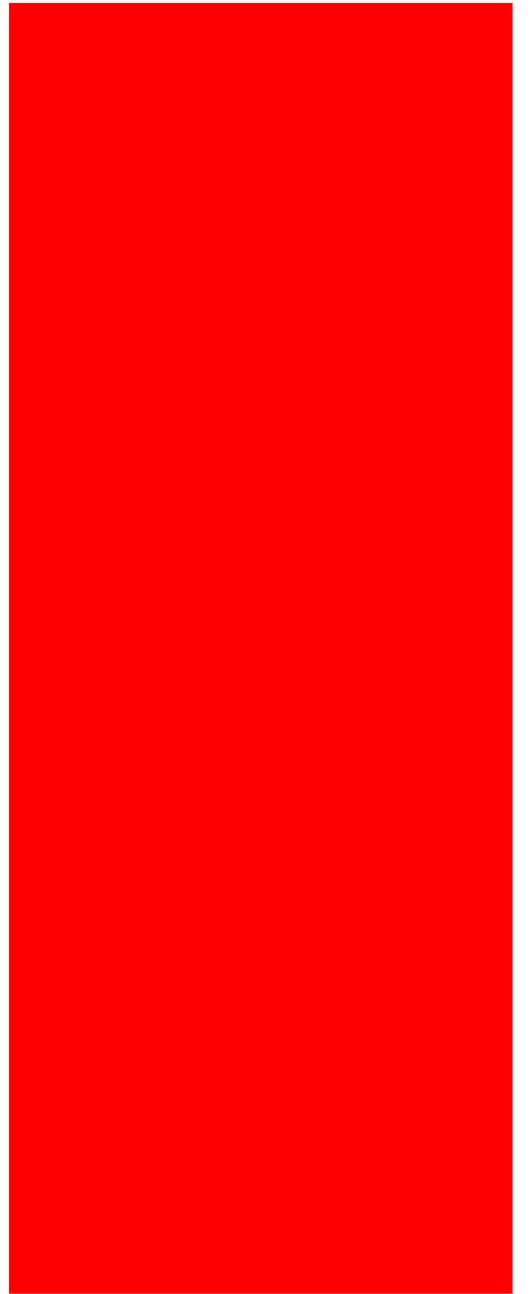


41 SECTION D – MEMBER
ENROLLMENT AND
DISENROLLMENT

42 D.1



Section D: Member Enrollment and Disenrollment

D.1 Describe your enrollment procedure requirements, including how you will ensure that you will coordinate with DHH and its Agent.

Aetna Better Health[®] understands that DHH contracts with an Enrollment Broker (EB) who is responsible for the Coordinated Care Network (CCN) Program's enrollment and disenrollment process for all Medicaid potential members and members. We believe that working with DHH and its EB will be a seamless process, as we have extensive experience and strong working relationships with State departments and EBs in several states, including Connecticut, Illinois, Pennsylvania and Texas.

Enrollment Procedure Requirements

There are two phases of the enrollment process: the initial electronic transfer of new members at the beginning of the contract and the enrollment received after the initial implementation period. Aetna Better Health's processes and procedures to execute the enrollment process are identical for both groups of members. The only difference is the time frames required for execution (21 days for the initial transfer, 10 days for subsequent transfers.) Aetna Better Health is equipped and prepared to meet the required time frames to execute enrollment for both groups of new members.

In order to enroll our initial members expediently and make services available to them in the appropriate timeframe after enrollment, Aetna Better Health will work with DHH and the EB to obtain electronic transfer of enrollment files and two (2) years of claims history for assigned members.

Electronic transfer of enrollment files

Aetna Better Health has the capacity for real-time connectivity to all DHH-approved systems. Our File Transfer Protocol (FTP) site will be tested so that files can be uploaded and downloaded securely. File receipt and submission will be automated using a standard, secure FTP push/pull methodology that has an integrated encryption/decryption process. We are able to transmit, receive and process data in current HIPAA-compliant and DHH specific formats and/or methods, including secure FTP over a secure Virtual Private Network (VPN), which will be in use at the start of DHH systems readiness review activities. All exchanges of data with DHH will be at the highest level of HIPAA compliance, as specified in the DHH HIPAA Business Associate Agreement. Our HIPAA-compliant system will include capability for ASC X12N 834 Benefit Enrollment and Maintenance batch transactions.

Aetna Better Health will receive enrollment files from the EB that can be validated and processed in a timely manner. The EB will also provide, via a daily 834 X12 transaction, updates on members newly enrolled, disenrolled or with demographic changes. At the end of each month, the EB will reconcile enrollment and disenrollment and provide Aetna Better Health with a full 834 X12 reconciliation file. We will work closely with the EB to make certain that all transfer of information is HIPAA-compliant and meets DHH standards as specified in the DHH HIPAA Business Associate Agreement.

We will work closely with DHH and the EB to maintain the confidentiality of each member's medical records and protected health information during the enrollment process. Our goal is to have a seamless transition to the Louisiana CCN program for members and their current providers. To accomplish this, Aetna Better Health's requirements for the daily enrollment files from the EB should include:

- Name, addresses and phone numbers of all new members
- Name, phone number and after hours phone number of the preferred PCP if the affirmed choice is made when the member enrolls
- For automatic assignments, the file should include the name of the most recent CommunityCARE 2.0 PCP, if applicable

To maintain member Protected Health Information (PHI) in compliance with HIPAA-mandated standards, Aetna Better Health will work with the EB to develop standard reports and audit trails to monitor and manage all data processes that are in accordance with DHH requirements.

Assigning PCPs to members

The enrollment file provided by the EB to Aetna Better Health should include two years of claims data information for each member. By obtaining this information from the EB, we will be able to:

- Learn important details about the member's health (e.g., is the member pregnant or does the member have any chronic health conditions?)
- Determine whether the member has an existing arrangement with a PCP
- Allow the system to place the member with his/her current PCP

If the member has not chosen a PCP, Aetna Better Health will automatically assign a PCP to the member within 10 days from enrollment into Aetna Better Health. Every attempt will be made to assign the member to a PCP with whom the member has a historical relationship. If there is no historical relationship, the member will be automatically assigned to a PCP who is assigned to an immediate family member enrolled in the CCN program. If other immediate family members do not have an assigned PCP, automatic assignment will be made to a PCP with whom a family member has a historical relationship. If there is no member or immediate family historical usage, members shall be automatically assigned to a PCP using an algorithm developed by the proposer, based on the age and sex of the member and geographic proximity. Aetna Better Health will comply with the following maximum travel time and/or distance requirements to PCPs, as determined by mapping software (e.g. Mapquest, Google Maps):

- Travel distance for members living in rural Parishes shall not exceed 30 miles
- Travel distance for members living in urban Parishes shall not exceed 10 miles

We understand that requests for exceptions as a result of prevailing community standards must be submitted in writing to DHH for approval.

If the member is automatically assigned to a PCP, we will allow the member to change their PCP, at least once, during the first ninety (90) days from assignment to the PCP/Patient Centered Medical Home (PCMH) without cause. From the ninety-first (91st) day, the member may be locked into the assignment to the selected PCP for a period of up to 12 months beginning from



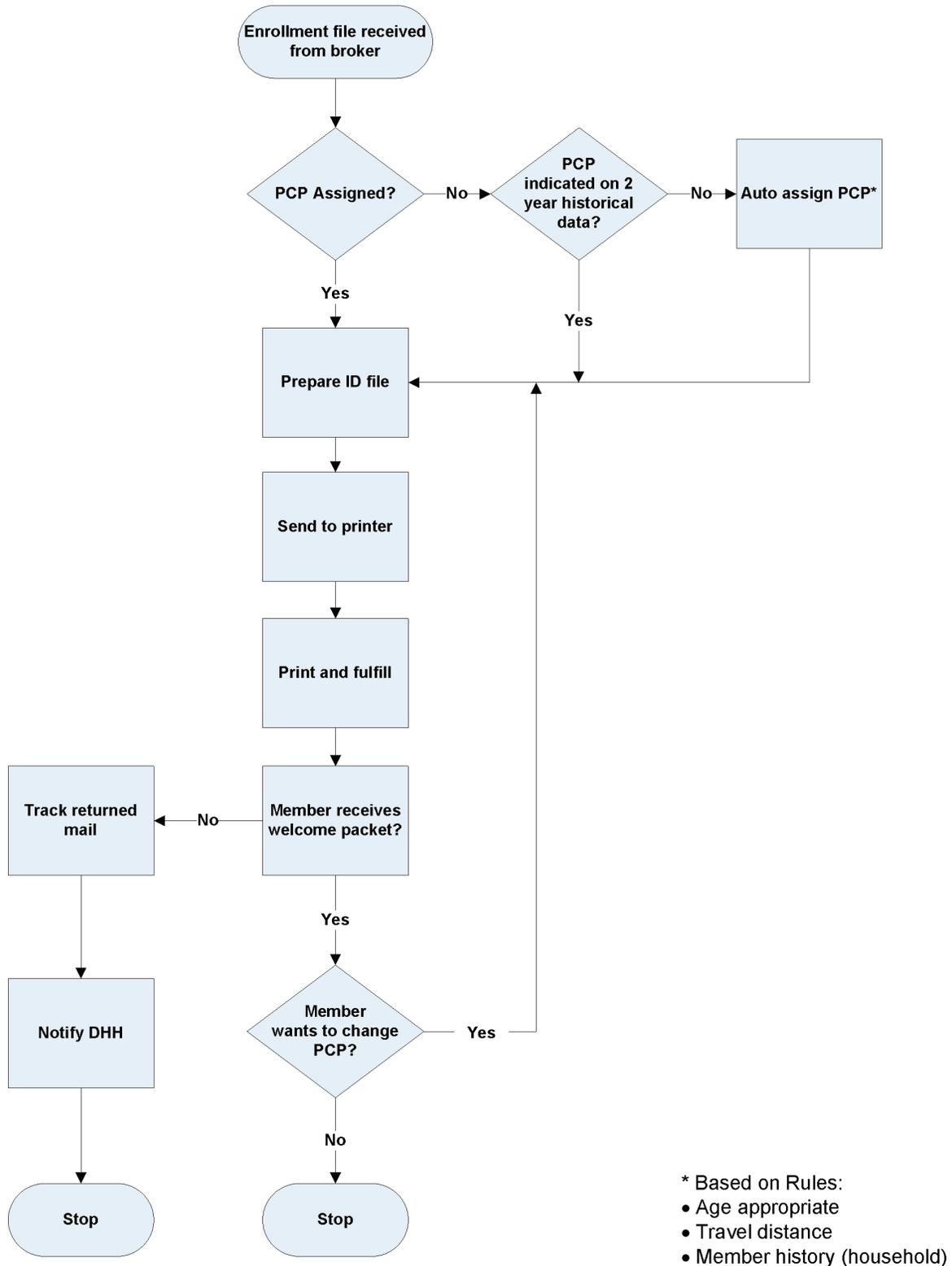
the original date the member was originally assigned to the PCP. If a member requests to change his or her PCP with cause, at any time during the enrollment period, we agree to grant the request.

Aetna Better Health understands that the PCP automatic assignment methodology must be provided thirty (30) days from the date Aetna Better Health signs the contract with DHH and that approval must be obtained from the Department prior to implementation. Once approved by DHH, this methodology will be made available via the Aetna Better Health's website, Provider Handbook, and Member Handbook.

During the phase-in implementation of the CCN program, Aetna Better Health will have up to twenty-one (21) days to provide welcome packets to new members. During subsequent phases, we will send a welcome packet to new members within ten (10) business days from the date of receipt of the file from DHH or the EB identifying the new member.

Aetna Better Health's enrollment process, assignment of PCPs (when applicable) and welcome packet fulfillment is detailed in the flow chart below.

Initial Enrollment – Assignment of PCPs



Members with Special Needs

Newly assigned pregnant members may retain their current OB/GYN as their PCP of record if there are problems with the pregnancy or if the member is in the third trimester of pregnancy, even if the OB/GYN is not a participating network provider. Similarly, members with chronic conditions or other special needs may stay with their current PCP, even if that PCP is not a participating network provider, for 90 days after enrollment or completion of the course of treatment.

Outreach to providers not in yet in our provider network

If the member currently has a health care provider and/or PCP that is not a network provider with Aetna Better Health, our Case Management personnel will work with our Provider Services team to encourage the provider to become a part of our network. If the provider decides not to join our network, our Case Management personnel will assist the member in finding an appropriate in-network PCP/PCMH. We will also confirm that the PCMH chosen is geographically convenient for the member. We understand that any willing provider who is enrolled in our provider network and meets the criteria as a PCMH provider (e.g., signed Case Management program registration agreement) may be selected by a member as their PCP/PCMH.

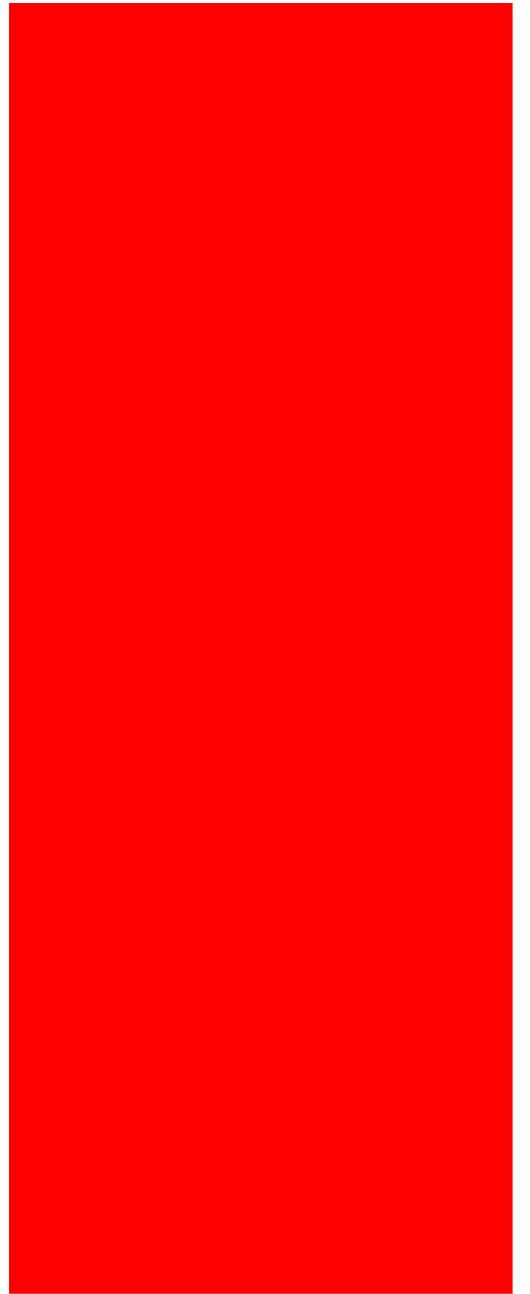
Suspension of and/or Limits on Enrollment

Aetna Better Health will identify the maximum number of CCN members we are able to enroll and maintain under the Contract prior to the initial enrollment of Medicaid eligibles. We will accept Medicaid members as CCN members in the order in which they are submitted by the EB without restriction as specified by DHH up to the limits specified in the Contract. We will provide services to CCN members up to the maximum enrollment limits specified in the Contract. We understand that DHH reserves the right to approve or deny the maximum number of CCN members to be enrolled in Aetna Better Health based on DHH's determination of the adequacy of our capacity.

Consistent with DHH reporting requirements, Aetna Better Health will submit a quarterly update of the maximum members in each GSA. We will track slot availability and notify the EB when filled slots are within 90 percent of capacity. In addition, we will be responsible for maintaining a record of total PCP linkages of Medicaid members and provide this information quarterly to DHH.

We understand that DHH will notify Aetna Better Health when our enrollment levels reach 95 percent of capacity and will not automatically assign Medicaid eligibles. In the event our enrollment reaches 65 percent of the total enrollment in the GSA, we will not receive additional members through the automatic assignment algorithm. DHH's evaluation of a CCN's enrollment market share shall take place on a calendar quarter.

43 D.2



D.2 Describe your approach to meeting the newborn enrollment requirements, including how you will:

- Encourage Members who are expectant mothers to select a CCN and PCP for their newborns; and
- Ensure that newborn notification information is submitted, either by you or the hospital, to DHH or its Agent within twenty-four (24) hours of the birth of the newborn.

Identifying Expectant Mothers for Newborn CCN and PCP Selection

Aetna Better Health employs a multi-pronged approach to identifying and contacting expectant mothers at least sixty (60) calendar days prior to the expected date of delivery to encourage the mother to choose a CCN and PCP for her newborn.

Internal resources for identifying expectant mothers

- ***Information from Eligibility Rosters:*** Data analysts review eligibility rosters to identify members with a pregnancy indicator and refer them to Case Management.
- ***Management Reports:*** A series of internal reports indicates whether a member may be pregnant (e.g., health risk assessments, pharmacy reports, laboratory reports, emergency department logs). Case Managers review pregnancy indicators from these reports to identify an expectant mother.
- ***Member Services Representatives:*** A Member Services Representative will refer any member who is or may be pregnant or has questions about perinatal services to the Case Management Department.
- ***Other Case Managers:*** If a Case Manager identifies a pregnant member, he/she will forward the contact information to the Case Management Department.
- ***Concurrent Review/Prior Authorization Personnel:*** When concurrent review or prior authorization personnel identify a pregnant member, he/she will forward the contact information to the Case Management Department for follow-up.
- ***Other Health Plan Personnel:*** Our employees understand and are educated about our high risk Perinatal Case Management program. Any contact with plan personnel can generate a referral.

External resources for identifying expectant mothers

- ***Members:*** Any pregnant member can self-refer to our Perinatal Case Management program.
- ***Providers:*** The pregnant member shall be assured direct access within the Aetna Better Health's provider network to routine OB/GYN services, and the OB/GYN shall notify the PCP of his/her provision of such care and shall coordinate that care with the PCP.
- ***Hospitals:*** Aetna Better Health will be responsible for assuring that hospital subcontractors report the birth of newborns within twenty-four (24) hours of birth for enrolled members using DHH's web-based Request for Newborn Manual system. If the mother has made a CCN and/or PCP selection, this information will be reported. If not selection is made, the newborn will be automatically enrolled in the mother's CCN. We understand that enrollment

of newborns will be retroactive to the date of birth. Hospitals are required to notify the DHH within 24 hours of the birth of any child who may meet eligibility provisions for the Medicaid Program.

To facilitate the process of registering every eligible newborn into LEERS, we will communicate this information to our contracted hospitals through a variety of vehicles, which include, but are not limited to:

- On-site visits
- Provider manual, updated and distributed annually
- Provider newsletters
- Provider information on our website
- Ad hoc communication opportunities

Early identification and Case Management intervention are important to the success of Aetna Better Health's Perinatal Case Management program.

Coordinating Prenatal and Postpartum Care and Services

Perinatal Case Management

The focal points of Aetna Better Health's prenatal and postpartum services include:

- ***Early identification*** - Identify pregnant members as early as possible through collaborative efforts with internal and external resources to improve birth outcomes.
- ***Ongoing support and interventions*** - Follow each member throughout their pregnancy and the 60-day postpartum period.
- ***Coordination with community support services*** - Refer and assist members to access community resources, such as WIC, school and community-based teen pregnancy programs, mentoring programs for pregnant adolescents and depression counseling services.

As such, our program consists of the following fundamental components:

- ***Improved birth outcomes*** - Provide Case Management and Care Coordination services and assure that prenatal and postpartum interventions are effective and timely
- ***Identification of risk factors*** - Assess pregnant women to identify any risk factors and conduct periodic reassessments throughout the pregnancy
- ***Education*** - Provide appropriate educational materials and respond quickly to any questions or concerns that the member may have. Inform members about prenatal, infant and child care classes available in the community.
- ***Access to community and faith-based services*** - Provide information about and assistance to obtain available community services and programs.
- ***Coordination of care for identified risk issues*** -
 - Assist with referrals to perinatologists and other specialty providers.
 - Refer for screening, counseling, and appropriate treatment for HIV and other Sexually Transmitted Diseases (STDs).
 - Referral for domestic violence services.

Better Health

- Assess for behavioral and substance abuse issues and enrollment into behavioral health services.
- Encourage postpartum follow-up visits and referrals.
- **Identification and resolution of barriers to care** - Collect and track information about each member's pregnancy, birth outcomes, Case Management interventions, compliance with scheduling and keeping appointments and provide any needed assistance with transportation or other barriers to care.
- **Quality network providers** - Maintain a diverse network of maternity health care professionals to meet members' needs and assure members receive comprehensive prenatal and postpartum care from qualified, culturally competent maternity care providers.
- **Community outreach** - Conduct member and community outreach and education to “spread the word” about the benefits of early and comprehensive prenatal and postpartum care and the services that are readily available through our health plan.
- **Holistic, culturally sensitive care** - Provide special consideration for:
 - Pregnant adolescent members
 - Members with a history of high risk pregnancies (such as previous low birth weight babies)
 - Members with co-morbidities (e.g., diabetes, HIV/AIDS)
 - Pregnant members with a history of substance abuse or mental illness
 - Members with limited English proficiency, auditory disabilities, low health literacy or other potential barriers to care

High Risk Perinatal and Postpartum Case Management

Aetna Better Health's Perinatal Case Management Program is designed to assess for high risk maternal and fetal issues and coordinate and manage the care of women with high risk pregnancies. We recognize that each member's pregnancy is a unique experience, and that many behavioral, social and medical factors can result in a high risk pregnancy. Examples of high risk issues addressed in our Case Management program include:

- High risk medical or behavioral health conditions and co-morbidities (including current or historical), such as:
 - Preterm labor
 - Asthma
 - Diabetes
 - Sickle cell anemia
 - Sexually transmitted diseases
 - Depression
 - Serious mental illness
 - Multiple gestation
 - Short spacing between births (less than 18 months)

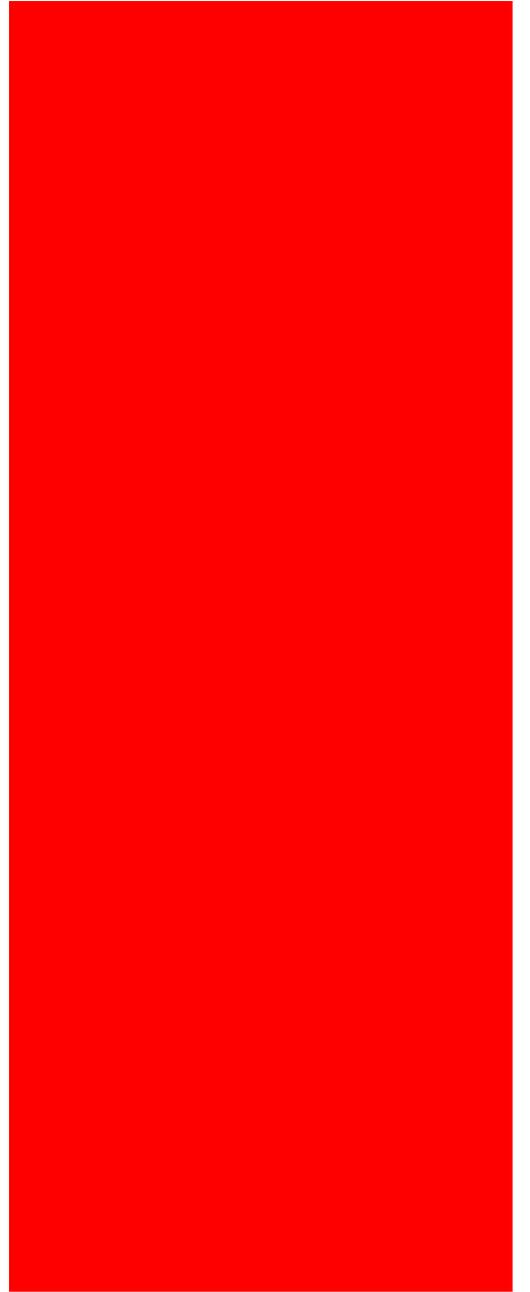
- Hypertension
- Rh incompatibility
- Gestational diabetes
- Age (e.g., younger than age 15, older than age 35)
- Social stressors such as:
 - Homelessness
 - Domestic violence
 - Single parent
 - Teen parent
- Fetal factors such as:
 - Exposure to infections, damaging medications and/or addictive substances
 - Serious health conditions for the baby

Women with high risk pregnancies may require monitoring and interventions that closely track conditions, identify complications and evaluate their impact on the baby. These may include additional provider visits, referrals to perinatologists or maternal/fetal medicine specialists, other specialists, amniocentesis and fetal monitoring. Aetna Better Health's perinatal Case Managers work closely with all high risk members to develop a customized care plan that includes supporting the authorization of and monitoring adherence to care plans of pregnant women by assessing for and resolving barriers, serving as a center point for communication among all involved parties and identifying community resources to assist members.

Once the expectant mother is referred to Case Management, Case Managers are trained to discuss CCN and PCP selection for her newborn. Our Case Managers will also use the online Louisiana Electronic Event Registration System (LEERS) system administered by DHH/Vital Records Registry after identifying any pregnancy and will provide any relevant information. After verifying that the newborn has a record on the system awaiting activation, Case Managers will notify the hospital and all attending and consulting physicians that the newborn will be enrolled with Aetna Better Health.

To facilitate prompt enrollment, Aetna Better Health will require our hospital providers to complete the online LEERS registration process for the newborn within 24 hours of the birth of the child. Our Case Managers or Case Management Associates will periodically check Medicaid eligibility to determine if the Medicaid Identification has been activated.

44 D.3



D.3 Describe the types of interventions you will use prior to seeking to disenroll a Member as described in CCN Initiated Member Disenrollment, Section § 11 of this RFP. If applicable, provide an example of a case in which you have successfully intervened to avert requesting the disenrollment of a member.

Aetna Better Health is committed to achieving excellence in all operational areas. We know that one way to accomplish this goal is by fostering positive, trusting relationships between members, providers and health plan personnel. As a result, we make every effort to preserve and maintain these relationships for as long as the circumstances will permit. However, there are rare instances when these relationships are unable to develop as fully or as smoothly as we would wish, including, but not limited to, the following:

- The member misuses or loans the member's CCN-issued ID card to another person to obtain services. In such case, Aetna Better Health will report the event to the Medicaid Program Integrity Section.
- The member's behavior is disruptive, unruly, abusive, or uncooperative to the extent that enrollment in the CCN seriously impairs the organization's ability to furnish services to either the member or other members and the member's behavior is not caused by a physical or mental health condition.

Working with the Member to Avert Disenrollment

Requesting involuntary disenrollment of a member is an act we take only after considerable effort to improve the working relationship between the member, the provider, and our team members. In a situation where a member exhibits uncooperative or disruptive behavior, our Medical Management personnel will investigate the reasons behind the problem and initiate a corrective action plan that may entail one or more of the following strategies:

- Conducting individualized member outreach and education
- Referring the member to a behavioral health and/or substance abuse program (if applicable)
- Assigning a member to a Case Manager or to a different PCP (if applicable)
- Scheduling one-on-one counseling or mediation sessions with the relevant parties to work through the issues

Additionally, Aetna Better Health's Member Advisory Council will be asked to examine our processes to avert member disenrollment, along with our member retention processes. We will also rely on the Member Advisory Council to provide guidance to improve the effectiveness of these programs.

Working with the Provider to Avert Disenrollment

One way Aetna Better Health works to avert disenrollment is through our Provider Assistance Program. One of the components of this program is for our Member Services Representatives to work with providers to measure missed appointments and reduce the likelihood of future occurrences. Under the Provider Assistance Program, the provider submits a Provider Assistance Form to the designated Provider Services Representative for his/her practice, to notify Aetna Better Health about a member who has missed appointments. The form is routed to the Member

Services Department for documentation and follow-up. A Member Services Representative will reach out to the member to provide education regarding the importance of keeping appointments, and may refer the member to Case Management for intervention by a Case Manager, especially if a member's care is jeopardized due to missed appointments. As part of this intervention, the Case Management team will work with the member to identify any barriers to care, such as a lack of transportation, and assist the member in finding ways to overcome them (e.g. referring them to our transportation vendor and/or assisting them in scheduling transportation for their next provider office visit). By identifying potential barriers to receiving care, and assisting providers through the provision of member outreach and education, this process facilitates communications between Aetna Better Health, its members and providers. By creating further opportunities to improve relationships between members and providers, disenrollment can be averted.

Disenrollment Process

In the highly unlikely event that all of our interventions and other efforts fail to rectify the issues with the member, to rebuild the relationship between the member and Aetna Better Health or the member and the provider, as appropriate, then Aetna Better Health will begin the process of involuntarily disenrolling the member from our health plan. Any involuntary disenrollment will be conducted within the DHH's requirements and according to our own DHH-approved internal policies.

Internal Process

Only an Aetna Better Health Manager or higher level personnel has the authority to initiate an Aetna Better Health involuntary disenrollment request form. The involuntary disenrollment request form and all supporting documentation are forwarded to the COO. The COO has the responsibility of reviewing the request to make certain that it is not based on an adverse change in the member's health status, utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from a special need. The COO will present requests that meet the standards to the Quality Management Oversight Committee (QMOC) for review. The QMOC will determine if the request is valid and in compliance with Aetna Better Health's policy and DHH requirements. Any QMOC review that results in a determination that the request is invalid will be communicated back to the requesting Manager that the member will remain an Aetna Better Health member. Any QMOC review that results in a determination that the request is valid will be communicated to the member and to DHH's Enrollment Broker (EB) by the COO. Aetna Better Health's COO is also responsible for communicating the decision regarding the involuntary disenrollment request to the requesting Manager, and other appropriate Aetna Better Health personnel.

Communicating Request for Disenrollment to the Member and Enrollment Broker

Once the internal process for member disenrollment has been approved by our QMOC, Aetna Better Health will issue a written explanation to the member about our request for disenrollment in the month following member notification. Aetna Better Health will also submit disenrollment requests to the EB, which will include the member's name, ID number, detailed reasons for requesting the disenrollment, and a description of all measures taken to correct member behavior and otherwise avert disenrollment, prior to requesting disenrollment, utilizing the CCN Initiated Request for Member Disenrollment form.

Aetna Better Health will not submit a disenrollment request at such a date that would cause the disenrollment to be effective earlier than forty-five (45) calendar days after the occurrence of the event prompting the request for involuntary disenrollment. We will make certain that involuntary disenrollment documents are maintained in an identifiable member record.

Aetna Better Health understands that requests will be reviewed on a case-by-case basis and are subject to the sole discretion of DHH or the EB. We further recognize that all decisions are final and not subject to the dispute resolution process by Aetna Better Health.

The EB will provide written notice of disenrollment to the member and request that the member choose a new CCN. The notice shall include a statement that if the member disagrees with the decision to disenroll the member from Aetna Better Health, the member has a right to file an appeal directly through the State Fair Hearing process. This includes:

- The right to a hearing
- The method for obtaining a hearing
- The rules that govern representation at the hearing
- The right to file grievances and appeals
- The requirements and timeframes for filing a grievance or appeal
- The availability of assistance in the filing process
- The toll-free numbers that the member can use to file a grievance or an appeal by phone
- The fact that, when requested by the member:
 - Benefits will continue if the member files an appeal or a request for State Fair Hearing within the timeframes specified for filing
 - The member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.

In a State Fair Hearing, the Division of Administrative Law shall make the recommendation to the Secretary of the DHH who has final authority to determine whether services must be provided.

Aetna Better Health understands that until the member is disenrolled by the EB, we will continue to be responsible for the provision of all core benefits and services to the member.

Example of How Member Disenrollment was Averted

Aetna Better Health has had a very small percentage of members over the years whose issues and/or behavior were potential reasons for disenrollment. However, when these issues were brought to our attention, our Member Services, and Case Management personnel worked together to get the member the care needed.

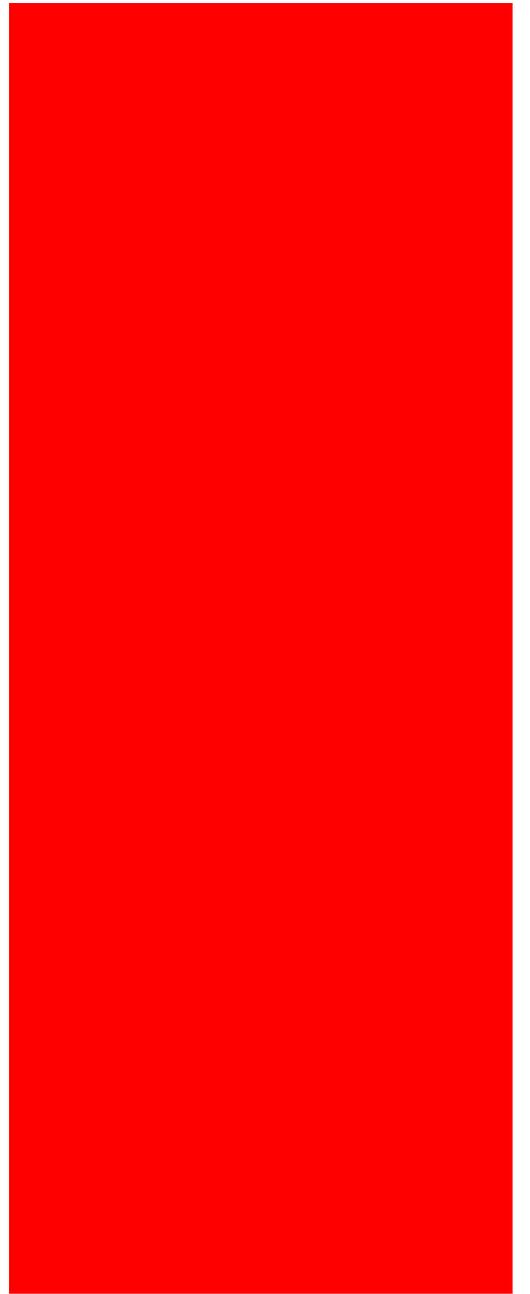
For example, one member was calling Member Services at one of our health plans four to five times a day, asking for benefits and services that were not covered by the state's Medicaid plan. Member Services Representatives patiently and repeatedly explained the covered benefits to him over the phone. After several such incidents, the member was referred to Case Management, where an assessment revealed that he had previously sustained a traumatic brain injury. The Case Manager assisted the member in obtaining behavioral health services to assist with complications

from his condition. The member remains in Case Management, but the frequent phone calls to the health plan have stopped.

Another health plan member called Member Services on a regular basis to complain about what she perceived to be a lack of covered benefits and an insufficient provider network. She was frequently verbally abusive to Member Services Representatives with whom she interacted. After multiple incidents, the Member Services Manager directed that any time the member called, she be put through to him immediately so that he could take her calls personally. After a few conversations, he invited her to attend a Member Advisory Council meeting to provide input in a group setting. The member felt like she had more of a voice in the process and became much less combative. The frequency of the phone calls also dropped dramatically.

These members' issues were logged into QNXT™, our information processing system, to alert the Member Services Representatives and clinicians if there were further issues that arose. Since our personnel were aware of the issues, they were able to positively manage the members by giving them more attention, understanding, and referrals for behavioral health services, thereby averting disenrollment.

45 D.4



D.4 Describe the steps you will take to assign a member to a different Provider in the event a PCP requests the Member be assigned elsewhere.

Aetna Better Health makes every effort to promote positive, trusting relationships between members, providers, and health plan personnel. We recognize the importance of the PCP role in understanding and providing care for the member's health needs. We also realize the importance of the member being a good fit for the PCP's practice and that there are occasions where a PCP may request that a member under their care be transferred to another provider. These may include:

- Deterioration of relationship
- Perceived rude/abusive behavior
- Excessive use of Emergency Department (ED)
- Non-adherence to treatment
- Failure to keep appointments
- Potential drug-seeking behavior
- Medical complexity
- Fraudulent use of services
- Need for care from a different specialty provider

If the member wishes to remain with his or her PCP or provider, Aetna Better Health will attempt, through education and communication, to resolve any difficulties or compliance issues between the member and provider, unless the member has exhibited consistent patterns of abusive or threatening behavior.

Steps We Take Before Member Reassignment to another PCP

Member Advocate

If a PCP requests a member reassignment through our Provider Services Department, a member advocate will be sent the information and initiate contact with the member. The member advocate will advise the member about his/her rights and responsibilities and explain that he/she could be discharged from the health plan after three PCP discharges. After working with the member advocate, most members understand the severity of the situation and change their behavior in order to retain their health plan membership.

Provider Assistance Program

Aetna Better Health's Provider Assistance Program is designed to assist providers in resolving issues with members, and ultimately, to preserve the member/provider relationship and maintain continuity of care. Providers are informed in the provider manual and by Provider Services Representatives of their opportunity to seek assistance in dealing with member situations. The Member Services Department assumes primary responsibility for the program and Case Managers provide support, as appropriate.

The provider submits a form to his/her designated Provider Services Representative to notify Aetna Better Health of concerns with a member. The form is routed to a Member Services

Representative for documentation and outreach to the member. Reasons for provider requests for assistance with a member may include, but are not limited to:

- Communication barriers
- Deterioration of relationship
- Perceived rude/abusive behavior
- Excessive use of Emergency Department (ED)
- Non-adherence to treatment
- Failure to keep appointments
- Potential drug-seeking behavior
- Medical complexity
- Potential fraudulent use of services
- Need for care from different specialty provider
- Potential abuse of transportation

Responses by Member Services Representatives to provider requests may include:

- Educating the member regarding more effective behavior as necessary (e.g. appropriate use of the ED, cooperation with physician instructions, keeping scheduled appointment times)
- Interacting with a provider and his/her staff to facilitate improved communication with the member, including reminders about no cost telephonic interpretation services if appropriate
- Referring the member to a Case Manager for follow-up, as appropriate
- Referring members with three or more missed PCP appointments (no-shows) to Case Management

Provider Initiation of Reassignment Process

If the member continues to display inappropriate actions or behaviors, the provider has the option to remove the member from his or her panel. In these instances, the provider will notify the member and Aetna Better Health about the request to remove the member from the panel and the intention to provide a 30-day transition period. A copy of the request must also be sent to the Member Services Department.

Member Selection of New PCP

Aetna Better Health will issue a written explanation to the member about the provider's request for reassignment in the month following notification. The letter will instruct the member to call our Member Services Department to select a PCP. A Member Services Representative will work with the member to select a new PCP. Depending on the circumstances, a Care Coordinator or a Case Manager may assist and collaborate with the member during this process. Upon request by the member, Member Services and Provider Services will use the following criteria to create a list of appropriate PCPs from which the member can choose:

- Current provider relationships, other than PCP
- The need for children to be followed by a pediatrician
- The member's special medical needs

- The member's physical disabilities
- The member's language needs
- The member's cultural needs
- The member's area of residence
- The member's access to transportation
- The candidate PCP's appointment availability
- How well the candidate PCP's practice type fits the member's needs

If the member does not contact Aetna Better Health to select a PCP within 10 business days, he or she will automatically be assigned to one using the criteria listed above.

Once the member has selected or is automatically assigned a new PCP, our Member Services Department will update the system with the new PCP's information and request a new ID card to be sent to the member. Aetna Better Health will also submit reassignment requests to the EB, which will include the member's name, ID number, detailed reasons for reassigning the member to a different PCP, and a description of all measures taken to avert the reassignment prior to requesting disenrollment.