Request for Proposals

For

Ohio-Certified Psychiatric Residential Treatment Facilities (PRTF)

Date of Issue: June 9, 2023

Proposals must be received no later than 5:00 P.M. EST on July 21, 2023

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GENERAL INFORMATION

1.1 Introduction

Aetna Better Health® of Ohio, OhioRISE (Aetna), is seeking Proposals from qualified Respondents to create and implement Psychiatric Residential Treatment Facility (PRTF) services for OhioRISE (Resilience through Integrated Systems and Excellence) enrollees. These PRTF programs will be located within the State of Ohio and certified by the Ohio Department of Mental Health and Addiction Services (OhioMHAS). The Ohio Department of Health (ODH) will assist the Ohio Department of Medicaid (ODM) and OhioMHAS in regulatory oversight.

Interested Respondents should familiarize themselves with the following proposed Ohio Administrative Code regulations that will govern OhioRISE PRTF programs and processes. The proposed OhioMHAS Rules can be found HERE and the proposed ODM Rules HERE

Respondents should consider the **OhioRISE PRTF Program Manual** (Manual) to be the official PRTF Scope of Work. Information contained within the Manual will not be duplicated in this document. This Request for Proposals (RFP) will focus on the required elements for a successful Proposal to provide PRTF services to OhioRISE enrollees. All applicable sections of the Manual will be identified for each Proposal component. Draft version 0.6 of the Manual is referenced throughout this solicitation can be found here PRTF | OhioRISE – Aetna Better Health.

1.2 General Disclaimer

This Request for Proposals does not obligate Aetna to award a contract. All costs incurred in responding to this RFP will be borne by Respondent. This RFP and the process it describes are proprietary and are for the sole and exclusive benefit of Aetna. No other party, including any Respondent, is intended to be granted any rights hereunder. Any response, including written documents and verbal communication by any Respondent to this RFP, shall become the property of Aetna and may be subject to public disclosure.

1.3 OhioRISE Overview

Information on the inception, purpose, goals, and key stakeholders of OhioRISE can be found in Manual *Section 1: OhioRISE Purpose and Goals* (page 7), and *Section 2: OhioRISE Delivery System and Key Partners* (page 9).

1.4 Statement of Need

Psychiatric Residential Treatment Facility (PRTF) is a specific designation of the Centers for Medicare & Medicaid Services (CMS) that meets the requirements described in 42 C.F.R. 441.150 through 42 C.F.R. 441.184. Each state has the option to cover PRTF and the flexibility to further define PRTF expectations and functionality. It is an inpatient level of care in a community-based setting for Medicaid-eligible persons under the age of twenty-one (21) years. Services provided at a PRTF are trauma-informed, occur seven days per week, 24 hours per day, and must be conducted under the direction of a physician.

Ohio does not currently have policy to support PRTFs, so young persons in need of this intensity of service are being treated out-of-state. To help actualize Governor DeWine's vision of serving some of our most vulnerable youth and families as close to home as possible, ODM and OhioMHAS have developed policy to certify providers and add PRTF as a Medicaid-covered service, which will be a critical part of the continuum of community-based mental health services in Ohio, where youth with significant behavioral health (and those with co-occurring substance use or intellectual disability) needs will receive intensive residential treatment.

1.5 Inquiry Procedures

Aetna has designated the individual below as the Official Contact for purposes of this RFP. Respondents, potential Respondents, and other interested parties are advised to submit any and all questions regarding this RFP to the official contact before the specified deadline. Questions will not be accepted or answered verbally-outside of the Respondents' Conference. Respondents' questions regarding this RFP must be submitted in writing by June 20, 2023, prior to 5 P.M. Eastern Standard Time. All PRTF RFP questions should be addressed to:

Emma Johnson, JohnsonE3@aetna.com.

Outreach via other methods to discuss this RFP are not encouraged. Aetna will not be held responsible for oral responses to Respondents. Questions will be addressed in writing and posted to Aetna's PRTF RFP website PRTF | OhioRISE – Aetna Better Health by June 28, 2023 at 5 P.M. Eastern Standard Time for transparency amongst all potential Respondents.

1.6 Respondent Conference

A Respondent Conference call will be held on June 15, 2023, at 4 P.M. Eastern Standard Time via Microsoft Teams. Meeting details can be found here PRTF | OhioRISE – Aetna Better Health. The conference will serve as an opportunity for Respondents to ask specific questions of Aetna

concerning this RFP. Attendance at the Respondent Conference is not mandatory but is recommended. Oral answers given at the conference will be non-binding. Written responses to questions asked at the conference will be included on Aetna's PRTF RFP website PRTF | OhioRISE – Aetna Better Health.

1.7 Delivery of Proposals

Please provide an electronic copy of the Proposal no later than 5 P.M. EST on July 21, 2023, to OhioRISERFP@Aetna.com. The subject line should indicate conveyance of "**OhioRISE PRTF Proposal by Respondent's Organization**". Late Proposals received after this time will not be considered and will not be opened. Faxed Proposals will not be accepted.

Please use Microsoft Office and standard PDF files. Clearly label submission documents and include Organization's name in the name of the electronic files. Request a read receipt to ensure the Proposal was received by Aetna. Unsigned Proposals will not be evaluated.

Failure to abide by these submission instructions may result in disqualification of any non-compliant Proposals.

1.8 Multiple Proposals

A separate Proposal is required in each of the below scenarios:

- Respondent is planning to implement PRTF programs at more than one physical address.
- Respondent is planning to implement PRTF programs in different buildings (may or may not be the same physical address) that will serve different age, gender or subspeciality populations.
- Any time more than one program/facility/accreditation license is required.

1.9 Eligibility

Provider organizations whether not-for-profit or for-profit corporations or partnerships are eligible to submit Proposals in response to this RFP.

To qualify for a contract with Aetna for OhioRISE PRTF services, Respondents must meet or indicate ability to meet the following minimum qualifications before the start date of the contract:

a. Ohio Business License,

b. Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF) or Council on Accreditation of Services for Families and Children (COA) as a behavioral health residential treatment facility,
c. OhioMHAS certification as a class one residential facility,
d. OhioMHAS PRTF certification, and
e. All PRTF providers must secure an active provider agreement with ODM as a PRTF, prior to serving OhioRISE enrollees.

Manual *Section 5: PRTF Service Definition, Licensing,* and *PRTF State Survey Agency Requirements* (pages 38-39) contain additional information on licensing and agency requirements for OhioRISE PRTFs.

PROGRAM FRAMEWORK

2.1 Definition and Purpose of PRTF

The PRTF requirements in this RFP have been guided by best practices that emphasize:

1. Individualized, trauma-informed services with a focus on skill building;
2. Young person and family (or caregiver) voice in treatment and program decisions; and
3. Family engagement and involvement throughout the process to enable successful outcomes for the young person following completion of PRTF treatment.

The purpose of treatment in a PRTF is to provide inpatient level of care in a sub-acute residential setting focused on improving a youth's behavioral health condition to the point where that level of care is no longer necessary. It is neither an indefinite "placement" nor a long-term setting; but a discrete, intensive treatment episode of typically no more than six (6) months, which is deployed when young persons need an elevated level of clinically supervised interventions and supports.

The provider(s) selected through this RFP process will be expected to align PRTF programming with the core values of the Building Bridges Initiative (BBI)[1] which include the principles of:

1. Family Driven and Youth Guided Care,
2. Cultural and Linguistic Competence,
3. Clinical Excellence and Quality Standards,
4. Accessibility and Community Involvement, and
5. Transition Planning and Services (between settings and from youth to adulthood).

[1] Building Bridges Initiative Home - Building Bridges Initiative (buildingbridges4youth.org)

Successful PRTF programs will focus on long-term outcomes in the community rather than concentrate on targeting acute negative behaviors.

Manual *Section 3: Psychiatric Residential Treatment Facility Purpose and Goals* (page 11) and *Section 5: PRTF Service Definition, What is a PRTF?* (page 14) provide further detail.

2.2 Target Population

Collectively, the network of OhioRISE PRTF providers should be able to serve young persons with behavioral health needs:

- Of three age categories:
  - Six (6) to twelve (12) years,
  - Thirteen (13) to seventeen (17) years, and
  - Eighteen (18) to twenty-one (21) years.
- Who are male, female, non-binary, and transgender. PRTFs must be able to accept and accommodate the needs of LGBTQIA youth with affirming treatment that respects and accounts for gender and sexual identity.
- With externalizing behaviors including but not limited to:
  - Physical aggression,
  - Problem sexual behaviors (including those considered abusive, coercive, and reactive)
  - Self-harming behaviors (including Non-Suicidal Self-Injury [NSSI], self-mutilating, stimming, and compulsive behaviors)
  - Suicidal behaviors
  - Substance use.
- With internalizing behaviors and symptoms including, but not limited to:
  - Thoughts of suicide or self-harm
  - Thoughts of homicide or harm to others
  - Perceptual abnormalities including primary and secondary psychotic processes
  - Problem eating behaviors
- With co-occurring physical health conditions
- With co-occurring intellectual disability conditions, such as young persons with MI/ID, traumatic brain injuries, neurocognitive disorders, and other cognitive disorders.

Each PRTF program ***will not*** be required to serve all ages, genders and behavioral health conditions noted above. Respondent is asked to thoughtfully demonstrate how the needs of young persons with co-occurring physical health and substance use conditions will be addressed while residing at the PRTF.

Manual *Section 4: Who May Benefit from PRTF* (page 13) gives additional context on those intended to be served by OhioRISE PRTFs.

2.3 Clinical Criteria. This RFP is intended for OhioRISE enrollees who meet the clinical need for PRTF services as outlined by ODM. The PRTF Admission, Continued Stay and Discharge Clinical Criteria can be found in Manual, *Appendix C: PRTF Clinical Criteria* (page 72).

2.4 Facility Site and Description

One of the intended outcomes of this RFP, is for PRTFs to be available throughout the state of Ohio. While it is not the expectation that every PRTF serve the complete ranges of ages, behaviors and genders as outlined in Target Population, RFP Section 2.2; the ideal would be to have at least one PRTF program in each of the following three state regions:

Region	*Counties*
Northeast	Ashtabula, Belmont, Carroll, Columbiana, Crawford, Cuyahoga, Erie, Geauga, Hancock, Harrison, Huron, Jefferson, Lake, Lorain, Mahoning, Marion, Medina, Monroe, Ottawa, Portage, Sandusky, Seneca, Stark, Summit, Trumbull, Tuscarawas, Union, Wood, Wyandot
Central & Southeast	Ashland, Athens, Coshocton, Delaware, Fairfield, Fayette, Franklin, Gallia, Guernsey, Highland, Hocking, Holmes, Jackson, Knox, Licking, Meigs, Morgan, Morrow, Muskingum, Noble, Perry, Pickaway, Pike, Richland, Ross, Vinton, Washington, Wayne
West	Adams, Allen, Auglaize, Brown, Butler, Champaign, Clark, Clermont, Clinton, Darke, Defiance, Fulton, Greene, Hamilton, Hardin, Henry, Lawrence, Logan, Lucas, Madison, Mercer, Miami, Montgomery, Paulding, Preble, Putnam, Scioto, Shelby, Van Wert, Warren, Williams

Respondents may own or lease the property and are required to provide current information on the property's zoning and licensing status.

PRTFs will provide a home-like environment that is positive and that nurtures interactions between the youth and their caregivers at the PRTF. This helps reduce the tensions of living in a group setting, while providing stability and flexibility. Details such as décor and layout should be thoughtfully planned to ensure the environment is inviting and consoling. Items such as artwork, plants, pillows and area rugs; as well as the paint colors, lighting fixtures and furniture; should be welcoming while being selected for comfort and durability. The home-like environment of the PRTF should not compromise participant, staff, or visitor safety.

Allowing opportunities for PRTF program participants to choose their room furnishings or other domestic provisions will increase the young person's sense of choice and self-expression.

A tobacco-free policy must be maintained through the premises. A naloxone policy must be included to ensure on-site access to, staff training in the administering of, and proper disposal of naloxone.

There should be an open-access policy so that family/caregivers can visit youth at any time, aside from extenuating circumstances when this is clinically contraindicated, or limited by court order or written directive of legal guardian.

Further details on building and environment expectations can be found in the Manual *Section 5: PRTF Service Definition, PRTF Building and Living Requirements* (page 37). Respondents will be required to adhere to all federal and state licensing and safety requirements to maintain Ohio PRTF certification and serve OhioRISE enrollees.

SCOPE OF WORK

3.1 Evidence-Based Practices

Ohio has a strong focus on the use of evidence-based practices (EBPs) for all levels and manner of service delivery. The PRTFs procured through this RFP must utilize evidence-based and evidence-supported approaches to treatment. Training, supervision, and quality assurance strategies to monitor practice fidelity and track outcomes should be described in the Proposal. Respondents should explain how EBPs will be implemented, sustained, and regularly measured.

3.2 Organizational Culture

OhioRISE PRTFs must develop an organizational culture that emphasizes trauma-informed care, vision-driven and involved leadership, workforce support, and young person and family voice. Respondents should describe how their program will adopt change management approaches that are strengths-based, relational and collaborative. There should not be any elements of coercion, punishment, or the requirement to attain certain levels or points. This empathic style of communication and engagement should be applied throughout all aspects of the organization and be evident in interactions between staff and leadership, and between staff and PRTF participants. Aligning with BBI, feedback from young persons served, their families and other stakeholders should be sought and liberally incorporated.

See Manual *Section 5: PRTF Service Definition Treatment Environment* (page 24), *Trauma-Informed Treatment* (page 25), *Young Person and Family Engagement* (page 26) for addition requirement details.

3.3 Seclusion and Restraint

Unfortunately, many of the young persons who will be served in OhioRISE PRTFs have witnessed or experienced trauma. While restricting a person's movement is often done for imminent safety reasons, it can potentially traumatize them, those doing the constricting, and bystanders. Aetna strongly encourages providers to strive to be restraint-free. Value Based Contracting incentives may be leveraged to promote achieving this for the OhioRISE PRTFs.

Manual *Section 5: PRTF Service Definition: Restraint, Seclusion and Time-Out* (page 34), *Section 10: Training: Seclusion and Restraint Training* (page 50) and *Section 14: Definitions*: *Definitions Related to Restraint and Seclusion (*page 63) provide further context on regulatory requirements expectations, and related training.

3.4 Service Components

OhioRISE PRTFs will be required to provide **ALL** the PRTF Service Components detailed in the Manual. Highlights include the following:

- **Stakeholder Collaboration**. OhioRISE is specifically designed for multi-system involved youth. OhioRISE PRTFs are therefore expected to collaborate with any governmental, community or other stakeholder entity that may be integral to or peripherally supporting the Child and Family Team (CFT). Manual *Section 9: Collaboration with Other System* Partners (page 47) expounds further.

- **Clinical Service Components,** including admission expectations, therapeutic environment, assessment, young person and family engagement, clinical interventions, treatment planning, care coordination and care transitions are explained in Manual *Section 5: PRTF Service Definition* (pages 15-28), *Section 7: Pathway to PRTF Admission Criteria and Admissions* (page 43).

- **Transitions of Care,** as detailed in Manual *Section 5: PRTF Service Definition: Transition Planning and Post Transition* (page 22), *Section 5: PRTF Service Definition: Care Coordination, Transition Planning and Continuity of Care* (page 28), *Section 7: Pathway to PRTF* (page 41), *Section 8: Pathway from PRTF* (page 44), and Section *9: Collaboration with Other System Partners* (page 47). Respondents are encouraged to focus on this element of care as points of transition can increase the risk of young persons and their families disengaging from care and subsequently experiencing negative outcomes.

- Information on **Education Service Components** can be found in Manual *Section 5: PRTF Service Definition* (pages 30-34). PRTFs are required to facilitate the ongoing provision of an

appropriate educational program that is consistent with state and federal education laws. PRTFs serving adolescents and young adults should also provide for the career-technical and vocational needs of the young persons in their program.

3.5 Personnel and Training

It is vital that PRTFs employ strategic hiring procedures to identify highly qualified candidates who can support the mission of the PRTF to provide compassionate and individualized care to youth and active, supportive engagement of their families. Intentional hiring practices and consistent training can help ensure that the PRTF staff composition reflects the diversity of the population served. Successful PRTFs will be able to maintain the staffing resources needed to ensure individualized treatment, engagement of families, and implementation of the chosen EBP(s) to fidelity; while consistently meeting the minimum required staffing ratios with flexibility to meet the dynamic needs of program residents. OhioRISE PRTF staffing and training requirements are discussed in the Manual, *Section 6: Staffing* (page 39) and *Section 10: Training* (page 48).

3.6 OhioRISE PRTFs Serving Youth with Co-Occurring Mental Illness and Intellectual Disability (MI/ID)

Respondents intending to serve OhioRISE enrollees with MI/ID, should review the additional programmatic requirements extending to clinical services, facility specifications, staffing considerations and educational provisions. These can be found in Manual, *Section 5: PRTF Service Definition: Criteria for Providers Contracted to Serve Youth with MI/ID* (page 23), and *Appendix D: Criteria for PRTFs Serving Youth with MI/ID* (page 77).

3.7 Reporting and Quality Requirements

By accepting an award under this RFP, Respondents agree to comply with all Aetna monitoring and reporting requirements, whether related to claims, data exchange, quality management, service utilization, clinical outcomes, care coordination, or network adequacy. Manual *Section 11: Data and Quality* (pages 51-59) describes the baseline performance and quality metrics expected of successful Respondents. Other performance indicators and program measures can be proposed in responses to this RFP. These measures should capture program quality, OhioRISE enrollee satisfaction, and community tenure. Respondents should propose quality improvement methods that will integrate results of measures into ongoing program enhancement.

These reporting requirements may change over time depending upon the needs of OhioRISE, ODM direction or other state or federal obligations. Flexibility of PRTF informatics infrastructure and operation systems is beneficial.

3.8 Performance Standards

OhioRISE PRTFs will be required to meet all ODM provider credentialing and performance standards. Proposals should include a Compliance Plan, and a Business Continuity Plan.

3.9 Technology Capabilities

Respondents must have the information and technology (IT) infrastructure and capabilities necessary to satisfactorily perform all the required activities contained within this RFP and Manual. At a minimum, Respondents must have electronic claims submission and an electronic health record (EHR) ready for use. PRTFs will be required to electronically exchange information with Aetna that may include daily census and capacity data. Reporting and quality metrics described elsewhere in this RFP and Manual should be submitted electronically as well.

SUBMISSION REQUIREMENTS

It is expected that Proposals will demonstrate the Respondent's knowledge of the needs of their target population and highlight their related experience in service provision.

Emphasis should be on completeness and clarity of content. Proposals should be straightforward, conveying a concise description of the Respondent's ability to meet all the requirements of the OhioRISE PRTF RFP and Manual. Respondents are encouraged to include youth and family perspectives as well.

4.1 Proposal Format

1. **General Guidance.** Proposals must conform to all instructions, conditions, and requirements included in this RFP. For each section as indicated, the Respondent must fully answer all the listed questions; and those answers must be identified by the same numbering as their related question. To enhance efficiency and readability, if Respondent has provided an answer to a question in another part of the Proposal, make reference to that

section and do not repeat the response. Respondents whose Proposals exceed the page limits or that fail to follow the required outline will be deemed non-responsive and not evaluated.

2. **Attachments.** Attachments other than explicitly identified in the Proposal Outline ***(Appendix 1)*** are not permitted and will not be evaluated. Further, the required Appendices or Forms must not be altered or used to extend, enhance, or replace any component required by this RFP. Failure to abide by these instructions may result in disqualification.

3. **Style Requirements.** This is an electronic submission. Submitted Proposals must conform to the following specifications:
   - Paper Size: 8 ½ x11 (Letter)
   - Page Limit: Maximum 50 pages, exclusive of Executive Summary and Attachments
   - Font Size: 12
   - Margins: Normal (1 inch)
   - Line Spacing: 1 ½

4. **Pagination.** The Respondent's name must be displayed in the header of each page. All pages including the required Appendices and Forms, must be numbered in the footer.

4.2 Proposal Content

A. **Cover Sheet.** The Cover Sheet ***(Appendix 2)*** is Page 1 of the Proposal.

B. **Table of Contents.** All Proposals must include a Table of Contents that conforms with the required Proposal Outline.

C. **Executive Summary.** All Proposals must include an Executive Summary that should not exceed two (2) pages in length and should be signed by Respondent agency leadership. It should summarize the PRTF program being proposed, including total number of individuals to be served and service location.
This component of the Proposal should demonstrate the Respondent's understanding of the services requested in this RFP, including how the staff and services needed will be provided. Statement and discussion of anticipated major difficulties in accomplishing the work (if any), together with the potential or recommended approaches to their solution should be included here as well. The Executive Summary should also illustrate the Respondent's overall program design response to achieving the deliverables as defined in this RFP.

D. Main Proposal

1. Organizational Profile

a. **Purpose/Mission/Philosophy:** Briefly describe the purpose, mission, and philosophy of the agency and the proposed PRTF program. This section should also describe the agency's plan to adhere to applicable state and federal laws, regulations and policies governing the provision of services in an Ohio-Certified PRTF.
Emphasize how Respondent's organization is seen as a trusted community partner and collaborator.

b. **Corporate Status and Years of Operation:** Provide a brief history of the agency and its corporate status: whether that be for-profit or not-for-profit organization. Describe the organization's size and reach- including number of persons and geographic area(s) served. Respondents must be registered to do business in the State of Ohio and submit proof with Proposal ***(Attachment A)***.

c. **Governance and Organizational Structure:** Describe the governing body of Respondent organization. List the names, race and business addresses of all members of its Board of Directors, indicating which, if any, are self-disclosed service recipients or family members of people who have received services ***(Attachment B)***. Response should explain how the agency's staff and leadership are reflective of the community, culturally competent and responsive to the population(s) being served. Provide a copy of your organizational structure that includes position titles and the names of those occupying those positions ***(Attachment C)***.

d. **Qualifications/Certification/Licensure.** Describe Respondent agency's qualifications and interest in providing the kinds of services being requested through this RFP, and how agency meets eligibility requirements. If these accreditations and certifications have not yet been obtained, the Respondent must convey the extent to which these processes have been initiated, their current status, and timeline to completion. If already obtained, submit proof ***(Attachment D)*****.** Please list the continuum of services offered by Respondent agency. Be sure to highlight all the strengths that are considered an asset to the program. Indicate the length, depth, and applicability of all prior experience in providing requested services, the skill and expertise of lead staff, and any significant programmatic accomplishments or accolades received by the Respondent's organization to date.

e. **References.** Respondents are required to provide two (2) letters of reference, one of which must be from a CME ***(Attachment E)***. These letters must include the agency name, contact name, mailing address, phone number and email address of the writer. Letters must

also include the nature of the writer's relationship with the Respondent. This is NOT a Letter of Support. The writer must be able to detail a prior relationship of services provided by the Respondent agency. Respondent should also include a letter from another state's placement partner if Respondent currently acts as a PRTF for another state.

2. Facility Description

a. Provide the location of the Respondent's administrative offices, as well as the proposed location for the PRTF. Please describe the extent to which the program site is appropriately zoned and licensed, or anticipated timeline for this. Respondents are not required to obtain possession of physical space or zoning compliance prior to submission of a Proposal.

b. Does the Respondent currently control this site? If not, provide details on how and when the site will be available.

c. Provide a description of campus design. Include the type of housing arrangement (for instance whether it will be cottage or dormitory/unit-styled). Explain how other programs or levels of care will be separated if also located on the same campus. Describe the various areas that will be used as sleeping accommodations, common areas, treatment areas, recreational areas, family visiting areas, and spaces designated for team meetings. If available, provide schematic of building/campus ***(Attachment F)***.

d. List the proposed number of PRTF beds at the facility, including number of beds per room and number per unit/cottage/dorm. Explain if they will be separated by age, gender, treatment track or another characteristic.

e. Explain how the space will align with regulations and best practices for ensuring a home-like setting that promotes recovery and resilience.

f. If the intended PRTF beds are currently being used for another purpose, Respondent must explain the transition plan for those beds and the youth being served by them.

3. Safety

a. Describe the safety and security features that will be deployed, including physical structures such as locking mechanisms, fences and gates.

b. Include a description of Respondent's camera and monitoring system. Explain where they will be located on the premises, and the policy for storing and disclosing the recorded footage.

c. Articulate if young persons in treatment at PRTF will be able to keep their own personal electronic devices such as smart phones or tablets. Explain how Respondent will monitor internet access and ensure safety of persons in treatment.

d. Provide information on how Respondent will vet visitors to the PRTF; whether they are there to see a young person in treatment, or for some other reason.

4. Target Population

Describe specific target population for which Respondent plans to provide PRTF services. Provide information on the anticipated ages and genders to be served. Indicate the clinical areas of focus for the PRTF and any specific behaviors or conditions the program will address. Explain why this population was chosen- including any information on community level of need or Respondent's experience with that particular population. Detail how Respondent's program will serve and support the inclusion of OhioRISE membership noting areas of culture, language, gender, sexual preference, socioeconomic status, and neurodiversity. Discuss how the Respondent's PRTF activities will positively impact the target population.

5. Youth and Family Centered Care

a. Discuss how Respondent will elicit and sustain engagement of OhioRISE enrollees in all aspects of their PRTF program. Describe how this would be initiated pre-admission and maintained throughout the young person's treatment course at the PRTF and post discharge. How will Respondent promote the young person's self-direction? What techniques or strategies will be deployed to foster rapport or ignite motivation?

b. Discuss how Respondent will elicit and sustain consistent, ongoing, and active engagement of family members/caregivers of the young persons being served at the PRTF. Describe how this would be initiated and maintained throughout the young person's time in treatment at the PRTF, while including attention to family voice. Describe visiting policies including visiting hours, and whether Respondent will be assisting with transportation or accommodations for family members. If a young person's family or natural supports are not involved, how will Respondent promote this? How will Respondent assist in family finding efforts? Will siblings be included in family visits and family therapy sessions? Detail how Respondent will work with family/caregiver to receive and support the young person when they no longer need to be at the PRTF. How will Respondent work with Public Children's Service Agencies (PCSAs) on these efforts for those youth in agency custody?

c. Explain how young persons and families will influence their treatment and programming activities.

d. Respondents must discuss how young persons and their families will be represented in the PRTF governance structure.

e. Describe the role peer and family supports will have in Respondent's PRTF programming. Relay as well if Respondent will have any ongoing interaction with PRTF graduates and their families and if there is an opportunity to coach them to be peer supports.

6. Engagement with OhioRISE Care Coordinators, Care Management Entities (CMEs) and other Care Coordination Agencies

Discuss how Respondent will collaborate with the young person's care coordinator-whether that care coordinator is with OhioRISE or another entity- and support their CFT. List the anticipated touchpoints or situations where these interactions will occur. Describe how Respondent will facilitate in-person, telephonic and telehealth communication between the young person and their OhioRISE care coordinator. Detail the manner of anticipated engagement Respondent will have with CMEs, including those serving the geographic area where Respondent's PRTF is (to be) located.

7. Stakeholder Engagement

Discuss Respondent's systemic approach to, experience with, and capacity to coordinate with key state and local child and youth-serving systems including:

- Coordination with the courts and correctional systems for court-involved youth and young adults (such as the Ohio Juvenile Courts and the Ohio Department of Youth Services (DYS), as well as the Ohio Department of Rehabilitation and Correction);

- Coordination with state and local child welfare agencies to support permanency goals and prevent placement disruption for children and youth with behavioral health challenges (such as the Ohio Department of Jobs and Family Services and local PCSAs);

- Coordination with the state and local agencies (such as the Ohio Department of Developmental Disabilities and county Boards of Developmental Disabilities [BDD]) or similar county/regional entities to serve children and youth with intellectual and developmental disabilities and children and youth with autism with co-occurring behavioral health conditions;

- Coordinating with the state and local agencies (such as Ohio Family and Children First and county Family and Children First Councils) that enhance services for children, youth, and families;

- Coordination with the Ohio Department of Education and local school systems;

- Coordination with ODM or its designee specifically regarding the Ohio Home Care waiver;

- Coordination with state, county, and regional agencies (such as the Ohio Department of Mental Health and Addiction Services, Alcohol, Drug Addiction and Mental Health Services Boards) to serve youth with cooccurring mental health and SUD challenges.

8. Diversity, Equity, Inclusion and Cultural Competency

Detail how Respondent will meet the cultural, linguistic, and spiritual needs of the young persons and their families being served by Respondent's PRTF. Aside from cognitive and learning disabilities, explain ways Respondent will provide reasonable accommodation for young persons and their families with visible and invisible disabilities. Describe the plan to meet the needs of LGBTQIA and specifically transgender youth. Articulate how PRTF staff will navigate working with young persons and their families from varied backgrounds and foster a therapeutic milieu environment.

9. Education and Employment

Respondent should delineate how educational services will be provided for young persons in PRTF treatment. Indicate how the Respondent will accommodate special education needs such as Individualized Education Plan (IEP) or 504. Discuss how educational needs will be met for those young persons being served by the PRTF whose level of clinical acuity prevents them from participating appropriately in the chosen education model. For those young persons who were not able to regularly attend school prior to admitting to PRTF, describe if Respondent will facilitate credit recovery or remediation options, as applicable.

a. If serving adolescents or young adults, illustrate how Respondent will connect them to any desired vocational, technical, or professional training. Indicate if college-level study will be an option, as well as employment opportunities.

b. Transition Age Youth. If Respondent plans to serve young persons ages 14 to 21 years, please discuss targeted programming related to promoting their independence and competency of skills necessary for adulthood.

10. Quality Improvement and Assurance

Respondents should discuss how they plan to meet all the reporting requirements outlined in the PRTF RFP and Manual- mentioning any system, IT or staff resources; and how they will use the data collected to inform quality and performance improvement initiatives. Please detail how Respondent plans to address any potential Quality of Care concerns. Describe a process that will be utilized to do root cause analyses on major incidents or concerning data trends. Explain how Respondent will solicit and utilize young person and family feedback regarding their experience with the PRTF.

11. Clinical Philosophy and EBPs

Respondents should describe how the foundational principles of System of Care, High Fidelity Wraparound, BBI, trauma-informed, whole-person care, and family engagement will be demonstrated throughout all aspects of the proposed PRTF program. The EBPs and evidence-supported interventions to be used must be detailed including a description of how they will be implemented, rationale for selecting them, their effectiveness for desired target population, if any modifications will be needed. If more than one EBP will be used, please indicate how they will be complimentary.

12. Therapeutic Programming

Respondents shall submit a sample weekly schedule of what young persons will experience while in treatment at PRTF ***(Attachment G)***. In the narrative response, please note if in addition to individual, group, milieu, and family therapies; if Respondent will also be providing ancillary services, occupational therapy, recreational therapy, expressive therapies or any other adjunctive or allied behavioral health services. Indicate any type of specialty assessments that will be available to young persons receiving treatment at Respondent's PRTF.

13. Psychiatric and Nursing Services

Respondents should illustrate how psychiatric services will be delivered at the PRTF, detailing which types of services, their frequency and availability, and who will be providing them. Please also discuss the nursing services and staffing protocols.

14. Program Clinical Criteria

Respondents should discuss in detail the admission criteria for their proposed PRTF, and how those align with the chosen EBPs. With the expectation that referrals from Aetna will be prioritized, please explain any exclusionary criteria, and how Respondent plans to minimize declining referrals from Aetna- including the specific reasons why that would occur.

Describe how treatment goals will be determined and Respondent's treatment planning process. Specify how Respondent will assess treatment progress and address when lack thereof. Explain how young persons, their families and CFTs will know when they have been successfully treated at PRTF and can transition back to their homes and communities.

15. Escalated Situations

Illustrate how Respondent will navigate behavior crises at PRTF. Be sure to include aspects of crisis plan development and use of de-escalation techniques. While Aetna strongly encourages providers to be restraint-free, Respondents must detail their processes surrounding occurrences of seclusion and restraint, taking care to describe what should transpire before, during and after the incident. Explain when it would be appropriate to call for police intervention or seek inpatient psychiatric hospitalization, and the hospital with which PRTF will have an agreement. Share insight on steps and strategies Respondent will take to avoid precipitously discharging an OhioRISE young person from the PRTF, as PRTF-initiated discharges that occur prior to successful treatment completion that were not otherwise approved by Aetna will not be permitted.

16. Transitions

Disruptions or transitions of any kind can be unsettling. Their effects can be magnified in people who have experienced trauma. Respondent should describe how young persons will be supported through all the transition points associated with PRTF treatment, such as admission, home visits, and discharge. Provide detail on how Respondent would approach planned and unplanned transitions. Describe the role that the young person's family, natural supports and CFT would play at times of transition. Propose a six-month, post-PRTF model to support youth transitioning from PRTF to home and community settings.

17. Co-occurring Substance Use Treatment

Discuss how Respondent will assess and address substance use issues for young people being served at PRTF. Describe evidence-based approaches that will be used, and Medication Assisted Treatment (MAT) capabilities. Please convey any naloxone- or tobacco- related policies that will be implemented.

18. Physical, Dental and Vision Healthcare

OhioRISE enrollees receiving behavioral health treatment at a PRTF program must continue to have their physical health needs met including appropriate diagnosis and management of physical health conditions and usual screening and preventive interventions including those for vision and dental health. Please discuss how Respondent will achieve this. Also articulate how

acute injuries or illness will be addressed; as well as ensuring young people being served at PRTF can access medical specialty providers if needed. Explain if PRTF will have onsite medical or nursing staff that could perform primary care services. Indicate the level of physical health condition severity that Respondent will be able to address while young person is in PRTF treatment. Respondent should notate here the hospital with which an agreement will be in place to provide urgent/emergent physical health services to young persons receiving treatment at the PRTF.

19. Staffing Requirements

Proposals must include a proposed staffing plan for the PRTF. Responders must describe the staff categories, including the extent to which they have the appropriate training, experience, and credentialing to perform assigned duties- including need for multi-lingual and multi-cultural staff. Brief job descriptions, minimum qualifications and hours per week must be provided for all staff categories. Please do not include resumes.

a. **Staffing Levels.** Please describe the 24-hour staffing ratio for Respondent's PRTF, and the category of staff that is included in those ratio calculations. Explain Respondent's capacity to adapt staffing to the individual needs of the young people being served.

b. **Staff Acquisition and Retention.** Explain recruitment strategies to ensure qualified and diverse personnel. Share plans to retain, promote and professionally develop PRTF staff.

c. **Staff Training and Supervision**. Provide an overview of the staff onboarding process. Describe how staff will receive the required trainings as outlined in the Manual. State how staff will be trained in, and fidelity attained and monitored for chosen EBPs. Explain, as well, the training staff will receive on de-escalation/diffusion techniques, and restraint strategies. Detail Respondent's supervision policies for both unlicensed and licensed staff, and whether this will occur in individual or group format. Indicate how staff will be coached and supported on issues of boundaries, transference, power dynamics and secondary trauma. Respondent should also include how staff will attain skill acquisition in effective family engagement in all aspects of PRTF services.

20. Data and Technology Requirements. Responders must demonstrate sufficient capacity to collect and manage healthcare data.

a. Submit flowcharts and brief narrative descriptions of the Respondent's proposed information systems to meet the requirements outlined in the RFP and Manual.

b. Describe Respondent's current use and support of Electronic Health Records (EHRs). Include how EHR will integrate into administrative and clinical functions such as care coordination, utilization management and supporting population health strategies

c. Explain Respondent's capacity to collect and manage required data regarding admission, discharge, and service provision. Proposals must describe the Respondent's past practice in submitting data to other contracted (or regulatory) entities, and explain how processes will be incorporated for the new PRTF

d. Indicate if PRTF will have bidirectional connection with a Health Information Exchange (HIE).

e. Explain Respondent's telehealth capabilities, and if young persons in treatment at the PRTF would be able to see health providers not physically located at the PRTF.

f. Denote Respondent's videoconferencing capabilities. Will young persons in treatment at the PRTF be able to use this to visit virtually with family, natural supports, or other professionals?

g. **Data Privacy:** If your organization or any proposed subcontractor has, in the past five (5) years suffered any breach or loss of personal, financial, or other data considered private or confidential, please provide a description of such breaches, and provide details on what steps were taken to address the issue, both in the short and long terms to prevent recurrence.

21. **Subcontractors and Delegates**. Respondents must list any subcontractors or delegates to be utilized for implementation of their proposed PRTF, providing agency name and functions/roles/services subcontractors or delegates will provide. Respondent should provide information on how they plan to ensure subcontractors or delegates adhere to all PRTF contract requirements. If there will not be any subcontractors or delegates working with Respondent to provide PRTF services, please note this explicitly ***(Attachment H)***.

22. **Work Plans**
    a. Proposals must include a detailed implementation project plan and timeline ***(Attachment I)***, including the identification of all necessary steps to operationalize the PRTF program target dates, and responsible individuals. Proposals should include a timeline that details the following:
        i. The steps taken and those still needed to obtain, build, or remodel the physical setting/structure for the PRTF,
        ii. Anticipated timeline for achieving all necessary state or federal licensing and certifications,
        iii. Process to hire, orient and train staff;
        iv. An estimated date by which Respondent will be able to serve OhioRISE enrollees in their PRTF.
    b. Proposals should include a Compliance Plan that provides an overview of how the Respondent will ensure adherence to all regulations and requirements pertaining to operating a successful PRTF. This Compliance Plan should include detail on how the Respondent will implement the following compliance-related components: policies

and procedures, oversight and accountability, education and training, reporting, monitoring and auditing, enforcement, and issue resolution ***(Attachment J)***.

c. A Business Continuity Plan must also be submitted. This document should indicate how the Respondent will maintain operations and continue to provide PRTF services to OhioRISE enrollees in the event of an unplanned disruptive incident or disaster. It should identify essential business functions, the systems and processes that must be sustained, potential risks and business impact, response/mitigation strategies, roles and responsibilities, and how communication with occur with all stakeholders including Aetna and OhioRISE enrollees and their families ***(Attachment K)***.

23. Professional Responsibility *(Attachment L)*

Professional responsibility information includes information concerning any complaints filed with or by professional, state and/or federal licensing/regulatory organizations within the past five (5) years against Respondent's organization or employees relating to the provision of services. If such complaints exist, please indicate the date of the complaint(s), the nature of the complaint(s), and the resolution/status of the complaint(s); including any disciplinary actions taken.

Proposals should also include information about litigation, pending and/or resolved within the past two (2) years, that relates to the provision of services by Respondent's organization and/or its employees. If such litigation exists, please include the date of the lawsuit, nature of the lawsuit, the dollar amount being requested as damages, and if resolved, the nature of the resolution (e.g., settled, dismissed, withdrawn by plaintiff, verdict for plaintiff with amount in damages awarded, verdict for Respondent, etc.)

Respondent may submit information which demonstrates recognition of their professional responsibility, including accreditations, certifications, and/or professional memberships.

This information collected from these inquiries will be used in Aetna's decision. It may be shared with other vested stakeholders including the Ohio Department of Medicaid (ODM), the Ohio Department of Mental Health and Addiction Services (OhioMHAS), the Ohio Department of Developmental Disabilities (DODD), and the Ohio Department of Health (ODH). Aetna reserves the right to request any additional information to assure itself of a Respondent's professional status.

24. Fiscal Viability

Please note that Aetna requires that the financial stability of all potential business partners be thoroughly vetted. All financial statements and disclosures will be held in strict confidentiality and within the parameters of this RFP only. *Failure to submit financial statements and disclosures will require an explanation and will be a factor in the final decision-making process.*

a. **Financial Summary:** Respondents must provide high-level information on the past three (3) years of cash flow ***(Appendix 3/Attachment M)***.

b. A copy of the most recent audited or compiled financial statement is requested. If this is not available, provide instead a copy of Respondent's Year End 2022 Income Statement and Balance Sheet ***(Attachment N).***
c. In addition, please include an anticipated budget for the PRTF program, including start-up and ongoing projected requirements ***(Attachment O).***

PROPOSAL EVALUATION AND SELECTION

5.1 Evaluation Committee

Proposals submitted to Aetna for this solicitation will be reviewed by an Evaluation Committee comprised of individuals with the appropriate programmatic, clinical, technical and other subject matter expertise.

Additional Aetna staff may also assist in the evaluation process. This assistance could include but is not limited to the initial mandatory requirements review, contacting of references, or answering technical questions from evaluators.

Aetna may seek reviews from end users of the work, recommendation of subject matter experts, or those with an interest in the work. Aetna may adopt or reject any recommendations it receives from such reviews and give them such weight as Aetna believes is appropriate.

Proposals found to be responsive (that is, complying with all instructions and requirements described herein) will be reviewed, rated and scored. Proposals that fail to comply with all instructions will be rejected without further consideration. Attempts of any Respondent (or representative of any Respondent) to contact or influence any member of the Evaluation Committee may result in disqualification of the Respondent.

5.2 Minimum Submission Requirements

All Proposals must comply with the requirements specific in this RFP. To be eligible for evaluation, Proposals must (1) be received on or before the due date and time; (2) meet the Proposal Format requirements; (3) follow the required Proposal Outline; and (4) be complete. Proposals that fail to follow instructions or satisfy these minimum submission requirements will not be reviewed further.

5.3 Evaluation Methodology

Aetna intends to conduct a comprehensive, fair, and impartial evaluation of Proposals received in response to this RFP. All responsive Proposals received by the deadline will be evaluated by Aetna. During the evaluation process, all information concerning the submitted Proposals will remain non-public and will not be disclosed to anyone whose official duties do not require such knowledge.

At any time during the evaluation process, Aetna may contact Respondents to (1) provide clarification of their Proposal, or (2) obtain the opportunity to interview the proposed key personnel. Reference checks may also be made at this time. Please note there is no guarantee that Aetna will look for information or clarification outside of the submitted written Proposal. Therefore, it is important that the Respondent ensures all sections of the Proposal have been completed to avoid the possibility of having their score reduced for lack of information.

The evaluation committee will review the components of submitted Proposal. Each section will be evaluated on the Respondent's understanding of RFP and Manual requirements, quality and completeness of response, and their approach and solutions.

The evaluation committee will review the scoring in making its recommendations of the successful Respondent(s).

Aetna may submit a list of detailed comments, questions, and concerns to one or more Respondents after initial evaluation. Aetna will only use written responses for evaluation purposes. The total scores for those Respondents selected to submit additional information may be revised as a result of the new information received.

The evaluation team will make its recommendation based on the above-described evaluation process.

5.4 Scoring Framework

Category	*Weighted Percentage*
Organizational Profile	13%
Programming and Services	42%
Staffing Requirements	13%
Facilities and Security	15%
Program Integrity	11%
Solution Design	6%

Aetna is seeking to craft a network of PRTF programs that can address the full spectrum of needs of OhioRISE enrollees. In addition to pursuing statewide availability, particular consideration will be given to Respondents with intent of serving:

- Children (latency age) and young adults,

- Niche clinical subpopulations such as problem eating behaviors and problem sexual behaviors,
- Co-occurring substance use, physical health conditions, and
- Young persons with cognitive delays and other developmental disabilities.

5.5 Respondent Notice

If a Respondent is chosen, Aetna will notify the successful Respondent(s) in writing of their selection and Aetna's desire to enter into contract with them to provide PRTF services to OhioRISE enrollees. Aetna may, as a courtesy, notify Respondent(s) not selected through this RFP. In the event that Aetna is not able to fully execute a contract for OhioRISE PRTF services with an originally selected Respondent(s) of this RFP, Aetna may proceed with the next highest scorer.

CONTRACT TERMS AND CONDITIONS

6.1 Term of Contract

OhioRISE PRTF providers will be subject to Aetna's standard Provider Agreement ***(Appendix 3)*** with State Compliance Addendum ***(Appendix 4)***, and the Psychiatric Residential Treatment Facility Contracting Components ***(Appendix 5)***.

The ODM PRTF Rate Report can be found HERE. These rates were developed to support the requirements detailed in the Manual and this RFP. Selected Respondents seeking rates greater than one hundred percent (100%) of those published by ODM will have to explicitly substantiate their outlier status before their contract with Aetna can be executed. There will be the availability to leverage member-specific Single Case Agreements (SCAs) to support meeting the individualized treatment needs of OhioRISE enrollees in special circumstances.

6.2 Value-Based Agreements

Aetna intends to deploy Value-Based Contracts (VBCs) with OhioRISE PRTFs. As this is a new service and provider type to the Aetna OhioRISE network, the first twelve (12) to eighteen (18) months will be instructive in gathering baseline data, upon which to build incentive framework. Possible target outcomes could include reduction/elimination of seclusions and restraints, lowering of PRTF readmission/hospitalization rates, or significant reduction in number of

placements post PRTF discharge. Respondents are encouraged to suggest potential VBC parameters.

GENERAL RULES GOVERNING PROPOSAL SUBMISSION

7.1 Revisions to RFP

Aetna reserves the right to change, modify or revise the RFP at any time. Any revision to this RFP will be posted to Aetna's PRTF RFP website PRTF | OhioRISE – Aetna Better Health, along with the original RFP solicitation. Respondents should regularly check the website to determine whether additional information has been released.

7.2 Proposal Binding

By signing and submitting its Proposal, each Respondent agrees that the contents of its Proposal are available for establishment of final contractual obligations for a minimum of 180 calendar days from the proposal deadline for this RFP. A Respondent's refusal to enter into a contract which reflects the terms and conditions of this RFP or the Respondent's Proposal, may in the sole discretion of Aetna, result in rejection of Respondent's Proposal.

7.3 Reservation of Rights

1. Aetna may:

   A. Disqualify any Respondent whose conduct or Proposal fails to confirm to the requirements of this RFP;
   B. Have unlimited rights to duplicate all materials submitted for purposes of RFP evaluation;
   C. Consider a late modification of a Proposal if the Proposal itself was submitted on time and if the modifications were requested by Aetna through a written request for clarification;
   D. Negotiate as to any aspect of the Proposal with any Respondent and negotiate with more than one Respondent at the same time, including asking for Respondents' "Best and Final" offers.

2. The award decisions made by Aetna as a result of this RFP are final and are not subject to appeal.

7.4 Confidentiality

Respondents shall treat information obtained from Aetna that is not generally available to the public as confidential and/or proprietary to Aetna. Respondents shall exercise all reasonable precautions to prevent any information derived from such sources from being disclosed to any other person or entity. Respondents agree to indemnify and hold harmless Aetna, its officials and employees, from and against all liability, demands, claims, suits, losses, damages, causes of action, fines and judgements (including attorney fees) resulting from any use or disclosure of such confidential and/or proprietary information by the Respondent, or by any person acquiring such information directly or indirectly from the Respondent.

7.5 Incurring Costs

Aetna is not liable for any costs incurred by Respondents for work performed in preparation of a Proposal or response to this RFP.

7.6 Prime Contractor Responsibility

The selected Respondent(s) from this RFP will be required to assume responsibility for all services described in their Proposals whether or not they provide the services directly. Aetna will consider the selected Respondent as the sole point of contact with regard to contractual matters.

7.7 Disclosure of Proposal Contents

Information provided within Proposals will be held in confidence and will not be revealed or discussed with competitors. All material submitted as part of the RFP process becomes the property of Aetna and will only be returned at Aetna's option. Proposals submitted to Aetna may be reviewed and evaluated by any person other than competing Respondents. Aetna retains the right to use any/all ideas presented in any reply to this RFP. Selection or rejection of a Proposal does not affect this right.

7.8 Life of Proposals

Aetna expects to select the successful Respondent(s) as a result of this RFP within approximately 75 days of the submission deadline. However, Proposals that are submitted may be considered for selection up to 180 days following the submission deadline of this RFP. By submission of a Proposal, Respondents agree to hold the terms of their Proposals open to Aetna for up to 180 days following the submission deadline.

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APPENDIX 1: PROPOSAL OUTLINE

A. Cover Sheet
B. Table of Contents
C. Executive Summary
D. Main Proposal
    1. Organizational Profile
    2. Facility Description
    3. Safety
    4. Target Population
    5. Youth and Family Centered Care
    6. Engagement with OhioRISE Care Coordinators, Care Management Entities, and other Care Coordination Agencies
    7. Stakeholder Engagement
    8. Diversity, Equity, Inclusion and Cultural Competency
    9. Education and Employment
    10. Quality Improvement and Assurance
    11. Clinical Philosophy and EBPs
    12. Therapeutic Programming
    13. Psychiatric and Nursing Services
    14. Program Clinical Criteria
    15. Escalated Situations
    16. Transitions
    17. Co-occurring Substance Use Treatment
    18. Physical, Dental and Vision Healthcare
    19. Staffing Requirements
    20. Data and Technology Requirements

E. Attachments

- Attachment A: Ohio Business License
- Attachment B: Board of Directors
- Attachment C: Organizational Structure
- Attachment D: Proof of Licensing or Credentialing as a Residential Facility
- Attachment E: References
- Attachment F: PRTF Facility Schematic
- Attachment G: Sample Weekly PRTF Schedule
- Attachment H: List of Subcontractors or Delegates
- Attachment I: Project Plan and Timeline
- Attachment J: Compliance Plan
- Attachment K: Business Continuity Plan
- Attachment L: Professional Responsibility

- Attachment M/Appendix 3: Financial Summary
- Attachment N: Financial Statement
- Attachment O: Proposed Budget

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APPENDIX 2: COVER SHEET

REQUEST FOR PROPOSAL

Ohio-Certified Psychiatric Residential Treatment Facility (PRTF)

Aetna Better Health® of Ohio, OhioRISE

Proposal Cover Sheet

Responder /Agency Name: Click or tap here to enter text.

Address: Click or tap here to enter text.

Agency Contact and Title: Click or tap here to enter text.

Email: Click or tap here to enter text. Phone Number: Click or tap here to enter text.

Proposed PRTF Program Address:

Click or tap here to enter text.

I certify that to the best of my knowledge and belief, the information contained in this Proposal is true and correct. I am a duly authorized signatory for the Responder and can confirm compliance with all applicable state and federal laws and regulations. I therefore attest to understanding that if awarded a contract to provide PRTF services as a result of this Proposal, the Responder will adhere to all future versions of the PRTF Program Manual and related Ohio Administrative Code Rules pertaining to PRTF.

_____ Date: Click or tap here to enter text.

Signature of Authorizing Official

Name and Title: Click or tap here to enter text.

Click or tap here to enter text.

(Printed Name and Title)

APPENDIX 3: FINANCIAL SUMMARY (ATTACHMENT M)

Respondent Name: Click or tap here to enter text.

Will the PRTF be a new corporate entity or part of an existing entity? Click or tap here to enter text.

Name the parent entity if not the same as the Respondent: Click or tap here to enter text.

Abbreviated Income Statement and Balance Sheet (as of December 31):

	2020	*2021*	*2022*
Annual Total Revenue			
Net Income before Taxes			
Cash			
Accounts Receivable			
All other Assets			
Total Assets			
Total Liabilities			
Shareholder Equity			
Total Liabilities and Equity			
Net Cash Flow from Operations			

If you do not have this information, please explain why, and the measures you will put in place to assure your financial stability in providing PRTF services to OhioRISE enrollees: Click or tap here to enter text.

APPENDIX 4: PROVIDER AGREEMENT

PROVIDER AGREEMENT

AETNA HEALTH INC. D/B/A AETNA BETTER HEALTH OF OHIO, on behalf of itself and its Affiliates ("Company"), and **[INSERT PROVIDER NAME],** on behalf of itself and any and all of its Group Providers and locations ("Provider"), are entering into this Provider Agreement (the "Agreement") as of the Effective Date listed below.

The Agreement includes this cover/signature page and the **General Terms and Conditions** and **Definitions** that follow, and the **Medicaid Product Addendum**. It also includes and incorporates one or more of the following parts: **Service and Rate Schedule(s)**, **State Compliance Addendum(a)**, other **Product Addendum(a)**, or other attachments or addenda.

PRODUCT CATEGORIES:
As of the Effective Date, Provider agrees to participate in each Product Category checked below. Important information on how Product Categories can be added to or deleted from this list is contained in the Agreement.

✓ **Medicaid Products (as defined in the Agreement)**

EFFECTIVE DATE: [DATE] (or later date that credentialing is complete) (the "Effective Date")

TERM: This Agreement begins on the Effective Date, continues for an initial term of one (1) year, and then automatically renews for consecutive one (1) year terms. The Agreement may be terminated by either Party at any time after the initial term or non-renewed at the end of the initial or any subsequent term, for any reason or no reason at all, with at least one hundred and twenty (120) days' advance written notice to the other Party. Additional termination provisions are included in the Agreement.

The undersigned representative of Provider has read and understood this Agreement, has had the opportunity to review it with an attorney of Provider's choice, and is authorized to bind Provider, including all Group Providers and Provider locations, to the terms of the Agreement.

PROVIDER

By:_____

Printed Name:_____

Title:_____

COMPANY

By:_____

Printed Name:_____

Title:_____

FEDERAL TAX I.D. NUMBER:_____

NPI NUMBER:_____

As required by Section 8.6 ("Notices") of this Agreement, notices shall be sent to the following addresses:

Provider:

_____

_____

_____

Company:

Aetna Health Inc. d/b/a Aetna Better Health of Ohio

7400 W Campus Rd., New Albany OH 43054

ATTN: Plan Chief Executive Officer

GENERAL TERMS AND CONDITIONS

1.0 PROVIDER OBLIGATIONS

1.1 General Obligations. Provider agrees that it and all Group Providers will:

(a) provide Covered Services to Members according to generally accepted standards of care in the applicable geographic area and within the scope of its/their licenses and authorizations to practice;

(b) obtain and maintain all applicable license(s), certification(s), registration(s), authorization(s) and accreditation(s) required by Applicable Law;

(c) comply with all Applicable Law related to this Agreement and the provision of and payment for health care services; Provider represents that neither it nor any Group Provider has been excluded from participation in any Federal or state funded health program, or has a report filed in the National Practitioner Data Bank (NPDB);

(d) comply with Company's credentialing/recredentialing requirements and applicable Participation Criteria; Provider understands that no Group Provider may serve as a Participating Provider until that provider is fully credentialed and approved by the applicable peer review committee;

(e) require all Group Providers in all Provider locations, to provide Covered Services to Members in compliance with the terms of this Agreement; any exceptions must be approved in advance, in writing, by Company;

(f) obtain from Members any necessary consents or authorizations to the release of their medical information and records to governmental entities, Company and Payers, and their agents and representatives;

(g) obtain signed assignments of benefits from all Members authorizing payment for Provider's services to be made directly to Provider instead of to the Member, unless Company specifically directs otherwise or the applicable Plan requires otherwise;

(h) treat all Members with the same degree of care and skill as they treat patients who are not Members; Provider further agrees not to discriminate against Members in violation of Applicable Law or Company Policies;

(i) maintain an ongoing internal quality assurance/assessment program that includes, but is not limited to, the supervision, monitoring and oversight of its employees and contractors providing services under this Agreement;

(j) cooperate promptly, during and after the term of this Agreement, with reasonable and lawful requests from Company and Payers for information and records related to this Agreement, as well as with all requests from governmental and/or accreditation agencies. Among other things, Provider agrees to provide Company and Payers with the information and records necessary for them to properly administer claims and the applicable Plan; resolve Member grievances, complaints and appeals; comply with reporting requirements related to the Affordable Care Act (ACA) (including, but not limited to, information related to the ACA's medical loss ratio requirements); perform quality management activities; and fulfill data collection and reporting requirements (e.g., HEDIS);

(k) not provide or accept any kickbacks or payments based on the number or value of referrals in violation of Applicable Law. Unless disclosed in advance to Company and the affected Member, Provider will not accept any referral from persons or entities that have a financial interest in Provider, or make any referrals to persons or entities in which Provider has a financial interest;

(l) refer Members only to other Participating Providers (including, but not limited to pharmaceutical providers and vendors), unless specifically authorized otherwise by Company and/or permitted by the applicable Plan and Company Policies;

(m) unless prohibited by Applicable Law or a violation of a specific peer review privilege, notify Company promptly about any: (i) material litigation brought against Provider or a Group Provider that is related to the provision of health care services to Members and/or that could reasonably have a material impact on the services that Provider renders to Members; (ii) claims against Provider or a Group Provider by governmental agencies including, but not limited to, any claims regarding fraud, abuse, self-referral, false claims, or kickbacks; (iii) change in the ownership

or management of Provider; and (iv) material change in services provided by Provider or any loss, suspension or restriction of licensure, accreditation, registration or certification status of Provider or a Group Provider related to those services.

(n) The provider will report to Aetna immediately, but no later than one business day after discovering any critical incidents defined in paragraphs (E)(1) through (E)(5) of rule 5160-44-05 of the Administrative Code, as well as all deaths for a youth enrolled on the OhioRISE program. Additionally, upon discovering the incident, the provider will take immediate action to ensure the health and welfare of the individual.

1.1 **Provider and Group Provider Contact and Service Information**. Provider agrees that it has provided Company with contact information, including, but not limited to, a list of Group Providers and Provider locations, that is complete and accurate as of the Effective Date. Provider will notify Company within ten (10) business days of all changes to the list of Group Providers, the services it/they provide and all contact and billing information for Provider and Group Providers. Provider understands that failure to keep all such information current and to periodically confirm its accuracy as reasonably requested by Company, will be a material breach of this Agreement. Company's additional requirements for updating information and the actions it may take if Provider fails to confirm its information are outlined in the Provider Manual and/or related Policies made available to Provider.

1.2 **Compliance with Company Policies**. Provider agrees to comply with Company Policies, including, but not limited, those contained in the Provider Manual, as modified by Company from time to time. If a change in a Company Policy would materially and adversely affect Provider's administration or rates under this Agreement, Company will send Provider at least ninety (90) days advance written notice of the Policy change. Provider understands that Policy changes will automatically take effect on the date specified, unless an earlier date is required by Applicable Law. Provider is encouraged to contact Company to discuss any questions or concerns with Company Policies or Policy changes.

1.3 **Claims Submission and Payment**. Subject to Applicable Law, Provider agrees:

(a) to accept the rates contained in the applicable Service and Rate Schedule(s), regardless of where services are provided, as payment in full for Covered Services (including for services that would be Covered Services but for the Member's exhaustion of benefits (e.g., above the annual maximum));

(b) that it is responsible for and will promptly pay all Group Providers for services rendered, and that it will require all Group Providers to look solely to Provider for payment;

(c) to submit complete, clean, electronic claims for Covered Services provided by Provider and Group Providers, containing all information needed to process the claims, within three hundred sixty five days of the date of service or discharge, as applicable, or from the date of receipt of the primary payer's explanation of benefits if Company or Payer is the secondary payer. This requirement will be waived if Provider provides notice to Company, along with appropriate evidence, of extraordinary circumstances outside of Provider's control that resulted in a delayed submission;

(d) to respond within forty-five (45) days to Company or Payer requests for additional information regarding submitted claims;

(e) to notify Company of any underpayment or payment/claim denial dispute within no later than 12 months from the date of service or 60 calendar days after the payment, denial, or partial denial of a timely claim submission, whichever is later and to follow Company's dispute and appeal Policies for resolution;

(f) to notify Company promptly after becoming aware of any overpayment (e.g., a duplicate payment or payment for services rendered to a patient who was not a Member) and to cooperate with Company for the prompt return of any overpayment. In the event of Provider's failure to cooperate with this section, Company shall have the right to offset any overpaid amount against future claims;

(g) that Company and Payers will not be obligated to pay for claims not submitted, completed or disputed/appealed as required above, or that are billed in violation of Applicable Law, this Agreement or Company Policies, and that Members may not be billed for any such claims;

(h) in the event that Provider acquires or takes operational responsibility for another Participating Provider, the then current agreement between Company and such Participating Provider will remain in place and apply to Covered Services provided by such Participating Provider for the longer of: (i) one (1) year; or (ii) the expiration of the then current term of such agreement. Notwithstanding the foregoing, Company may notify Provider with at least sixty (60) days' prior written notice that the terms of this Agreement shall sooner apply to such Participating Provider.

(i) Company and the Ohio Department of Medicaid (ODM)have the right to audit or review its paid claim, and recover any identified overpayments as allowed under ODM's Ohio Resilience Through Integrated and Excellence (OhioRISE) Plan Provider Agreement with the company and Ohio Revised Code (ORC) 5164.57.

1.4 **Member Billing**. Provider agrees that Members will not be billed or charged any amount for Covered Services. If services are not reimbursed because of Provider's failure to comply with its obligations under this Agreement (e.g., for late submission of claims), Members may not be billed for those services. A Member may be billed for services that are not Covered Services under the Member's Plan (including for services that are not considered "medically necessary" under a Plan) as long as the Member is informed that those services are not covered and has agreed, in advance, to pay for the services. This section will survive the termination of this Agreement.

2.0 COMPANY OBLIGATIONS

2.1 **General Obligations**. Company agrees that:

unless an exception is stated in the applicable **Product Addendum**, Company or Payers will: (i) provide Members with a means to identify themselves to Provider; (ii) provide Provider with an explanation of provider payments, a general description of products and a listing of Participating Providers; (iii) provide Provider with a means to check Member eligibility; and (iv) include Provider in the Participating Provider directory(ies) for the applicable Plans;

(a) it, through its applicable Affiliate(s), will be appropriately licensed, where required, to offer, issue and/or administer Plans in the service areas covered by this Agreement;

(b) it is, and will remain throughout the term of this Agreement, in material compliance with Applicable Law related to its performance of its obligations under this Agreement;

(c) it will notify Provider of periodic updates to its Policies as required by this Agreement and make current Policies available to Providers through its provider websites or other commonly accepted media.

2.2 **Claims Payment**. Subject to Applicable Law, the terms of each applicable **Product Addendum(a) and Service and Rate Schedule(s)**, and Company's payment and review Policies (e.g., prepayment review of certain claims), andCompany agrees:

(a) when it is the Payer, to pay Provider for Covered Services rendered to Members; and

(b) when it is not the Payer, to notify the Payer to forward payment to Provider for Covered Services,

within twenty-one (21) days of receipt of a clean, complete, undisputed ~~electronic~~ claim. While Company may service or process payment for claims on behalf of Payers who are not Affiliates (e.g., self-funded plan sponsors), Provider acknowledges that Company has no legal or other responsibility for the payment of those claims. However, Company will use commercially reasonable efforts to assist Provider, as appropriate, in collecting payments from Payers.

The Company will notify providers who have submitted claims of claim status (paid, denied, and suspended/ held) within 30 calendar days of receipt.

3.0 NETWORK PARTICIPATION

Provider agrees that it and Group Providers will participate in the Product Categories checked on the signature sheet to this Agreement. Company has the right, upon ninety (90) days written notice to Provider, to:

(a) add Product Categories (e.g., Medicare or a new Product Category not existing as of the Effective Date); and
(b) add types of Plans (e.g., PPO, HMO) and/or specialty programs (e.g., disease management or women's health) in any Product Category.

Company will notify Provider of the rates that will apply for any addition and will, as necessary, send Provider a new or revised **Product Addendum** and **Service and Rate Schedule**.

Provider can decline any addition by notifying Company in writing, within thirty (30) days of receiving Company's notice. A variation of an existing Product Category, Plan type or specialty program at existing terms and rates will not be considered "an addition" under this section.

Company is not required to designate, include, or continue to include Provider, any specific Group Provider(s) or any specific Provider location(s) as a preferred provider or Participating Provider in any specific Product Category, Plan (or Plan variation), product, specialty program or geographic area. Company may operate networks in which Provider is not included, whether for specific Payers/customers or otherwise. In certain situations, Provider may treat a Member of a Plan or Product Category in which Provider does not participate (e.g., a Member traveling out of area, emergency services). In those situations, Company may apply rates and terms (e.g., no balance billing) that Provider has accepted under this Agreement for Covered Services provided to those Members. Not all Product Categories and Plan types are available in all geographic locations.

4.0 CONFIDENTIALITY

Company and Provider agree that Provider's medical records do not belong to Company. Company and Provider agree that the information contained in the claims Provider submits under this Agreement belongs to Company and/or the applicable Payer and may be used by Company and/or the applicable Payer for quality management, plan administration and other lawful purposes. Each Party will maintain and use confidential Member information and records in accordance with Applicable Law. Each Party agrees that the confidential and proprietary information of the other Party is the exclusive property of that other Party and, unless publicly available, each Party agrees to keep the confidential and proprietary information of the other Party strictly confidential and not to disclose it to any third party without the other Party's consent, except: (a) to governmental authorities having jurisdiction; (b) in the case of Company's disclosure, to Members, Payers, prospective or current customers, or consultants or vendors under contract with Company; and (c) in the case of Provider's/Group Providers' disclosure, to Members for the purpose of advising a Member of potential treatment options and costs. Except as otherwise required by Applicable Law, Provider will keep the rates and the development of rates and other terms of this Agreement confidential. However, Provider is encouraged to discuss Company's provider payment methodology with patients, including descriptions of the methodology

under which the Provider is paid. In addition, Provider and Group Providers are encouraged to communicate with patients about their treatment options, regardless of benefit coverage limitations. This section will survive the termination of this Agreement.

5.0 ADDITIONAL TERMINATION/SUSPENSION RIGHTS AND OBLIGATIONS

5.1 **Termination of Individual Group Providers**. Company may terminate the participation of one or more individual Group Providers or locations by providing Group with at least ninety (90) days written notice prior to the date of termination.

5.2 **Termination for Breach**. This Agreement may be terminated at any time by either Party upon at least sixty (60) days prior written notice of such termination to the other Party, upon such other Party's material breach of its obligations under this Agreement, unless such material breach is cured within sixty (60) days of the notice of termination.

5.3 **Immediate Termination or Suspension**. Company may terminate or suspend this Agreement with respect to Provider or any Group Provider or location, with written notice to Provider, due to: (a) Provider's or the applicable Group Provider's failure to continue to meet the licensure and other requirements of the applicable Participation Criteria; (b) bankruptcy or receivership or an assignment by Provider for the benefit of creditors; (c) Provider's or the applicable Group Provider's indictment, arrest or conviction of a felony; or for any indictment, arrest or conviction of criminal charge related to fraud or in any way impairing Provider's or a Group Provider's practice of medicine; (d) the exclusion, debarment or suspension of Provider or a Group Provider from participation in any governmental sponsored program, including, but not limited to, Medicare or Medicaid; (e) change of control of Provider to an entity not acceptable to Company; (f) any false statement or material omission of Provider or a Group Provider in a network participation application and/or related materials; or (g) a determination by Company that Provider's continued participation in provider networks could reasonably result in harm to Members. To protect the interests of patients, including Members, Provider will provide immediate notice to Company of any of the events described in (a)-(f) above. Provider may terminate this Agreement, with written notice to Company due to: (x) Company's failure to continue to maintain the licensure and authorizations required for it to meet its obligations under this Agreement; or (y) Company's bankruptcy or receivership, or an assignment by Company for the benefit of creditors.

5.4 **Obligations Following Termination**. Upon termination of this Agreement for any reason, Provider agrees to provide services, at Company's discretion, to: (a) any Member under Provider's care who, at the time of the effective date of termination, is a registered bed patient at a hospital or facility, until such Member's discharge or Company's orderly transition of such Member's care to another provider; and (b) in any other situation required by Applicable Law. The applicable **Service and Rate Schedule** will apply to all services provided under this section. Upon notice of termination of this Agreement or of participation in a Plan, Provider will cooperate with Company to transfer Members to other providers. Company may provide advance notice of the termination to Members.

5.5 **Obligations During Dispute Resolution Procedures**. In the event of any dispute between the Parties in which a party has provided notice of termination for breach under Section 5.2 above, and the dispute is required to be resolved or is submitted for resolution under Section 7.0 below, the termination of this Agreement shall cease and the Parties shall continue to perform under the terms of this Agreement until the final resolution of the dispute.

6.0 RELATIONSHIP OF THE PARTIES

6.1 **Independent Contractor Status/Indemnification**. Company and Provider are independent contractors, and not employees, agents or representatives of each other. Company and Provider will each be solely liable for its own activities and those of its employees and agents, and neither Company nor Provider will be liable in any way for the activities of the other Party or the other Party's employees or agents. Provider acknowledges that all Member care and related decisions are the responsibility of Provider and/or Group Providers and that Policies do not dictate or control Provider's and/or Group Providers' clinical decisions with respect to the care of Members. Provider agrees to indemnify and hold harmless Company from any and all third party claims, liabilities and causes of action (including, but not limited to, reasonable attorneys' fees) arising out of Provider's and/or Group Providers' provision of care to Members. Company agrees to indemnify and hold harmless Provider and Group Providers from any and all third party claims, liabilities and causes of action (including, but not limited to, reasonable attorneys' fees) arising out of the Company's administration of Plans. This provision will survive the termination of this Agreement.

6.2 **Use of Name**. Provider agrees that its name and other identifying and descriptive material can be used in provider directories and in other materials and marketing literature of Company and Payers, including, but not limited to, in customer bids, requests for proposals, state license applications and/or other submissions. Provider will not use Company's or its Affiliates' or a Payer's names, logos, trademarks or service marks without Company's and/or the applicable Payer's prior written consent.

6.3 Interference with Contractual Relations. Provider will not engage in activities that would cause Company to lose existing or potential Members, including but not limited to, advising Company customers, Payers or other entities currently under contract with Company to cancel, or not renew their contracts. Except as required under this Agreement or by a governmental authority or court of competent jurisdiction, Provider will not use or disclose to any third party, membership lists acquired during the term of this Agreement including, but not limited to, for the purpose of soliciting individuals who were or are Members or otherwise to compete with Company. Nothing in this section is intended or will be deemed to restrict: (a) any communication between Provider and a Member, or a party designated by a Member, that is determined by Provider to be necessary or appropriate for the diagnosis and care of the Member; or (b) notification of participation status with other insurers or plans. This section will survive the termination of this Agreement for a period of one (1) year following termination or expiration.

7.0 DISPUTE RESOLUTION

7.1 Dispute Resolution. Company will provide an internal mechanism under which Provider can raise issues, concerns, controversies or claims regarding the obligations of the Parties under this Agreement. Provider will exhaust Company's internal mechanism before instituting any arbitration or other permitted legal proceeding. The Parties agree that any discussions and negotiations held during this process will be treated as settlement negotiations and will be inadmissible into evidence in any court proceeding, except to prove the existence of a binding settlement agreement.

7.2 **Arbitration**. Any controversy or claim arising out of or relating to this Agreement, including breach, termination, or validity of the Agreement, except for injunctive relief or any other form of equitable relief, will be settled by confidential, binding arbitration, in accordance with the Commercial Rules of the American Arbitration Association (AAA). **COMPANY AND PROVIDER UNDERSTAND AND AGREE THAT, BY AGREEING TO THIS ARBITRATION PROVISION, EACH MAY BRING CLAIMS AGAINST THE OTHER ONLY IN THEIR INDIVIDUAL CAPACITY, AND NOT AS A PLAINTIFF OR CLASS MEMBER IN ANY PURPORTED CLASS OR REPRESENTATIVE PROCEEDING FOR ANY DISPUTE ARISING OUT OF OR RELATING TO THIS AGREEMENT.** The arbitrator may award only compensatory damages for breach of contract, and is not empowered to award punitive, exemplary or extra-contractual damages. Where a Party's claim is for greater than Ten

Million Dollars ($10,000,000), a panel of three (3) arbitrators (one chosen by each Party and the third to be a former Federal district court judge agreed upon by the Parties) will preside over the matter, unless the Parties agree otherwise. If a Party's claim is for less than Ten Million Dollars ($10,000,000), a single (1) arbitrator will preside over the matter, unless the Parties agree otherwise. The arbitrator(s) are bound by the terms of this arbitration provision. In the event a Party believes there is a clear error of law and within thirty (30) days of receipt of an award of $250,000 or more (which shall not be binding if an appeal is taken), a Party may notify the AAA of its intention to appeal the award to a second arbitrator (the "Appeal Arbitrator"), designated in the same manner as the original, except that the Appeal Arbitrator must have at least twenty (20) years' experience in the active practice of law or as a judge. The award, as confirmed, modified or replaced by the Appeal Arbitrator, shall be final and binding, and judgment thereon may be entered by any court having jurisdiction thereof. No other arbitration appeals may be made. Except as may be required by law or to the extent necessary in connection with a judicial challenge, permitted appeal, or enforcement of an award, neither a Party nor an arbitrator may disclose the existence, content, record, status or results of dispute resolution discussions or an arbitration. Any information, document, or record (in whatever form preserved) referring to, discussing, or otherwise related to dispute resolution discussions or arbitration, or reflecting the existence, content, record, status, or results of dispute resolution discussions or arbitration is confidential. The Parties are entitled to take discovery consistent with the Federal Rules of Civil Procedure (including, but not limited to, document requests, expert witness reports, interrogatories, requests for admission and depositions). This section will survive the termination of this Agreement.

8.0 MISCELLANEOUS

8.1 **Entire Agreement**. This Agreement and any addenda, schedules, exhibits or appendices to it constitutes the entire understanding of the Parties and supersedes any prior agreements related to the subject matter of this Agreement. If there is a conflict between the **General Terms and Conditions** and a **Product Addendum** or **Service and Rate Schedule**, the terms of the applicable **Product Addendum** and corresponding **Service and Rate Schedule** will prevail for that Product Category. If there is a conflict between an applicable **State Compliance Addendum** and any other part of the Agreement, the terms of the **State Compliance Addendum** will prevail, but only with respect to the particular line of business (e.g., fully insured HMO) or Product Category.

8.2 Waiver**/Governing Law/Severability/No Third Party Beneficiaries/Headings**. The waiver by either Party of a breach or violation of any provision of this Agreement will not operate as or be construed to be a waiver of any subsequent breach of this Agreement. Except as otherwise required by Applicable Law, this Agreement will be governed in all respects by the laws of the state where Provider is located, without regard to such state's choice of law provisions. Any determination that any provision of this Agreement or any application of it is invalid, illegal or unenforceable in any respect in any instance will not affect the validity, legality and enforceability of such provision in any other instance, or the validity, legality or enforceability of any other provision of this Agreement. Other than as expressly set forth in this Agreement, no third persons or entities are intended to be or are third party beneficiaries of or under the Agreement, including, but not limited to, Members. Headings in the Agreement are for convenience only and do not affect the meaning of the Agreement.

8.3 **Limitation of Liability**. A Party's liability, if any, for damages to the other Party related to this Agreement, will be limited to the damaged Party's actual damages. Neither Party will be liable to the other for any indirect, incidental, punitive, exemplary, special or consequential damages of any kind. This section will survive the termination of this Agreement.

8.4 **Assignment**. Provider may not assign this Agreement without Company's prior written consent. Company may assign this Agreement, in whole or in part, from time to time. To support a partial assignment, Company may duplicate this Agreement, including one or more of the relevant **Product Addenda** and **Service and Rate Schedules**, and assign the duplicate while retaining all or part of the original. If Company sells all or a portion of a Product Category in which Provider participates (e.g., a line of business), Company may also create and assign to the purchaser a duplicate of this Agreement including the relevant **Product Addenda** and **Service and Rate Schedules**. If Company assigns this Agreement to any entity other than an Affiliate, Company will provide advance written notice to Provider.

8.5 **Amendments**. This Agreement will be deemed to be automatically amended to conform with all Applicable Law promulgated at any time by any state or Federal regulatory agency or governmental authority. Additionally, Company may amend this Agreement, upon at least ninety (90) days prior written notice to Provider. If Provider is not willing to accept an Amendment that is not required by Applicable Law, it may terminate the Agreement, with at least sixty (60) days written notice to Company in advance of the effective date of the Amendment.

8.6 **Notices**. Notices required to terminate or non-renew the Agreement or to decline participation in a new Product Category or Plan/program, must be sent by U.S. mail or nationally recognized courier, return receipt requested, to the applicable Party's most currently updated address. Any other notices required under this Agreement may be sent by letter, electronic mail or other generally accepted media, to the applicable Party's last updated address.

8.7 **Non-Exclusivity**. This Agreement is not exclusive, and does not preclude either Party from contracting with any other person or entity for any purpose.

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DEFINITIONS

Affiliate. Any corporation, partnership or other legal entity that is directly or indirectly owned or controlled by, or which owns or controls, or which is under common ownership or control with Company. Plans may be offered by separate Company Affiliates and each of those Affiliates is considered to be a Party to this Agreement.

Applicable Law. All applicable Federal and state laws, regulations and governmental directives related to this Agreement, as well as, with respect to Provider, applicable accreditation agency/organization requirements.

Covered Services. Those health care and related services for which a Member is entitled to receive coverage or program benefits under a Plan.

Group Provider. A health care provider: (a) employed by Provider; or (b) who, through a contract or arrangement with Provider, provides services to Members for which Provider is reimbursed under this Agreement or who otherwise bills for services under this Agreement, whether on a regular or on call basis. Group Provider includes all of the persons and entities that provide services to Members in any of Provider's practice arrangements or locations and under any of its tax identification numbers, unless specifically excluded, as explained in the Agreement.

Member. A person covered by or enrolled in a Plan. Member includes the subscriber and any of the subscriber's eligible dependents.

Participating Provider. A health care provider that participates in Company's participating provider network(s) for the applicable Plan.

Participation Criteria. The participation criteria (e.g., office standards, DEA requirements, etc.) that apply to various types of Participating Providers under Company Policies.

Party. Company or Provider, as applicable.

Payer. A person or entity that is authorized to access one or more networks of Participating Providers and that: (a) is financially responsible for funding or underwriting payments for benefits provided under a Plan; or (b) is not financially responsible to fund or underwrite benefits, but which contracts directly or indirectly with persons or entities that are financially responsible to pay for Covered Services provided to Members. Payers include, but are not limited to, Company, insurers, self-funded employers, third party administrators, labor unions, trusts, and associations.

Plan. A health care benefits plan or program for which Provider serves as a Participating Provider; the terms of each specific Plan are outlined in the applicable summary plan description, certificate of coverage, evidence of coverage, or other coverage or program document.

Policies. Company's policies and procedures that relate to this Agreement, including, but not limited to, Participation Criteria; Provider Manuals; clinical policy bulletins; credentialing/recredentialing, utilization management, quality management, audit, coordination of benefits, complaint and appeals, and other policies and procedures (as modified from time to time), that are made available to Provider electronically or through other commonly accepted media. Policies may vary by Affiliate, Product Category and/or Plan.

Product Category. A category of health benefit plans or products (e.g., Commercial Health, Medicare,

Workers' Compensation) in which Provider participates under this Agreement, as more fully described on the applicable **Product Addendum(a)**.

Provider Manual. Company's handbook(s), manual(s) and guide(s) applicable to various types of Participating Providers and Product Categories.

MEDICAID PRODUCT ADDENDUM

For purposes of the Agreement and this Medicaid Product Addendum (this "Addendum"), the capitalized terms "Plan(s)" and "Product Category(ies)" shall each include "Medicaid Products", as defined in the **Service and Rate Schedule (Medicaid Products)**.

1. **Definitions**.
   a. Government Sponsor(s). A state agency or other governmental entity authorized to offer, issue, and/or administer a Medicaid Product, and which, to the extent applicable, has contracted with Company to operate and/or administer all or a portion of such Medicaid Product.
   b. State Contract(s). Company's contract(s) with Government Sponsor(s) to operate and/or administer one or more Medicaid Products.
2. **Payment for Covered Services**. The compensation set forth in the **Service and Rate Schedule (Medicaid Products)** shall *only* apply to services that Provider renders to Members covered under the Medicaid Products set forth therein. Provider acknowledges and agrees that if an Affiliate of Company is the Payer for a particular Medicaid Product, such Affiliate's duties, obligations, and liabilities under the Agreement shall be strictly limited to the services Provider renders to Members covered under that Medicaid Product.
3. **Overpayments to Provider**. If Provider identifies an overpayment that it received relating to any Medicaid Product, Provider shall comply with Section 6402(a) of the Patient Protection and Affordable Care Act (currently codified at 42 U.S.C. § 1320a-7k(d)) and its implementing regulations. In addition to Company's other overpayment-recovery rights, Company shall have the right to recover from Provider any payment that corresponds to services previously rendered to an individual whom Company later determines, based on information that was unavailable to Company at the time the service was rendered or authorization was provided, to have been ineligible for coverage under a Medicaid Product when Provider rendered such service.
4. **Medicaid Product/State Contract Requirements**. Because Company is a party to one or more State Contracts, Provider must comply with Applicable Law, with certain provisions of the State Contracts, and with certain other requirements that are uniquely applicable to the Medicaid Products. Some, but not all, of these provisions and requirements are set forth in the **State Compliance Addendum (Medicaid Product)** and/or the Provider Manual for the Medicaid Products, both of which are incorporated herein and binding on the Parties. Provider agrees that all provisions of this Addendum shall apply equally to any employees, independent contractors, and subcontractors that Provider engages in connection with the Medicaid Products, and Provider shall cause such employees, independent contractors, and subcontractors to comply with this Addendum, the State Contract(s),

and Applicable Law. Any subcontract or delegation that Provider seeks to implement in connection with the Medicaid Products shall be subject to prior written approval by Company, shall be consistent with this Addendum, the State Contract(s), and Applicable Law, and may be revoked by Company or a Government Sponsor if the performance of the subcontractor or delegated person or entity is unsatisfactory. Provider acknowledges that the compensation it receives under this Addendum constitutes the receipt of federal funds.

5. **The Federal 21st Century Cures Act ("Cures Act")**. Provider acknowledges and agrees that because it furnishes items and services to, or orders, prescribes, refers, or certifies eligibility for services for, individuals who are eligible for Medicaid and who are enrolled with Company under a Medicaid Product, Provider shall maintain enrollment, in accordance with Section 5005 of the Cures Act, with the Medicaid program of the Government Sponsor of that Medicaid Product. If Provider fails to enroll in, is not accepted to, or is disenrolled or terminated from the Medicaid program of that Government Sponsor, Provider shall be terminated as a Participating Provider for that Medicaid Product.

6. **Government Approvals**. One or more Government Sponsors or other governmental authorities may recommend or require that the Parties enter into the Agreement, including this Addendum, prior to execution of a State Contract and/or prior to issuance to Company of one or more government approvals, consents, licenses, permissions, bid awards, or other authorizations (collectively, the "Government Approvals"). Provider acknowledges and agrees that all Company obligations to perform, and all rights of Provider, under the Agreement as it relates to the Medicaid Products are conditioned upon the receipt of all Government Approvals. The failure or inability of Company to obtain any Government Approvals shall impose no liability on Company under the Agreement as it relates to the Medicaid Products.

7. **Immediate Termination or Suspension Due to Termination of State Contract**. This Agreement and/or Addendum may be terminated or suspended by Company, upon notice to Provider and at Company's discretion, without liability to Company, if a State Contract expires or is suspended, withdrawn, or terminated.

8. **Termination of Medicaid Products**. Company may exercise its for cause and immediate termination rights in the Agreement as to, and may terminate without cause with ninety (90) days prior written notice, one or more specific Medicaid Products, in which case the Agreement between Company and Provider with respect to all other Medicaid Products shall remain in full force and effect. Company may exercise its termination rights under the Agreement with respect to this Addendum. In the event this Addendum is terminated for any reason, such termination shall not in and of itself constitute termination of any of Company's other products, plans or programs.

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SERVICE AND RATE SCHEDULE

(Medicaid Products)

1.0 PRODUCT / NETWORK PARTICIPATION

Provider shall be a Participating Provider in the network(s) of the following (all together, the "Medicaid Product(s)"):

A. The Medicaid and/or CHIP Plans and/or any other publicly funded or subsidized managed care programs for low-income, uninsured, underinsured or otherwise qualified individuals offered by Company within the State, including specifically the program for complex behavioral health and multi-system needs known as "OhioRISE (Resilience through Integrated Systems and Excellence)" or its successor(s).

B. The fully integrated Medicare-Medicaid Plans (a/k/a MMPs) offered by Company within the State.

C. Any other Medicaid Products included in the **State Compliance Addendum (Medicaid Products)** incorporated into this Agreement.

2.0 SERVICES & COMPENSATION

Company, or the applicable Affiliate that is the Payer responsible for a particular Medicaid Product, shall compensate Provider for the Covered Services that Provider renders to Members covered under that Medicaid Product, and shall do so on a timely basis, consistent with the claims-payment procedure described in 42 U.S.C. § 1396a(a)(37)(A) and subject to the terms of the Agreement, according to the following rates *or* Provider's actual billed charges, whichever is less:

Medicaid and/or CHIP Plans:	100% of the Aetna Medicaid Market Fee Schedule
Medicare-Medicaid Plans:	100% of the Aetna Medicare-Medicaid Plan Market Fee Schedule

3.0 DEFINITIONS AND OTHER TERMS AND CONDITIONS

A. Aetna Medicaid Market Fee Schedule (AMMFS) is defined as a fee schedule that is based upon the contracted location where service is performed and the applicable State Medicaid Fee Schedule.

B. Aetna Medicare-Medicaid Plan Market Fee Schedule (AMMPMFS) is defined as a fee schedule that is based upon the contracted location where service is performed and the applicable Medicare Allowable Payment (Inpatient Services), Medicare Allowable Payment (Outpatient Services), Dialysis Services Payment, Home Health Care Services Payment, or Medicare Physician Fee Schedule (as applicable).

C. Medicare Allowable Payment (Inpatient Services) is defined as the current payment as of discharge date that a hospital will receive from Company, subject to the then current Medicare Inpatient Prospective Payments Systems and will be updated in accordance with CMS changes, provided, however, that exempt units for psychiatric, rehabilitation and skilled nursing facility services will be paid in accordance with the applicable Medicare Prospective Payment Systems. These payments are intended to mirror the payment a Medicare Administrative Contractor (MAC) would make to the hospital, less (with respect to DRG-based payments) the payments for

Operating Indirect Medical Education (IME), Direct Graduate Medical Education (DGME) and adjustments due to Company payment and processing guidelines. The current Medicare Allowable payment is final and is exclusive of cost settlements, reconciliations, or any other retroactive adjustments as completed by a MAC for both overpayments and underpayments.

D. Medicare Allowable Payment (Outpatient Services) is defined as the current payment that Provider will receive from Company for outpatient services or procedures, pursuant to the Outpatient Prospective Payment System (OPPS), where applicable payment for these services is geographically adjusted using the provider-specific wage index. The Medicare Allowable Payment (Outpatient Services) is subject to Company's payment and processing guidelines and is final and will not be impacted by cost settlements, reconciliations, or any other retroactive adjustments performed by a Medicare Administrative Contractor (MAC) for both overpayments and underpayments. Pursuant to CMS rules, specific revenue codes are packaged when billed without HCPCS codes. Payment for these dependent, ancillary, supportive, and adjunctive items and services is packaged into payment for the primary independent service reported with an applicable HCPCS codes. Therefore, separate payment will not be made for claims reported with these packaged revenue codes when billed without HCPCS codes. Consistent with this, Company will not make separate payment(s) for packaged revenue codes. Company will follow the OPPS payment updates as published annually by CMS in the OPPS final rule.

E. Dialysis Services Payment is defined as the current payment that Provider will receive from Company for dialysis services based on CMS's ESRD Prospective Payment System (PPS).

F. Home Health Care Services Payment is defined as the current payment that Provider will receive from Company for home health care services based on the CMS Home Health prospective payment system (PPS).

G. Medicare Physician Fee Schedule (MFS) is defined as a fee schedule established by Company for use in payment to providers for Covered Services, which is based upon Centers for Medicare & Medicaid Services (CMS) Geographic Pricing Cost Indices (GPCI) and Resource Based Relative Value Scale (RBRVS) Relative Value Units (RVU) [including Outpatient Prospective Payment System (OPPS) cap rates]; the Clinical Laboratory Fee Schedule (CLAB); the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Fee Schedule; including PEN (DMEPOS) and 'Medicare Part B Drug Average Sales Price (ASP)'. Coding and fees determined under this schedule will be updated as CMS releases code updates, changes in the MFS relative values, including OPPS cap payments, or the CMS conversion factors. Company plans to update the schedule within sixty (60) days of the final rates and/or codes being published by CMS. However, the rates and coding sets for these services do not become effective until updates are completed by Company and payment is considered final and exclusive of any retroactive or retrospective CMS adjustments. Company payment policies apply to services paid based upon the Medicare Physician Fee Schedule.

H. Medicare-Medicaid Plans. Where Company is the responsible payor for Medicare and Medicaid Covered Services, rates for each service are determined by whether CMS and other applicable Government Sponsors regard that service as a Medicare Covered Service or a Medicaid Covered Service when and as provided by a particular provider, and by a Member's benefit limits under each program. For Covered Services that are Medicare Covered Services when and as provided by Provider (inclusive of Member copayment or coinsurance), Company shall compensate

Provider at the AMMPMFS rate. For Covered Services that are *only* covered under Medicaid when and as provided by Provider (such as, but not limited to, long-term care and home and community based waiver services), Company shall compensate Provider at the AMMFS rate. When a service is covered under *both* Medicare and Medicaid, Company will determine the rate (Medicare or Medicaid) according to applicable law, coordination-of-benefit principles, and the terms of Member's Plan. Rates do not include, and Company is not responsible for, supplemental or wrap-around payments unless required by Company's contracts with Government Sponsor.

I. Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The Parties acknowledge that payments (including, but not limited to, those based on a percentage of Medicare) will not reflect CMS Quality Payment Program adjustment factors or incentive payments (*e.g.*, Merit-Based Incentive Payment System (MIPS), Alternate Payment Models (APM)).

J. Additional Compensation. Company may, from time to time and in its discretion, offer additional compensation to Provider in connection with Member health, quality improvement and/or care management services provided (e.g., additional well visit coverage for Members, enhanced care management outreach).

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APPENDIX 4: STATE OF OHIO COMPLIANCE ADDENDUM

State Compliance Addendum

OHIO

The State Compliance Addendum attached to this Agreement, is expressly incorporated into this Agreement and is binding upon the Parties to this Agreement. In the event of any inconsistent or contrary language between the State Compliance Addendum and any other part of this Agreement, including but not limited to exhibits, attachments or amendments, the Parties agree that the provisions of the State Compliance Addendum shall prevail, but, if applicable, only with respect to a particular line of business (e.g., fully-insured HMO) and/or Product.

1.1 General Obligations

The following shall be added to subsection (h) in Section 1.1 General Obligations:

"and shall observe, protect, and promote the rights of Members as patients."

1.2 Provider and Group Provider Contact and Service Information

The following shall be added after the second sentence of Section 1.2 Provider and Group Provider Contact and Service Information:

"Provider agrees to make best efforts to provide to Company at least ten (10) days advance notice, and in any event will provide notice as soon as reasonably practicable, of any cancellation or material modification of policies of general and professional liability and other insurance."

1.3 Compliance with Company Policies

The following shall be added to the end of Section 1.3 Compliance with Company Policies:

"In accordance with the requirements of O.R.C. Section 3963.03(D), Company shall provide applicable policies, procedures, or guidelines associated with utilization management, quality improvement, or similar program upon request by Provider within fourteen (14) days of such request."

2.2 Claims Payment

The following shall be added to the end of Section 2.2 Claims Payment:

"In accordance with the requirements of O.R.C. Section 3963.03(A)(4), the contracting entity or Payer responsible for processing payment for Covered Services due Provider shall be available on the provider secure website at www.aetna.com. The First Health client list is available at **www.directprovider.com**."

5.4 Obligations Following Termination

The following shall be added to the end of Section 5.4 Obligations Following Termination:

"If this Agreement terminates as a result of insolvency or discontinuation of operations of Company, and as to Members of HIC that become insolvent or cease operations, Provider shall continue to provide Provider Services to Members as needed to complete any medically necessary services commenced but not completed at the time of Heath Insuring Corporation's insolvency or discontinuation of operations, provided that Provider shall not be obligated to provide such services beyond the occurrence of any of the following: (i) the end of the thirty-day period following the entry of a liquidation order under Chapter 3903 of the Ohio Revised Code; (ii) the end of the Member's period of coverage for a contractual prepayment or premium; (iii) the Member obtains equivalent coverage with another HIC or insurer, or the Member's employer obtains such coverage for the Member; (iv) the Member or the Member's employer terminated coverage under its contract; or (v) a liquidator effects a transfer of the HIC's obligation under the contract under Ohio Revised Code section 3903.21 (A)(8)."

6.1 Independent Contractor Status/Indemnification

The following shall be added before the third sentence of Section 6.1 Independent Contractor Status/Indemnification:

"Company shall maintain oversight of the offering of Covered Service provided by Provider to Members as required by applicable state laws or regulations. Notwithstanding,".

7.1 Dispute Resolution

The following shall be added to the end of Section 7.1 Dispute Resolution:

"In accordance with the requirements of O.R.C. Section 3963.03(A)(5), Company's internal mechanism for resolving disputes is available on the provider secure at www.aetna.com."

7.2 Arbitration

The following shall be added to the end of Section 7.2 Arbitration:

"This section is subject to and modified as necessary to comply with O.R.C. Section 3963.02(F)(1)-(3)."

8.0 Miscellaneous

The following shall be added to the end of Section 8.0 Miscellaneous:

"8.8 Defined Terms. The terms used in this Agreement and that are defined by Chapter 1751 of the Ohio Revised Code, are used in the Agreement in a manner consistent with those definitions.

8.5 Amendments

The following shall be added to the end of Section 8.5 Amendments:

"In accordance with the requirements of O.R.C. Section 3963.04(A)(1)-(4) and Section 8.6 of this Agreement, Company shall: (i) provide at least fifteen (15) days notice prior to the effective date if the amendment to this Agreement is a non-material change; and (ii) provide at least ninety (90) days notices prior to the effective date if the amendment to this Agreement is a material change. Such notices shall be entitled "Notice of Material Amendment to Contract." If within fifteen (15) days after receipt of such

notice, Provider objects in writing to the material amendment, and there is no resolution of the objection, either Party may terminate the Agreement in accordance with TERM of the Agreement no later than sixty (60) days prior to the effective date of the material amendment. If Provider does not object to the material change the change shall be effective as specified in the notice."

As required by O.R.C. Section 3963.03(A)(6), the schedules, exhibits, attachments or addenda attached to this Agreement include the following:

	Title	Subject
a)	Provider Agreement	Terms of the contract
b)	Compliance Addendum	Ohio Regulatory Language
c)	Services and Rate Schedule	Compensation
d)	Service and Pay to Location Form	Location of Physician
e)	Summary Disclosure Form	Summary

LIST OTHER ADDENDA REQUIRED FOR THIS PRODUCT OR MEDICAID COMPLIANCE

APPENDIX 5: PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY CONTRACTING COMPONENTS

aetna™

Psychiatric Residential Treatment Facility Contracting Components

[Provider] agrees and acknowledges that the following information is accurate as of [date]. This form is hereby incorporated into the Provider Agreement.

For each location, please complete the following:

Location Address: _____

Tax ID	
NPI	
Number of beds	
Age Ranges	
Gender(s)	
PRTF Rate Category	☐Base ☐MI/ID ☐Cottage ☐MI/ID Cottage
Facility Security	☐Locked ☐ Staff Secure
Expected PRTF implementation date	
Clinical Focus Areas	☐General Mental Health ☐Substance Use ☐Autism Spectrum Disorders ☐Brain Injury ☐Problem Eating Behaviors ☐Problem Sexual Behaviors ☐Human Trafficking ☐Co-occurring Physical Health Conditions ☐Primary Psychotic/First Episode ☐Other
Admission criteria	

Certification

As a duly authorized signatory for the above-named Provider, I certify:

(1) That to the best of my knowledge, the information documented in this Psychiatric Residential Treatment Facility Contracting Components Addendum is true and accurate,

(2) Acknowledgement that maintaining a contract with Aetna to Provide Psychiatric Residential Treatment Facility (PRTF) services to OhioRISE enrollees is dependent upon:
   a. Adhering to all Ohio Administrative Code Rules pertaining to Psychiatric Residential Treatment Facilities,
   b. Adhering to all future versions of the OhioRISE PRTF Program Manual,
   c. Maintaining successful certification by the Ohio Department of Mental Health and Addiction Services (OhioMHAS) as a PRTF,
   d. Maintaining credentialling and enrollment with the Ohio Department of Medicaid (ODM),
   e. Maintaining successful surveys with the Ohio Department of Health (ODH) and the Centers for Medicare & Medicaid Services (CMS),

(3) That Aetna will be provided with written notification at least ninety (90) days in advance of any of the following occurrences:
   a. Closure of PRTF,
   b. Permanent subtraction or addition of PRTF beds,
   c. Changes in population to be served by PRTF.

(4) That OhioRISE enrollees who are referred by Aetna and meet the mutually agreed upon PRTF Admission criteria will be prioritized.

(5) Acknowledgement that approval by Aetna is required for the following clinical matters:
   a. PRTF Program Admission Criteria,
   b. Provider-initiated discharges prior to successful treatment completion that were not due to OhioRISE enrollee needing to be hospitalized in an acute inpatient setting.

Signature*:

Name* **Date*:**

Designation*: