment wherein they may create and/or generate reports on an ad-hoc basis. We will assign designated DHH staff members an NID number granting them role-based access as a non-Aetna Better Health user. In addition, authorized users will have access to SPOC, Aetna Medicaid's Single Point of Contact Help Desk, providing toll-free system and technical support 24/7/365. SPOC personnel will answer questions regarding Aetna Better Health's System functions and capabilities; report recurring programmatic and operation problems to appropriate personnel for follow-up; redirect problems or queries that are not

supported by the Systems Help Desk, as appropriate, via a telephone transfer or other agreed upon methodology; and redirect problems or queries specific to data access authorization to the appropriate DHH personnel. Recurring problems not specific to Systems unavailability identified by the Systems Help Desk will be documented and reported to Aetna Better Health management within one (1) business day of recognition so that deficiencies can be promptly corrected. An issue management system will assist in that regard, providing SPOC personnel an automated means to record, track and report all questions and/or problems reported to the Systems Help Desk.

d) Reporting back to providers within the network.

Aetna Better Health shares information with our providers by way of the following distribution channels:

Care Coordination Activities – Case managers may share information, such as a change in a member’s risk profile, with providers in the course of coordinating that member’s care.

Provider Services – In addition to accessing their Provider Profile via AboveHealth[®], Provider Service Representatives may hand-deliver providers’ Provider Profiles as part of their regularly scheduled site visits.

Quality Management/Performance Improvement Initiatives – Aetna Better Health may distribute the results of performance improvement initiatives to providers via blanket or targeted mailings.

ActiveHealth Care Engine – Aetna Better Health maintains an advantage in the integrated care coordination of our members as a result of our affiliate, ActiveHealth’s, CareEngine[®] System – a claims-based clinical support system combined with an automatic message generator called Care Considerations. The system integrates medical and pharmacy claims data and laboratory results within member-centered records that are then compared to over 1,500 evidence-based clinical rules and related algorithms developed by ActiveHealth’s team of board certified physicians and pharmacists. It then identifies member specific opportunities to optimize care and communicates evidence-based treatment recommendations – “Care Considerations” – to providers.

AboveHealth[®] – Aetna Better Health’s secure, HIPAA-compliant web portal for members and providers, this secure, ASP-based application synchronizes data on a daily basis with QNXT[™] through data extract and load processes, allowing members to check eligibility status and review benefits and prior authorization status. Providers are afforded additional functionalities, including:

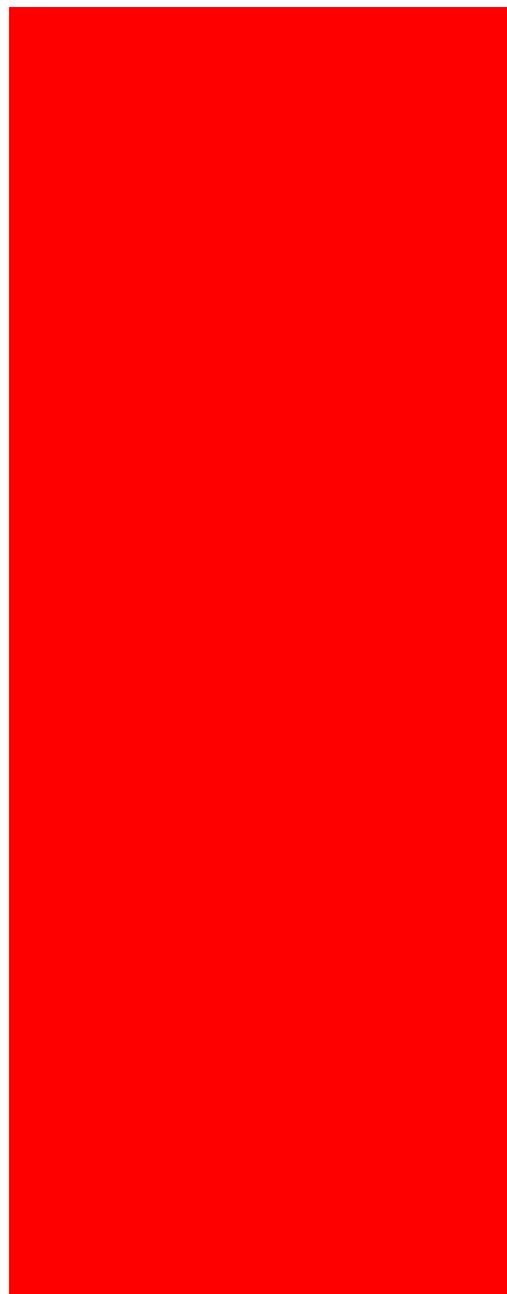
- Member eligibility verification
- Panel roster review
- Searchable provider list
- Claim status search
- Remittance advice search
- Authorization submittal
- Authorizations search

The portal is configured to provide HEDIS[®] scorecard data, as well as alerts indicating when a member is due or past due for a HEDIS[®]-related service (e.g., well-child check-up, need for asthma controller medication, immunizations). This information is integrated within the application's provider panels/rosters. If a member is due or past due for a service, a "flag" appears next to the member's name, which, when clicked, permits providers to view a description of the needed service(s).

Automated Clearinghouse Vendors - Aetna Better Health's EDI vendors have automated procedures whereby providers are notified of any batch rejection. The report provides, at a minimum, the following information, permitting the provider to troubleshoot the issue and resubmit accordingly:

- Date batch was received by the CCN;
- Date of rejection report;
- Name or identification number of CCN issuing batch rejection report;
- Batch submitters name or identification number; and
- Reason batch is rejected.

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R.11 Provide a detailed profile of the key information systems within your span of control.

Aetna Better Health and its affiliates have over 25 years experience designing, implementing, and maintaining information systems for our respective healthcare plans. Today, our information system collects, stores, integrates, analyzes, validates, and reports data on over 1.3 million members in health plans spanning 10 states, assimilating the case management, service provision, claims and reimbursement data necessary to support their financial, medical and operational management. Our Information Systems (IS) team, led by a Vice President of Technology Support with over 15 years' experience, includes 71 experienced FTEs. Together, they coordinate and perform key functions, including the system architecture and operations design, application development, software engineering, quality assurance and Electronic Data Interchange (EDI) support, necessary to support our members and providers, state and regulatory organizations.

Aetna Better Health's Information Management and Systems Director will have the necessary training and experience in information systems, data processing and reporting to oversee all our information systems functions. This includes, but is not limited to, establishing and maintaining connectivity with DHH information systems and providing necessary and timely reports to DHH. The Information Management and Systems Director will work closely with IS personnel to develop and maintain written policies, procedures, and job descriptions necessary to "lock in" system and operational improvements. Annual reviews will verify policies and procedures (P&Ps) continued agreement with current practices.

Hardware

When Aetna Medicaid designed the information systems for Aetna Better Health, the goal was to use powerful, reliable and expandable data processing systems to serve the needs of Aetna Better Health and its affiliates' members now and far into the future. High speed LAN and WAN, in addition to clusters of servers, provide the foundation for our information system, and multiple levels of redundancy support uninterrupted access. Should one server node go down, others temporarily assume its processing burden such that the event is virtually imperceptible to the end user. In fact, this methodology provided 99.99 percent uptime for all core business systems in 2010.

In addition, servers can be added to the cluster to increase performance vertically, and servers can accept increases in RAM and processing power to grow horizontally – all without ever bringing the applications down. Such scalability will allow our systems to match any escalation in demand associated with DHH's performance requirements while at the same time maintaining system uptime and performance.

Data Communications Hardware

Aetna Medicaid's network infrastructure consists entirely of Cisco routers, switches and firewalls, providing 99.99 percent uptime on the network for 2010. Standardizing on Cisco has provided maximum latitude in equipment configurations. Cisco was chosen because it provides the most reliable hardware in the industry, with worldwide 'follow-the-sun' technical support.

Cisco routers support the MPLS network, external traffic to the Internet, and connections to other private networks.

Application Server Hardware

Aetna Medicaid's core business applications run on a cluster of Hewlett Packard ProLiant DL 380/580 BL 460 servers. Each server is equipped with a minimum of two dual-core Intel processors and 4GB of RAM. This configuration provided core business application users 99.99 percent or better uptime in 2010. These servers utilize f5 Global Load Balancing services for load balancing network traffic and for user access to the core business applications. Applications loaded on this server pool access data from high-end database servers. These 64-bit, Itanium class servers attach to EMC, Hitachi HDS and HP EVA storage arrays via Brocade switches. This configuration provides all necessary computing power and redundancy and can be scaled dynamically to meet growing requirements.

Telecommunications Hardware

Aetna Medicaid chose the industry leading systems from Avaya to build an enterprise level telecommunications system. The corporate office runs on Avaya's Communications Manager Platform, which maintains extra capacity to cover any unforeseen spikes and growth spurts, handling up to 375,000 calls an hour if necessary. This server is one part of a cluster of Avaya PBXs that provide virtually unlimited growth potential. Data can be shared between servers through distributed IP support, allowing real-time backup of data to the hot-site and dynamic distribution of calls if needed. They are managed 24 hours a day by Aetna Better Health telecommunications personnel. The telecommunications system is configured with multiple levels of redundancy to maximize uptime. In fact, it would take four separate points of failure throughout the nation to bring the system down. Should such an interruption ever occur, an agent could securely configure the PBX to support a Work-at-Home (WAH) strategy, providing authorized personnel remote connectivity. This provides members and providers with a virtually fail-safe means to reach Aetna Better Health whenever necessary. Our call management system currently satisfies the Automated Call Distribution (ACD) system requirements provided in section 12.16.1 of this RFP.

Desktop Workstation Hardware and Software

Aetna Better Health's Information Management and Systems Director will work closely with Aetna Medicaid's IT personnel to see to it that employee workstations are configured in accordance with contract requirements. The two have reviewed the Coordinated Care Network (CCN) Program requirements provided in section 16.3.11 of this RFP and confirmed that the following departments, or their operational equivalent, will be compatible with DHH requirements at Systems Readiness Review:

- Call Center Operations
- Claims EDI Operations
- Authorized Services Operations
- Member Services Operations

Software

QNXT™ - At the core of Aetna Medicaid's application architecture is QNXT™, a rules-based information processing system comprising 28 integrated modules that maintain the following:

- Claims data, including associated adjudication, COB and TPL processes
- Demographic, eligibility and enrollment data, including prior coverage
- Provider contract configuration, including network and services
- EDI processes
- QM/UM including, but not limited to Prior Authorizations and concurrent reviews

QNXT™ leverages Microsoft's .NET architecture, providing for flexible, scalable, and seamless systems integration. In addition, the system's foundational database is Microsoft's SQL Server, permitting a wide variety of applications to analyze the data, display results, and print standardized and customized reports.

The cornerstone of Aetna Medicaid's claims adjudication process, QNXT™ accepts – via the supporting technical interfaces – daily enrollment files from each health plan's respective Enrollment Broker, then updates our member records accordingly. Automated processes will reconcile QNXT™'s resident member files with DHH's monthly update and record the results for DHH's review should it be necessary. Aetna Better Health's enrollment team then validates the data for accuracy, auditing relevant files and reviewing any resultant fallout reports. Should the process bring any errors to light, enrollment personnel will promptly notify DHH and work the issue to resolution.

QNXT™ will use regular downloads of provider data from DHH's website, www.lamedicaid.com, to coordinate provider enrollment records. Enrollment personnel will then use unassigned enrollment reports to verify each member's assignment to an individual PCP, seeing to it that our PCP assignment file is as current and complete as possible. System queries identify new enrollments and generate welcome letters accordingly. These are added to new member welcome packets, which are then mailed to new members. Updated date-sensitive PCP assignment information is available to DHH in electronic format upon request.

QNXT™ supports automation of routine processes, thus introducing improved efficiencies and accuracy to the adjudication process. For example, three-tier logic matches claims and authorizations based on criteria such as member, provider, service code, and dates of service. The system automatically deducts claimed services from authorized units, thus reducing the need for manual affiliation by claims analysts.

Several applications compliment QNXT™'s claims processing functionality. The first, **iHealth**, enforces select payment policies from one of the industry's most comprehensive correct coding and medical policy content libraries. The second, McKesson's **ClaimCheck**®, expands upon those capabilities by allowing claims leadership to define and combine specific claims data criteria, such as provider or diagnosis, to set up unique edits that deliver enhanced auditing power.

As the steward of our members' demographic, capitation, PCP, and eligibility and enrollment data, QNXT™ serves as the primary source of data for multiple applications, including our web-based care management business application (Dynamo™), our principal member and Medical Management application, VisionPro and Encounter Management (EMS) systems. Our systems

architecture diagram, provided at the end of this section, illustrates how the exchange of data between these systems, and throughout our organization, addresses the needs of our members.

Our Web-based Care Management Business Application (Dynamo™)— Aetna Better Health’s primary care management platform, our web-based care management business application (Dynamo™), supports the Integrated Care Management (ICM) model activities including; but not limited to CM, DM and BH assignment, assessment, and care planning. The application’s ability to enforce preconfigured workflow rules and prompt predefined, event-driven actions supports compliance with associated standards. Branched logic provides case managers context sensitive information, such as: assessment deadlines, case management notes and service accessibility data, thereby supporting more effective case management. Our web-based care management business application (Dynamo™) allows providers and members alike web-based access by which they may perform such tasks as update care plans, complete assessments and submit updates to assigned Case managers via a secure, HIPAA compliant web portal. The result is a highly collaborative care management environment.

Encounter Management System – EMS, a proprietary Aetna Medicaid system, warehouses claims data, formats encounter data to contract requirements and processes CMS1500, UB04, dental, and pharmacy claims. Current coding protocols (e.g., standard CMS procedure or service codes, such as ICD-9, CPT-4, HCPCS-I, II) are kept on file as well. The system uses state provider and medical coding information – in conjunction with claims data culled from QNXT™’s data tables – to produce reports for the purposes of tracking, trending, reporting process improvement and monitoring submissions of encounters and encounter revisions.

General Risk Model (GRM) – Aetna Medicaid’s predictive modeling tool assimilates information from a variety of sources, including the Actuarial Services Data Base (ASDB) described below, and transforms it into a series of markers measuring both risk and opportunity. It then scores these markers and assigns a rank to every member, reflecting both the level of risk and potential opportunity for improvement, thereby helping CMs provide the appropriate level of care coordination. In addition to its risk algorithms, the application identifies members who meet specific rules-based criteria for individual treatment interventions.

ASDB – Aetna Medicaid’s Actuarial Services Data Base (ASDB) supports Aetna Better Health’s reporting and analytical capabilities, such as our multidimensional predictive modeling and statistical outlier analysis. The application houses eligibility, provider, prior authorization and claims data and serves as a key data source for a diverse user base, including Medical Management, Finance and Operations.

Analysts can use the proprietary Actuarial Analytics Web Portal (AAWeb), an interactive interface, as a point-and-click query tool to access reports, drill down into data and export information from ASDB. For instance, AAWeb can generate customized analyses to identify favorable and unfavorable cost and utilization trends, measure performance against key benchmarks, and review summary information. It is a powerful tool that affords Aetna Better Health’s Medical Management personnel access to member and provider profiles, as well as current cost and utilization trends. This gives Aetna Better Health the ability to disseminate analysis results on treatment best practices to providers, who can then identify and prevent

unnecessary migrations to higher levels of care and the development of chronic health conditions.

Aetna Better Health reporting analysts will cull data from ASDB, QNXT™ and our web-based care management business application (Dynamo™) as necessary to satisfy the chart of deliverables provided in section 18.8 of this RFP, supporting compliance with stated timeliness, accuracy and completeness standards. We maintain strict P&Ps providing for the review of all deliverable prior to submission to DHH.

ActiveHealth Care Engine – Aetna Better Health maintains an advantage in the integrated care coordination of our health plan members as a result of our affiliate ActiveHealth’s CareEngine® System – a claims-based clinical support system combined with an automatic message generator called Care Considerations. The system integrates medical and pharmacy claims data and laboratory results within member-centered records that are then compared to over 1,500 evidence-based clinical rules and related algorithms developed by ActiveHealth’s team of board certified physicians and pharmacists. It then identifies member-specific opportunities to optimize care and communicates evidence-based treatment recommendations – “Care Considerations” – to providers. At the same time, the system generates “Wellness Considerations” for members: communiqués focusing on prevention and wellness issues such as childhood immunizations, breast cancer screening, and disease appropriate screening and vaccinations.

Grievance and Appeals Database – Aetna Medicaid maintains an internal, proprietary application that supports the Grievance and Appeals process by tracking member and provider issues from inception to resolution. This affords us the means to address not only issues affecting individual member and provider satisfaction, but potential trends in the delivery system as a whole, permitting health plan personnel to take prompt, corrective steps to minimizing risks to performance standards.

www.AetnaMedicaid.com – Aetna Medicaid maintains a public website for Aetna Better Health, with separate web pages providing static information tailored to health plan members’ and providers’ respective needs. Members and providers wishing to take advantage of Aetna Better Health’s secure web capabilities are provided a link to Aetna Better Health’s secure web portal, AboveHealth®, described below.

AboveHealth® – AboveHealth® is a secure HIPAA-compliant web portal for Aetna Better Health’s members and providers. Designed to foster open communication and facilitate access to a variety of data in a multitude of ways, this secure, ASP-based application synchronizes data on a daily basis with QNXT™ through data extract and load processes, allowing members to check eligibility status, review benefits and prior authorization status, and send secure emails to Aetna Better Health’s member services personnel. Providers are afforded additional functionalities, including:

- Member eligibility verification
- Panel roster review
- Searchable provider list
- Claim status search

- Remittance advice search
- Submit authorizations
- Search authorizations

We configure the portal to provide HEDIS[®] scorecard data, as well as alerts indicating when a member is due or past due for a HEDIS[®]-related service (e.g., well-child check-up, need for asthma controller medication, immunizations). This information is integrated within the application's provider panels/rosters. If a member is due or past due for a service, a "flag" appears next to the member's name, which, when clicked, permits providers to view a description of the needed service(s).

Policies and Procedures (P&Ps) dictate that our website and portal comply with applicable provisions of the Americans with Disabilities Act. In addition, our websites will satisfy the respective requirements stipulated in sections 10.3 and 12.10 of this RFP.

Information Systems Monitoring

Aetna Medicaid's core business systems maintained a 99.99 percent uptime through the 2010 calendar year, due largely to the combined efforts of personnel at our Network Operation Center (NOC), Operation Command Center and Production Services and System Platform Performance Departments. The four share one common goal: the optimization of our core business systems' performance. Our NOC and Operation Command Centers, for example, monitor systems performance 24/7/365 via state-of-the-art applications and tools, such as IBM Tivoli Monitoring (ITM) products. ITM is an event management/problem detection tool that can monitor Windows Server system attributes and System Event logs, as well as ASCII logs. It interfaces with other enterprise monitoring tools to provide a comprehensive yet consolidated view of problems across the enterprise. Production outages and system issues are managed by the Production Services Department which assembles and coordinates teams and vendors to facilitate quick resolution and provide escalation when needed. And finally, the System Platform Performance (SPP) Department provides enterprise-wide performance monitoring, tuning, trend analysis and reporting for large-scale and midrange systems/platforms and mainframe systems and applications in support of business operations. SPP aims to promote optimum throughput and efficient use of resources to meet established service level agreements and availability goals.

Disaster Recovery and Business Continuity

Aetna Medicaid's disaster backup and recovery strategy is to provide and maintain an internal disaster recovery capability. This strategy leverages the internal computer processing capacity of two state of the art, hardened computer centers located in Middletown and Windsor, Connecticut. Both facilities have extensive fire suppression systems, dual incoming power feeds, UPS, and backup diesel generators supporting 24/7/365 operation. Physical access is strictly controlled and monitored, and access to vital areas is segregated by floor and business function as appropriate. The two data centers house Aetna Medicaid's computer processing capabilities on three major platforms, mainframe (Z/OS), mid-range (Various UNIX versions), and LAN (Windows on X86 processors). The data centers are load balanced and supplemented by quick-ship and capacity-on-demand contracts, permitting each center to back the other up in the event of disaster. We maintain contracts with national vendors providing for replacement equipment and supplemental capacity as needed, further promoting compliance with recovery time objectives (RTO).

In the event of a data center disaster, the RTO to resume most production processing is four days from disaster declaration for all mainframe and mid-range systems and five days for LAN systems. Portfolios of highly available applications, such as web and pharmacy, have RTO's of six hours or less. These applications utilize mirroring and/or load balancing technologies between the datacenters to make certain that the reduced RTO's can be met. Aetna Medicaid's voice and data network backbones are fully redundant using SONET ring technology and are recovered within 1 hour of a data center outage. In short, Aetna Medicaid's data center recovery strategy and its application RTO's are consistent with or better than industry standards.

Data Backup

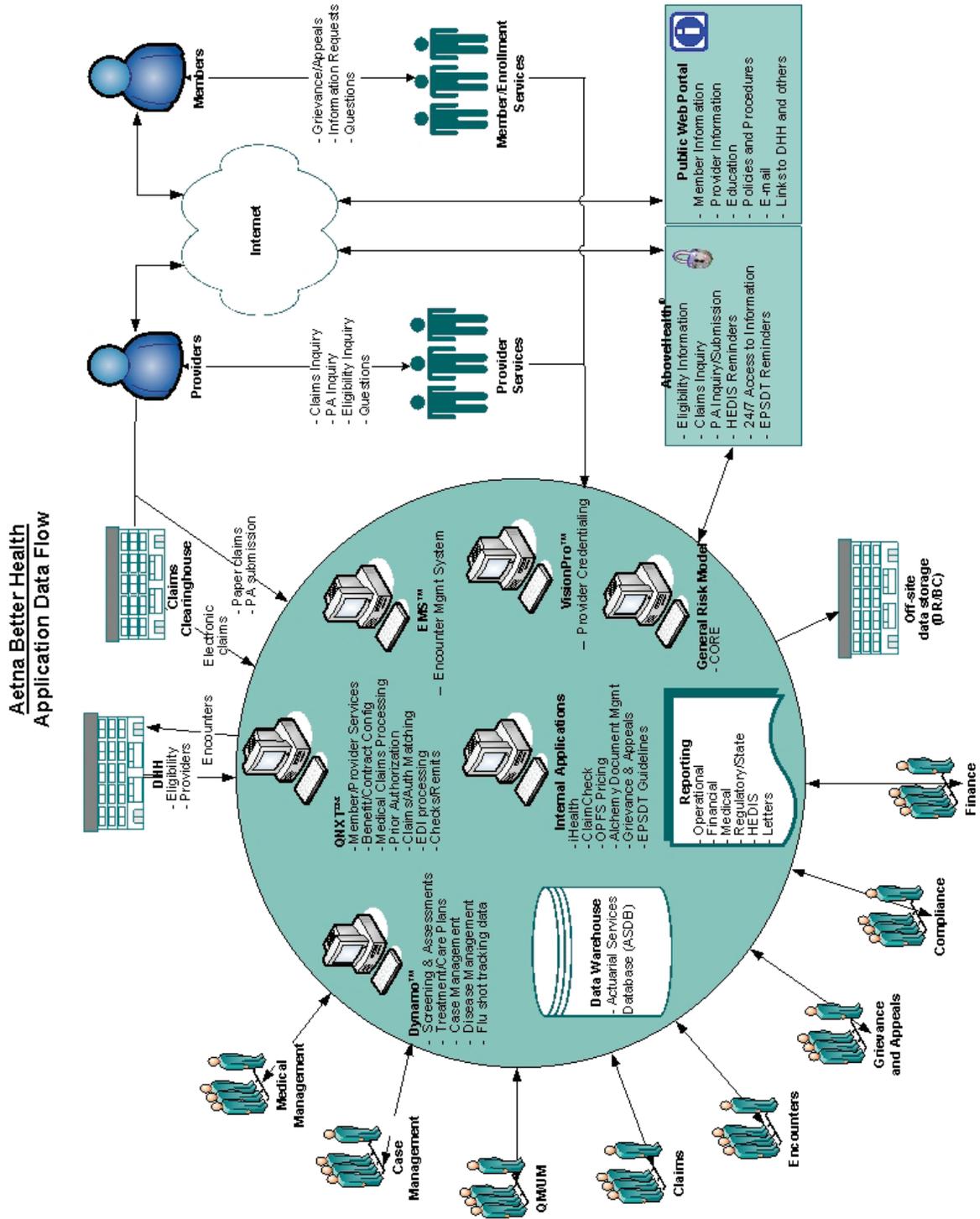
Infrastructure and application data is secured and stored offsite on a daily basis. Backed-up data is cross vaulted between the two computer centers, with mainframe backups stored primarily on disk media and mid-range/LAN backups stored primarily on tape. Additionally, all mainframe disk data is mirrored to the alternate data center providing a simplified and timelier recovery for that piece of the environment. Any customer data lost as a result of a data center catastrophe will be recovered through re-submittals by service providers and/or recovery reconciliation teams.

Systems Refresh Plan

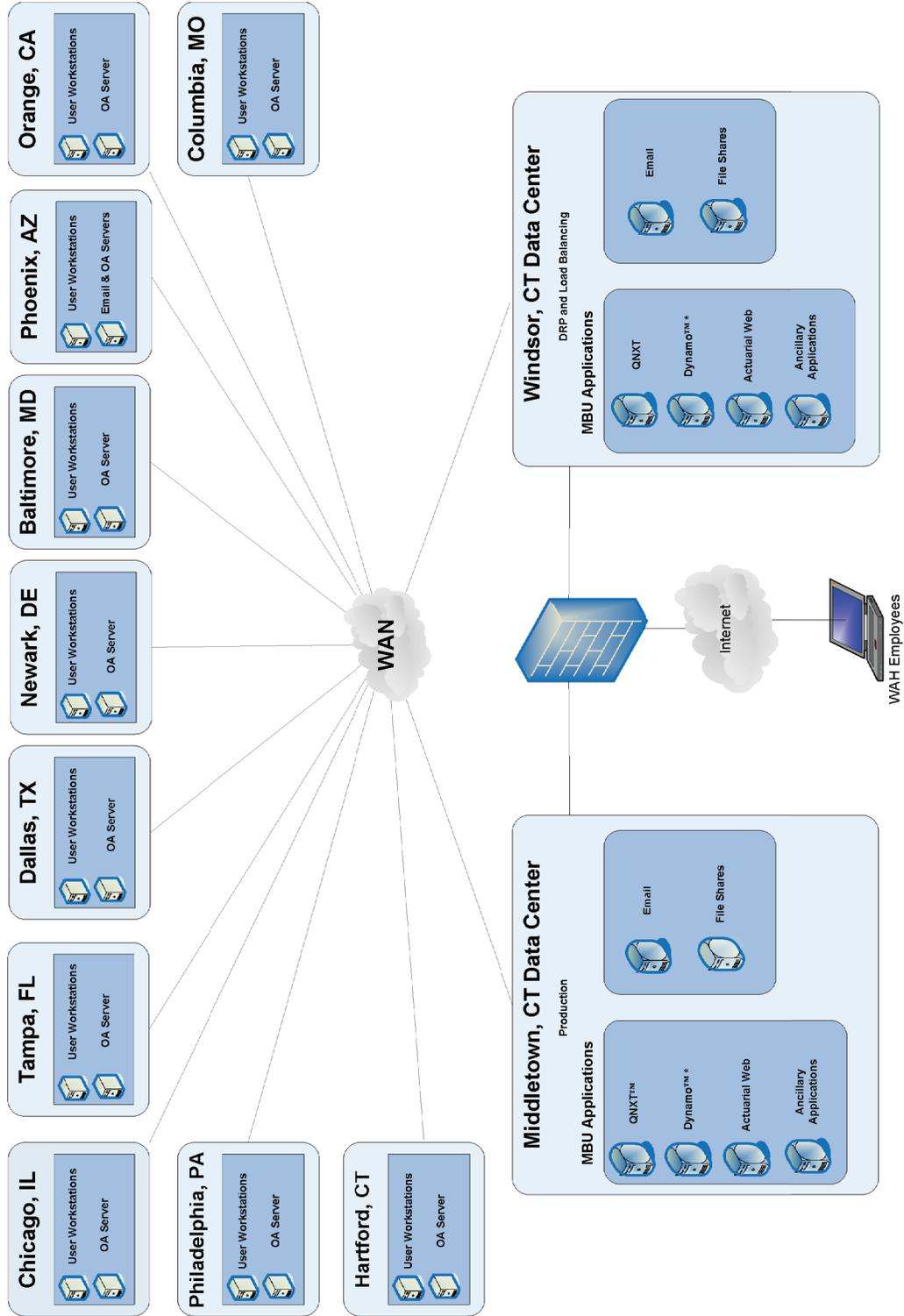
On an annual basis, Aetna Better Health will provide DHH an annual Systems Refresh Plan. The plan will outline how we will systematically assess the information systems within our span of control to determine the need to modify, upgrade and/or replace application software, operating hardware and software, telecommunications capabilities, information management policies and procedures, and/or systems management policies and procedures in response to changes in business requirements, technology obsolescence, personnel turnover and other relevant factors. The plan will also outline the steps we will take to see that the version and/or release level of all of systems components (application software, operating hardware, operating software) is always formally supported by the Original Equipment Manufacturer (OEM), Software Development Firm (SDF), or a third party authorized by the OEM and/or SDF to support the systems component.

Aetna Better Health maintains systems process and procedure manuals documenting and describing the manual and automated procedures associated with our management information systems. We will develop, prepare, print, maintain, produce, and distribute to DHH distinct Systems design and management manuals, user manuals, quick reference guides, and any updates as necessary. These will contain information about, and instruction for, using applicable systems functions and accessing applicable system data. All manuals will be made available in printed form and on-line, with electronic versions updated immediately, and printed versions updated within ten (10) business days of any system change or update taking effect.

The following pages provide a diagram illustrating Aetna Better Health's Information Systems Infrastructure, as well a table listing our core business applications, the number of years Aetna Medicaid or the respective vendor has supported them, and associated information.



Aetna Medicaid Business Unit Technical Architecture



* Our web-based care management business application (Dynamo™)*



Information Systems Support

Aetna Medicaid’s IT organization manages the selection, maintenance and operation of software applications, leveraging the deep skill set of personnel averaging over 10 years’ of role-related experience each. In some instances, software vendors staff their own personnel at Aetna Medicaid’s offices to better assist in the support and maintenance of their respective software. The following table provides the details of Aetna Medicaid’s software applications that support Aetna Better Health’s core business applications.

Core Business Applications

Functionality	Name	Version/ Release	Years Supported	Currently Supported	Vendor Contact Contact's Phone Number Contact's email address Contact's Address
Claims Processing	QNX™	3.4	20	YES	TriZetto/QCSI Heather Marberry (480) 414-7147 Heather.Marberry@trizetto.com 14647 S. 50th St., Suite 150, Phoenix, AZ 85044
Case Management	Dynamo™ ⁶	3.7.008	12	YES	IMA Technologies Lisa Schwenke (800) 458-1114 lisa@casetrakker.com 1816 Tribute Rd, Suite 100, Sacramento, CA 95815-4323
Encounter Processing	EMS	7.3	7	YES	Internal Aetna Better Health, Operations and IT Colleen Gurule (602) 659-1722 GuruleS@aetna.com 4645 Cotton Center Blvd, Bldg 1, Phoenix, AZ 85040
Data Mining and Analysis	ASDB	10.10.1	7	YES	Internal Aetna Better Health, Actuarial Services and

⁶ Our Web-based care management business application (Dynamo™)

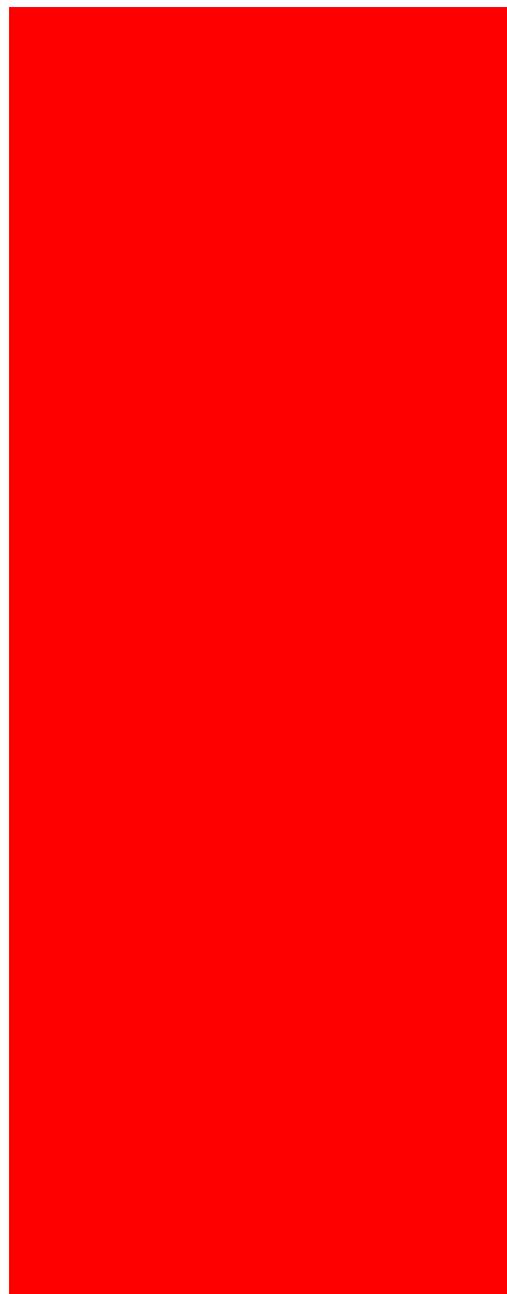


Part Two: Technical Proposal
Section R: Information Systems

Functionality	Name	Version/ Release	Years Supported	Currently Supported	Vendor Vendor Contact Contact's Phone Number Contact's email address Contact's Address
					(602) 659-1130 Reese.T2@aetna.com 4645 Cotton Center Blvd, Bldg 1, Phoenix, AZ 85040
Predictive Modeling	General Risk Model (GRM)	10.10.1	5	YES	Internal Aetna Better Health, Actuarial Services and IT Paul Fawson (602) 659-1782 FawsonP@aetna.com 4645 Cotton Center Blvd, Bldg 1, Phoenix, AZ 85040
Member Health Risk Assessment	ActiveHealth	1.0	2	YES	ActiveHealth Management Gary Bucello (703) 995-6395 GBucello@activehealth.net 102 Madison Avenue New York, NY 10016
Provider/Member Web Portal	AboveHealth®	3.2	12	YES	Healthation Laura Kampfenkel (858) 617-6341 lkampfenkel@healthation.com 12348 High Bluff Drive, Suite 200, San Diego, CA 92130

* Note: All of the core systems denoted in the table are in active use by Aetna Better Health.

129 R.12



R.12 Provide a profile of your current and proposed Information Systems (IS) organization.

Aetna Better Health, together with its affiliates, has more than 25 years experience designing, implementing, and maintaining information systems for our respective healthcare plans. Today, our information system collects, stores, integrates, analyzes, validates, and reports data on over 1.3 million members in health plans spanning 10 states, assimilating the case management, service provision, claims and reimbursement data necessary to support their financial, medical and operational management. Our Information Systems (IS) team, led by a Vice President of Technology Support with over 15 years' experience, includes 71 experienced FTEs. Together, they coordinate and perform key functions, including the system architecture and operations design, application development, software engineering, quality assurance and Electronic Data Interchange (EDI) support, necessary to support members and providers, state and regulatory organizations.

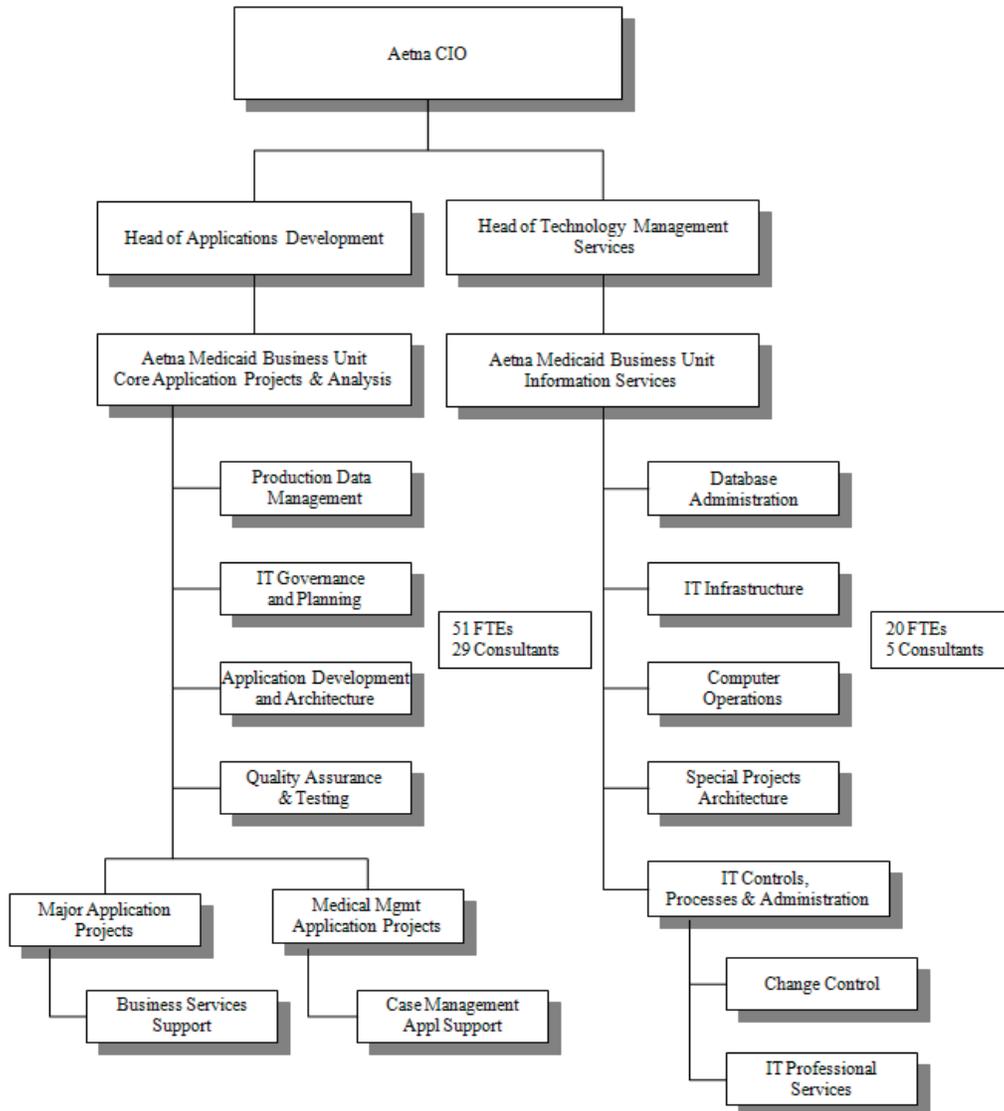
Aetna Better Health's Information Management and Systems Director will have the necessary training and experience in information systems, data processing and reporting to oversee all our information systems functions. This includes, but is not limited to, establishing and maintaining connectivity with DHH information systems and providing necessary and timely reports to DHH. The Information Management and Systems Director will work closely with DHH representatives, health plan leadership, IS personnel and other stakeholders to continuously improve the quality and responsiveness of health plan services for members and providers alike. This includes monitoring and evaluating the cross-functional flow of data between Case, Quality, Utilization Management, Provider, and Member Services departments to identify and implement improvements supporting timely access to the accurate information necessary to address the unique needs of CCN Program members. The Director will work closely with IS personnel to develop and maintain written policies, procedures, and job descriptions necessary to "lock in" system and operational improvements. Annual reviews will verify policies and procedures (P&Ps) continued agreement with current practices.

Aetna Better Health's information systems currently possess the scalability to accommodate Louisiana's CCN Program. Our extensive use of proven, automated processes minimizes the need to hire personnel to support less efficient, more error-prone manual processes. With the exception of the addition of the Information Management and Systems Director role, we anticipate that our current Information Systems organizational structure will allow us to satisfy the unique needs of Louisiana's CCN Program.

Aetna Better Health has engaged KPMG since 2000 to perform SOC I TYPE II audits, including Operating Effectiveness for Claims Processing Controls and Related General Computer Controls. All audit reports have reflected unbiased opinions.

The following pages include our Information Systems department's organizational structure and staffing model.

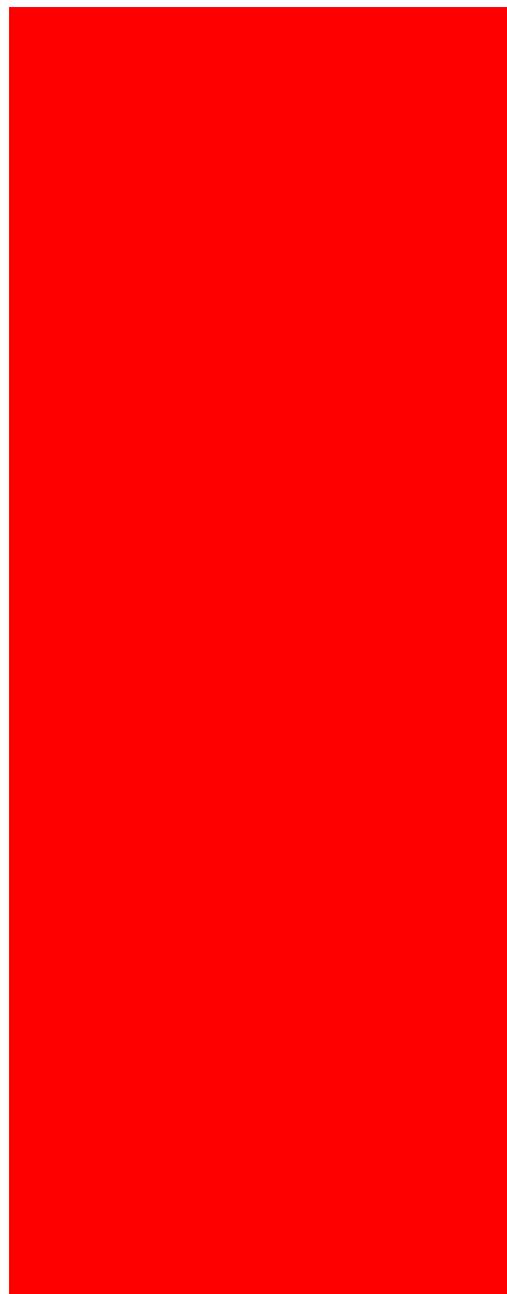
Aetna MBU IT Support



Aetna Better Health's Information Systems Organizational Profile

Job Class:	In-House FTE's	Average Years of Exp in Field	Average Years in Org.	Outsourced FTE's	Average Years of Exp in Field	Average Years in Org.
Software Developer	19	12	6	10	8	1
System Analyst/Project Mgmt	24	10	6	11	7	1
Data Reporting	5	10	5	1	5	0.5
Database Administration	4	12	5	2	5	0.5
Electronic Data Interchange (EDI)	11	9	5	4	4	1
Quality Assurance/Testing	1	10	6	6	5	0.5
Network Engineer	2	11	7			
Control/Computer Operations	6	8	7			
Controls and Processes	7	11	7			
IT Leadership/Administration	3	15	9			
Total FTE's	71			34		

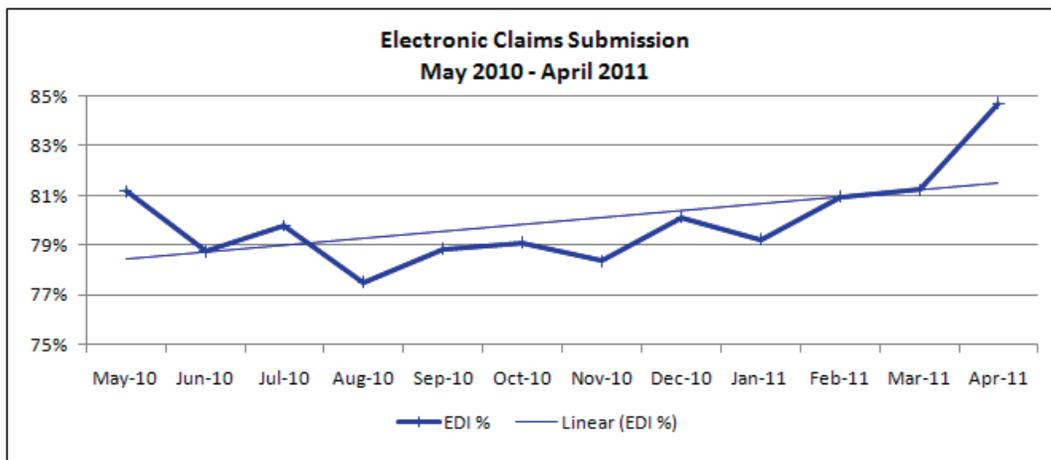
130 R.13



R.13 Describe what you will do to promote and advance electronic claims submissions and assist providers to accept electronic funds transfers.

Aetna Better Health continually looks for opportunities to improve service to our participating and non-participating providers. To that end, we accept and generate HIPAA compliant electronic transactions from/to any provider interested in and capable of electronic claims submission [i.e. Electronic Data Interchange (EDI)], electronic remittance advices (ERA), and/or claims payment via electronic funds transfer (EFT).

Our proven ability to promote and advance electronic claims submissions is illustrated below. EDI submissions for all Aetna Better Health’s plans averaged 80% for the twelve months ending April 30th 2011, reaching a high of 85% that same month. EFT payments as a percentage of dollars paid averaged 50% over the same twelve month period.



Aetna Better Health will bring that same experience to DHH’s CCN Program, applying the following four-step strategy to move providers along the EDI/ERA/EFT adoption continuum:

Step 1: Provider education and outreach will emphasize the advantages of EDI, ERA and EFT adoption. Provider Services Representatives (PSRs) will use new provider orientations as an opportunity to explain the benefits of each. They will also cover related administrative and system requirements. On a quarterly basis, PSRs will conduct site training for network providers which may include: 1) initial on-site orientation for new providers, 2) follow-up visits with established providers, and 3) focused trainings as indicated by provider request, performance, complaints, or member grievances.

During these face-to-face training sessions, PSRs will promote the benefits of EDI, ERA and EFT transactions, explain the process and provide enrollment forms (ERA/EFT) or instructions (EDI) to interested providers. The same information will be readily accessible at Aetna Better Health’s provider website. Step-by-step instructions on how to initiate EDI services and EDI vendor contact information will also be available via Aetna Better Health’s Provider Manual. Supplemental information may be distributed via Provider Claims Reference Materials – also

available via the provider website – and provider newsletters, where electronic services transactions will remain a standing item.

Listed below are some of highlights of provider EDI, ERA, and EFT education.

	Benefits	Requirements
EDI	<ul style="list-style-type: none"> Accurate submission and immediate notification of submission errors from the EDI clearinghouse Faster processing resulting in prompt payment Ability to track claim processing status via Aetna Better Health website Aetna Better Health pays certain EDI transaction fees, depending on the vendor 	<ul style="list-style-type: none"> Agreement with an electronic clearinghouse Software to transmit electronic claims
EFT	<ul style="list-style-type: none"> Automatic deposit of payment Faster receipt of payment No paper checks to deposit Immediate verification of payment 	<ul style="list-style-type: none"> Bank account number A voided check/savings account deposit slip Signed EFT Authorization Form
ERA	<ul style="list-style-type: none"> Electronic file of processed claims from Aetna Better Health Electronically posts payments to the provider's practice management system Faster reconciliation of account receivables Simplified reconciliation process 	<ul style="list-style-type: none"> Ability to accept HIPAA standard 835 electronic remit transactions

Step 2: To facilitate electronic claims submission, Aetna Better Health maintains a strong relationship with Emdeon, the largest, most experienced automated claims clearinghouse in the country. Emdeon offers an additional level of support to providers that utilize their services, including technical support, training and tutorials. In addition, providers receive prompt, detailed reports regarding claims submission accuracy, allowing them to better target related opportunities for improvement.

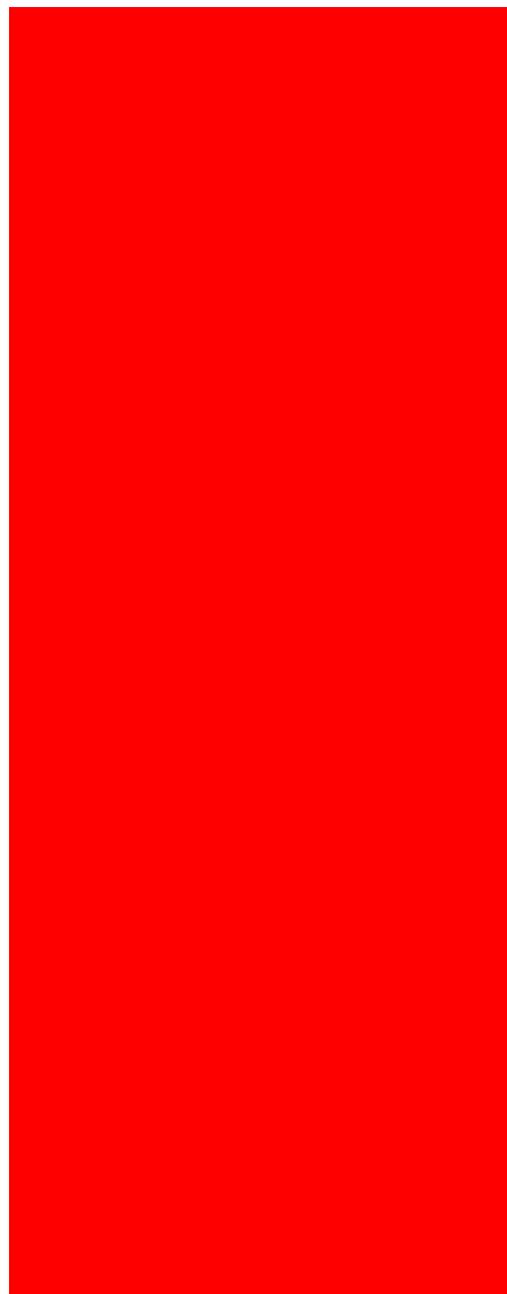
Step 3: Provider education and outreach will address the advantages and steps necessary to initiate Electronic Remittance Advices (ERAs), affording providers a means to introduce added efficiencies to their claims management process. The enrollment process will mirror that required to initiate EFT, allowing providers to easily initiate a service that can deliver substantial cost savings.

Step 4: DHH's monthly claims dashboard will provide Aetna Better Health's Provider Services Manager an overview of EDI utilization. In addition, Aetna Better Health Finance Department produces a Claims Data Summary report that identifies 1) providers submitting large volumes of paper claims, and 2) high-dollar provider payments not made via EFT. The Provider Services Manager reviews the report to identify providers for targeted outreach. Additional education and outreach may be initiated if existing EDI providers fall below submission averages.



Aetna Better Health will work closely with DHH, providers and provider associations to continuously promote and advance EDI, EFT and ERA adoption. We will begin provider education and outreach prior to go-live in each GSA, giving providers ready access to the instruction and information necessary to initiate the desired service or services.

131 R.14



R.14 Indicate how many years your IT organization or software vendor has supported the current or proposed information system software version you are currently operating. If your software is vendor supported, include vendor name(s), address, contact person and version(s) being used.

Aetna Better Health, through a subcontract arrangement with Aetna Medicaid, has access to a comprehensive suite of IT tools and solutions. Our IT organization today serves over 1.3 million Medicaid health plan members in 10 states. It is flexible and responsive, led by a Vice President of Technology Support with over 15 years' experience. The IT organization manages the selection, maintenance and operation of software applications, leveraging the deep skill set of personnel with an average of over 10 years' role-related experience each. In some instances, software vendors staff their own personnel at Aetna Better Health's offices to better assist in the support and maintenance of their respective software. The following table provides details of the software applications comprising Aetna Better Health's core business applications.



Core Business Applications

Functionality	Name	Version/ Release	Years Supported	Currently Supported	Vendor Contact Contact's Phone Number Contact's email address Contact's Address
Claims Processing	QNXT™	3.4	20	YES	Trizetto/QCSI Heather Marberry (480) 414-7147 Heather.Marberry@trizetto.com 14647 S. 50th St., Suite 150, Phoenix, AZ 85044
Case Management	Dynamo™7	3.7.008	12	YES	IMA Technologies Lisa Schwenke (800) 458-1114 lisa@casetrakker.com 1816 Tribute Rd, Suite 100, Sacramento, CA 95815-4323
Encounter Processing	EMS	7.3	7	YES	Internal - Operations and IT Colleen Gurule (602) 659-1722 GuruleS@aetna.com 4645 Cotton Center Blvd, Bldg 1, Phoenix, AZ 85040
Data Mining and Analysis	ASDB	10.10.1	7	YES	Internal - Actuarial Services and IT Tom Reese (602) 659-1130 ReeseT2@aetna.com 4645 Cotton Center Blvd, Bldg 1, Phoenix, AZ 85040

⁷ Our Web-based care management business application (Dynamo™).

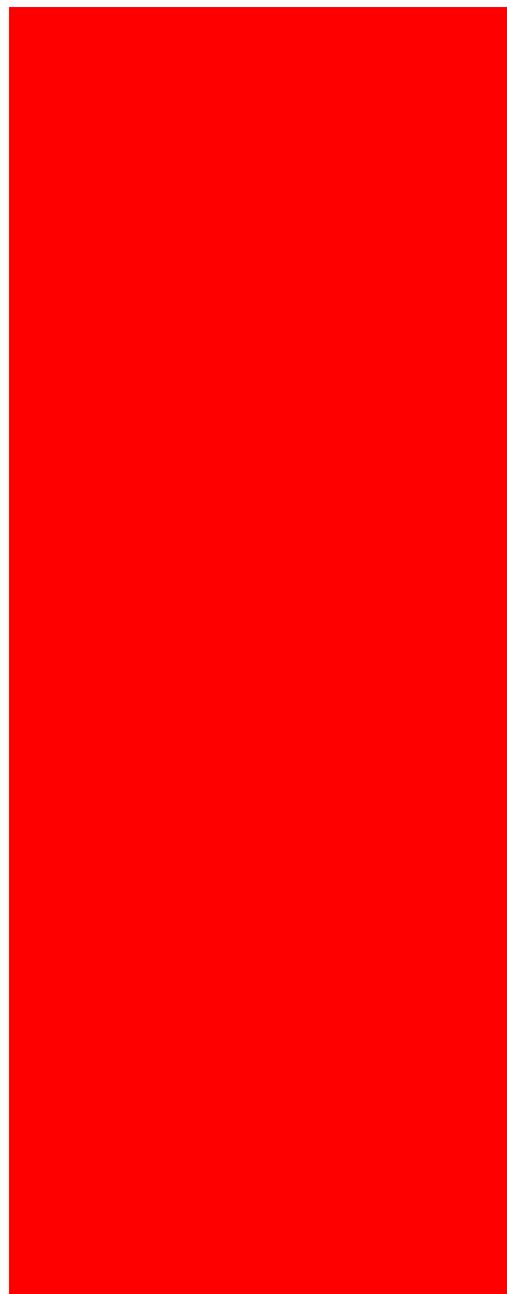


Part Two: Technical Proposal
Section R: Information Systems

Functionality	Name	Version/ Release	Years Supported	Currently Supported	Vendor Vendor Contact Contact's Phone Number Contact's email address Contact's Address
Predictive Modeling	General Risk Model (GRM)	10.10.1	5	YES	Internal - Actuarial Services and IT Paul Fawson (602) 659-1782 FawsonP@aetna.com 4645 Cotton Center Blvd, Bldg 1, Phoenix, AZ 85040
Member Health Risk Assessment	ActiveHealth	1.0	2	YES	ActiveHealth Management Gary Bucello (703) 995-6395 GBucello@activehealth.net 102 Madison Avenue New York, NY 10016
Provider/Member Web Portal	AboveHealth®	3.2	12	YES	Healthation Laura Kampfenkel (858) 617-6341 lkampfenkel@healthation.com 12348 High Bluff Drive, Suite 200, San Diego, CA 92130

* Note: All of the core systems denoted in the table are in active use by Aetna Better Health.

132 R.15



R.15 Describe your plans and ability to support network providers' "meaningful use" of Electronic Health Records (EHR) and current and future IT Federal mandates. Describe your plans to utilizing ICD-10 and 5010.

Aetna Better Health and its affiliates have been collaborating with multiple state agencies in the development of HIT and related [e.g., Electronic Health Record (EHR)] technology since its inception. We continually monitor Federal and state initiatives supporting implementation of the technical and administrative infrastructure necessary to develop, support and maintain local, regional and national Health Information Exchanges and coordinate our own support initiatives accordingly.

Delaware Physicians Care, Inc. (DPCI), an Aetna Better Health affiliate has been actively involved in the development and deployment of a clinical information sharing utility as part of the Delaware Health Information Network (DHIN) initiative. This health information network, acknowledged as the nation's first self-sustaining statewide Health Information Exchange, provides electronic sharing of Electronic Medical Record (EMR) patient information among participating healthcare providers, whether primary care, specialist, hospital or ancillary. In addition, Aetna Better Health's affiliate in Arizona continues to work with AHCCCS (the Arizona State Medicaid agency), providing resources and technology in support of the Arizona Health Information Exchange (HIE) platform and ongoing enhancements. These efforts have culminated in the development of a highly accomplished data analysis and reporting team, powerful predictive modeling capabilities, and personnel that has been collaborating with State entities on development of HIE and EHR for many years.

Our longstanding participation in initiatives such as these has allowed us to compile best practices and lessons learned into a comprehensive knowledge base from which we develop mechanisms aimed at promoting providers' meaningful use of HIT:

These include:

- 1) Provider Manual – A section within the Aetna Better Health Provider Manual provides an overview of HIT.
- 2) Provider Newsletters/Email – Provider newsletters and e-mails inform providers of time-sensitive provider education and training opportunities provided by Aetna Better Health's Provider Relations personnel or offered through external entities, such as Louisiana's Health Information Technology (LHIT) Resource Center.
- 3) Aetna Better Health Website – The provider section of Aetna Better Health's website affords providers access to the summary and time-sensitive information described above, in addition to hyperlinks directing them to other resources, such as the Agency for Healthcare Research and Quality's National Resource Center website and its virtual Health IT Toolbox.
- 4) Provider education and training – Provider orientations offer Aetna Better Health the opportunity to introduce network providers to the various HIT resources.

Aetna Better Health will, as requested by DHH, meet with work groups or committees to coordinate activities and develop system strategies that will actively promote healthcare reform initiatives in Louisiana. Our core information systems have the flexibility and interoperability necessary to accommodate the State's pending consolidation of all hospital, physician and other provider information into a statewide health information exchange. We understand that health information exchange is an important, inherent part of meaningful use and so continually survey the HIT/HIE environment in order to keep our information technology infrastructure strategically aligned. We will use our knowledge of Louisiana's HIE landscape, in conjunction with our understanding of our provider's relative HIT maturity levels, to help integrate our provider population into relevant Health Information Exchanges.

Provider Support

Provider Relations personnel will work closely with CCN Program providers, giving clear, concise, and consistent information on the HIE/HIT resources at their disposal. In doing so, we will enable them to plan and implement their HIT initiatives in concert with the State's own, thereby positioning themselves for the maximum incentive reimbursement allowable under CMS' Meaningful Use Rule.

As registration for Louisiana's Medicaid EHR Incentive Program opened on January 3, 2011, we expect that many providers will already be actively involved in implementing the required capabilities by the Contract's go-live date. As in other states, however, we will position ourselves to assist providers at any point along the HIT adoption and implementation continuum. This may include any of the following activities:

- 1) Directing providers to CMS' Official Website for the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs. The website contains not only User Guides to Registration and Attestation to assist providers in completing the registration and attestation process, but a list of EHR technology that is certified for the program and specification sheets with additional information on each Meaningful Use objective. The website also assists providers in determining their eligibility for the appropriate Medicare and/or Medicaid program. Eligible professionals eligible for both the Medicare and Medicaid EHR Incentive Programs must choose which incentive program they wish to participate in when they register.
- 2) Providers need not possess a certified EHR in order to register for the Medicare and/or Medicaid EHR Incentive Program(s). Hence, we encourage them to register as soon as possible to avoid payment delays.
- 3) Calling providers' attention to the following items required for enrollment.

Eligible Professionals

- National Provider Identifier (NPI).
- National Plan and Provider Enumeration System (NPPES) User ID and Password.
- Payee Tax Identification Number (if you are reassigning your benefits).
- Payee National Provider Identifier (NPI) (if you are reassigning their benefits).

Hospitals

- CMS Identity and Access Management (I&A) User ID and Password.
- CMS Certification Number (CCN).
- National Provider Identifier (NPI).
- Hospital Tax Identification Number
 - Reminding providers to verify that they have enrollment records in the appropriate systems, including the following: National Provider Identifier; National Plan and Provider Enumeration System; and Provider Enrollment, Chain and Ownership System (PECOS).
 - Encouraging providers to contact the Louisiana Health Information Technology (LHIT) Resource Center. As the Regional Extension Center for Louisiana, the LHIT Resource Center is the local resource for technical assistance, guidance and information to support and accelerate healthcare providers' efforts to adopt and meaningfully use EHRs. Services offered are based on the provider's current level of electronic health record adoption.

TIER 1: Assistance converting from a paper office to an EHR system and then achieving meaningful use

TIER 2: Assistance in achieving meaningful use if the provider has an EHR system but has not implemented the required components

TIER 3: Meaningful use gap analysis for a provider who has fully implemented an EHR system

The LHIT Resource Center:

- Manages project timelines, expectations and accountability for contract requirements
- Serves as a neutral, credible source for information on health IT and EHRs
- Offers volume pricing discounts on the purchase of IT hardware and software (through supported vendors)
- Offers access to low interest loans to help finance EHR adoption, implementation or upgrade
- Provides continued support beyond EHR installation and meaningful use achievement
- Serves as a meaningful use expert as new regulations in Phases 2 and 3 are released
- Facilitates timely registration to receive meaningful use incentive payments, if applicable
- Facilitates reimbursement for staff training through the Louisiana Workforce Commission's Small Business Employee Training Program
- Provides programming to assist providers in meeting additional goals such as NCQA Patient-Centered Medical Home (PCMH) recognition
 - Providing technical support (e.g., education, training, tools, and provision of data relevant to patient clinical care management) to assist in providers' transformation to PPC®-PCMH recognition or JCAHO PCH accreditation. Both PPC-PCMH and JCAHO- PCH accreditations are tightly tied to Meaningful Use outcomes, and Aetna Better Health has strategically aligned PCMH criteria to facilitate providers' achievement of CMS' Phase 1

requirements for demonstrating Meaningful Use (MU). Thus, as we assist providers in satisfying the broader requirements necessary to obtain PPC®-PCMH recognition or JCAHO PCH accreditation per the following DHH targets, we are at the same time seeing to it that they satisfy the subset of those requirements necessary to earn MU Phase 1 certification.

PPC®-PCMH recognition or JCAHO PCH accreditation targets			
Contract Year	Level 1	Level 2	Level 3
1	20%	*	*
2	30%	10%	*
3	10%	40%	10%

* No target set

We facilitate data interchange between PCMH practices, specialists, labs, pharmacies, and other providers throughout their MU evolution using tools such as our affiliate, ActiveHealth’s, CareEngine® System. The system integrates medical and pharmacy claims data and laboratory results within member-centered records that are then compared to over 1,500 evidence-based clinical rules and related algorithms developed by a team of board certified physicians and pharmacists. It then identifies member specific opportunities to optimize care and communicates evidence-based treatment recommendations, or “Care Considerations,” to providers, allowing them to modify treatment plans and/or communicate evidence-based treatment recommendations accordingly.

The following page contains a chart mapping each MU criterion to the corresponding PCMH level. A provider need only indicate what level they occupy relative to PCMH criterion, and Aetna Better Health provider relations personnel can immediately determine where they sit with regard to Meaningful Use and help plan next steps accordingly.

Crosswalk: PPC-PCMH Recognition/Meaningful Use

NCQA PPC-PCMH Recognition Standards	Meaningful Use Health Outcome Policy Priority
<p>Access and Communication</p> <ul style="list-style-type: none"> • Written standards for patient access and patient communication 	<p>Engage Patients and families in their health care</p> <ul style="list-style-type: none"> • Provide patients with an electronic copy of health info • Provide patients with timely electronic access to health info • Provide Clinical Summaries for each visit
<p>Patient Tracking and Registry Functions</p> <ul style="list-style-type: none"> • Basic non-clinical data • Searchable Clinical Data • Uses paper or electronic based charting tools for clinical info • Uses data to identify important diagnoses • Generates lists of patients and reminds patients and clinicians of needs services. 	<p>Improving quality, safety, efficiency, and reducing health disparities</p> <ul style="list-style-type: none"> • Maintain an up-to-date problem list of diagnoses • Record demographics • Record changes in vital signs • Generates lists of patients by specific conditions • Implement 5 clinical decision support rules
<p>Care Management</p> <ul style="list-style-type: none"> • Adopts evidence-based guidelines for 3 conditions • Conducts care-management • Coordinates Care 	<p>Improve Care Coordination</p> <ul style="list-style-type: none"> • Capability to exchange key clinical information among providers of care • Provide summary care record for each transition of care
<p>Patient Self-Management Support</p> <ul style="list-style-type: none"> • Actively supports patient self-management 	<p>Engage patients and families in their health care</p> <ul style="list-style-type: none"> • Send reminders to patients • Provide patients with an electronic copy of their health information • Provide patients with timely electronic access to their health information
<p>Electronic Prescribing</p> <ul style="list-style-type: none"> • Uses electronic system to write prescriptions • Has electronic prescription writer with safety and cost checks 	<p>Improving quality, safety, efficiency, and reducing health disparities</p> <ul style="list-style-type: none"> • Generate and transmit permissible prescriptions electronically • Maintain active medication list • Maintain active medication allergy list
<p>Test Tracking</p> <ul style="list-style-type: none"> • Tracks Tests and identifies abnormal results • Uses electronic systems to order and retrieve tests 	<p>Improving quality, safety, efficiency, and reducing health disparities</p> <ul style="list-style-type: none"> • Use CPOE • Incorporate clinical laboratory-test results into EHR as structured data
<p>Referral Tracking</p> <ul style="list-style-type: none"> • Tracks referrals using paper-based or electronic system 	<p>Improve Care Coordination</p> <ul style="list-style-type: none"> • Capability to exchange key clinical information among providers of care • Provide summary care record for each transition of care and referral

<p>Performance Reporting</p> <ul style="list-style-type: none"> • Measures Clinical Performance • Reports Performance • Transmits Reports with standardized measures electronically to external entities 	<p>Improving quality, safety, efficiency, and reducing health disparities</p> <ul style="list-style-type: none"> • Report ambulatory quality measures to CMS or the States
<p>Advanced Electronic Communications</p>	<p>Verify adequate privacy and security protections for personal health information</p>

Aetna Better Health understands that providers may demonstrate some reticence towards HIE/HIT-related expenditures. We have trained our Provider Relations and Information Systems personnel to address what existing providers have indicated are their primary concerns with regard to HIT adoption and implementation. These include:

Uncertainties Surrounding Meaningful Use

The Centers for Medicare & Medicaid Services’ (CMS) July 2010 release of the finalized definition of “meaningful use” as it pertains to certified Electronic Health Record (EHR) technology addresses many providers’ questions concerning incentive payments for the meaningful use of certified EHR technology, providing detailed explanations of the following:

- Incentive Eligible Professionals (EPs) and eligible hospitals
- Incentive payment amounts, the basis for payments, and the process for making payments
- The methodology for demonstrating adoption, implementation and upgrading, and the requirements for monitoring these activities
- Prior approval conditions that must be met in order to receive Federal Financial Participation (FFP) for reasonable administrative expenses
- Financial oversight requirements/measures to combat fraud and abuse
- “Meaningful Use,” its three main components (below) and the phased approach to its implementation:
 - The use of a certified EHR in a meaningful manner, such as e-prescribing.
 - The use of certified EHR technology for electronic exchange of health information to improve quality of health care.
 - The use of certified EHR technology to submit clinical quality and other measures.

Uncertainty regarding Return on Investment

CMS’ Finalized Rule for Meaningful Use provides details regarding how, under the Medicaid incentive plan, eligible physicians can receive up to \$63,750 to purchase and use qualified EMRs. For practices that have not deployed an EMR, the Medicaid program offers up to \$21,250 per physician to help purchase and implement a system (the physician must purchase before 2016 to be eligible). Thereafter, the Medicaid incentives offer up to \$8,500 per physician for “meaningful use” of the EMR. The “meaningful use” payments will be available for up to five years (with no payments being made after 2021). Medicaid-eligible professionals must pay at least 15 percent of the cost to purchase and maintain their EMR technology.

In addition, the Agency for Healthcare Research and Quality’s (AHRQ) National Resource Center (NRC) for Health IT’s Knowledge Library contains extensive research concerning HIT’s return on investment, including how to quantify associated benefits related to:

- Improved patient safety outcomes
- Reduced complications rates
- Reduced cost per patient episode of care
- Enhanced cost and quality performance accountability
- Improved quality performance

Other factors potentially impacting ROI include the section 179 tax write-off permitting practices to deduct up to \$500,000 of software and related equipment.

Lack of Available Technical Assistance

As described earlier, Aetna Better Health will assist CCN providers in registering for the appropriate EHR incentive program. In addition, we will refer them to Louisiana’s Health Information Technology (LHIT) Resource Center for technical assistance, guidance and information. Finally, we will provide technical support (e.g., education, training, tools, and provision of data relevant to patient clinical care management) to assist in providers’ transformation to PPC®-PCMH recognition or JCAHO PCH accreditation.

Workflow burdens, particularly in small offices

Among the tools accessible via AHRQ’s NRC website is the “Time and Motion Database,” enabling organizations to measure the impact of Health IT systems on clinical workflow through the collection of time-motion study data.

Workforce development and training needs

The “Health IT Adoption Toolbox,” available via AHRQ’s NRC website, contains a range of resources relevant to the various stages of considering, planning, executing, and evaluating the implementation of Health IT. This includes tools supporting the gap analyses and skills assessments necessary to identify workforce development and training needs requiring attention prior to any provider’s conversion to an EMR.

Existing Legacy Health IT Systems

Louisiana’s Health Information Technology (LHIT) Resource Center is charged with assisting health professionals in implementing and becoming “meaningful users” of electronic health records. This includes assisting providers in the assessment of existing legacy Health IT systems and their viability in light of the ARRA’s meaningful use requirements. Available resources include technical personnel skilled in the development and execution of conversion plans facilitating the seamless conversion from legacy Health IT systems to certified EMRs.

Legal Requirements and Privacy Concerns

Yet another tool accessible via AHRQ’s NRC website is the “The Health Information Privacy and Security Collaboration (HISPC) Toolkit”, providing guidance on conducting organization-level assessments of business practices, policies, and state laws that govern the privacy and security of Health Information Exchange (HIE).

ICD-10 and 5010 Compliance

Aetna Better Health has an efficient and effective IT organization that serves over 1.3 million Medicaid health plan members in 10 states. Aetna Better Health’s IT organization is flexible and responsive, led by a Vice President of Technology Support with over 15 years’ experience.

Aetna Better Health's Chief Operating Officer (COO) has the authority and responsibility to direct the activities, performance and outcomes of the IT subcontract.

Under the direction of our COO, Aetna Better Health's IT organization maintains systems migration plans supporting compliance with current and future Federal IT mandates. In addition, Aetna Better Health dedicates considerable resources towards the development and maintenance of the business and systems infrastructure necessary to support such mandates, recent examples including HIPAA 5010 implementation and the adoption of ICD-10. Aetna Better Health has implemented solutions specifically engineered to address these mandates and their evolving requirements. For example, ClaimCheck[®] and iHealth, two claims auditing applications, enforce business rules pertaining to "medically unlikely" services and possess the functionality necessary to accommodate future edits.

The various steps, or stages, of our systems migration plan follow:

Migration Planning: Aetna Better Health's systems migration plans align with our standard Change Order Process (COP), beginning with a readiness assessment comprising a high level analysis of the strategy required to implement the requirements. Once the readiness assessment is completed, the project team defines the scope of work by developing a project charter with realistic and actionable plans for the overall project implementation. Key stakeholders are identified and a communication plan established and executed along with the project plan.

Gap Analysis/Impact Assessment: Aetna Better Health performs a gap analysis and impact assessments prior to any system conversion/upgrade, determining the potential impact to current business operations and defining and developing specific business and technical requirements within and across transactions. Each gap, as well as its respective solution, is then documented for subsequent validation via use case or test scenario.

System Implementation: Aetna Better Health will base system implementation planning on an inventory of systems and environments requiring modification prior to implementation of any additional functionality. Once systems are aligned and environments have been identified, associated translators are modified to accommodate required formats. This includes:

- Reviewing and updating mappings
- Modifying existing and incorporating new business rules as necessary
- Updating and applying custom edits

Testing: Aetna Better Health's testing plans include defined transaction based test scenarios covering all systems, interfaces, transactions, and reports, including end-to-end testing with all clearinghouses, providers, system/software vendors and third-party administrators as applicable. Data and results are reviewed and communicated with any entity involved in data submission, acceptance or processing to verify that expected results are accurate and issues resolved. Reports track results and validate testing activities, provide verification of the enhancements and serve as the platform for their migration to the production environment.

Monitoring and Management of Performance: Aetna Better Health performs post implementation reviews subsequent to any migration, monitoring the success rate of functionalities including, but not limited to: 1) Claim processing; 2) Timely claim adjudication; 3) Return of requested benefit information; 4) Accurate claim status inquiries; and 5) Accurate

payment remittance advice and fund transfer. Aetna Better Health will develop control plans for compliance auditing and develop and distribute procedure manuals to help guide best practices around new business features and data. Perhaps most importantly, understanding that the changes in any one migration will not necessarily resolve every issue associated with its predecessor, we continuously assess our business operations for opportunities to enhance operational workflow and productivity. Aetna Better Health's systems configuration supports migration from one HIPAA version to another in the following ways:

- Microsoft's BizTalk with HIPAA Accelerator™ processes HIPAA-compliant transactions easily and efficiently, allowing Aetna Better Health to accept information electronically from almost any HIPAA-compliant contractor or provider. Microsoft BizTalk with HIPAA Accelerator™ is a data transformation application that translates data to and from the full spectrum of HIPAA transactions sets in a highly customizable, flexible, and robust server-based environment. Moreover, Accelerator has the Washington Publishing Company (WPC) Implementation Guide schemas for each HIPAA ANSI X12 transaction embedded directly into its application engine, including a facility to update these schemas automatically as the transaction sets are updated over time.
- Foresight's HIPAA Validator™ InStream™ is a fully functional HIPAA editing and validation application. It validates HIPAA transactions through all seven levels of edits as defined by the Workgroup for Electronic Data Interchange and Strategic National Implementation Process (WEDI/SNIP), has all standard HIPAA code sets embedded, and can support custom, trading-partner-specific companion guides and validation requirements. In addition, it supports validation at the individual edit level, allowing Aetna Better Health to accept all compliant records that pass at a lower level of edit, rather than requiring all seven levels of edits. The application also provides descriptive error reports to submitters to facilitate quick error resolution.

Aetna Better Health follows the Strategic National Implementation Project (SNIP) recommendations for testing created by the Workgroup for Electronic Data Interchange (WEDI), further promoting system compliance with federal IT mandates. Following the WEDI, Aetna Better Health complies with the following federally mandated HIPAA transactions:

- ASC X12N 834 Benefit Enrollment and Maintenance
- ASC X12N 835 Claims Payment Remittance Advice Transaction
- ASC X12N 837I Institutional Claim/Encounter Transaction
- ASC X12N 837P Professional Claim/Encounter Transaction
- ASC X12N 276 Claims Status Inquiry
- ASC X12N 277 Claims Status Response
- ASC X12N 278 Utilization Review Inquiry/Response
- ASC X12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products

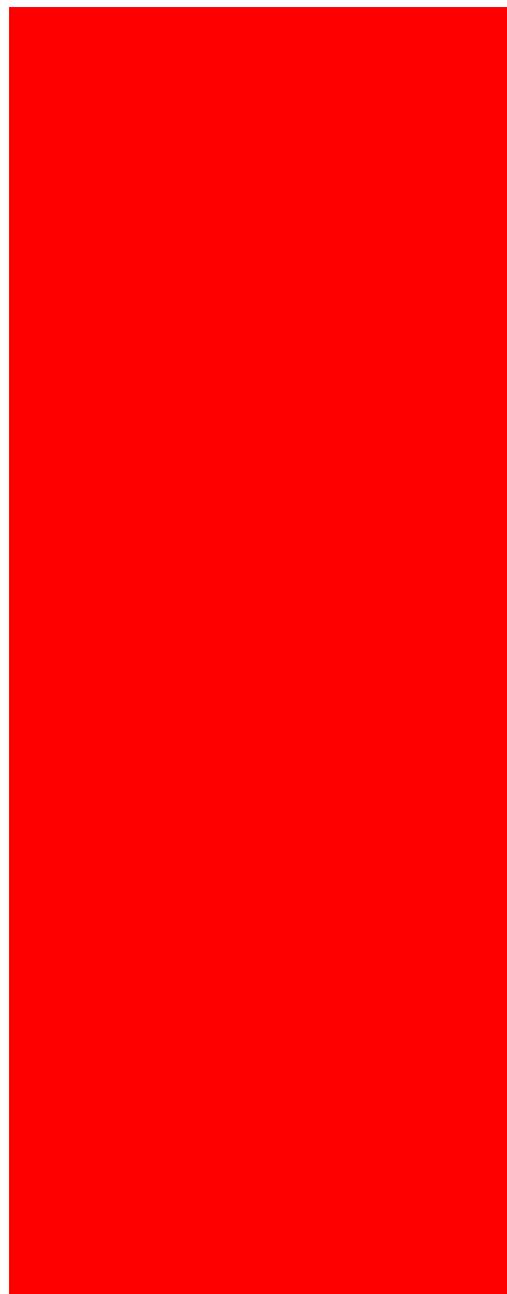
To support successful implementation of ICD-10-Clinical Modification (CM) and ICD-10-Procedure Coding System (PCS) on October 1, 2013, Aetna Better Health has taken the following steps:

- An assessment was completed in 2010 to identify all operational and technical processes and systems that will be impacted by the upgrade to ICD-10 codes. This resulted in the identification of work streams that have started efforts to analyze, develop, test, and implement the upgrade of our processes to the new coding.
- Development and testing of the ASC X12 version of 5010 claim and encounter transactions was performed in 2010 to allow the receipt and delivery of ICD-10 codes. Production target dates for utilizing these transactions have been determined, and deployment will be completed by the January 1, 2012 compliance date.
- The version upgrade that supports the acceptance and consumption of the ICD-10 codes within our QNXT™ adjudication system is targeted for 3rd quarter 2011.
- Workgroups have been developed to identify milestones for all ICD code-dependent processes and systems.

Aetna Better Health is currently compliant with all HIPAA and other federal IT mandates, and Aetna Better Health's IT personnel regularly attend national seminars, review professional journals, and monitor the U.S. Department of Health and Human Services and contracting states' websites to monitor and prepare for any future mandate. All Aetna Better Health personnel are required to attend mandatory HIPAA awareness training, where they are instructed on confidentiality, privacy, information safeguards, and penalties imposed for noncompliance.

Aetna Better Health is prepared to respond to any DHH or Federal programmatic changes that would impact IT processes, requirements, or systems.

133 R.16



R.16 Describe the procedures that will be used to protect the confidentiality of records in DHH databases, including records in databases that may be transmitted electronically via e-mail or the Internet.

Aetna Better Health has more than 25 years experience designing, implementing, and managing privacy programs. We currently own, manage or administer health plans serving more than 1.3 million Medicaid members in 10 states. Aetna Better Health is committed to the proper use and disclosure of confidential information in full compliance with federal and state laws and regulations. We maintain and actively enforce policies and procedures protecting the confidentiality of member records in compliance with all applicable federal and state laws, rules and regulations, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy requirements. All information concerning members or potential members is treated as privileged communication, held confidential, and divulged only upon written consent of DHH or the member/potential member. We maintain written safeguards that:

- State that the Aetna Better Health will identify and comply with any stricter state or federal confidentiality standards which apply to specific types of information or information obtained from outside sources;
- Require a written authorization from the member or potential member before disclosure of information about him or her under circumstances requiring such authorization
- Do not prohibit the release of statistical or aggregate data which cannot be traced back to particular individuals; and
- Specify appropriate personnel actions to sanction violators.

Responsibility for Maintaining Confidentiality

Aetna Better Health's Chief Executive Officer (CEO) will be responsible for privacy compliance activities. Responsibilities include:

- Verifying an individual's identity and authorization to request medical records
- Reviewing and responding to requests in compliance with HIPAA guidelines
- Documenting privacy-related questions and requests and responses
- Tracking and reporting monthly member privacy and compliance-related requests and actions taken
- Per contract or state mandate, notifying the appropriate state agencies if a subpoena or other formal legal process requesting member confidential or PHI is received

Aetna Better Health conducts privacy and security training for all workforce members (regular and contingent employees, i.e. temporary and independent contractors) and requires all new personnel sign an agreement to acknowledge receipt and understanding of the *Workforce Confidentiality* policy upon hire. In addition, we contractually require all network providers to safeguard member protected health information and treat members' records as confidential in accordance with all applicable federal and state laws, rules, and regulations governing medical records. In accordance with the provisions of Appendix C of this RFP, we will execute business

associate agreements with business partners that may use and disclose protected health information. In addition, we include confidentiality and privacy requirements in all provider and subcontractor contracts. Provider representatives emphasize the importance of these requirements during pre-contract and subsequent visits.

Use and Disclosure of Confidential Information

Aetna Better Health maintains written safeguards restricting the use and disclosure of information concerning members or potential members to purposes directly related to the performance of any workforce member's role. Aetna Better Health apprises employees, contractors and providers of members' rights during orientation, ongoing training and contract negotiation.

We will release medical records of members only as authorized by the member, as may be directed by authorized personnel of DHH, appropriate agencies of the state of Louisiana, or the United States Government. Policies and procedures will mandate that release of medical records of CCN Program members remain consistent with the provisions of confidentiality in this RFP.

In accordance with HIPAA standards, we provide members with a Notice of Privacy Practices on how Aetna Better Health uses and discloses protected health information. The Notice of Privacy Practices explains members' rights to access, amend, request confidential communication of, request privacy protection of, restrict use and disclosure of, and receive an accounting of disclosures of protected health information. The Notice of Privacy Practices is available on Aetna Better Health's website in English and Spanish.

Standards for electronic and physical security

To best protect the privacy and confidentiality of our members' information, Aetna Better Health will implement and enforce the following administrative, physical and technical security measures prohibiting unauthorized access to regions of the data communications network inside our span of control. We will conduct a security risk assessment and communicate the results in an information security plan provided no later than fifteen (15) calendar days after Contract award. The risk assessment will also be made available to appropriate federal agencies.

Administrative Safeguards

In accordance with its *Workforce Confidentiality* policy, Aetna Better Health has implemented administrative safeguards providing for the security of members' protected health information. Members of Aetna Better Health's workforce have access to confidential information only as necessary to perform their work activities. In working with that information, they are required to:

- Protect confidential information used in the course of work activities against inadvertent or intentional disclosure to unauthorized parties.
- File all confidential information when not using it, and must not discuss the information with any individual who does not have a legitimate business need to know that information.
- Not release their authentication codes or devices or passwords to any other person, and do not allow anyone access to Aetna Better Health systems under their authentication codes or devices or passwords.
- Not allow any unauthorized person to use or access Aetna Better Health systems.

- Use an appropriate Aetna Better Health cover sheet, which contains a statement describing the limitations on the release of confidential information when faxing information.
- Immediately remove confidential information from a printer or copier.
- Not solicit confidential information from outside sources except as necessary to perform their job functions. Workforce members must not disclose to Aetna Better Health confidential information of a former employer.
- Not remove from the premises those materials or information that contain or disclose confidential information at any time, whether during employment, or upon termination of employment.
- Upon termination of employment of contract for any reason, return all Aetna Better Health property, documents, and records and must not release or share any confidential information obtained during employment by or while contracting with Aetna Better Health.
- Dispose of confidential information in specially designated disposal bins.

Aetna Better Health workforce members who violate the *Workforce Confidentiality* policy may be subject to disciplinary action, up to and including termination and legal action.

Physical Safeguards

Aetna Better Health Security

Every Aetna Better Health employee is issued a photo identification card key following background check and hire. The key grants access to the suite during business hours only. Managers can request extended suite access for their employees; however, this requires approval from senior management. Aetna Better Health strictly monitors visitor access. Lost or stolen keys are reported immediately so that the key card can be de-activated.

MBU Facility Security

Aetna Better Health's administrative facilities are staffed around the clock, with special emphasis placed on physical security and controlled access. Only authorized individuals have access to the building to their particular work area. Aetna Better Health uses electronic card readers, unique access badges, surveillance cameras and security guards to promote a secure physical environment.

All entry points to the facility are automatically secured during business and non-business hours. Access to the building, via electronic card reader, is only granted during times established for each cardholder based on the access needs of the user and the user's department. A person having a business purpose in the building is assigned a unique access badge for entry into the building and interior areas. Employees must pass through at least two separate access points to reach their final work area. Visitor access is tightly controlled through the use of visitor badges provided at the time of sign-in at the reception desk and through visitor escort at all times during their visit. Camera surveillance and security guards provide security support.

Card keys control physical access to the corporate data center and network operations center. The Facilities Department coordinates the issuance of the card keys.

In addition, Aetna Better Health requires outside vendors, even those under a business associate agreement, who are on-site for an extended time frame (e.g., audit) to sign a site-visit

confidentiality agreement. All records, such as authorization and access activity, are maintained in a secure database for reporting and analysis.

Data Center Security

Physical access to Aetna Better Health's data center is restricted to designated and approved personnel. Three access points are required to enter the corporate data center. Transaction usage into this area is compiled and reviewed regularly to see that only authorized personnel with legitimate business purposes have access to this sensitive area.

Other Physical Safeguards:

Aetna Better Health's privacy and confidentiality measures include physical security features designed to safeguard processor sites through required provision of fire retardant capabilities, as well as smoke and electrical alarms, monitored by security personnel

Technical Safeguards

Aetna Better Health maintains an automated Management Information System (MIS) which accepts and processes provider claims, verifies eligibility, collects and reports encounter data and validates prior authorization and pre-certification in accordance with DHH and federal reporting requirements. Policies and procedures facilitate compliance with all HIPAA requirements across all systems and services, including transaction, common identifier, and privacy and security standards. We maintain a secure, password-protected email system for the submittal and receipt of all personal health information.

Electronic Health Information Transactions

Aetna Better Health's management information system currently supports DHH's required technical interfaces and complies with all applicable requirements of the Health Insurance Portability and Accountability Act (HIPAA). We are, and will continue to be, responsive, within a reasonable timeframe, to any and all adjustments or modifications to future HIPAA procedures, policies, rules and statutes that may be required during the term of our contract. Our management information system configuration supports migration from one HIPAA version to another in the following ways:

- Microsoft's BizTalk with HIPAA Accelerator™ processes HIPAA-compliant transactions easily and efficiently, enabling Aetna Better Health to accept information electronically from almost any HIPAA-compliant contractor or provider. Accelerator has the Washington Publishing Company (WPC) Implementation Guide schemas for each HIPAA ANSI X12 transaction embedded directly into its application engine, including a facility to update these schemas automatically as the transaction sets are updated over time.
- Foresight's HIPAA Validator™ InStream™ is a fully functional HIPAA editing and validation application. It validates HIPAA transactions through all seven levels of edits as defined by the Workgroup for Electronic Data Interchange and Strategic National Implementation Process (WEDI/SNIP), has all standard HIPAA code sets embedded, and can support custom, trading partner- specific companion guides and validation requirements. The application also provides descriptive error reports to submitters to facilitate quick error resolution.

Aetna Better Health follows the Strategic National Implementation Project (SNIP) recommendations for testing created by the Workgroup for Electronic Data Interchange (WEDI),

further promoting system compliance with federal IT mandates. Aetna Better Health complies with the following federally mandated HIPAA transactions:

Federally Mandated HIPAA Transactions:

- ASC X12N 834 Benefit Enrollment and Maintenance
- ASC X12N 835 Claims Payment Remittance Advice Transaction
- ASC X12N 837I Institutional Claim/Encounter Transaction
- ASC X12N 837P Professional Claim/Encounter Transaction
- ASC X12N 276 Claims Status Inquiry
- ASC X12N 277 Claims Status Response
- ASC X12N 278 Utilization Review Inquiry/Response
- ASC X12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products

We will provide DHH documentation on systems and facility security and provide evidence or demonstrate HIPAA compliance as part of this contract's associated Transition Phase.

System Safeguards

Role-Based Access: Electronic security measures are in place at a number of different levels. Personal computer access is controlled via network security. For all access (logical and physical) to the network, operating systems and data applications, all levels of management are required to review and formally affirm user access rights. Periodic and routine reports are generated and distributed to functional management for their review, edit, comments and corrections. If an employee changes department or position, management is required to re-assess the employee's access based on the new and different job responsibility and request the new or appropriate access rights for both system and physical access. QNXT™ and our web-based care management business application (Dynamo™), for example, use a hierarchical, role-based security configuration to control online inquiry and update activities. Specific, standardized user profiles, or "roles", have been defined and the appropriate security rights granted to each role. Users are assigned to a role based on the requirements of their job duties.

This role-based configuration, common to all Aetna Better health core business systems, restricts access to information on a "least privilege" basis, limiting not only users' access to application modules, but their rights to modify data accordingly. Any access point is automatically locked down upon three (3) unsuccessful logon attempts, and a record maintained of all such incidents.

Aetna Better Health takes the security of our members' data very seriously and so maintains significant protocols and controls with regard its external use. Per our standard operating procedure regarding requests for system access by an external agency, we will configure a DHH-supplied PC or laptop such that authorized external users have access – via Citrix – to a secure, inquiry-only environment wherein they may create and/or generate reports on an ad-hoc basis. We will reach mutual agreement with DHH on the number staff members that need a NID number granting them role-based access as a non-Aetna Better Health user. Authorized users will have access to SPOC, Aetna's Single Point of Contact Help Desk, providing toll-free system and technical support 24/7/365. SPOC personnel will answer questions regarding Aetna Better Health's System functions and capabilities; report recurring programmatic and operation problems to appropriate personnel for follow-up; redirect problems or queries that are not supported by the Systems Help Desk, as appropriate, via a telephone transfer or other agreed

upon methodology; and redirect problems or queries specific to data access authorization to the appropriate DHH personnel. Recurring problems not specific to Systems unavailability identified by the Systems Help Desk will be documented and reported to Aetna Better Health management within one (1) business day of recognition so that deficiencies can be promptly corrected. An issue management system will assist in that regard, providing SPOC personnel an automated means to record, track and report all questions and/or problems reported to the Systems Help Desk.

With regard to this contract, global access to all functions will be restricted to specified personnel jointly agreed upon by DHH and Aetna Better Health. Aetna Better Health executive management will approve all other access roles. Once approved, only authorized individuals will be allowed to make changes or revisions to these roles.

System Passwords: All system passwords must be periodically changed, and policies require that employees may not share passwords or access applications for which they are not authorized. Passwords must be changed every sixty (60) days and the system tracks the previous five passwords and does not allow reuse. After three (3) incorrect password entries, all access is prevented until security personnel working through the Help Desk reset the password. Policies provide that any software loaded to the network or individual workstations must be authorized and monitored by Information Services.

Audit Trails: Aetna Better Health's information system's configuration places the controls necessary to preserve information integrity at key areas throughout the processing sequence, including core application data extraction, transformation, cleansing, load, refresh and access points. We will work with DHH to develop a methodology supporting the testing and periodic and spot audits of these controls upon contract award.

We incorporate audit trails within our core business systems that allow information on source data files and documents to be traced through the processing stages to the point where the information is finally recorded. These audit trails contain, at a minimum:

- The unique log-on or terminal ID, the date, and time of any create/modify/delete action and, if applicable, the ID of the system job that effected the action
- The date and identification "stamp" displayed on any on-line inquiry

These measures provide auditors or other authorized parties the means to trace data from the final place of recording back to its source data file and/or document if necessary. In addition, the systems are able to generate listings, transaction/update reports and transaction/error logs upon request, further facilitating the auditing of individual records and batch audits.

Database Security: On a database level, Aetna Better Health information is stored in separate databases with separate security access at Aetna Medicaid's data center. Database access rights are granted on a table and user/user group basis. Only specified individuals may make changes or revisions to these settings based on authorized documentation from authorized personnel.

All systems are accessed through the Local Area Network (LAN), the Wide Area Network (WAN) for remote locations or via the Internet. Each user who needs access to the network or the Internet must have the proper authorizations and a unique password. Internet access is also protected by firewall hardware and software to prevent unauthorized use and to allow

appropriate monitoring capabilities. Each system has its own security, limiting what an individual may see or transact based on the individual security level. In addition, each system contains data integrity controls preventing the alteration of finalized records.

Remote Access: Under the direction of Aetna Better Health’s corporate Chief Information Officer (CIO), remote access is established, controlled and maintained by IT network engineering personnel. Policies and procedures require two-factor user authentication via Virtual Private Network (VPN) or similar means, which we will submit for DHH’s approval no later than fifteen (15) calendar days after Contract award. Aetna Better Health currently manages remote access according to the following standards:

- Secured VPN provides secure access for system inquiry and update
- Secure remote access is strictly controlled and is enforced via one-time password authentication or public/private keys with strong password phrases
- Company employees with remote access privileges must make sure that the computer remotely connected to the corporate network is not connected to any other network.
- Remote access is provided only to the following classes of employees:
- IT employees regularly providing on-call production support
- Executives of the company
- Employees whose positions require remote access due to job requirements as approved by their department management

Confidentiality and Privacy Risk Assessment

The Audit Services Department provides independent oversight and risk assessment to assure that critical risks are identified, mitigated and managed to an acceptable level to achieve operating objectives. The Audit Services Department engages in many different types of reviews using accepted industry and governmental standards and collaborates with all operating departments to assess, document and test compliance with procedures. Moreover, it investigates opportunities to make the security process more effective and efficient.