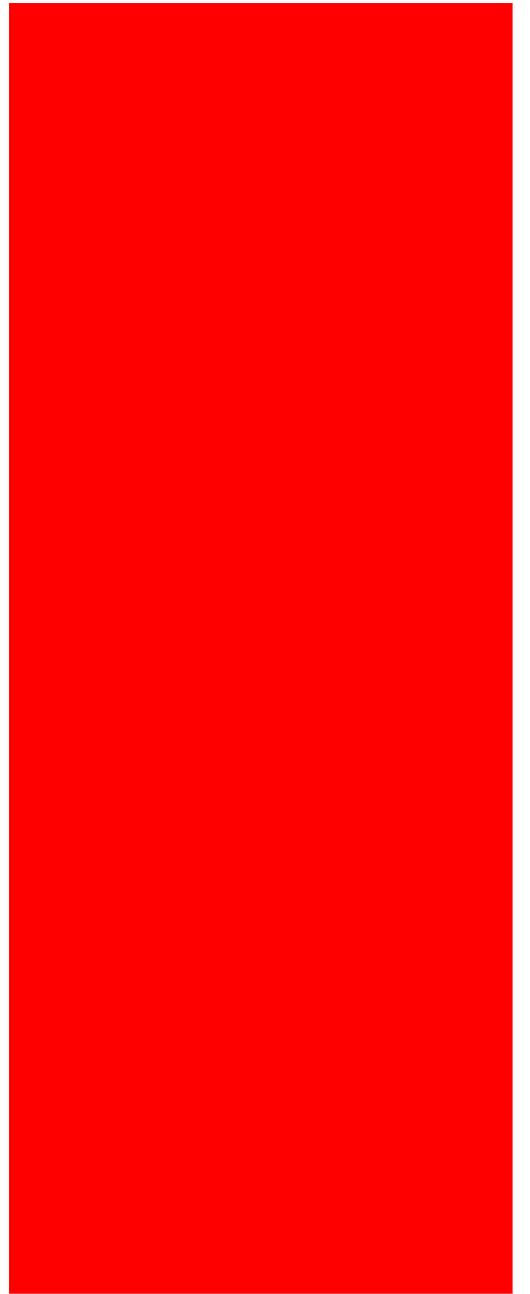


58 SECTION G –
PROVIDER NETWORK

59 G.1



Section G: Provider Network (Section §7 of RFP)

G.1 Provide a listing of the proposed provider network using the List of Required In-Network Providers as described in this RFP, including only those providers with whom you have obtained a signed LOI or executed subcontract. LOIs and signed subcontracts will receive equal consideration. LOIs and subcontracts should NOT be submitted with the proposal. DHH may verify any or all referenced LOIs or contracts. Along with the provider listing, provide the number of potential linkages per PCP.

Using providers with whom you have signed letters of intent or executed contracts, provide individual GeoAccess maps and coding by GSA for: 1) hospitals, 2) primary care providers, FQHCs, and RHCs; and 3) Specialists. You should provide individual maps as well as overlay maps to demonstrate distance relationships between provider types.

The CCN should provide an Excel spreadsheet of their proposed provider network and include the following information: (Sample spreadsheet is available in the Procurement Library)

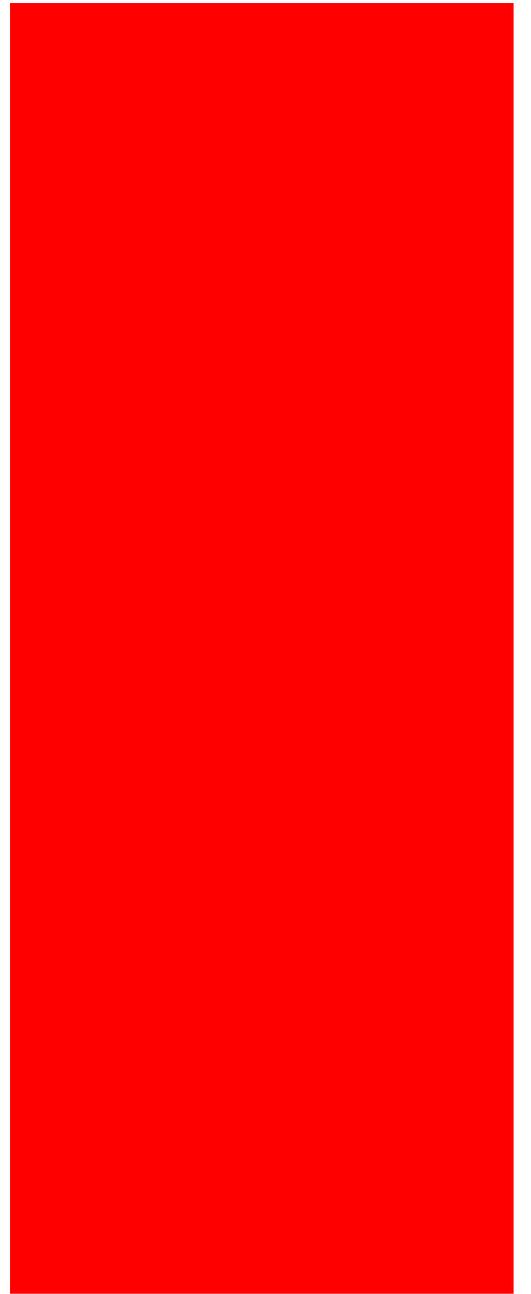
- 1. Practitioner Last Name, First Name and Title - For types of service such as primary care providers and specialist, list the practitioner's name and practitioner title such as MD, NP (Nurse Practitioner), PA (Physician Assistant), etc.**
- 2. Practice Name/Provider Name - - Indicate the name of the provider. For practitioners indicate the professional association/group name, if applicable.**
- 3. Business Location Address - Indicate the business location address where services are provided including but not limited to, 1st line of address, 2nd line of address, City, State, Postal Code**
- 4. Provider Type and Specialty Code - Indicate the practitioner's specialty using Medicaid Provider Type and Specialty Codes.**
- 5. New Patient - Indicate whether or not the provider is accepting new patients.**
- 6. Age Restriction - Indicate any age restrictions for the provider's practice. For instance, if a physician only sees patients up to age 19, indicate < 19; if a physician only sees patients age 13 or above, indicate > 13.**
- 7. If PCP - the number of potential linkages.**
- 8. If LOI or contract executed.**
- 9. Designate if Significant Traditional Provider.**
- 10. GEO coding for this location.**

Included is the spreadsheet of the Aetna Better Health® proposed provider network. Provider information will be validated through our credentialing and data gathering process through our end to end provider contracting process after the award is announced. In addition, the provider specialty list provided by Department of Health and Hospitals (DHH) in the CCN-Prepaid Systems Guide is a limited subset of the specialties in Aetna Better Health's proposed provider network, so we have deferred to the methodology DHH utilized on their April 2011



Medicaid provider file listing to determine the Provider Types and Specialty Codes for certain providers.

60 G.2



G.2 Describe how you will provide tertiary care providers including trauma centers, burn centers, children’s hospital, Level III maternity care; Level III (high risk) nurseries, rehabilitation facilities, and medical sub-specialists available twenty-four (24) hours per day in the GSA. If you do not have a full range of tertiary care providers describe how the services will be provided including transfer protocols and arrangements with out of network facilities.

Aetna Better Health and its affiliates have a long and proven history of building and managing networks serving the diverse needs of Medicaid members in both urban and rural areas. Our most recent successful experiences in establishing tertiary care networks in Florida and Pennsylvania and significantly expanded our Missouri operations; this experience will serve us well in Louisiana as we build new networks that meet all the tertiary needs of our members. In these affiliated operations, Aetna Better Health had initially secured Letters of Intent (LOIs) with providers and converted them to full provider agreements prior to the implementation date. We are following this same process in Louisiana, where we have secured LOIs with tertiary providers, verify appropriate coverage through GeoAccess, and convert LOIs to full provider agreements prior to the implementation date in each GSA.

As a result of our experience with network development, monitoring and training activities, we have built a network in Louisiana that is diverse and responsive to member needs, and which will provide members with a choice across the full range of tertiary services and services provided by medical sub-specialists that are available twenty-four hours per day. To accommodate the special needs of Louisiana members, we have pursued letters of intent and contracts with providers who currently serve the existing Medicaid fee-for-service membership as well as additional providers across provider types. Our goal is to provide for a seamless transition of members to Aetna Better Health, preserving continuity of care and avoiding member transition to new providers. However, it is our standard operating procedure to never disrupt a member’s ongoing course of treatment with an out-of-network provider. The transition will occur when the treatment has been completed or the member’s condition is stable enough to allow a transfer of care. We are especially sensitive to continuity of care for members with special health care needs (MSCHN), children with special health care needs (CSCHN), members with disabilities and members with chronic diseases.

The paragraphs below describe how we will provide tertiary care services available twenty-four hours per day and accommodate members if we do not have the full range of tertiary services in our network.

Providing Tertiary Care Services

Aetna Better Health successfully uses a comprehensive approach to validate that our tertiary and sub-specialty network maintains the ability to provide the full range of tertiary care services. Overseen by our Chief Operating Officer (COO), our Network Development, Provider Services, Quality and Utilization Management, Member Services and other departments work together to verify that services are available and arrange for services in the event of any network gaps. In rare instances where we do not have services available in-network, we make arrangements to provide care through out-of-network providers utilizing various contracting and transfer

protocols. In these instances we coordinate transition and care management processes with the Primary Care Provider (PCP), the member and the member’s family/caregiver and other involved providers (e.g., ancillary and carved out service vendors).

We have successfully signed LOIs with large integrated health systems and their affiliated physicians to provide for tertiary care services to members on a 24-hour-a-day basis. In addition to health systems, we are also conducting ongoing recruitment with individual tertiary facilities and medical sub-specialists. Our recruitment strategy is to target all Louisiana Medicaid providers for a LOI, collaborate with our Aetna commercial¹ counterparts to recruit additional existing Aetna commercial providers who serve our current existing commercial membership, then continue to approach all additional providers in Louisiana regardless of whether they accept Medicaid. We also recruit from surrounding states that have providers within the travel distance requirements. We provide education to our providers throughout this process to prepare them to handle our membership, including completion of our credentialing process, education regarding the Louisiana Medicaid program and training on Aetna Better Health policies, procedures, and use of administrative tools.

Our recruitment strategy has resulted in LOIs with integrated health systems, individual facilities, and medical subspecialists. The table below shows some of the facilities with which we have signed LOIs or contracts and the tertiary services they provide, by GSA:

GSA A

System	Trauma Centers	Burn Centers	Children’s Hospital	Level III Maternity	Level III Nursery	Rehab Facilities
Ochsner Foundation Hospital					X	
East Jefferson General Hospital					X	
United Medical Healthwest New Orleans						X
United Medical Rehabilitation Hospital						X

¹ Aetna Inc. is not licensed to sell health insurance in Louisiana. Our commercial network serves primarily national accounts.

GSA B

System	Trauma Centers	Burn Centers	Children's Hospital	Level III Maternity	Level III Nursery	Rehab Facilities
Ochsner Medical Center Baton Rouge					X	
Specialty Hospital of Luling						X
Lane Regional Rehab Center						X
Ascension Gonzales Rehabilitation Hospital						X
Teche Specialty Hospital						X
Sage Rehabilitation Institute						X

GSA C

System	Trauma Centers	Burn Centers	Children's Hospital	Level III Maternity	Level III Nursery	Rehab Facilities
Christus Schumpert					X	
Women and Children's Hospital			X		X	
Christus St Frances					X	
Shriners Children's			X			
Leesville Rehab Hospital						X
Rehabilitation Hospital of Jennings						X

Twenty-Four Hour Availability

Aetna Better Health provides access to all emergency medical care twenty-four hours per day, seven days per week and provides telephone coverage to members instructing members where to receive emergency and urgent health care services. In addition, upon execution of contracts with providers, Aetna Better Health will contract with tertiary facilities and such contracts require that providers provide access to services twenty-four hours per day, seven days per week. Our Provider Services Representatives educate providers regarding these requirements during new provider orientation and reinforce them during routine provider office visits.

Ongoing Network Monitoring

Aetna Better Health will routinely conduct analysis of our network to verify that we continue to provide access to the full range of tertiary services within travel distance and after-hours accessibility requirements using a variety of tools including quarterly GeoAccess reports; appointment availability/after-hours surveys; and analysis of member complaints, member satisfaction results and out-of-network utilization. Aetna Better Health personnel bring results from these monitoring tools to our Service Improvement Committee (SIC) and Quality Management/Utilization Management Committee (QM/UM Committee) to discuss data, identify issues, review action plans and monitor status. The SIC discuss issues, performs research, gathers preliminary data and identifies end-to-end root causes identification. The goal of SIC is to identify service initiatives and other actions that will improve accessibility and availability of care. The result of these efforts are report to the Quality Management/Utilization Management (QM/UM) Committee. The QM/UM Committee is our principal forum to systematically identify, discuss, and resolve issues that impact both members and providers. Committee members review trended data, approve recommended intervention activities, identify improvement activities, assign action plans, and monitor action plans to completion. The committee also utilizes results from network development activities to improve our network and enhance quality of care. Special emphasis is given to accessibility and availability of care for MSCHN, CSCHN, disabled members and members with chronic diseases.

Addressing Deficiencies if Unable to Provide Access

Aetna Better Health actively recruits tertiary and sub-specialist providers on an ongoing basis as part of our routine activities to enhance our network. Our recruitment plan is to build a network that replicates the fee-for-service system and also includes additional providers in order to avoid gaps in care and the need to transition care. However, in the unlikely event that some providers remain outside our participating network, Aetna Better Health has a process, described below, to transition care and avoid continuity of care issues in both the short-term and long-term.

Short-term Interventions to Address Deficiencies

If medically necessary tertiary services are unavailable through a participating provider, Aetna Better Health has a transfer protocol where we transport members to the closest tertiary provider and arrange for immediate access to services. We identify members who need special assistance or care during the transition and notify the involved physicians and facilities of those special needs. If emergency services are provided at nonparticipating tertiary care facilities, Aetna Better Health will reimburse all services at 100% of the Medicaid fee-for-service reimbursement in effect on the date of service. In instances where we transport members, Aetna Better Health's medical management and provider services teams share all relevant medical information,

complete prior authorizations and/or individual single case agreements (SCAs) with providers, as necessary, to secure tertiary care services. Sharing of medical information is consistent with privacy and HIPAA requirements. We are aware that facilities within each GSA in Louisiana currently follow a process for coordinating and transferring care. Our medical management team will work within this process while implementing transfer protocols. We will never disrupt a member's on-going course of treatment with an out-of-network provider until either the treatment has been completed or the member's condition is stable enough to allow a transfer of care.

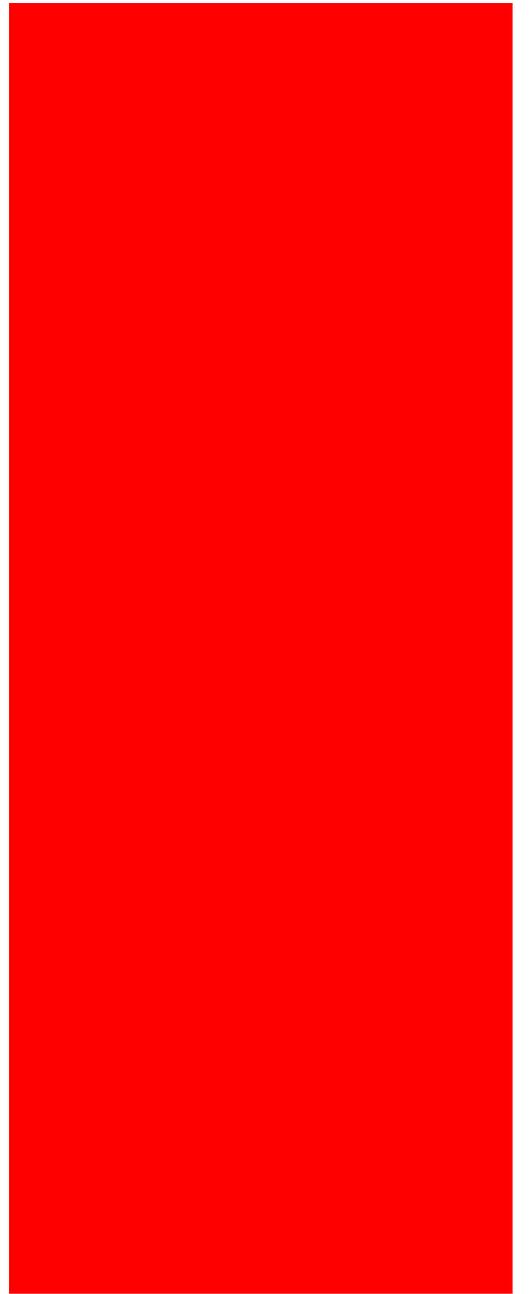
Our medical and provider services teams use feedback from these daily activities to address issues as they arise and prevent them from recurring. Upon learning of the need to authorize specialty care to an out of network provider, our network development team pursues contracts with that out of network provider or other nearby providers who can offer those same services.

Long-term Interventions to Address Deficiencies

To proactively provide consistent access to services and avoid gaps, our network development personnel recruit out-of-network providers including those with whom we have authorized care and/or executed a SCA. We continually assess use of out-of-network services and have developed monthly reporting to verify that our network contains adequate numbers and types of providers. Our Network Development team uses this information to evaluate recruitment opportunities.

As mentioned above, we perform GeoAccess analysis to monitor network adequacy and supplement this information with data from appointment availability/after-hours surveys, member complaint data, information from our Case Management personnel on difficulties for finding access to services and member and provider satisfaction survey results to identify patterns across the network or areas where we can enhance our network of tertiary services across certain services or geographical locations. We proactively use outcomes of these analytical efforts to enhance the network and avoid future gaps. In addition, regular contact with medical management, member services and other departments occur during our cross-functional Service Improvement Committee meetings, in which access to care issues can be addressed and action plans identified.

61 G.3



G.3 Describe how you will handle the potential loss (i.e., contract termination, closure) in a GSA of a) a hospital and b) all providers within a certain specialty.

Aetna Better Health and its affiliates have a well-established process for identifying potential losses and implementing protocols that provide for continued service to members. Under the direction of Aetna Better Health's chief operating officer (COO), the director of network development/contracting is responsible for maintaining a viable provider network in the event of a contract termination or closure. Aetna Better Health works with the Department of Health and Hospitals (DHH), members, providers, and community organizations to facilitate continuity of care and minimize impact to members and providers.

Monitoring Potential for Loss

Aetna Better Health[®] routinely monitors the network for viability and continuity, with focus on hospitals and provider groups with known or suspected viability problems or known to be at risk for closure. This monitoring serves as an early warning system and allows us to identify potential contract termination or facility/office closures, prevent abrupt closure, prevent member disruption, and provide for seamless delivery of services to members. The following are examples of key indicators used in our monitoring process:

- ***State licensure issues*** – monitored monthly by the Provider Relations Department
- ***Medicare/Medicaid sanction reports*** – monitored monthly by the Provider Relations Department using the United States Department of Health and Human Services, Office of Inspector General's exclusion list
- ***Credentialing or re-credentialing concerns*** – monitored by the Quality Management Department and required to be reported through the Credentialing Committee and Quality Management/Utilization Management Committee including State regulatory boards
- ***Failure to secure or renew required insurance*** – provider contracts require that providers immediately notify Aetna Better Health of failure to secure or renew required insurance. This is monitored by the Quality Management Department through the credentialing process and by provider relations representatives during site visits
- ***Financial Triggers*** – includes multiple requests within short time lines from a facility or a provider for advance payments to cover payroll expenses – monitored by the provider relations and Finance Departments
- ***Concerns raised by personnel that make closure suspect*** – our Concurrent Review Nurses, Case Managers, Quality Management Nurses, etc. are trained to report concerns of facilities or certain providers who may close or terminate their contract
- ***Complaints from members or providers about the availability of care or services*** – Provider relations and/or quality management personnel resolve these issues on a daily basis and escalate trends to senior management as needed.

In addition to monitoring hospitals and providers, we maintain communication with officials from state agencies and obtain information from public sources such as newspapers and the internet to identify potential closures.

Addressing Loss of Hospitals or Providers within a Specialty

Aetna Better Health's primary concerns during hospital/provider losses are the safety of members and continuity of care. We take the actions listed below upon learning of potential contract termination, closure for any reason, or quality of care concerns.

- 1) Increase communication with the hospital and/or providers, up to and including site visits or meetings held prior to the effective date of contract termination or any change related to contract status that could have an impact on members
- 2) Reduce/halt placement or assignment of members, including:
 - A) Cease assignment of members to PCPs and authorization of services to specialists
 - B) Halt admissions or placement of members into the affected hospital
 - C) Coordinate care with new hospitals/specialists to allow for continuity of care and prevent delays in service. This may include arranging care with out of network hospitals and specialists or arranging for care to continue with the current provider throughout the course of treatment (if appropriate).
- 3) Request a corrective action plan (CAP) which must be approved by :
 - a) The CAP must include steps by the hospital/provider to correct the immediate problem, prevent it from reoccurring, and a plan to provide members with medically necessary services without interruption, delay, or effect on quality of care
 - b) Upon review of the corrective action plan, Aetna Better Health either continues to monitor the situation or notifies the hospital/provider of contract termination
- 4) Notify DHH, our affected members, and providers if the contract is to be terminated. In accordance with DHH regulations, we will provide written notice to DHH no later than seven business days of any network provider contract termination that materially impacts our network (as defined by DHH). We will provide notification regardless of whether the contract is terminated by Aetna Better Health or the provider and include the reasons for the proposed termination. Aetna Better Health will also provide hospitals and provider groups with ninety days advance notice prior to a contract termination without cause.

Example of Handling Termination

Through our experiences in other Medicaid health plans, Aetna Better Health has expertise in addressing and effectively handling provider losses and has protocols in place to address the concern. Our experience reflects that terminations across all providers within a certain specialty are typically due to reimbursement or administrative/operational issues. Upon receipt of termination from a hospital or all providers within a certain specialty, Aetna Better Health would first attempt to salvage the relationship by communicating with the provider(s) to understand the root cause of the termination. If there was a loss of providers within the same specialty, we would even consider antitrust violations that may be occurring and communicate such concerns to DHH. If the provider expressed that termination is due to a reimbursement issue, we may work with the provider on potential alternative reimbursement methodologies. These alternative structures would keep the provider at Medicaid reimbursement, but potentially allow them to

share in savings on initiatives they lead that drive to better quality for the members, creating advantages for the member, provider and Aetna Better Health.

In situations where providers express concerns regarding administrative/operational issues, we would address these concerns in various ways, including the following:

- Consider eliminating or alleviating prior authorization requirements for that provider or group of specialty providers, allowing for a "gold card" status. In these cases, Aetna Better Health would review utilization reports frequently and periodically sample cases to monitor the "gold card" status and verify that the provider is appropriately utilizing services. If there was a suspicion of inappropriate utilization, Aetna Better Health would meet with the provider to address any issues or findings.
- Potentially place a Case Manager within the provider's office to assist with the management of our members
- Assign a dedicated point person within our member services team (such as a member advocate) that could assist the provider with member issues, such as appointment compliance, coordination to specialists and transportation arrangements
- Determine if certain members of the provider group would be willing to remain as participating providers within our network. Aetna Better Health has experience in our other Medicaid health plans where the entire group terminates, but as we meet with the group in an attempt to retain the contract, we have been able to convince certain providers within the group to remain participating.
- Leverage our larger Aetna relationship with the provider. We have been successful in including our commercial counterparts to assist in the retention of a significant relationship with a Medicaid provider, based upon the larger overall Aetna relationship.
- If we are unable to prevent sufficient providers across a specialty from terminating their contracts, we have the ability to set the providers in our system as non-participating, but treat them as participating for authorization requirements. This eliminates the administrative authorization burden of being non-participating. We have been effective in retaining access to care for our members through this process.
- Complete single case letters of agreements with non-participating providers to allow for the continuation of care for members to access to needed services.
- Pursue contracts with available providers in contiguous parishes or Border States that would allow us to meet access standards.

For example, in our Delaware plan, there was a shortage of orthopedic surgeons who accept Medicaid. We had one main group in a county who provided access for our members for several years. The group merged with another non-participating group and decided to terminate their contract. Our executive leadership and network development personnel held several meetings with the group in an attempt to retain them as participating providers. We were successful in keeping access to some of the providers as participating, but some did proceed to terminate. For those that terminated, we set them up in our claims payment system to allow them to see members as if they were participating, thus eliminating administrative burdens. This structure allowed them to continue seeing existing members as well as follow up with new members they

may have treated while on call at the hospital. During the entire process, the Delaware plan continually updated the State on the progress of our discussions and the outcome.

Member Transition

Aetna Better Health transitions members, following established procedures, if the hospital/provider closes or terminates, or there are quality issues with the potential for harm to members. In these instances, Aetna Better Health forms a transition team comprised of personnel from departments involved in the particular transfer, such as Members Services, Care Management, Utilization Management, Quality Management, Provider Services, etc. to assist in the transition process. The team re-assesses the member, identifies members who need special care or assistance during the transition, revises the care plan, and coordinates a seamless transfer of the member and member's medical records. Aetna Better Health may relocate members to a participating or non-participating hospital/provider within the same geographic or nearby location or may implement specific actions as follows:

- For PCPs who participate in a large provider group, we notify members in advance and provide an opportunity to select another PCP. If the member does not select a PCP, we auto-assign the member to a PCP located close to the member's residence and allow the member to change at a later date if requested.
- For specialists that participate in a large provider group, we review our prior authorization (PA), case management records and claims data to determine if services have been authorized or recently provided and identify members undergoing active treatment. In these situations, we contact members to reassure them there will be no disruption in their care plan during the transition, and provide the member with contact information and timelines. We locate other network or out of network providers who could provide the needed services and our Member Services personnel assist with the transition. Our Network Development team then works with existing providers to discuss the possibility of remaining in the network (if appropriate and if the termination is not for quality of care reasons). Our Network Development team also pursues contracts with out of network providers to verify that we have the appropriate numbers and types of providers in the network.

Members may remain in the facility or under the provider's care depending on the reason for the provider termination, and Aetna Better Health contractually requires providers to provide continued services to members as appropriate in the event of termination. Our approach is to work with the terminating hospital/provider for as long as our member's quality of care is not at risk. The member's Case Manager or a Member Services Representative assist the member with the change of providers.

Under each circumstance, we provide translation services for members during transition to avoid misunderstanding and reduce anxiety; facilitate continuity and quality of care; and maintain confidentiality of information.

Natural Disasters

Louisiana's unique geography renders the state susceptible to natural disasters. Mindful of these risks, Aetna Better Health's Emergency Management Plan (EMP) and Disaster Plan for Louisiana will comprise measures supporting not only business continuity, but the welfare of our health plan members during any public health emergency. The plans detail the recovery efforts

we would implement to minimize impact to our members and maintain operations. In the event of a major disaster, Aetna Better Health would postpone elective procedures, transport members to the nearest facility, notify providers and members of the closure, and arrange for increased case/care coordination for members that need to be transitioned or transported.

Aetna Better Health's internal policies and procedures complement existing national, state and local emergency preparedness infrastructure. We educate members regarding existing resources and assist them in their efforts with regard to emergency preparation, response and recovery. To better assist members in navigating resources, Aetna Better Health's Member Handbook and website will contain a directory and links to key emergency preparedness resources. Member Services Representatives and Case Managers will receive training to the extent that they are able to increase members' awareness of available emergency preparedness programs and resources.

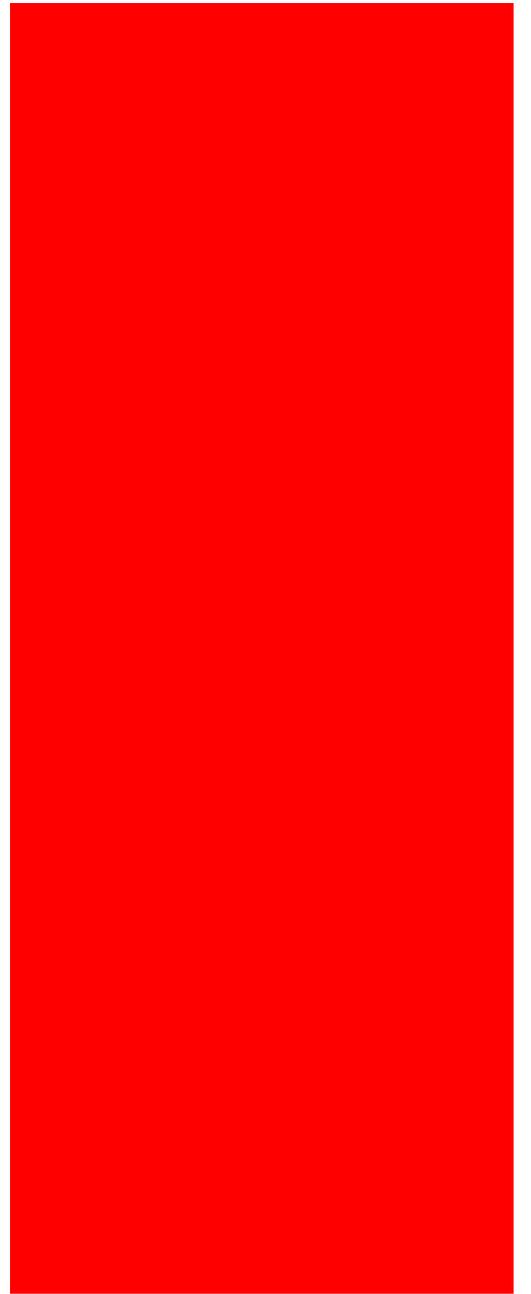
Aetna Better Health's Board of Directors has ultimate responsibility for ensuring the organization has a program for continual assessment and testing for disaster preparedness and recovery within the organization and among its subcontractors. The Board of Directors has delegated the responsibility for the preparation of an annual Disaster Plan to Aetna Better Health's Chief Executive Officer (CEO). The annual Disaster Plan addresses the business continuity and disaster recovery planning functions necessary to maintain Aetna Better Health's members' accessibility to health services in times of business disruption.

Key to its disaster preparedness and recovery function is the regular review of Aetna Better Health's disaster program. Each year we will provide for the continued maintenance and update of the Disaster Plan through the capture of actual experience and/or periodic mock drills. Annually, health plan management will conduct an assessment of the written Disaster Plan. The results of these assessments will be reported through the Quality Management Oversight Committee to Aetna Better Health's Board of Directors. In the event revisions to the Emergency Management Plan are deemed necessary, Aetna Better Health will submit proposed edits to DHH for approval no less than 30 days prior to implementation of requested changes.

Other Temporary Losses

Aetna Better Health also monitors for temporary deficiencies that fall between business failure and disasters. For example, a network physician may suddenly no longer perform services. In this situation, we immediately arrange coverage from another physician, typically the physician's covering or backup physician. In our experience, backup physicians are usually already credentialed; however, if not, we would arrange for expedited credentialing and assist the provider in facilitating the credentialing process. If there is no covering physician, we identify other network providers with capacity and transition members to the physician closest to their residence. Further, we review our prior authorization, case and disease management records and advise the backup physician of cases that may need attention.

62 G.4



G.4 The CCN is encouraged to offer to contract with Significant Traditional Providers (STPs) who meet your credentialing standards and all the requirements in the CCN's subcontract. DHH will make available on www.MakingMedicaidBetter.com a listing of STPs by provider type by GSA. Describe how you will encourage the enrollment of STPs into your network; and indicate on a copy of the listing which of the providers included in your listing of network providers (See G.1) are STPs.

Aetna Better Health, Inc. and its affiliates understands the importance of including Significant Traditional Providers (STPs) in our network and the role they play in providing access to quality care for our members. We have extensive experience in building networks that include significant and high volume traditional Medicaid providers in our other Medicaid states including Pennsylvania, Missouri, Delaware and Texas, and are familiar in working with and engaging STPs into our Medicaid programs. We will apply this experience to our network development efforts in Louisiana, which includes pursuing contracts with all STPs in the area as a key component of our network.

Process for Targeting STPs and Encouraging Enrollment

Aetna Better Health has targeted STPs using a variety of methods to encourage a maximum amount of participation in our network. Our initial recruitment began by identifying and targeting all Louisiana Medicaid providers, which includes all providers identified as STPs on the Department of Health and Hospitals' (DHH's) website. We have pursued full contracts or LOIs with each Louisiana Medicaid provider, collaborated with our Aetna commercial plan to begin contracting discussions with existing Aetna commercial providers into the Aetna Better Health network, and approached additional providers in Louisiana regardless of whether they accept Medicaid. We work with STPs and other providers to educate them regarding Louisiana Medicaid and Aetna Better Health, and validate that they meet our credentialing standards and contract requirements.

Aetna Better Health's network development personnel communicate with STPs using a variety of outreach methods to encourage maximum participation. We have delivered information to STPs regarding the Louisiana Medicaid Program and Aetna Better Health through mailings, blast faxes and daily phone calls. We follow up with providers and make personal visits to those who have not yet responded or returned a signed contract or LOI. Our recruitment efforts are ongoing and we track and report the status of all recruitment efforts to aid in follow up with providers.

All providers who agree to participate will go through our credentialing process and receive an extensive orientation session regarding the Louisiana Medicaid program and Aetna Better Health policies and procedures before seeing members. Since STPs are high volume Medicaid providers, we will work extensively with them during the implementation process to assist them in smoothly transitioning from fee-for-service to managed care. We will have provider services, claims, medical management and other resources available to assist them in filing claims and answer questions in order to avoid disruption to their cash flow or administrative processes.

Summary of STP Recruitment Efforts

The table below summarizes recruitment efforts, current status and Aetna Better Health's ongoing recruitment plans to further increase STP participation.

Outcome of Recruitment Efforts	Number of STPs*	Status/Description	Recruitment Plan
Signed LOI or Contract	575	Aetna Better Health has an executed LOI or Contract from the provider	Convert LOIs to contracts upon contract award. Secure any missing documentation for existing contracts to prepare for counter-execution
In process	1168	Aetna Better Health has conducted outreach to many STPs who indicated they will sign the LOI (but have not yet returned it) or would consider signing an LOI	Follow up with STPs upon State award as we anticipate that many will enter into a contract with Aetna Better Health at this time
Invalid contact information	220	We were unable to locate valid contact information using the DHH provider file. We used various additional sources to obtain contact information including collaborating with our Aetna commercial plan to search their provider database	Continue research efforts to obtain valid contact information. Work with DHH to share findings from our research and update provider demographic data
Unwilling to accept Medicaid and/or rates	226	Certain providers indicated that they do not accept Medicaid members at all, which is odd, as by the STP definition of they have a high volume Medicaid. Others have informed us they prefer not to add any further Medicaid members to their practice, or that the Medicaid reimbursement rates are too low	After award, request on-site meetings with these providers to address their issues, explain that the Coordinated Care Network CCN program in itself won't add more Medicaid to their panel; the majority of their panel will move from FFS to CCN and periodically re-approach them to determine if they will reconsider entering into a contract in the future. For those that have informed us they do not take Medicaid, continue to outreach to confirm that they do not take Medicaid and inform DHH so their data may be updated.
Waiting for State award	467	Certain STPs indicated interest in entering into a contractual agreement but will not sign a contract or LOI until the State has awarded the business	Follow up with STPs upon State award as we anticipate that many will enter into a contract with Aetna Better Health at this time
Carve Out Providers	77	These providers are not providers that the CCN would contract (such as specialized behavioral health)	N/A
Duplicates	132	These providers were on the DHH file	N/A

Outcome of Recruitment Efforts	Number of STPs*	Status/Description	Recruitment Plan
		more than one time (multiple addresses or multiple specialties)	
Non STP Provider Types	1095	Based on the definition in § 7 7.14.2 of the RFP, these provider types do not match the definition and are not considered STPs for the CCN (DME, Laboratory, Transportation, etc)	Aetna Better Health has actively recruited these providers and has many LOIs and contracts with these providers. We will continue to contract them after award.

TOTAL: 3960

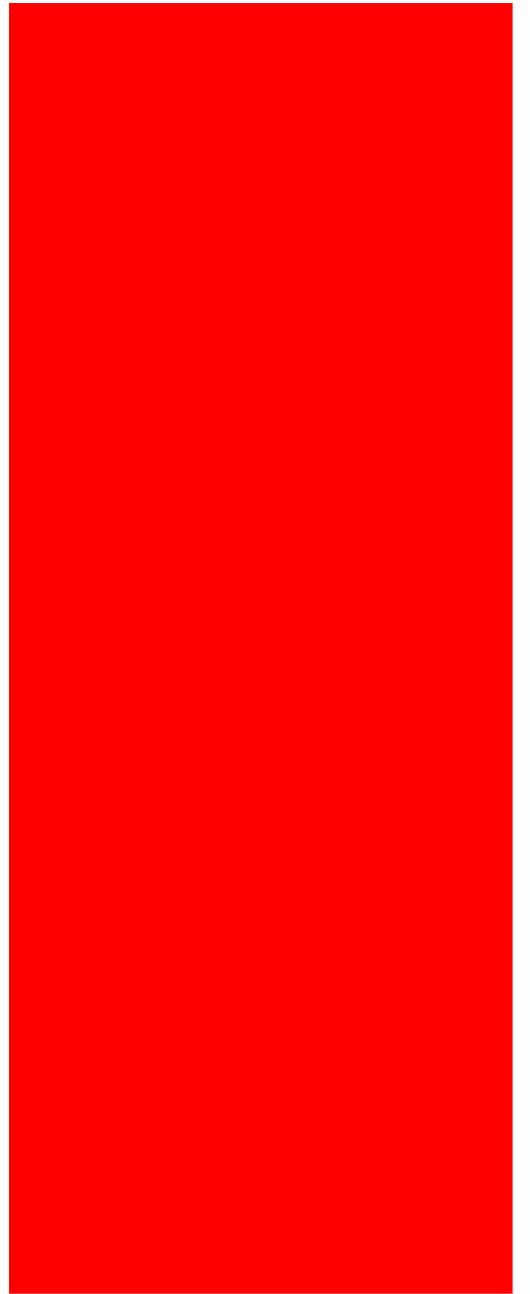
* Aetna Better Health utilized the same counting logic as was found on the DHH file. Some providers were listed individually, others were listed only at the group level.

Aetna Better Health will continue to pursue contract efforts with STPs on an ongoing basis as part of our routine contracting activities.

Listing of STPs

Please see Appendix R for a listing our Aetna Better Health's network providers. We have indicated the providers who serve as STPs in this network listing.

63 G.5



G.5 Based on discussions with providers in obtaining Letters of Intent and executed subcontracts as well as other activities you have undertaken to understand the delivery system and enrollee population in the GSA(s) for which a proposal is being submitted, discuss your observations and the challenges you have identified in terms of developing and maintaining a provider network. Provide a response tailored to each GSA of the following provider types/services:

- Primary Care
- Specialty Care
- Prenatal Care Services
- Hospital, including Rural Hospital
- Office of Public Health
- Private Duty Nursing/Home Health Services;
- FQHC
- School Based Health Clinic

Network Development Experience

Aetna Better Health and its affiliates have a long and proven history of building and managing networks serving the diverse needs of Medicaid members. We have developed and currently manage provider networks that deliver full range Medicaid health care services in ten states across the country including Arizona, California, Connecticut, Delaware, Florida, Illinois, Maryland, Missouri, Pennsylvania, and Texas. Our expertise in collaborating with community based providers such as federally qualified health centers (FQHCs), rural health clinics (RHCs), PCMHs, and school based health clinics (SBHCs) is key to our provider network development plan. Drawing upon this expertise, Aetna Better Health's overarching goal is to develop and maintain provider networks that are available and accessible to our membership in Louisiana.

Several major systems including, but not limited to, specialists, hospitals, and federally qualified health centers (FQHCs) have declined at this point to sign letters of intent (LOIs) with Aetna Better Health. These providers have relayed to us their intention to wait until the RFP process is complete and DHH has selected the CCNs it intends to offer to members before entering into contract negotiations. Aetna Better Health's network development expertise and provider recruitment strategies are targeted and have proven to be effective in other states. As a result, we remain confident that we will be able to include these providers in our network once DHH has made the contract award for the CCN program.

Aetna Better Health also encountered a unique contracting difficulty in GSA B which it has not experienced in any other state where it operates a Medicaid managed care plan, all as more fully described in that section, and which warrants DHH's attention from a RFP response as well as a program integrity standpoint.

Network Development Strategies

Leveraging our significant network development expertise and utilizing Louisiana's existing Medicaid provider network as our centerpiece, Aetna Better Health will build a strong, comprehensive, and accessible network. Under the direction of our Chief Executive Officer

(CEO), Aetna Better Health's Network Development Director (Director) has overall responsibility for the provider network development plan in Louisiana. The Director has assembled a team of Aetna Better Health network development experts to conduct our Louisiana provider recruitment and outreach efforts. Our Director meets weekly with the team to review network development progress, identify and discuss challenges in engaging sufficient providers by type, address provider questions arising during the recruitment process (e.g., issues with prior authorization processes), and develop plans of action to resolve any identified barriers. Our network development committee is comprised of key Aetna Better Health leadership including, but not limited to, our CEO and COO.

Our Director has established effective lines of communication designed to promote the successful development of a robust provider network in a timely manner. Network development team members are required to participate in network development meetings a minimum of three (3) times per week to discuss and monitor day to day progress including, but not limited to, appropriate resource allocation, challenges and successes in connecting with providers, accurate and timely reporting, and review of received and outstanding provider letters of intent (LOIs) and contracts. Team members must also access and review the following communications to monitor the progress of the provider network:

- Daily provider tracking reports that are updated on a daily basis, maintained in our network tracking database, and contain current information on outreach efforts and status of provider communications
- Daily provider LOI and received contracts report
- Weekly provider report that compares week-to-week progress in the growth of the network
- Weekly GeoAccess reports
- Weekly network report by GSA that illustrates the progress of the entire network including received LOIs and contracts and providers stratified by provider type

We have implemented a blended provider recruitment strategy and continue to conduct a targeted outreach campaign to Medicaid providers in geographic service areas (GSAs) A, B, and C. Our campaign includes face-to-face outreach, print materials, and telephonic contact to encourage providers to join our network. Accessibility and availability are a primary focus in building our network. Our network development approach attracts qualified Louisiana Medicaid providers to participate in a robust network that meets access standards while providing the highest quality care to our members. In addition, our network development emphasizes recruiting and contracting with existing safety net programs such as RHCs, FQHCs and school based clinics.

Network Development Observations and Challenges

To meet the needs of Louisiana members, we have we have pursued LOIs and contracts with providers who currently serve the existing membership as well as additional providers across provider types. These strategies have surfaced the following recurring themes and challenges in recruiting provider types across GSAs A, B, and C:

Primary Care Providers

Aetna Better Health has successfully entered into conversations with a majority of the current Medicaid fee-for-service primary care providers (PCPs) in all GSAs. Many of these providers, with the exception of the FQHCs addressed separately below, have executed LOIs or contracts to demonstrate their desire to participate with Aetna Better Health. The remaining PCPs have indicated they are waiting until DHH awards the CCNs. Based on our observations from meeting with PCPs, Aetna Better Health has identified there is/are:

- 1) Need for administrative relief from the current specialist and emergency room referral process
- 2) Obstacles in engaging with other providers for effective care coordination
- 3) Issues with current transportation system for nonemergency medical care
- 4) Insufficient appointment availability for members
- 5) Need for meaningful reports to identify members in need of preventive care, with special health care needs, at risk for inpatient readmission, etc.
- 6) Concerns regarding the administrative and financial burden of obtaining National Committee for Quality Assurance (NCQA) recognition or Joint Commission on Accreditation of Healthcare Organization accreditation

Specialty Care Providers

Aetna Better Health provider recruitment activities in this area have identified a shortage of specialist providers in the current LA Medicaid network. Specialists and PCPs currently participating in the Medicaid network have indicated they are looking to the CCN to improve access to specialty providers. We believe specialists are hesitant to participate in the Medicaid network due to the current reimbursement structure and the administrative burden associated with serving Medicaid eligible members.

Prenatal Care Services

Aetna Better Health has built a robust OB/GYN network statewide. We will continue to actively identify, recruit and contract with OB/GYNs. If we experience a future deficiency, we will authorize care from an out-of-network OB/GYN provider and actively recruit that provider and/or other providers in that specialty and geographic location. We would also provide alternatives such as Certified Nurse Midwives, and for gynecologic care, we may assist the member in finding a contracted PCP that provides routine well-woman care as an alternative. In the event a pregnant woman needs obstetrical care, we will make every effort to obtain care for this member with the closest participating OB/GYN provider. If no participating OB/GYN providers are available, or if the member is past the 24th week of pregnancy and is already in an active course of treatment with a non-participating provider, we will authorize out-of-network services.

Hospitals

Aetna Better Health has reached out to every hospital in the State of Louisiana to discuss the LOI process. We understand that it is common practice for hospital organizations to choose not to execute LOIs for any bidding entity and to work cooperatively with the entity that is awarded the business. We have discovered there are hospitals that are waiting for DHH to announce the

awards before they will discuss participating with Aetna Better Health. Some hospitals are looking for the CCN to offer shared savings in addition to 100% of the current Medicaid fee schedule. We have encountered unique challenges in contracting with providers in GSA B which are discussed in greater detail below in the section titled “Geographic Service Area B.”

Rural and critical access hospitals were initially concerned regarding the CCN initiative and felt the CCNs may decide to contract only with the larger more urban hospitals; however, the revised RFP, along with our active outreach to the rural and critical access hospitals has alleviated some of the concerns. These hospitals are engaging in productive conversations with Aetna Better Health.

Office of Public Health

Aetna Better Health has met with and received an executed LOI from the Office of Public Health. We also agreed to work with the Office of Public Health to execute a "Cooperative Endeavor Agreement" to work with OPHs more than 70 Public Health Units to collaborate on CCN member outreach, education, and to provide the following services:

- Immunizations
- Sexually transmitted diseases
- Family planning
- Weight management -- see value add in section S2
- Perinatal home visits

Private Duty Nursing/Home Health Services

We understand that private duty nurses and home health services are essential to supporting our members with special health care needs in the community or least restrictive environment. Aetna Better Health has received LOIs from these providers in numbers to provide sufficient availability and accessibility for community-based services for our members. To promote member choice, Aetna Better Health will continue to actively identify, recruit and contract with additional these providers in this GSA.

Federally Qualified Health Centers

Aetna Better Health has reached out directly to the FQHCs in across the state. Numerous FQHCs have informed us they have executed agreements with one competitor. These providers have indicated they are unwilling to execute LOIs with other potential CCNs. The majority of the FQHCs have indicated that they will work with any CCN once the award has been announced.

School Based Health Clinics

There has been some confusion amongst the SBHCs on whether their services are a CCN Covered Service. We’ve been educating these providers on the RFP requirements regarding the SBHCs services being a CCN covered benefit. Some SBHCs are sponsored by FQHCs and due to the FQHC issues identified above we have not secured LOIs for the FQHC SBHCs. In addition, with the SBHCs closing for the summer, trying to find the correct contact has proved to be challenging at times. Despite those issues, we have still been successful in securing LOIs with several SBHCs. One major SBHC sponsor in several parishes is CHRISTUS Health. We have secured a LOI for all CHRISTUS Health SBHCs and we’ve started furthering discussions on the

challenges they have with members and how we can collaborate together to improve the outcomes for CCN members.

Geographic Service Area A

Aetna Better Health has found the providers in GSA A to be very receptive to our efforts to include them in our network. We believe that the January 1, 2012 implementation date is driving these providers to prepare for the upcoming changes. The providers are responding positively, for the most part, by asking positive questions and becoming engaged in the process.

Geographic Service Area B

One differentiating factor for GSA B lies in the wide held belief amongst providers (e.g., primary care providers, specialists, hospitals) that there is no urgent need to make a decision regarding network participation. Numerous providers in GSA B have informed Aetna Better Health that they will remain uncommitted to a CCN until the award has been announced or even until after the implementation of GSA A. While this has created a challenge in obtaining letters of intent (LOI) from potential providers in this GSA, Aetna Better Health has continued our “feet on the street” approach and telephonic outreach efforts to meet with and educate providers.

Specifically, Aetna Better Health approached hospitals in GSA B for the purposes of signing a LOI to participate in our CCN network. Aetna Better Health was informed by certain hospitals in GSA B which were members of Acadiana HealthCare Alliance that they would not contract with any CCN directly, but would only do so through Verity HealthNet. Likewise, it is also our understanding that the Baton Rouge Medical Center Hospitals are represented by Verity and also require an agreement to pay an access fee in order to obtain an LOI from them. Accordingly, representatives of Aetna Better Health met with representative of Acadiana HealthCare Alliance. In that meeting, we were advised that, in return for the payment of an access fee of between \$1.00 and \$2.00 PMPM, (i) Verity could assure any CCN that contracted with it that the hospital members would sign a LOI, but that (ii) no assurances could be made that any physician members associated with Verity or the Acadiana hospitals would agree to participate in the CCN program, notwithstanding the payment of the access fee. We were also advised in that meeting that the Verity access fee would be shared with the hospitals via Verity’s agreement to split its fee with Acadiana HealthCare Alliance.

Earlier in 2010, during our contracting efforts we were told by the Baton Rouge General Medical Center hospitals that we would have to work through Verity to access their services and get an LOI signed. Our representatives met with Verity executives who made the same representations that were made in our meeting with Acadiana HealthCare Alliance as outlined above.

Aetna Better Health does not pay access fees to secure providers. Our experience has taught us that working closely with physicians and hospitals are a critical component of a successful managed Medicaid program. There is no identifiable value gained by working through a third party to access providers— quality of care delivered is not improved and cost of care delivered is increased. Medicaid managed care networks can not be administered like commercial rental networks. In fact, we have never encountered a situation like this in any other state in our twenty-five year history of being in this business.

Considering that other CCN plans have agreed to pay the access fee gives us cause for concern about the accuracy of the provider listings and GeoAccess maps signed by those CCN plans that

contracted with Verity. The question is, if Verity can not give any assurance about which physicians would participate in a CCN network, how do the affected hospitals know which providers from Verity's network to include in their calculations for network adequacy and the underlying GeoAccess reports? The network listed by Aetna Better Health for GSA B does not include any Acadiana HealthCare Alliance hospital that would only contract with Aetna Better Health if it paid an "access fee" to Verity HealthNet.

Aetna Better Health remains willing to execute LOIs directly with the hospitals in question and will continue to engage directly with the hospitals on contract discussions.

Geographic Service Area C

One differentiating factor for GSA C lies in the wide held belief amongst providers (e.g., primary care providers, specialists, hospitals) that there is no urgent need to make a decision regarding network participation. Numerous providers in GSA C have informed Aetna Better Health that they will remain uncommitted to a CCN until the implementation of GSA A and B. While this has created a challenge in obtaining letters of intent (LOI) from potential providers in this GSA, Aetna Better Health has continued our "feet on the street" and telephonic outreach efforts to meet with and educate providers.

Aetna Better Health Strategies for Overcoming Network Development Challenges

Aetna Better Health will develop, monitor, and maintain robust provider networks to serve our members in the State of Louisiana. Our provider networks in geographic service areas (GSAs) A, B, and C will meet or exceed availability, accessibility, and adequacy standards and will be in place prior to the operation readiness review. Our provider networks will consist of primary care providers (PCPs), specialist physicians in individual and group practices, obstetrics and gynecological providers, hospitals, private duty nurses, home health services, FQHCs, RHCs, SBHCs and other provider types. We will offer sufficient provider availability and accessibility to deliver covered services in accordance with the Department of Health and Hospital (DHH) service accessibility standards. Our provider networks will be enhanced by the partnerships we develop with community-based organizations and other key stakeholders. Aetna Better Health will support and manage our networks in delivering high quality health care to our members and promptly address any gaps or deficiencies.

Aetna Better Health will work directly with DHH to overcome the network development challenges in each GSA. We will support our providers by reducing or eliminating undue administrative burdens, offering competitive reimbursement, and providing experienced personnel (e.g., provider services) and streamlined processes (e.g., prior authorization) designed to promote the delivery of quality, appropriate, and timely health care services to our members in Louisiana. Our strategies include, but are not limited to, the following:

Primary Care Providers

In an effort to improve or resolve the above-identified challenges, Aetna Better Health will:

- 1) Eliminate the referral process for PCPs to refer members to in-network specialists or the emergency room.
- 2) Provide Case Managers who will assist PCPs with coordination of care.

- 3) Contract with a qualified vendor for non-emergency medical transportation to provide members with appropriate access to services.
- 4) Develop a provider network that is diverse and sufficient in size to meet availability standards. Review member inquiries and requests for information, satisfaction surveys, and complaints to identify and address provider appointment availability issues.
- 5) Utilize our business management system, QNXT™, to generate data-driven reports regarding members with special health care needs, member utilization (e.g., preventive care, emergency room, inpatient readmission), and provider practice patterns.
- 6) Educate providers about our pay for performance (P4P) to incentivize their transition to the patient-centered medical home (PCMH) model. Support and monitor providers through the NCQA recognition and JCAHO accreditation processes.

In addition to working with existing PCPs in the rural parishes, we are actively exploring relationships with other providers to potentially expand into rural service areas to increase access to services and complement the existing providers in the area. For example, Aetna and Walgreens are developing a strategic approach to meet the needs of Louisiana residents. This partnership is being formed to leverage Walgreens pharmacies throughout the entire State of Louisiana. Walgreens currently has five Take Care Clinics in Louisiana, with the ability to expand within the 143 Walgreen retail stores located in the State offers significant potential for further clinic expansion. Walgreens anticipates using these sites to improve access to preventive, outpatient and urgent care services. At all locations throughout Louisiana, Walgreens provides consistent clinical support and therapy management to improve medication adherence levels, improve patient and physician satisfaction and improve clinical outcomes.

Walgreens is uniquely positioned to provide convenient health and wellness services, supported by member education and community outreach. They plan to expand their presence within the at-risk population through the use of various outreach activities, such as Walgreens Wellness Buses and participation in community wellness activities, including health fairs and “Walk with Walgreens” events. Walgreen Co. is also reviewing ways to maximize technology to reach underserved populations in heavily rural areas.

We are beginning discussions on the potential to use Walgreens pharmacies and Take Care Clinics to administer childhood and adult immunizations and health risk assessments; including screenings in a targeted effort to improve HEDIS^{®2} scores, as well as patient education in support of other health services. We believe this would be a valuable effort in all areas of the State (rural and urban) to increase access for our members to receive these services.

In addition, the two entities will collaborate to see that patients go to the appropriate care provider in effort to divert inappropriate traffic away from emergency departments.

Specialty Care Providers

Aetna Better Health will eliminate the need for referrals to in-network specialists and emergency services and provide education and support to our providers through the following resources:

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

Provider Relations Representatives

Aetna Better Health provider services representatives (PSRs) are locally based and provide accurate and timely information and education to providers and potential providers regarding participation in the Aetna Better Health provider network. Representatives are dedicated to supporting providers through the prompt receipt and resolution of issues, inquiries, and requests for information including, but not limited to, prior authorization, provider grievances and disputes, specialist availability, and community-based resources.

Member Services Representatives

Aetna Better Health will have a Louisiana based Member Services Department to assist our members in navigating the CCN. Our member service representatives (MSRs) will all be locally based and will provide prompt resolution to members' inquiries. MSRs provide support to members by providing information regarding many issues, among them is the identification and contact information for providers. In the event a member or potential member calls member services to inquire about selecting a specific provider, we first check to see if that provider is in network. If that provider is not yet in our network, the MSR will contact our Network Development Department to review the status of the provider to determine if that provider is in the process of contracting with us. If the provider is in the process of contracting with us, we advise the member to continue seeing that provider. If the provider has not agreed to contract with us, we will assist the member in selecting a different PCP and our provider network team will contact the provider to ask them to join our network. Should the provider agree to join our network, we will reach back out to the member to notify them that the provider will be added to our network.

In addition, our provider directory will be maintained on our website so members can access the most up to date network information.

Case Managers

Aetna Better Health Case Managers will assess, plan, facilitate and advocate options and services for our members. Our Case Managers will coordinate and communicate with our network providers to make sure our members are receiving the most appropriate quality services in a timely manner.

Access to Specialists/Telemedicine

Aetna Better Health has already begun outreaching providers that do not accept Medicaid today to understand the concerns and barriers to having them join our CCN. We have started reviewing the current Aetna network for other lines of business to determine if there are relationships we can leverage to get access to the providers and we've also started reviewing the universe of providers available in Louisiana, regardless of their status with Aetna's other lines of business.

Aetna Better Health has been engaged in discussions with the University of New Mexico and its telemedicine model Project ECHO (Extension for Community Healthcare Outcomes). This model provides a new nationally and internationally awarded method for delivering timely access to specialty care for underserved and rural populations in the state. Using advanced video-conferencing technology, academic medical centers (AMCs) conduct periodic didactic lectures and teaching rounds at which multiple local PCPs present cases to a multidisciplinary team of specialists. The specialty team provides care co-management based on the latest medical evidence and care plans are executed by the local provider team as led by the PCP. This benefits

members by providing access to specialty care without the need to travel long distances to receive services.

Project ECHO was initially developed by the University of New Mexico to help meet the complex care management needs of patients with Hepatitis C in rural communities and correctional facilities. Local providers in this rural state did not have the knowledge to accurately diagnose the condition, select among complex treatment choices, properly monitor progress and make mid-course adjustments. The program has succeeded in developing “Knowledge Networks” that transfer specialist knowledge to otherwise underserved areas of the state.

Project ECHO has overcome the significant barriers of insufficiently timely physical access to specialists and long distance transport to the academic medical center. Originally unanticipated, the program has yielded the additional benefit of more effective execution of treatment plans in the local community where additional medical, social and community supports are available. Additionally the Project has led to increased satisfaction among consulting primary care providers and has led to measurable improvements in the confidence in treating these complex conditions.

The Project has been expanded to apply the same model of knowledge transfer to a variety of chronic, common and complex medical conditions including asthma, mental illness, substance abuse, chronic pain, diabetes, cardiovascular disease, high-risk pregnancy, HIV/AIDS, rheumatology and obesity.

Aetna Better Health will deploy Project ECHO in Louisiana by:

- Partnering with Project ECHO personnel at the University of New Mexico in a consultative relationship
- Continue initial discussions we’ve had with the LSU Medical School and Tulane Medical School to introduce Project ECHO and outline program deployment roadmaps
- Facilitating assistance from Project ECHO personnel in replicating service offerings at the AMC(s)
 - Training manuals, program descriptions and policies
 - Construction of multi-disciplinary teams of Louisiana specialists

The Louisiana AMC will use the existing Project ECHO technological infrastructure in New Mexico during early stages and later deploy its own infrastructure as the program matures and capacity needs increase. Project ECHO personnel will assist in the enlistment and training of interested local PCPs, and will work with Aetna Better Health to enlist and train local field-based Case Managers to help execute individual patient treatment plans.

Aetna Better Health will provide reimbursement to support the program (i.e. AMC set up costs, reimbursement to specialists for consultations, reimbursement to local PCPs for presenting cases via Project ECHO).

The benefits of Project ECHO to the health system include:

- Improved quality through reduced unnecessary variation in care

- Improved access to care for rural and underserved patient populations with reduced disparities of care
- Workforce training and force multiplier effects
- Improving professional satisfaction and retention
- Supporting the Patient-Centered Medical Home (PCMH) Model
- Cost-effective care – avoid excessive testing and travel
- Prevent costs of untreated diseases, e.g. liver transplants for untreated Hepatitis C cases
- Integration of Public Health into treatment paradigms

Prenatal Care Services

Aetna Better Health has extensive experience in meeting the prenatal needs of our pregnant members. We believe that pregnancy and birth outcomes for our members will improve if routine services are supported by prenatal and postpartum interventions that effectively address the specific needs or condition of the individual woman. As such, Aetna Better Health will establish a pregnancy care program that offers a comprehensive array of enhancements (e.g., care coordination, case management) to a pregnant member's routine prenatal and postpartum care, all of which are based on nationally recognized clinical guidelines and standards. Our Case Managers will assist high-risk pregnant women with the management of their pregnancy including coordination with other systems of care, e.g., behavioral health and postpartum follow-up. We will maintain and educate a network of prenatal care providers who are able to meet the diverse needs of our membership.

Hospitals

Aetna Better Health will continue to outreach to and engage hospital leadership following the CCN award to discuss collaboration in improving health care outcomes for our members. We have outreached every hospital in the State and have attempted to meet with many hospitals in person, especially those that are hesitant to execute a LOI. We have initiated discussions across the state with various hospitals to determine what type of programs we can collaborate on such as telemedicine, telemonitoring, embedded Case Managers in primary care offices, and pay for performance. As hospitals review our contract, if there are proposed terms that give them comfort regarding the relationship with Aetna Better Health, (such as specifically including language regarding critical access hospital status) we have been entertaining and discussing language to meet their needs.

Rural hospitals have expressed concern that the CCNs will try to redirect care purely for economic reasons. In those situations, as requested by certain hospitals, we have provided a letter to the hospitals in an effort to give them some comfort that we are committed to the rural communities and the role in these communities.

Office of Public Health

Aetna Better Health has met with and received an executed LOI from the Office of Public Health. We look forward to collaborating with the Office of Public Health in identifying and addressing state public health issues.

Private Duty Nursing/Home Health Services

Aetna Better Health has successfully engaged with these providers and has not identified any gaps in adequacy to date. Should we identify any concerns in the future, Aetna Better Health will discuss opportunities for service expansion with current providers who will meet the needs of the underserved areas.

Federally Qualified Health Centers

Aetna Better Health continues to outreach the FQHCs to keep the lines of communication open. We have secured a few LOIs with FQHCs that are not aligned with a specific competitor. We will educate FQHCs about adopting an open access appointment model to increase appointment availability by offering walk-in scheduling and/or setting aside appointment slots for members with urgent needs. By increasing appointment availability, we will encourage members to utilize the FQHC rather than going to the ER, support the PCP/member relationship, increase the quality of health care and reduce overall costs.

School Based Health Clinics

Aetna Better Health will continue our efforts in engaging with school based health clinics. These providers support the provision of educational and preventive health care services to young adults in school. We will work with the school based health clinics to identify and coordinate services for young adults whose individual education plans include medical, developmental, and behavioral services. Coordination of care will take place between the school setting and our network providers outside of the school setting.

Ongoing Network Development Plan

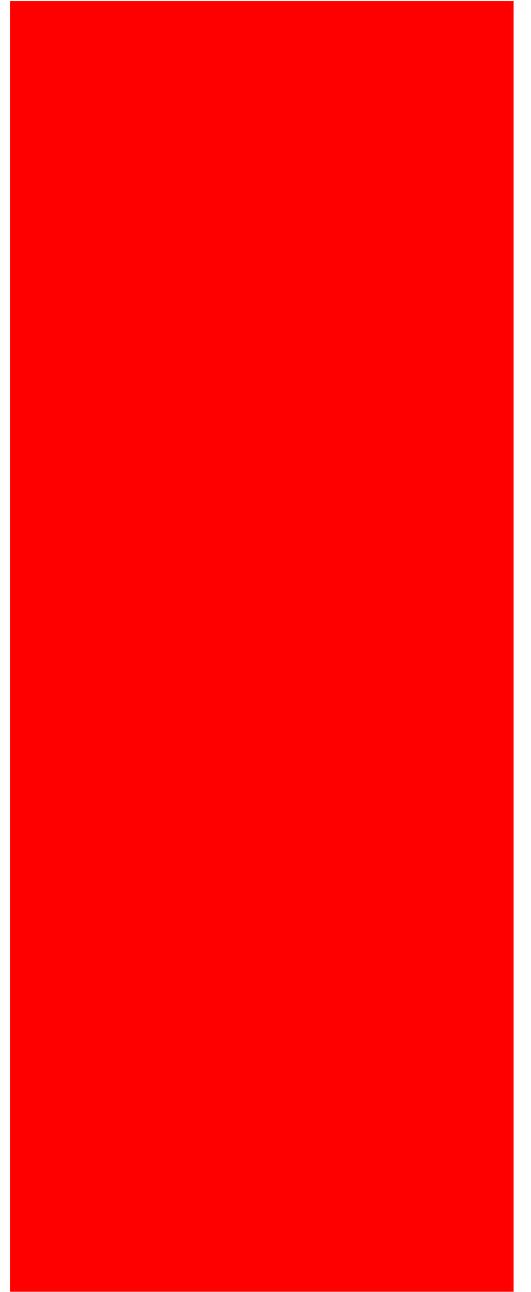
Aetna Better Health will utilize our network development plan (Plan) to continue developing relationships with current and potential providers in each GSA. Key personnel from various Aetna Better Health departments including, but not limited to, Network Development, Provider Services, Member Services, Utilization Management, and Medical Management will review our Plan on a quarterly basis to monitor progress and make necessary adjustments. The Plan will be updated annually or more frequently as needed. Our Plan is comprehensive, flexible, and will continue to adapt to changing membership, events, opportunities, and concerns. Our Plan is designed to:

- Offer sufficient providers to deliver covered services under the Louisiana Medicaid Coordinated System of Care Program
- Support provider arrangements with written agreements between the provider and Aetna Better Health
- Measure and monitor that services are geographically accessible and delivered promptly
- Measure and monitor compliance with Aetna Better Health policies and procedures
- Provide a patient-centered medical home system of care, including monitoring of practices' progress toward implementing patient-centered medical homes (PCMHs)
- Enhance the provider network to support the current and future needs of our membership, including responding to expected and unexpected changes that may occur

Access Standards and Out-of-Network Providers

When necessary, Aetna Better Health will authorize services from out-of-network providers. When this occurs, we will verify that the services are provided at no greater cost to the member than from a network provider. In addition to referrals from the Member Services and Case Management Departments, our Network Development Director (Director) will periodically review claims data for out-of-network services as a mechanism to assess network adequacy. On a monthly basis, we will run a “Top 10 Non-Participating Provider Activity Report” to identify potential contracting opportunities and take steps to secure contracts with these providers as appropriate.

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G.6 Describe your process for monitoring and ensuring adherence to DHH's requirements regarding appointments and wait times.

Aetna Better Health and its affiliates use a coordinated and proactive approach to monitor and verify adherence to the Department of Health and Hospitals' (DHH) requirements regarding appointments and wait times. We maintain written policies and procedures that describe our monitoring process and actions we take with providers who do not meet standards. Our policies and procedures include provisions for educating providers and working together with them to develop and implement corrective actions in the event that the provider does not adhere to the requirements.

Under the direction of the Chief Executive Officer (CEO) and in collaboration with various other Aetna Better Health departments, Aetna Better Health's Provider Services Department uses several monitoring tools to assess appointment availability and wait time compliance and shares feedback within the organization. We use the information to improve access to care at both the individual provider and overall network levels.

Monitoring Compliance with DHH Appointment and Wait Time Requirements

Aetna Better Health's Provider Services Department proactively educates providers regarding appointment and wait time standards to foster understanding and encourage compliance with DHH guidelines. We educate providers during initial new provider orientation, through follow up site visits (both routinely scheduled and ad hoc) and provider forums. We document appointment and wait time requirements in written materials such as the provider contract, provider handbook, and provider training kits which are distributed to providers and available on our website.

Aetna Better Health follows up our education efforts with network monitoring to verify compliance with appointment and wait time requirements according to Aetna Better Health's written policies. We conduct regular network analysis using various monitoring tools to proactively identify and improve access to care. Those tools include:

- GeoAccess analysis by GSA to identify potential areas to improve accessibility and availability of services
- Member-to-PCP ratio that takes into account PCP capacity and panel status
- Accessibility standards such as appointment availability, wait time in the office, and phone and after-hours accessibility
- Member grievances and provider complaints
- Member and provider satisfaction survey data
- General feedback from routine operations
- Services provided by out of network providers

Aetna Better Health compares results of monitoring tools against DHH standards and trends data over time to gauge network adequacy. We also review results across geographic locations and provider types to determine if potential concerns apply to the overall network or are limited to

individual providers, specific provider specialties, or certain geographic locations. These monitoring tools are described below.

Analysis of Data using Monitoring Tools

Aetna Better Health's Provider Services Department collaborates with other departments to analyze appointment availability and office wait times, member complaints, satisfaction survey results, and feedback from other departments:

- **GeoAccess** – Aetna Better Health runs GeoAccess data annually to formally analyze our network as part of our written Network Management Plan. In addition, we run data on a quarterly basis and submit findings to DHH. We use these data to identify areas where we can enhance our network further.
- **Provider Appointment Availability Surveys** – Provider Services Representatives (PSR) conduct annual surveys for primary care, OB/GYN and high-volume specialists to determine compliance against appointment and wait time standards. PSRs conduct audits monthly for subsets of the provider network, re-auditing the same provider on an annual schedule. PSRs follow a written script to inquire about appointment availability and track results in our Appointment Monitoring tool. The tool is an Excel spreadsheet that contains separate worksheets by provider type (i.e. internal medicine, pediatrics, specialist, etc). For each type of provider, there is a worksheet that contains a call script and a separate worksheet that contains the standards. RSRs use these worksheets as a guide while assessing provider offices, and document the results in the worksheet that contains the standards
- **Member and Provider Satisfaction Survey Data** – MCP conducts annual member and provider satisfaction surveys to assess areas that are working well and identify opportunities for improvement. Review of satisfaction data show that satisfaction scores are high and outperform the benchmark score for other Medicaid plans.
- **Grievance and Complaint data** – Aetna Better Health Provider Services Representatives work as part of a team with other Aetna Better Health departments to identify member complaints regarding appointment availability and wait times for individual providers. Provider Services Representatives review individual complaints with other personnel members and resolve issues in real-time as they arise. The Provider Services Department works with the Quality Management Department to address complaints that involve quality of care concerns. In addition to reviewing individual complaints, personnel also analyze trended data to identify network trends.
- **Member and Provider Satisfaction Survey Data** – Aetna Better Health conducts annual member and provider satisfaction surveys to assess areas that are working well and identify opportunities for improvement. Review of satisfaction data helps Aetna Better Health to identify any network-wide concerns regarding appointment availability and wait times and develop initiatives to improve network performance.
- **Feedback from Routine Activities** - In addition to identifying concerns through formal member complaints or satisfaction survey results, Aetna Better Health personnel may identify concerns with appointment availability through routine activities (i.e. Case Management, Utilization Management, Member Services). For example, Utilization Management personnel may learn that a provider is not providing services on a timely basis.

In these instances, Aetna Better Health personnel work to resolve the issue and arrange for the member's care. Another example is member outreach conducted by our quality management (QM) personnel regarding prevention and wellness appointments. Our QM nurses contact members to assist them in establishing prevention and wellness appointments and to follow up on missed appointments. Through this process QM personnel may learn of concerns regarding appointment availability. Issues identified through these activities serve as an additional source of network monitoring.

- Services Provided by Out-of-Network Providers – Aetna Better Health evaluates the use of out-of-network providers to provide covered services to develop trends and focus areas (by GSA and/or parish) where network improvement is necessary. We start with the providers that we have entered into single case agreements with to fill these network gaps.

The Provider Services Department resolves individual issues as they arise whenever possible and identifies trends that may occur across provider groups, geographic areas, or with certain services. We present status and concerns to the Service Improvement Committee (SIC), which assists in analyzing data, identifying opportunities for network-wide initiatives and developing action plans. The SIC provides reports to our Quality Management/Utilization Management (QM/UM) Committee, which is responsible for our quality improvement and utilization management initiatives, for further review and recommendations. The QM/UM Committee provides summary reports to our Quality Management Oversight Committee (QMOC) which maintains oversight of decisions made by our SIC and QM/UM Committees.

Follow Up Actions to Achieve Adherence to Requirements

Using the monitoring tools described above, our Provider Services Department collaborates with other internal Aetna Better Health departments to assess provider appointment availability and wait times and take actions for improvement that enhance access to care both for individual providers and the network as a whole. As described above, collaboration occurs within the SIC, QM/UM Committee, and QMOC, which elevate follow up actions through Aetna Better Health.

Follow Up regarding Appointment Availability and Wait Time Surveys

Providers who are compliant with standards as measured through our appointment availability and wait time surveys require no further action until the next assessment. Provider Services Representatives re-educate providers who are not compliant and continue to monitor them against the standards until they demonstrate compliance. If noncompliance persists, Aetna Better Health's Director of Provider Services implements an appropriate intervention(s), which may include:

- Contacting the provider via letter or telephone to express concern and offer assistance
- Visiting the provider to develop a corrective action plan in collaboration with the provider and an Aetna Better Health Medical Director, and following up on progress
- Limiting enrollment to the provider until availability and wait time indicators demonstrate improvement
- Terminating the provider's contract with Aetna Better Health. In these cases we would provide members with notice and allow them to choose a new PCP

Aetna Better Health continues follow up with the provider until the provider demonstrates compliance with the standards and addresses all concerns.

Follow Up regarding Member Complaints

Aetna Better Health Provider Services Representatives work with other Aetna Better Health departments to resolve member complaints regarding individual providers. Provider Services Representatives review individual complaints in collaboration with other personnel members and resolve issues as they arise by contacting the provider and following up on the particular issue. Provider Services Representatives use this contact as an additional opportunity to re-educate the provider regarding appointment and wait time standards and discuss any concerns with compliance. If complaints continue, or if the provider does not address the issue, Aetna Better Health takes corrective action similar to that mentioned above, such as developing a corrective action plan in collaboration with the provider and an Aetna Better Health Medical Director, restricting the number of new members assigned to the provider's panel, offering members in the provider's panel or under care of a specialist access to care at another provider, or terminating the provider contract.

For complaints that involve quality of care concerns, Provider Services works with Quality Management to address and resolve the issue. In these instances, Quality Management personnel are involved in communication/education of the provider and verifying that quality of care concerns are addressed and resolved. Quality Management personnel work with the provider services department and Aetna Better Health's medical director to implement corrective action as necessary.

Follow Up regarding Member and Provider Satisfaction Data

Aetna Better Health analyzes results from annual member and provider satisfaction surveys to identify opportunities for improvement regarding appointment availability or wait times on a network-wide basis. If data identify concerns with appointment availability or wait times, our Provider Services Representatives discuss the concerns with providers and re-educate them regarding the standards. Aetna Better Health may also implement other network-wide initiatives such as publishing standards in our Provider Newsletter and posting further information on our website.

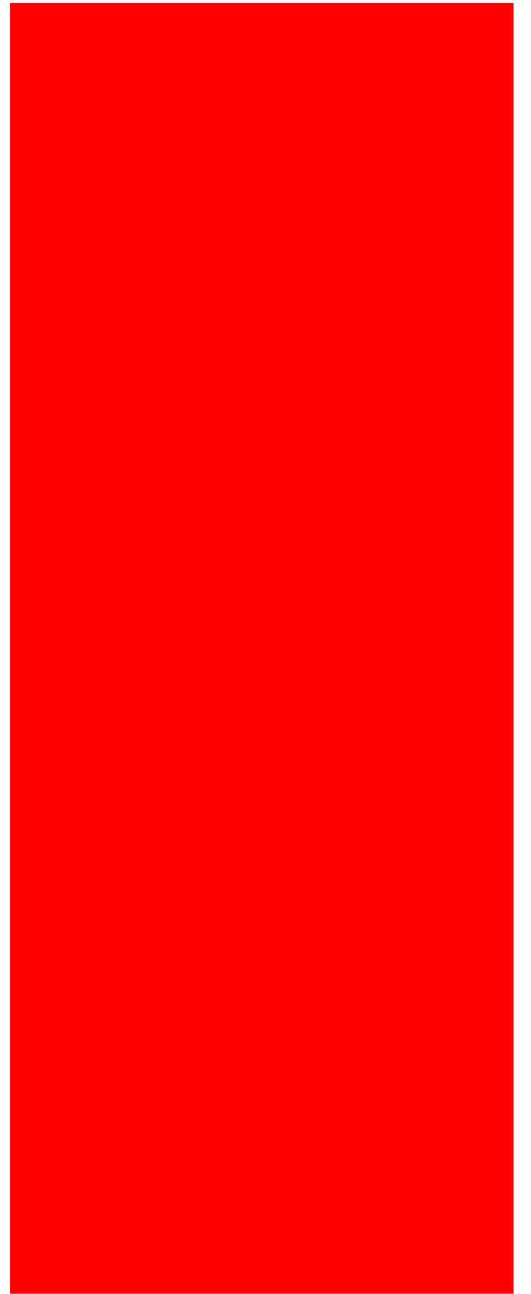
Follow Up through Routine Activities

Aetna Better Health personnel (i.e. Case Management, Utilization Management, and Member Services) follows up on concerns identified through routine activities that involve appointment availability. For example, Utilization Management or Quality Management personnel may identify that a certain provider is not providing services in a timely manner. In these instances, Aetna Better Health personnel work cross functionally to resolve the issue and arrange for the member's care. For example, quality management outreach personnel may identify that a member is having difficulty obtaining timely care for preventive services. Quality Management personnel assist the member by contacting the provider to arrange a more timely appointment for the member. If necessary, quality management personnel work together with Provider Services personnel to arrange an appointment with a different contracted provider or refer the member to a non-contracted provider who can meet the member's immediate needs. Personnel arrange needed authorizations and member transportation in these cases. The Provider Services Representative follows up with existing providers to correct any non-compliance with standards, take corrective action, and initiate recruitment of additional providers if needed.

Collaboration through Committees

As mentioned above, Aetna Better Health personnel present data and findings from network monitoring tools to our various cross-functional committees for further analysis and recommendations. Appointment Availability survey results, trended complaint data, satisfaction survey data, and findings from routine activities are presented to SIC and the QM/UM Committee, which prepares summary reports to the QMOC. These committees review recommendations and make additional suggestions, monitor status of corrective actions, and help to prioritize resources within the organization to achieve goals.

65 G.7



G.7 Describe your PCP assignment process and the measures taken to ensure that every member in your CCN is assigned a PCP in a timely manner. Include your process for permitting members with chronic conditions to select a specialist as their PCP and whether you allow specialists to be credentialed to act as PCPs.

Aetna Better Health Experience

One of the major concerns that Medicaid agencies have when converting from fee-for-service (FFS) to managed care is the impact that change has on continuity of care for members. Aetna Better Health has successfully transitioned members from other Medicaid managed care health plans and FFS programs with minimal disruption for our members and customers. For example, in 2008, we transitioned 10,000 members from FFS to managed care as the result of a 10-county contract expansion in Missouri. Our goal is to provide for a seamless transition of members to Aetna Better Health, preserving continuity of care and avoiding member transition to new providers.

Primary Care Provider Assignment Process

We believe the member's Primary Care Provider (PCP) serves as a central part of the member's PCMH and is the member's initial and most important contact. Under the direction of the Aetna Better Health Chief Operating Officer (COO), our Member Services Manager is responsible for developing, implementing, managing, and maintaining the PCP assignment process. This process includes the member's self-selection of a PCP, auto-assignment of a PCP, and the re-assignment of a PCP when necessary. We have established written policies and procedures (P&Ps) for linking every member to a PCP in a timely manner so members receive the services they need at the right place, right time and at the right setting. Our PCP assignment P&Ps:

- Encourage and support members in self-selecting a PCP
- Provide timely auto-assignment of PCPs to members
- Facilitate continuity of care through a smooth PCP re-assignment process
- Monitor provider network capacity to maintain accessibility and availability of PCPs and specialists
- Promote the use of specialists as PCPs

Aetna Better Health will promote continuity of care for our members through our collaboration with the Department of Health and Hospitals (DHH) in developing our PCP auto-assignment methodology. Aetna Better Health will submit our auto-assignment methodology to DHH within 30 days from the contract date for approval. Our members and providers will be educated on our PCP assignment process through the Aetna Better Health member handbook, provider manual, and website.

Role of the Enrollment Broker

The enrollment broker's responsibilities, as the agent of DHH, is to perform functions related to outreach, education, choice counseling, enrollment and disenrollment of potential members and members into a CCN. Aetna Better Health will provide a hard copy version of the Aetna Better Health provider directory and weekly electronic provider directory with updates to the

enrollment broker. This will allow the enrollment broker to assist members who choose to self-select a PCP from the Aetna Better Health provider network at the time of enrollment.

The enrollment broker will provide Aetna Better Health with daily and weekly transaction reports with updates on our members. These updates will identify members who are newly enrolled and their PCP assignments, if applicable. To prevent any delay in member PCP assignment, we will notify the enrollment broker when an Aetna Better Health provider is terminated from our provider network. This notification will take place on the business day following the provider's termination. Aetna Better Health will provide the enrollment broker with information on our member-provider linkages and the remaining capacity of our network providers on a quarterly basis.

Member Self-Selection of a Primary Care Provider

We encourage and support our members in selecting the PCP of their choice. Upon notification of the member's enrollment from the enrollment broker, Aetna Better Health will send a welcome packet to new members within ten (10) business days. Our welcome packet will educate our members on their rights and responsibilities in selecting a PCP, how and when to choose a PCP, and Aetna Better Health's auto-assignment process. This information will be provided through the following:

- Member handbook
- Aetna Better Health website
- Member welcome letter
- Provider directory

Our member handbook and website will also educate our members on the patient-centered medical home program (PCMH) and how to identify and select a PCMH. Our provider directory and website will clearly identify providers in our network and will highlight those that have reached PCMH status.

Members can self-select a PCP/PCMH through the enrollment broker at the time of enrollment, our member services hotline, and the Aetna Better Health website. In the event Aetna Better Health is not able to honor a member's selection, the Member Services representative will assist the member with the selection of a new PCP or auto-assign the member to a PCP/PCMH. These types of situations include, but are not limited to, when a member selects a PCP/PCMH in our provider network that has reached their maximum physician/patient ratio or has restrictions/limitations (e.g., pediatric only practice).

Members with Special Health Care Needs

Members identified as having special medical conditions or special needs (MSHCN) are contacted directly by an Aetna Better Health Member Services Representative (MSR) to assist the member in selecting a PCP/PCMH. If the MSHCN does not self-select a PCP/PCMH within 10 days of contact, Aetna Better Health will auto-assign a PCP/PCMH and notify the member by telephone or in writing.

All Aetna Better Health members who are pregnant shall choose a pediatrician, or other appropriate PCP/PCMH, for the care of their newborn baby before the beginning of the last trimester of gestation. In the event that the pregnant member does not select a pediatrician or

other appropriate PCP/PCMH during this time, Aetna Better Health will auto-assign a pediatrician or PCP/PCMH no earlier than 45 days prior to delivery and we will notify the member of the auto-assignment in writing. The letter will state that the member can change their newborn's PCP prior to delivery by calling Member Services. If we are not aware a member is pregnant until she presents at the hospital for delivery, we will auto-assign a pediatrician or PCP/PCMH to the newborn baby within one business day following the birth of the child.

Auto-assignment of a Primary Care Provider

We recognize there are numerous reasons that a member may choose not to self-select a PCP/PCMH. As a result, Aetna Better Health has an established process to automatically assign a PCP/PCMH to a member if the member: 1) does not make a PCP/PCMH selection within 10 days from the date of the member's enrollment, 2) selects a PCP/PCMH in our provider network that has reached their maximum physician/patient ratio and does not self-select another provider within 10 days following notification, or 3) selects a PCP/PCMH that has restrictions/limitations (e.g., pediatric only practice) and does not self-select another provider within 10 days following notification.

When making a PCP/PCMH assignment, Aetna Better Health will first identify the member's or member's family members' current or historic PCP/PCMH relationship. If there is no current or past PCP/PCMH relationship, Aetna Better Health will consider the following factors when assigning a PCP/PCMH:

- Special health care needs (e.g., children will be assigned to pediatricians)
- Physical disabilities
- Cultural and linguistic needs
- Age and gender
- Geographic proximity to the PCP/PCMH
- Access to transportation

The member's information is entered into Aetna Better Health's information processing system, QNXT™. Our auto-assignment process will assign a member to a PCP/PCMH based on the member's identified needs. Upon assignment, Aetna Better Health notifies the member in writing, of the PCP's name, location and office telephone number. The letter will state that the member can change their PCP within the first 90 days of the auto-assignment by calling Member Services.

Primary Care Provider Re-assignment

We believe that the member and PCP relationship is critical to the member's access and receipt of quality services in a timely manner. Aetna Better Health Member Services Representatives (MSRs) are responsible for assisting members in self-selecting a new PCP in a timely manner. We have written P&Ps for allowing members to select a new PCP including auto-assignment when 1) there are quality of care concerns with the provider, 2) a provider is terminated from our provider network, and 3) a PCP/PCMH re-assignment is part of the resolution to a member complaint or grievance. Our written P&Ps also include provisions that assist our member in accessing needed emergency or urgent care during the re-assignment transition period. Aetna

Better Health will submit our re-assignment P&Ps to DHH within 30 days of the contract award date.

Member Request

Members requesting a new PCP/PCMH for cause (e.g., quality of care) will be immediately re-assigned by an Aetna Better Health MSR. Members who are initially auto-assigned to a PCP/PCMH will be permitted to request a re-assignment at least once during the first 90 days of initial PCP/PCMH assignment. Following the initial 90 days, members may be required to remain with their assigned PCP/PCMH for up to 12 months from the original date of assignment. Aetna Better Health will consider this on a case-by-case basis. Members who request a PCP/PCMH re-assignment and do not self-select a PCP/PCMH within 10 days will be auto-assigned to a new PCP/PCMH. Aetna Better Health will notify the member in writing of the new PCP's/PCMH's name, location and office telephone number.

Primary Care Provider Termination from the Provider Network

Our MSRs will assist members in the re-assignment of a PCP/PCMH when the member's existing PCP/PCMH is terminated from the provider network. Our MSR will inform a member if the member's PCP/PCMH is terminated from participating in our provider network. Our MSR will make every effort to determine the member's PCP/PCMH choice prior to the effective date of the PCP's agreement termination. If the member does not select a new PCP/PCMH within ten days, the MSR will auto-assign the member to a new PCP /PCMH prior to the effective date of the PCP's termination. Aetna Better Health will notify the member in writing of the PCP's name, location and office telephone number.

Resolution to a Member Complaint or Grievance

Our MSRs will assist members in the re-assignment of a PCP/PCMH when the re-assignment is a resolution to a member's complaint or grievance. Our MSR will contact the member directly to assist the member in self-selecting a new PCP/PCMH. If the member does not select a new PCP/PCMH within ten days, the MSR will auto-assign the member to a new PCP /PCMH prior to the effective date of the PCP's/PCMH's termination. Aetna Better Health will notify the member in writing of the PCP's/PCMH's name, location and office telephone number.

Measures Taken to Ensure Every Member is Assigned to a PCP in a Timely Manner

Aetna Better Health is committed to assigning PCPs/PCMHs to our members in a timely manner. In order to accomplish this, we will 1) educate our members on the PCP/PCMH self-selection and auto-assignment processes, 2) monitor provider network capacity, 3) monitor PCP/PCMH accessibility and availability, and 4) work closely with the enrollment broker to provide current and accurate information on available providers in our network.

Member Education

Our members and/or members' family members or guardians are provided information regarding their ability to self-select a PCP/PCMH through the Aetna Better Health new member welcome packet. The welcome packet includes our member handbook, provider directory, and information on our member services hotline and website. Provider information is categorized by location, specialty, languages spoken and whether the provider is accepting new patients, which assists our members in easily identifying and choosing providers that meet their individual needs. Our MSRs are trained to assist members who call our member hotline in the self-selection of a

PCP/PCMH. Our website is updated daily as providers change their information and join or leave our provider network. This provides our members with the most current provider information possible. Aetna Better Health will also update our printed directory annually, per DHH requirements. Members receive a printed directory in their welcome packet; new copies of the printed provider directory will be available upon request.

Provider Network Capacity

Aetna Better Health has a robust provider network to support our members' right to choose their providers, through the availability of PCPs with diverse and culturally appropriate expertise. We monitor panel capacity levels for PCPs through QNXT™. We track the number of members assigned to any individual PCP against our maximum standard of 1: up to 2,500. If a provider's panel meets the maximum number, we enter an edit into the QNXT™ system and it no longer assigns members to that provider. This prevents a delay in members obtaining an initial appointment and having to contact Aetna Better Health to reselect a PCP. In these situations, Aetna Better Health notifies the provider that his/her panel meets Aetna Better Health's maximum panel size limit. In addition, we require that providers report to us on the number of additional members they will take as patients when they reach 85 percent of their panel capacity. Our Provider Services Representatives also verify panel status and capacity during routine provider site visits.

Primary Care Provider Accessibility and Availability

Aetna Better Health conducts appointment availability/after hours surveys on an initial and annual basis. We work with individual providers that fall out of compliance by implementing a corrective action plan to re-establish appointment availability standards and minimize the need to reassign members or freeze enrollment for that provider. We implement corrective action plans on a prospective basis in instances where it is necessary to reassign members, before the provider initiates care. The corrective action plan may include increased site visits, followed by a re-survey of the provider to verify that the deficiencies have been corrected.

Working with the Enrollment Broker

Aetna Better Health will work closely with the enrollment broker to prevent delays in assigning members to PCPs/PCMHs. Aetna Better Health will:

- Provide a hard copy version of the Aetna Better Health provider directory and weekly electronic provider directory updates to the enrollment broker to assist members who choose to self-select a PCP from the Aetna Better Health provider network at the time of enrollment. Additionally, Aetna Better Health's online provider directory is updated on a daily basis to assist the enrollment broker by providing the most current network information possible.
- Utilize daily and weekly transaction reports from the enrollment broker to track members who did not self-select a PCP/PCMH upon enrollment and enter member-selected PCP/PCMH assignments into QNXT™
- Notify the enrollment broker when an Aetna Better Health provider is terminated from our provider network on the first business day following the provider's termination.

Specialists as Primary Care Providers for Members with Chronic Conditions

Aetna Better Health's written Medical Management P&Ps outline processes that enable a member with special health care needs to request his/her specialist to act as a PCP. This process is very straightforward. If the specialist believes that the member would benefit from the specialist serving as the member's PCP, agrees to perform all of the services required of a PCP (as documented in our Provider Manual) and Aetna Better Health's Medical Director or designee approves the request, the specialist can serve as the member's PCP.

Upon receiving a request to have a specialist act as a PCP, Aetna Better Health will contact the provider to determine the provider's desire and capability to provide a full range of primary care services including, but not limited to, wellness, prevention, and care coordination. If the specialist agrees to act as the member's PCP, Aetna Better Health applies the same responsibilities to the specialist as we do to our PCPs. We formalize the specialist's acceptance of the member as a primary care patient and the specialist's associated primary care responsibilities through a formal written agreement with the specialist. In these instances, Aetna Better Health medical management personnel review and approve these requests when appropriate to facilitate effective and convenient access to medical services.

Specialist Credentialing as a Primary Care Provider

In order to participate in our provider network, Specialists must first successfully complete our credentialing process. All Aetna Better Health providers are required to complete our National Committee for Quality Assurance (NCQA) certified credentialing process before they may serve members. For a specialist to act as a PCP, Aetna Better verifies that the specialist has the appropriate training, experience, and specialization necessary to serve as the member's PCP. We also capture information regarding the languages spoken by providers, verifying that network providers offer services that reflect the diverse needs of our members. In addition, as part of our credentialing process, during our provider contracting visit, and during our initial orientation and ongoing visits throughout the year, we determine if the provider's office location allows physical access for members with disabilities. Our provider agreements require each provider to maintain facilities that permit access for all patients including, but not limited to, the entrance, parking, and restroom facilities. The following information describes Aetna Better Health's provider credentialing/recredentialing processes:

Credentialing/Recredentialing Processes

Aetna Better Health has written P&Ps to review, approve and periodically recertify all physicians and other licensed independent providers to gain and maintain acceptance into our network.

Aetna Better Health has a management agreement with our parent organization, Aetna Inc.'s, Credentialing Verification Organization (CVO). The CVO is NCQA-certified through January 29, 2013, and also holds URAC accreditation through October 1, 2012, to credential/recredential our network providers. The CVO is responsible for collecting data used to verify credentialing/recredentialing application data and for ongoing monitoring of state and federal sanctions. The CVO provides information regarding credentialing and recredentialing activities to Aetna Better Health's network management and Provider Services Departments.

Providers are required to complete the credentialing process, including application and verification of information, prior to network participation and successfully complete our

recredentialing process at least once every three years. Our credentialing/recredentialing process complies with all state and federal regulations and conforms to written notification timeframes and standards. Our written credentialing/recredentialing process complies with NCQA, URAC and CMS credentialing standards, as well as DHH requirements.

Our written P&Ps prohibit discrimination against any provider or group of providers for participation, reimbursement, indemnification when that provider or group or providers is acting within the scope of his or her license, or certification under applicable Louisiana laws or statutes, solely on the basis of that license or certification. Furthermore, if Aetna Better Health declines to include an individual or group of providers in our network, we will give the affected providers written notice of the reasons for our decision.

At a minimum, credentialing/recredentialing is required for all practitioners, including physicians and providers. Each individual provider who is a member of a contracting group, such as an independent physician association or medical group, is credentialed individually. Individual practitioners must complete an application, which includes a work history covering at least five years. The CVO conducts primary source verification of licensure, education and training, evidence of graduation and specialty training and valid Drug Enforcement Administration (DEA) or Department of Public Safety (DPS) Controlled Substances Registration Certificate. The CVO will contact the provider's office, if applicable, to complete the application and acquire additional needed documentation.

The CVO's participation criteria include business criteria, professional criteria, and professional competence and conduct criteria. Minimum data elements for credentialing/recredentialing, which must be included with applications for PCPs, are the following:

- Professional license number
- Hospital where applicant has privileges and the type of privileges (initial application only)
- Drug Enforcement Administration (DEA) and state controlled drug substance (DPS) number, when applicable
- Professional education and training of practitioner (initial application only)
- Board certification
- Work history
- Malpractice insurance coverage: name of current carrier, policy number, policy expiration date, amount of coverage per occurrence, and aggregate amount
- Statements from the applicant regarding:
 - Reasons for inability to perform the essential functions of the position for which the practitioner is applying to the network
 - Lack of present illegal drug use
 - History of loss of license and felony convictions
 - History of loss or limitation of privileges or disciplinary activity
- Attestation by the applicant of the correctness and completeness of the application

- Prior to allowing a physician into our network and every three years afterwards, selected participation criteria items (e.g., state license, medical schools, training, board certification) and supporting documentation are verified with primary sources

Credentialing Committee

Aetna Inc.'s regional Credentialing and Performance Committee (CPC) has decision making authority and may initiate professional review activities involving the professional competence or conduct of practitioners whose conduct adversely affects, or could adversely affect, the health or welfare of members. The CPC makes final determinations for those applicants for exceptions to Aetna's established requirements for professional competence and conduct. The decision-making peer review committee includes practitioners who hold an active professional license in Louisiana. Once the CPC has approved the provider for participation, a formal contract with the provider is executed. All individual providers or provider groups declined for network participation are given written notice, including the reasons for the decision.

Recredentialing Process

Aetna Better Health's recredentialing process occurs at a minimum of every three years for every provider and includes:

- Re-verification of licensure (and information on sanctions or limitations on licensure)
- Board certification if the physician or individual provider was due to be recertified or the provider indicates that board certification was obtained since the previous credentialing process
- DEA or DPS controlled substance registration certificate (if applicable)
- Current professional liability insurance coverage and updated claims history
- Sanction or restriction information from Medicare and Medicaid in accordance with the verification sources and time limits specified for the initial credentialing process
- Review of provider performance data including but not limited to member complaints, quality of care and Utilization Management

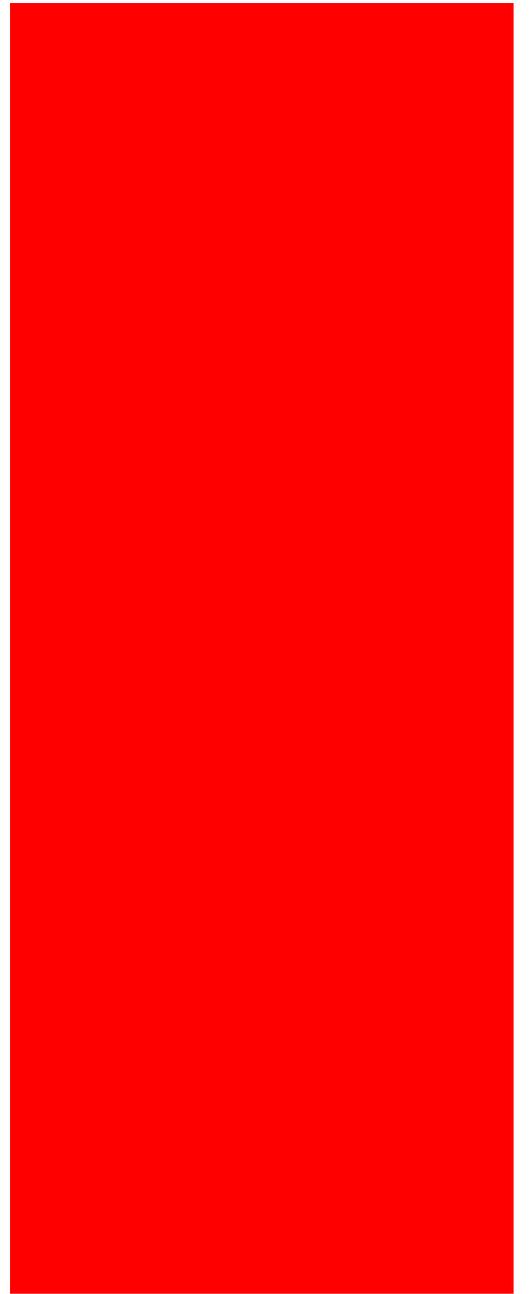
Between recredentialing cycles, we monitor ongoing issues including:

- State board sanctions
- Loss of license
- Reports from DHH and Louisiana Office of the Inspector General
- Member complaints
- Utilization review outliers
- Claims history
- Internally identified potential quality of care concerns

Practitioner Appeals Committee

Aetna Better Health will establish a Practitioner Appeal Committee (PAC) to consider practitioner appeals of adverse determinations. The PAC will meet on an ad hoc basis to conduct professional review hearings (involving the professional competence or conduct of practitioners

66 G.8



G.8 Describe your plan for working with PCPs to obtain NCQA medical home recognition or JHCAO Primary Home accreditation and meeting the requirements of Section § 14.

Aetna Better Health Experience with Patient-Centered Medical Homes

Aetna Better Health leads the Medicaid Managed Care industry in transforming primary care systems to Patient-Centered Medical Homes (PCMH). Our PCMH program goal is to provide members with primary healthcare that fully addresses their physical health, behavioral health and complex psychosocial needs in an integrated and well-coordinated manner. Aetna Better Health has valuable experience in the full implementation of PCMH with our affiliate health plan in Illinois along with advanced pilot programs in our Arizona market. Additionally, we are expanding our PCMH program to each of our health plans in ten states across the country with pilots expected in all markets by 2012.

Aetna Better Health’s successful collaboration with PCMH providers has improved outcomes in care coordination and care utilization. An example of this success is demonstrated with our Arizona affiliate. After identifying several instances of members’ over-utilization of emergency room (ER) visits, health plan leadership recommended a PCMH program to improve utilization management focusing on members with complex medical conditions and bio-psycho-social needs. As part of the PCMH program design, we identified members who were at high risk for frequent ER visits or hospitalization and determined these members often resided in nursing or assisted living facilities. The PCMH program provided integrated and coordinated care where our members resided through a personal care clinician and care team suited to address each member’s individual needs. Our efforts demonstrated a trend in reduction of ER utilization by these members.

While there is still much to learn about the effectiveness and care impact of the PCMH model, Aetna Better Health continues to work with providers to develop and expand our PCMH program as a means to innovate and transform primary care delivery. Aetna Better Health brings collective PCMH experience and knowledge to Louisiana and collaborates with the Department of Health and Hospitals (DHH) to design and implement a PCMH program that is practical and effective for both providers and members. We believe that our experiences in Illinois, Arizona and those being developed in other plans across the country are invaluable to DHH and our providers during the planning and implementation phases of our PCMH program. Aetna Better Health will submit our PCMH Implementation Plan to DHH within ninety (90) days of the contract “go-live” date.

Aetna Better Health’s Approach to Patient-Centered Medical Homes

Aetna Better Health provides members with individualized healthcare through a coordinated system of care that reflects what our members need to engage in their health care management. Promotion of the PCMH is central to our delivery approach of providing comprehensive primary care. The PCMH serves as the foundational building block for controlling costs, promoting quality, and improving access to care. Aetna Better Health’s PCMH program is designed to provide each member access to a personal clinician and care team who use patient-centered, evidence-based care strategies to provide holistic, highly coordinated care. Through our PCMH

program, Aetna Better Health's goals for our members include, but are not limited to, the following:

- Promoting access to healthcare providers who address the physical health, behavioral health and complex psychosocial needs of members in an integrated and well-coordinated manner
- Reducing ethnic and healthcare disparities and prevent marginalization of our members, who often have socioeconomic variables that place them at greater risk for poor health outcomes
- Educating and assisting members in their personal healthcare decision-making by providing access to individualized information, personal guidance, and quality services that improve members' navigation skills, health literacy, and healthcare experience
- Supporting members in receiving the right services, at the right time, and at the right location across the care continuum including community and home-based settings
- Strengthening the provider-member relationship and maximize point of care effectiveness, efficiency and accountability

In order to promote PCMH adoption, Aetna Better Health takes a practical view of the transformation process now under way with health reform. For most providers, transforming their practices to a PCMH that aligns with a highly coordinated system of care requires a fundamental shift in practice behavior coupled with a new perspective on the member's experience and place in the care delivery process. Our program lays the foundation to support a new primary care model with a focus on three core strategies:

- Providing members and PCMHs with actionable health information to drive clinical decision-making, quality and transparency in the care process
- Engaging and empowering members to better navigate and manage their healthcare
- Promoting the PCMH principles and approach as the preferred primary care model

These strategies support our PCMHs in effectively coordinating care at the member and population level while being patient-centered in their approach. It further bolsters the member's position in the care process as an informed consumer maximally engaged in decision-making regarding all aspects of their care.

Working with Primary Care Providers to Obtain NCQA Recognition or Joint Commission Accreditation

As part of our PCMH program development, we have actively engaged in evaluating national recognition programs such as the National Committee on Quality Assurance (NCQA) Physician Practice Connections®-Patient-Centered Medical Home (PPC®-PCMH) and the Joint Commission Primary Care Home (PCH) accreditation. Aetna Better Health has practice sites that have chosen the NCQA model recognition process and as a result, appreciate and understand the intensive process required to become recognized as PCMH under the NCQA process. In addition, we have stayed in tune to the Joint Commission, who will release their final PCH recommendations in July, 2011. As Louisiana promotes the NCQA and Joint Commission models, Aetna Better Health is well positioned to support practices that choose to pursue either medical home model. Key activities to support the PCMH adoption process include:

- Provider orientation
- Provider services center
- Provider manual
- Website
- Quarterly provider newsletters

Given our experience with PCMH program development, Aetna Better Health is prepared to meet or exceed the following timetables for PCPs to achieve NCQA PPC®-PCMH recognition or Joint Commission PCH accreditation:

Table 1. Timetable for Network Providers to Obtain NCQA Recognition or Joint Commission Accreditation

Year End	Percentage of Providers Obtaining NCQA Recognition or JCAHO Accreditation
Year One	Total of 20% of our PCPs will achieve NCQA PPC®-PCMH Level One recognition or Joint Commission PCH accreditation
Year Two	Total of 30% of practices will have achieved NCQA PPC®-PCMH Level One recognition or Joint Commission PCH accreditation Total of 10% of practices will have achieved NCQA PPC®-PCMH Level Two recognition or Joint Commission PCH accreditation
Year Three	Total of 10% of practices will have achieved NCQA PPC®-PCMH Level One recognition or Joint Commission PCH accreditation Total of 40% of practices will have achieved NCQA PPC®-PCMH Level Two recognition or Joint Commission PCH accreditation Total of 10% of practices will have achieved NCQA PPC®-PCMH Level Three recognition or Joint Commission PCH accreditation

Aetna Better Health will submit an annual report indicating PCP practices that have achieved NCQA PPC®-PCMH recognition, including the levels of recognition or Joint Commission PCH accreditation.

Collaborating with Providers during the Patient-Centered Medical Home Transformation

Aetna Better Health recognizes the process of becoming a PCMH is time and resource intensive. While the choice to engage in PCMH transformation is ultimately left to each individual provider or practice, Aetna Better Health plays a critical role in providing resources and support for providers who embrace the PCMH model but who may lack the resources and personnel to provide comprehensive PCMH services. Ten key areas where Aetna Better Health supports and collaborates with providers in their PCMH efforts include:

- 1) Team-Based Care Management and Coordination: Our Aetna Medicaid Business Unit’s medical management team works cooperatively with Aetna Better Health’s CMO, Medical Management Coordinator, and Quality Management Coordinator to manage and coordinate this process. This team supports a PCMH’s care coordination efforts, especially for complex

members with multiple chronic conditions. Aetna Better Health's Integrated Care Management (ICM) model provides a robust set of member-centered resources and programming to provide members with access to a holistic plan of care that addresses their physical and behavioral health needs. Aetna Better Health supplies PCMH providers with remote care management support and in some cases may embed or assign personnel directly to the PCMH practice site to assist with care coordination or care management for members with complex needs.

- 2) Improve Member Show Rate and Engagement: Aetna Better Health proactively supports PCMHs by educating members on the importance of keeping scheduled appointments. We educate members on their rights and responsibilities to keep appointments through the member handbook, member newsletters, website and through Case Managers for members receiving Case Management services. Aetna Better Health trains our PCMHs on best practices in managing members' missed appointments during our initial provider orientation, routine site visits, provider manual and website. To support our PCMHs in reducing member missed appointment occurrences, Aetna Better Health offers a provider assistance program. Through this program, PCMHs notify Aetna Better Health's Member Services Department when a member misses one or more appointment. Our Member Services Representatives (MSRs) reach out to those members to identify any barriers the member may be experiencing in attending scheduled appointments (e.g., transportation) and provide education regarding the importance of keeping appointments
- 3) Education Support and Reinforcement: Aetna Better Health's medical management team has expertise in providing individualized education and support to PCMHs. This team works with PCMHs to help members move from recovery toward resiliency and autonomy where members are self-managing their care at the highest level possible. Aetna Better Health will introduce our Care Considerations® to the DHH program. Care Considerations® is an innovative, claims-based clinical support system that electronically alerts providers and members about recommended interventions based on diagnosis, evidence-based clinical guidelines and the member's current treatment regimen. For example, if a provider is treating a member with asthma, but fails to use an optimal medication regimen, the system automatically sends information to the provider on evidence-based strategies to better manage the member's care.
- 4) Relationship Management: Aetna Better Health's care management team is adept at supporting PCMHs and members in managing relationships with other healthcare providers (e.g., specialists), family members and caregivers, community-based providers and advocacy organizations. Our experience and level of experience in working with vulnerable populations benefit PCMHs that have limited resources to coordinate care for complex members. Aetna Better Health's Provider Services personnel work closely with PCMHs to familiarize them with the availability and appropriate use of home and community-based services and the specific processes needed to access these services for members

assigned to their panels. Our provider manual includes detailed information related to all aspects of our home and community-based providers and services. Our PCMHs easily access information through the Aetna Better Health website.

- 5) Care Transition Support: Providing members with coordination of care through a PCMH, especially upon discharge from the hospital or after an outpatient procedure, is critical to preventing readmissions or subsequent unnecessary ER visits. The Aetna Better Health team supports members and PCMHs with strategies to reduce avoidable hospitalizations and aid in transitions across care environments. We also assist in coordinating home health care for our members during the discharge planning process to ensure wrap-around care post discharge or outpatient procedure.
- 6) Member Risk Stratification and Identification: Aetna Better Health's uses our Consolidated Outreach and Risk Evaluation (CORE) tool to identify the highest-risk, most vulnerable and chronically ill members who often require the most intense support and care. This proprietary, evidence-based application uses claims data to prospectively identify and assign these members to risk levels. Sharing this information with PCMHs aids in early engagement of the most complex members to prevent unnecessary utilization and promote early alignment with the PCMH.
- 7) Member Surveillance: Aetna Better Health is well-positioned to identify when a member's care needs or intensity of care changes. We use surveillance data or real time data to identify high Emergency Room (ER) utilizers. Surveillance data includes, but is not limited to, enrollment transition information from the member's provider, information received as part of a referral to care management or Primary Care Case Management (PCCM), or results of other assessments conducted by DHH or other entities. Through direct member outreach and the Utilization Management review process, we assist PCMHs in connecting with these members who may be at increased risk for poor health outcomes, who show a significant change in utilization patterns, or who could benefit from care coordination or PCCM.
- 8) Health Information Sharing: Aetna Better Health provides PCMH sites with a Provider Profile to support the sharing of essential clinical and member information. This Provider Profile contains key metrics with information PCMHs can use to drive every day clinical-decisions that support both member safety and continuous quality improvement. Key metrics include ER utilization information about the PCMH's assigned members and provide comparisons to other PCMHs in the same type of practice. We work with PCMHs to identify the root causes and provide education about the best use of ER services and encourage using open access scheduling techniques. We facilitate the implementation of interventions such as improved management of members who are high ER utilizers, encourage the use of after-hours clinics that offer non-emergent care appointments as well. This information is available on our website with

additional member information, such as the member's care plan and access to the member's Case Manager.

- 9) Performance and Outcome Improvement: Aetna Better Health supports our PCMHs in addressing care delivery from a quality, efficiency and value perspective. We share accountability for improving care with our PCMHs.
- 10) Innovative Incentive Models: Aetna Better Health works with healthcare providers and state agencies to develop and implement incentives to reward providers who exhibit a dedication to the PCMH model (e.g. PCMH preference in our PCP auto-assignment process).

The sharing of information and knowledge is essential to our providers' successful transformation to the PCMH program. As a result, Aetna Better Health encourages the use of a Learning Collaborative Forum as our PCPs move into their PCMH strategic planning and execution phases. This forum includes both PCPs and members and promotes discussions and sharing of ideas on how to improve the ten step program described above. PCPs review emerging best practices, seek feedback from colleagues to gain insight on implementation challenges, and work together to identify additional incentives for PCPs to transform to the PCMH program. Additional PCP support includes access to readiness assessment tools and information from national resources and practice management consultants that aid providers in their PCMH transformation efforts. Aetna Better Health provides a list of reputable transformation specialists and consultants that our PCPs can voluntarily choose to assist them with their PCMH efforts.

We recognize that all members benefit from a primary source of care that is accessible, continuous, comprehensive, member and family-centered, coordinated, compassionate and culturally appropriate. Aetna Better Health's PCMH approach supports PCPs during the PCMH transformation process in which we provide the oversight and support while the PCP assumes the primary responsibility of actively managing the member's care.

Patient-Centered Medical Home Incentives

We recognize that the PCMH program may result in our providers having to commit additional financial resources to their PCMH transformation. As a result, Aetna Better Health offers the following incentives to encourage and support our providers in engaging in the process:

Pay-for-Performance Incentives

PCMH-recognized providers and practices are able to participate in the Pay for Performance (P4P) incentives open to all network providers. We believe the PCMH model offers the best opportunity to promote movement to a care delivery model dedicated to continuous quality improvement and improving the member experience of care. Aetna Better Health's PCMH providers have a greater impact on outcomes and the overall quality of care provided to our members. As a result, our PCMH providers have the opportunity to earn additional P4P revenue at a higher level.

Per Member, Per Month Incentives

Aetna Better Health uses capitated monthly Per Member, Per Month (PMPM) care coordination payment intended to cover costs associated with additional administrative activities that support advanced care coordination and member education and engagement. As a simple example, in a

tiered payment system, a level one PCMH may be paid \$1.00 PMPM, a level two PCMH may be paid \$2.00 PMPM and a level three PCMH paid \$3.00 PMPM. This payment methodology allows for increased flexibility while supporting P4P efforts as providers move along the PCMH continuum.

Other Provider Incentives

Promoting the PCMH model as the standard of care and driving our members to receive care in a PCMH- recognized practice is a central component to our PCMH program design. Aetna Better Health recognizes and promotes our PCMH providers through the following:

- Clearly identifying PCMH providers as such in our provider directory and on our website
- Educating our members on the PCMH program and how to identify and self-select a PCMH through our member handbook, member services hotline, provider directory, and website
- Giving preference to our PCMH providers by including the PCMH status in our PCP auto-assignment algorithm

Further incentives include our Aetna Better Health team examining federal and state grants or resources available from NCQA, Joint Commission or other PCMH-transformation specialists. We work with providers to find strategies to encourage their alignment with PCMH principles and to find ways to support their efforts by serving as a collaborative partner. The PCMH landscape continues to change and is becoming increasingly more confusing for providers as new PCMH models emerge. Our experience and commitment to the PCMH model helps providers navigate the PCMH landscape and reach the capability to provide PCMH-level care to our members. In addition, we continually examine new payment methodologies for consideration as more experience is gained in the market and as trends and impact to care become more apparent under the collective PCMH model.

Patient-Centered Medical Home Quality Measurement and Evaluation

National guidelines for evaluating clinical and quality outcomes for PCMH are still being developed and validated by federal and state government entities and other providers as national pilots gain more experience. As part of our PCMH efforts, we are engaged in our own comprehensive internal evaluation process examining the various PCMH models and care trends. In our initial assessments, we propose aligning performance and quality measures with the protocols we use to track PCMH effectiveness. We have developed and maintained a care management system platform to store, analyze, track and monitor a variety of clinical, utilization, cost and practice data to determine PCMH program impact on member care and health outcomes. Examples of key metrics include, but are not limited to, the following:

Table 2. Patient-Centered Medical Home Quality Management Metrics

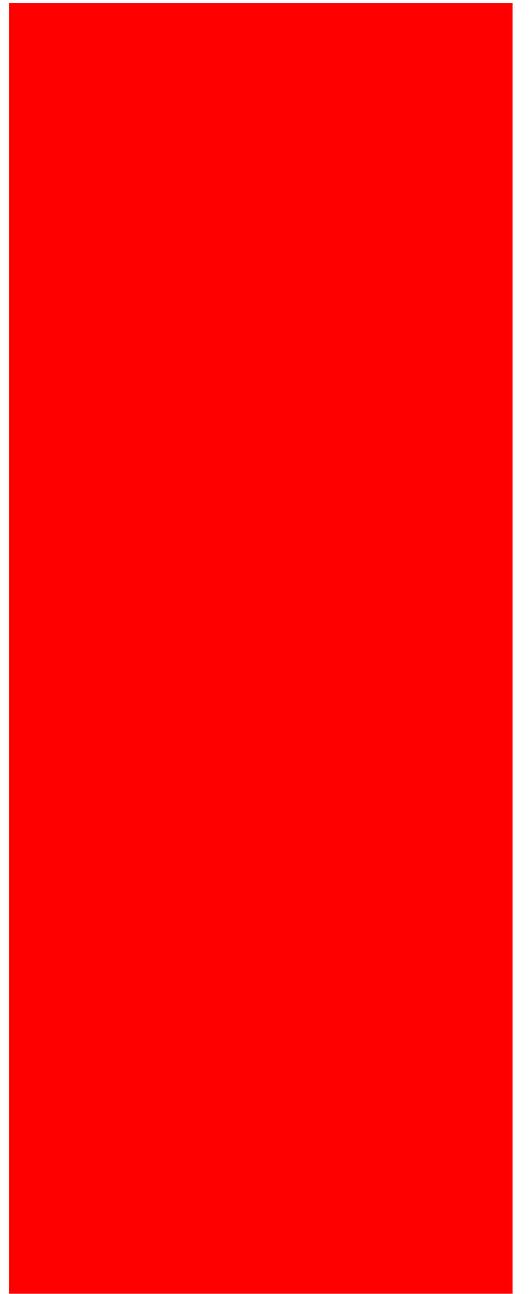
Measures	Access to Care Standards	Continuity of Care/ Service Coordination	Quality of Care Standard
Administrative	Well care missed appointment rates	Case & Disease Managers in the PCMH	Member satisfaction results
Clinical	HEDIS results	Avoidable admission and re-admission rates	HEDIS results and evidence-based guidelines

Practice	Behavioral Health Services integration within practice	Use of Health Information Technology in the practice	HEDIS comprehensive care measures
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PCMH measurement information are gathered using 12 months of data and collected from multiple sources, including but not limited to:

- Member engagement or focus groups (recommended to advise the PCMH)
- Results of member and provider satisfaction surveys
- Results of improvement in HEDIS specific measures
- Analysis of utilization results (ER visits, IP admissions, etc)
- Lessons learned from member and provider complaints and grievances

67 G.9



G.9 Describe how you will monitor providers and ensure compliance with provider subcontracts. In addition to a general description of your approach, address each of the following:

- **Compliance with cost sharing requirements;**
- **Compliance with medical record documentation standards;**
- **Compliance with conflict of interest requirements;**
- **Compliance with lobbying requirements;**
- **Compliance with disclosure requirements; and**
- **Compliance with marketing requirements**

Aetna Better Health[®] has policies and procedures in place for monitoring providers and validating compliance with provider subcontracts. Under the direction of our chief operating officer (COO), our Provider Services Department provides proactive education to providers, assesses providers' adherence to subcontract requirements, and communicates findings throughout the organization. We use the information to improve compliance with requirements at both the individual provider and overall network levels. Our overall approach is described below:

Proactive Education for Providers

Aetna Better Health proactively educates providers upon signing a contract with Aetna Better Health regarding the Louisiana Medicaid program and Aetna Better Health contract requirements. We have developed a robust training program for our provider network and encourage all providers to participate to foster provider adherence with Aetna Better Health policies and procedures and Medicaid regulations. In addition, Aetna Better Health requires that providers participate in our training sessions as part of the provider's contract with us. We use various training settings and tools to communicate contract requirements including provider forums, individual provider orientation sessions, and individual provider site visits. We supplement education sessions with written communications such as the provider contract and provider handbook. Aetna Better Health also posts the provider handbook and other information on our website.

Monitoring Compliance with Subcontracts

We monitor providers' compliance with contract requirements through various means, including analysis of data and communication with members, providers, internal departments and external organizations. We have multiple avenues to gather feedback and monitor compliance.

Examples of our process for monitoring compliance are as follows:

- ***Communication with Members:*** Aetna Better Health communicates with members through our processes for accepting member inquiries, grievances and requests for information, as well as through our care management activities. Members have opportunities to interact with us via phone, fax, mail, our website, by serving on committees, or by communicating information with member advocacy groups who in turn communicate with Aetna Better Health.

- **Interactions with Providers:** We have several interactions with providers where we gather feedback and monitor compliance with contract requirements. Our Provider Services Representatives conduct orientation sessions for new providers and continue to meet with providers during routine and ad hoc site visits thereafter. In addition, Aetna Better Health personnel from other departments, such as Case Management, Member Services, Quality Management and Utilization Management communicate with providers during routine Case Management, Medical Management or Quality Management activities. Our claims department also communicates with providers and identifies concerns regarding contract compliance through analysis of claims submitted by providers. Personnel from these internal Aetna Better Health departments has opportunities during these interactions to gather feedback, conduct audits and assess compliance with various contract requirements. Our provider contract requires providers to participate and cooperate with any internal or external assessments, as well as to monitor and report the quality of services provided under the agreement.
- **Feedback from External Agencies:** Aetna Better Health works closely with community organizations including provider and member advocacy groups. We seek and receive feedback from these organizations regarding issues of concern to members and providers. We will also work closely with the Department of Health and Hospitals (DHH) to gather and respond to concerns it may receive. This feedback serves as another avenue to monitor and assess provider compliance with subcontract requirements.

Aetna Better Health uses information received from the above sources to track and trend compliance with provider subcontracts. We then communicate issues throughout the organization using our cross-functional committee structure and take actions to encourage compliance with contract requirements.

Validating Compliance with Subcontracts

Aetna Better Health analyzes data and information gathered to identify individual provider or overall network concerns. Our provider contract requires providers to participate and cooperate with any corrective action plan initiated by Aetna Better Health and/or required by DHH. In addition, providers agree to be subject to monetary penalties, sanctions or reductions in payment if they fail to comply with contractual requirements, imposed at Aetna Better Health's discretion or as a directive by DHH. Upon identifying issues, personnel from the various Aetna Better Health departments mentioned work collaboratively with the particular provider(s) to implement corrective actions and re-monitors providers to verify that they continue to comply with requirements.

When Aetna Better Health personnel identify opportunities for network-wide initiatives, they bring the issue/suggestion to the Service Improvement Committee (SIC) for operational matters and the Quality Management/Utilization Management (QM/UM) Committee for clinical issues. These committees review data and make recommendations to improve the network, which may include making changes to our processes or conducting network-wide education efforts. The SIC and QM/UM Committee report findings to our Quality Management Oversight Committee (QMOC) which oversees quality improvement initiatives for Aetna Better Health.

Examples of Compliance

Aetna Better Health specifically addresses compliance with requirements regarding cost sharing, medical record documentation standards, conflict of interest, lobbying, disclosure, and marketing. Examples of each are as follows:

Cost Sharing

Provider Compliance	Description
Contract Requirements	<p>Aetna Better Health understands that there is no cost sharing requirement for CCN core benefits. Our provider contract states that providers may bill members to collect applicable copayments, coinsurance, or deductibles and requires providers to otherwise hold members harmless. Providers further agree not to accept waivers of the member protections listed under this section of the contract. Providers receive education regarding these requirements and agree to comply upon signing the Aetna Better Health provider contract.</p>
Tools for Monitoring Compliance	<p>Grievance Data - Personnel from various Aetna Better Health departments works together to review individual member grievances along with trended grievance data.</p> <p>Claims Audits – Our Claims Department reviews claims data to identify if providers are charging the appropriate amounts.</p> <p>Reports of Fraud and Abuse – Aetna Better Health provides tools for members to report suspected fraud and abuse. Members can notify Aetna Better Health by phone, by fax, or using a form on our website regarding instances where they have been inappropriately billed for services by providers. To illustrate, attached at the end of this response is the Fraud and Abuse Reporting Form for use by members of our Medicaid plan in Delaware (indicated as Exhibit A).</p> <p>Site Visits/Interactions with Aetna Better Health Personnel – Provider Service Representatives discuss providers’ understanding of cost sharing requirements during site visits and ongoing discussions. Personnel from other internal departments (i.e. care management) may identify noncompliance through discussions with providers.</p>
Indicators of Potential Noncompliance	<p>Providers who charge coinsurance, copayments or deductibles for CCN core benefits are noncompliant with contract requirements. Aetna Better Health personnel identify issues through audits of claims data.</p>
Corrective Actions	<p>Aetna Better Health personnel work with individual providers who are noncompliant to provide re-education regarding requirements. We re-assess performance and work collaboratively with providers and our medical director to develop a corrective action plan if noncompliance continues.</p>

Medical Record Documentation Standards

Provider Compliance	Description
<p>Contract Requirements</p>	<p>Aetna Better Health has established medical record documentation standards for providers that are specified in our provider contracts and provider handbook. Our provider handbook lists detailed medical record documentation requirements regarding content (e.g., medications prescribed, treatment received, referrals, recommendations for care and follow up). These criteria provide a guideline for organization, documentation of diagnostic procedures and treatment, communication and storage of medical records.</p> <p>Aetna Better Health requires that medical records are accurate and legible and kept at the site of the member’s treatment; documents all treatment plans including emergency services, outpatient services, and services provided by an out of network provider; safeguarded against loss, destruction, or unauthorized use; maintained in an organized fashion for all members evaluated or treated; and readily available for review.</p> <p>In addition to requiring documentation standards, our contracts also provide for record retention, member confidentiality and ability to audit records. Providers must adhere to Medicaid records retention requirements, where they agree to retain member records for a period of six years after the last payment was made for covered services provided to a member and retained further if the records are under review or audit. Providers must see that member records are made available for medical review or other monitoring upon request of DHH or Aetna Better Health</p>
<p>Tools for Monitoring Compliance</p>	<p>Medical Record Reviews - Aetna Better Health’s quality management personnel (under the direction of the QM director and CMO) is responsible for maintaining medical record standards and conducts medical record reviews for various reasons, including as part of an investigation for a grievance or appeal, ambulatory medical record review, or HEDIS review.</p> <p>Site Visits/Interactions with Aetna Better Health Personnel – Provider Service Representatives discuss providers’ understanding of medical record requirements during site visits and ongoing discussions. Personnel from other internal departments (i.e. care management, quality management) may identify noncompliance through discussions with providers.</p>
<p>Indicators of Potential Noncompliance</p>	<p>Records that are missing documentation regarding certain services or treatment plans, inaccurate, illegible, unavailable for review, improperly stored in an inappropriate location or retained for an inadequate amount of time are noncompliant with standards.</p>
<p>Corrective Actions</p>	<p>Aetna Better Health personnel work with individual providers who are noncompliant to provide re-education regarding requirements. Quality management personnel share results of audits with providers, discuss areas of noncompliance and actions required for improvement. We re-assess performance and work collaboratively with providers and our medical director to develop a corrective action plan if noncompliance continues.</p>

Conflict of Interest

Provider Compliance	Description
Contract Requirements	<p>Aetna Better Health maintains referral policies and procedures that describe our referral systems and guidelines. Consistent with DHH standards, these policies prohibit providers from making referrals for designated health services to healthcare entities with which the provider or a member of the provider's family has a financial relationship.</p> <p>Our provider contract contains requirements regarding required disclosures. The language states that the provider must comply with the disclosure provisions of 42 C.F.R. §455, Subpart B and disclose all required information regarding significant business transactions, ownership and control information to Aetna Better Health in accordance with the requirements of 42 C.F.R. §455.104-.106.</p>
Tools for Monitoring Compliance	<p>Grievance Data - Personnel from various Aetna Better Health departments works together to review individual member grievances along with trended grievance data.</p> <p>Conflict of Interest Form – Aetna Better Health requests that providers self-report any known conflicts of interests. We have a form available on our website for providers to complete and return</p> <p>Referral Patterns – Aetna Better Health personnel work with providers regarding referrals and may identify inappropriate referrals from providers where there is a conflict of interest. Personnel in particular, monitor referrals from providers who indicate a conflict of interest using our form.</p> <p>Reports of Fraud and Abuse – Aetna Better Health provides tools for members to report suspected fraud and abuse. Members can notify Aetna Better Health by phone, by fax, or using a form on our website regarding instances where they have identified a conflict of interest.</p> <p>Site Visits/Interactions with Aetna Better Health Personnel – Provider Service Representatives discuss conflict of interest and disclosure requirements during site visits and ongoing discussions. Personnel from other internal departments (i.e. Utilization Management, Care Management) may identify noncompliance through discussions with providers.</p>
Indicators of Potential Noncompliance	<p>Inappropriate referral patterns – providers who refer to healthcare entities with which the provider or a member of the provider's family has a financial relationship.</p> <p>Non-disclosures – Providers who do not disclose known conflicts of interest.</p>
Corrective Actions	<p>Aetna Better Health personnel work with individual providers who are noncompliant to provide re-education regarding requirements. We re-assess performance and work collaboratively with providers and our medical director to develop a corrective action plan if noncompliance continues.</p>

Lobbying

Provider Compliance	Description
Contract Requirements	<p>Aetna Better Health's provider contract contains requirements regarding the Byrd Anti-Lobbying Amendment. Language states that the provider agrees to comply with the Byrd Anti-Lobbying Amendment, which provides that contractors who apply or submit bids shall file the required certification that each tier will not use federal funds to pay a person or employee or organization for influencing or attempting to influence an officer or employee of any Federal agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any federal contract, grant or any other award covered by 31 U.S.C. §1352. Each tier shall also disclose any lobbying with nonfederal funds that takes place in connection with obtaining any Federal award. Such disclosures are forwarded from tier to tier up to the recipient.</p>
	<p>Grievance Data - Personnel from various Aetna Better Health departments works together to review individual member grievances along with trended grievance data.</p> <p>Reports of Fraud and Abuse – Aetna Better Health provides tools for members to report suspected fraud and abuse. Members can notify Aetna Better Health by phone, by fax, or using a form on our website regarding instances where they suspect that providers are engaging in inappropriate lobbying activities.</p> <p>Anti-Lobbying Form – Aetna Better Health requests that providers self-report any lobbying activities. We have a form available on our website for providers to complete and return.</p> <p>Site Visits/Interactions with Aetna Better Health Personnel – Provider Service Representatives discuss the Byrd Anti-Lobbying Amendment and requirements for registration as a lobbyist in Louisiana during site visits and ongoing discussions. Personnel from other internal departments (i.e. Utilization Management, Care Management) may identify noncompliance through discussions with providers.</p>
Indicators of Potential Noncompliance	<p>Inappropriate lobbying activities by the provider</p>
Corrective Actions	<p>Aetna Better Health personnel work with individual providers who are noncompliant to provide re-education regarding requirements. We re-assess performance and work collaboratively with providers and our medical director to develop a corrective action plan if noncompliance continues.</p>

Disclosure

Provider Compliance	Description
Contract Requirements	Our provider contract contains requirements regarding required disclosures. The language states that the provider must comply with the disclosure provisions of 42 C.F.R. §455, Subpart B and disclose all required information regarding significant business transactions, ownership and control information to Aetna Better Health in accordance with the requirements of 42 C.F.R. §455.104-.106.
Tools for Monitoring Compliance	<p>Grievance Data - Personnel from various Aetna Better Health departments works together to review individual member grievances along with trended grievance data.</p> <p>Conflict of Interest Form – Aetna Better Health requests that providers self-report any known conflicts of interests. We have a form available on our website for providers to complete and return</p> <p>Credentialing Application Addendum – As part of the credentialing and recredentialing process, providers complete a credentialing application addendum where they disclose information regarding significant business transactions and people/entities that have an ownership interest in the provider’s practice. For example, attached at the end of this response is the Credentialing Application Addendum used by our Medicaid plan in Delaware (Exhibit B).</p> <p>Anti-Lobbying Form – Aetna Better Health requests that providers self-report any lobbying activities. We have a form available on our website for providers to complete and return</p> <p>Site Visits/Interactions with Aetna Better Health Personnel – Provider Service Representatives discuss conflict of interest and disclosure requirements during site visits and ongoing discussions. Personnel from other internal departments (i.e. Utilization Management, Care Management) may identify noncompliance through discussions with providers.</p>
Indicators of Potential Noncompliance	Non-disclosures – Providers who do not disclose known conflicts of interest
Corrective Actions	Aetna Better Health personnel work with individual providers who are noncompliant to provide re-education regarding requirements. We re-assess performance and work collaboratively with providers and our medical director to develop a corrective action plan if noncompliance continues.

Marketing

Provider Compliance	Description
Contract Requirements	Aetna Better Health educates providers regarding limitations on marketing, reinforcing that marketing includes any communication, from a CCN or agent of a CCN, intended to influence the member to enroll in, not enroll in, or disenroll from a CCN.
Tools for Monitoring Compliance	<p>Grievance Data - Personnel from various Aetna Better Health departments works together to review individual member grievances along with trended grievance data.</p> <p>Site Visits – Provider Service Representatives review materials displayed for members in provider waiting rooms/exam rooms during routine site visits and note any inappropriate materials that are displayed for members.</p> <p>Interactions with Aetna Better Health Personnel – Provider Service Representatives discuss limitations on marketing during site visits and ongoing discussions. Personnel from other internal departments (i.e. Utilization Management, Care Management) may identify noncompliance through discussions with providers.</p>
Indicators of Potential Noncompliance	<p>Grievances from members that providers are inappropriately marketing CCN plans to them.</p> <p>Evidence of inappropriate marketing materials located in provider offices.</p>
Corrective Actions	Aetna Better Health personnel work with individual providers who are noncompliant to provide re-education regarding requirements. We re-assess performance and work collaboratively with providers and our medical director to develop a corrective action plan if noncompliance continues.

Other Aetna Better Health Monitoring Activities

In addition to our monitoring activities described above, Aetna Better Health conducts additional monitoring of the network on an ongoing basis to assess and validate compliance with Aetna Better Health policies and procedures, state and federal requirements. Those additional monitoring activities include, but are not limited to, assessments of claims, network accessibility and availability, cultural competency of providers, and verifying the providers treat members with dignity and respect.

Exhibit A: Sample Fraud and Abuse Reporting Form

Below is an excerpt from the website of our Medicaid plan in Delaware, including a copy of the form that members can complete and submit regarding suspected fraud and abuse:

You can report suspected fraud or abuse to Delaware Physicians Care in the following ways:

- By phone at 1-866-781-6403.
- By fax at 1-860-907-2300.
- Electronically, using the Fraud and Abuse Reporting Form below.

Note: If you provide your contact information, your identity will be kept confidential.

You can also report provider fraud to: Delaware Crime Stoppers at 1-800-TIP-3333 or The Attorney General's Medicaid Fraud Control Unit at 302-577-5000.

Please use this form to report suspected fraud or abuse of services paid for by Delaware Physicians Care. Please complete as much of the requested information below as you can.

* = Required Fields

*Name:	<input type="text"/>
*Provider or Practice Name:	<input type="text"/>
Address:	<input type="text"/>
City:	<input type="text"/>
*State:	<input type="text"/>
ZIP Code:	<input type="text"/>
Phone:	<input type="text"/>
Ext:	<input type="text"/>

Please include other information about the suspected member or provider. This may include their ID number, license number, etc.:

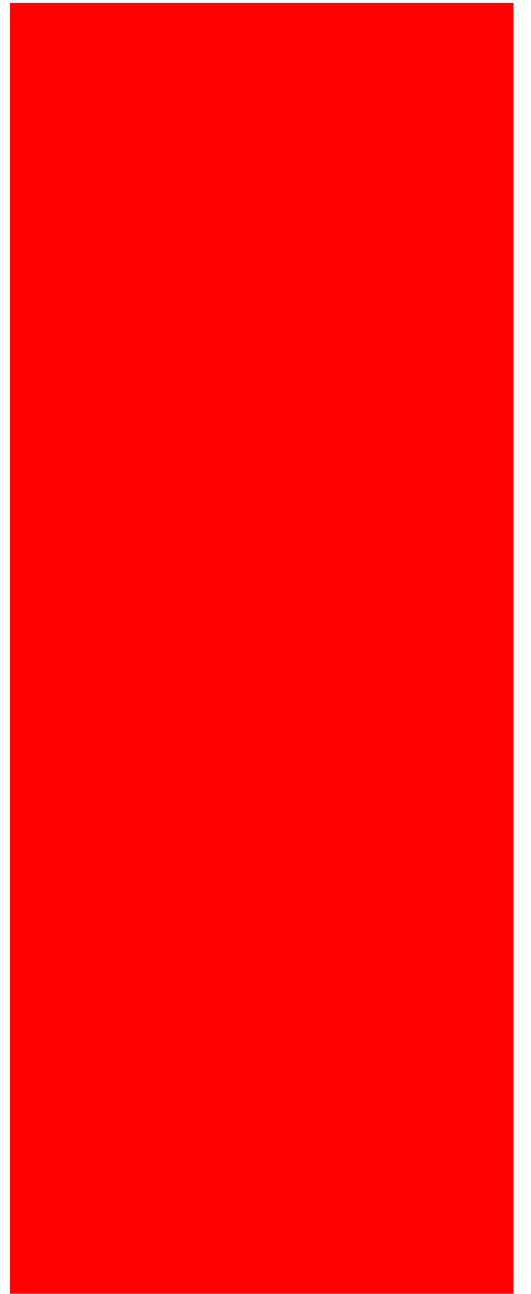
*Please describe the activity that may be fraud or abuse. Some examples are: Billing for services you did not receive, billing for services that were not provided or someone using your identity to received medical services. Please provide details that tell us 'who, what, when, where, why and how.':

Optional information: We would like to be able to discuss your response with you. Please provide your name, phone number, address and/or email address below. We will contact you for

more information if needed. If you provide your contact information, your identity will be protected to the extent allowed. Thank you for helping Delaware Physicians Care's efforts to detect fraud and abuse.

Name:	<input type="text"/>
Address:	<input type="text"/>
City:	<input type="text"/>
State:	<input type="text"/>
ZIP Code:	<input type="text"/>
Phone:	<input type="text"/>
Ext:	<input type="text"/>
Email:	<input type="text"/>

68 G.10



G.10 Provide an example from your previous experience of how you have handled provider noncompliance with contract requirements.

Aetna Better Health[®] uses comprehensive and proactive strategies to evaluate and improve provider performance. We have experience across our Medicaid health plans in acclimating providers who had previously operated under a fee-for-service system to a managed care environment. We are aware that this experience can be difficult for certain provider and have implemented processes to make this transition easier, including providing proactive provider education and monitoring regarding contract requirements. While all Aetna Better Health departments contribute to the process of monitoring and managing providers, the Board of Directors delegates oversight of clinical issues regarding provider noncompliance to the Chief Medical Officer (CMO) and non-clinical issues to our Chief Operating Officer (COO). In collaboration with other Aetna Better Health departments, the CMO and COO discuss data and issues at our cross-functional committee meetings, such as our Service Improvement Committee (SIC) and Quality Management/Utilization Management (QM/UM) Committee.

The SIC and QM/UM Committee implement and monitor opportunities for improvement for both the individual provider and overall network. Aetna Better Health has Policies and Procedures (P&Ps) in place that guide departments in monitoring performance and taking actions upon identifying provider performance issues. P&Ps address credentialing and re-credentialing, accessibility and availability of providers, peer review, and fair hearing. Our goal is to evaluate provider performance, meet the performance measures that have been approved by our Board of Directors and continually demonstrate improved outcomes from year to year.

Evaluating Provider Performance

The purpose of provider performance evaluation is to 1) establish if a provider fails to provide quality care; 2) determine if a provider follows contract provisions and relevant regulations; 3) discover provider dissatisfaction or potential viability issues before they become problematic, and 4) identify potential network gaps. Aetna Better Health departments work collaboratively to establish cooperation throughout the organization in measuring provider performance. We use the following methodologies to evaluate provider performance across non-medical and medical aspects on an ongoing basis:

Non-Medical Performance Indicators

- **Provider Availability Assessments** – Aetna Better Health Provider Services Representatives monitor compliance with appointment availability by conducting site visits to provider offices and reviewing the provider’s appointment books. Provider Services Representatives identify the next available appointment under various scenarios (i.e. request for a routine, urgent, maternity appointment, etc.) and assess compliance with Department of Health and Hospitals (DHH) standards. Provider Services reports a summary of findings to the Quality Management/Utilization Management (QM/UM) Committee. The committee compares findings with member complaints and satisfaction survey data to evaluate individual provider and network-wide performance.
- **Member Grievances and Provider Complaints** – Member Services, Provider Services, Network Development, Appeals/Grievances, Case Management, QM and the Compliance

Departments work together on Aetna Better Health cross-functional workgroups dedicated to reviewing member grievances and provider complaints. These workgroups track and trend member grievances and provider complaints on a regular basis to identify patterns and report findings to the SIC and QM/UM Committee. The committees identify providers who exceed grievance thresholds for appointment availability and assesses if grievances may be related to a gap in the provider network.

- **Member and Provider Satisfaction Surveys** – Aetna Better Health conducts annual member and provider satisfaction surveys to assess areas that are working well network-wide and identify opportunities for improvement. The SIC and QM/UM Committee review the results and develops recommendations for service improvement opportunities.
- **Chart Audits** – The purpose of chart audits is to evaluate documentation of medical information in the records of PCPs, OB/GYNs, and other specialists in the Aetna Better Health provider network. Audits include review of adult and child preventive elements as well as coordination of care with behavioral health providers. Our QM Department conducts audits and reports on findings to the QM/UM Committee.
- **Operational Assessments** - Aetna Better Health also monitors performance regarding operational and administrative requirements. Personnel from our Claims Department reviews claims data to verify that providers file claims correctly and follow appropriate billing procedures. Our Provider Service Representatives conduct proactive education regarding these requirements and assist providers with compliance. They have an opportunity while conducting site visits to identify any provider concerns or noncompliance with Aetna Better Health standards. Upon learning of concerns or noncompliance, Aetna Better Health Provider Service Representatives set up further education sessions with the provider and an Aetna Better Health claims educator to review requirements and assist the provider with achieving compliance. In addition, Aetna Better Health provides online tools to assist the provider in complying with claims requirements. For example, in our Arizona Medicaid plan, Aetna Better Health offers network provider’s access to Clear Claim Connection®, a provider reference tool that helps providers optimize their claims submission accuracy. Currently there are 2300 provider groups registered to use this web-based tool that providers can use to understand Aetna Better Health’s clinical editing logic. This allows them to better understand the rules and clinical rationale affecting adjudication. Providers access Clear Claim Connection® through Aetna Better Health’s web portal via secure login. Various coding combinations can then be entered to determine why, for example, a particular coding combination resulted in a denial. The provider may also review coding combinations prior to claim submission, to determine if applicable auditing rules and clinical rationale will deny the claim before it is submitted.

Disciplinary Actions

Through the systematic collection and analysis of data on provider performance, Aetna Better Health is able to evaluate and identify opportunities for improvement and determine the best intervention strategies for improving performance. For issues that are attributed to a particular provider, the provider’s issue or concern is brought before one of Aetna Better Health’s cross-functional committees or work groups where it can be researched and resolved by those who are closest to the situation. Follow up actions may involve provider education, corrective action, and

verification of sustained improvements in performance. Aetna Better Health takes further action in instances where provider performance does not improve or if there are significant QOC concerns, up to and including provider termination. Aetna Better Health's actions differ depending on whether concerns are non-clinical or clinical in nature.

Non-Clinical Issues

The Provider Services Department may take disciplinary actions for non-clinical reasons up to and including termination. The Provider Services Department reviews results from provider availability assessments and member complaints and directs Provider Services Representatives to follow up with providers who are non-compliant with standards. Follow up may include additional onsite visits or outreach telephone calls to re-educate the provider on compliance requirements. The Provider Services Representative continues to monitor provider compliance thereafter. Should the problem continue, Aetna Better Health works in collaboration with the provider to develop a Corrective Action Plan (CAP). The provider must submit the CAP within a certain time period and the CAP must be approved by Aetna Better Health. Upon receipt and approval of the CAP by Aetna Better Health, the Provider Services Representative monitors the provider's performance until the CAP is successfully completed. If the provider does not improve performance, the Aetna Better Health Medical Director or Chief Medical Officer contacts the provider to discuss non-compliance and offer assistance. Aetna Better Health may recommend further corrective action, panel or referral restrictions or possible termination from the network if unacceptable performance continues.

The Provider Services Department may also recommend termination for reasons of no cause. If Aetna Better Health believes a provider has taken some type of adverse action toward a member that is not considered as a "for cause" adverse action or breach of contract, Aetna Better Health will send a letter to the provider outlining the circumstances and request that the provider cease and desist from the adverse action(s) immediately. The letter notifies the provider that Aetna Better Health may proceed with contract termination if the provider does not correct the situation. The provider will be given thirty calendar days to respond in writing to this letter, either confirming or denying the circumstances in question. If the provider confirms the circumstances and indicates that they do not intend to stop the practice(s) in question, a second letter will be sent that terminates the provider's agreement without cause. Participating provider agreements may be terminated by either party for no cause with at least ninety days prior written notice to the other party.

Termination Procedures: When termination is recommended, Aetna Better Health follows provider pre-termination procedures which include review of the potential termination by multiple internal departments to assess implications of the termination and verify that the termination is implemented appropriately. The requesting department then presents findings at the SIC for a determination regarding whether to proceed with the termination. The Compliance Department reviews terminations recommended and sends notification to DHH as appropriate. Aetna Better Health implements the termination by notifying Aetna Better Health departments, the provider and affected members; arranging for transition of care; and updating our claims/provider data management systems to reflect the termination.

Clinical Issues

Aetna Better Health identifies Quality of Care (QOC) concerns and service complaints from both internal Aetna Better Health personnel and external referral sources (e.g., members, providers, state agencies). We identify many QOC concerns through calls received from members, their families or other individuals to our Member Services call center or other Aetna Better Health departments. As mentioned above, Aetna Better Health developed a workgroup dedicated to addressing escalated member-initiated concerns regarding providers. Aetna Better Health communicates QOC concerns internally through this process and reports trends to our QM/UM Committee. In addition, any received or perceived quality, risk management, abuse, neglect or safety issues are referred to the QM Department. A Medical Director receives escalated cases, reviews the referral data, then takes immediate action to resolve the issue or works with the provider to request further information. After review of the additional information, depending on the severity, the Medical Director may make recommendations to the provider, and track implementation of those recommendations or present the case to the Peer Review Executive session of the QM/UM Committee for review and recommendation. The CMO makes the final decision based upon committee recommendations which may include peer-to-peer contact by the CMO with the provider, development of a corrective action plan, provider education, restricting member assignment or referrals, or terminating the provider's contract. The CMO and QM/UM Committee both approve any corrective action plans that the provider submits and monitors the action plan through to completion.

Based on findings of the review or investigation of a QOC concern, Aetna Better Health reports information to DHH or the appropriate regulatory board or agency as appropriate. The CMO (or designee) notifies the affected provider of the proposed action. Aetna Better Health providers have the right to appeal the determinations and/or actions made by Aetna Better Health through our provider appeals process identified in our provider handbook. This includes the provider's right to request a Fair Hearing if they disagree with determinations related to their credentials.

In addition to the peer review process, Aetna Better Health also utilizes our re-credentialing process to determine whether a provider will continue participation in the Aetna Better Health network. This Credentialing Performance Committee (CPC) is responsible for reviewing provider qualifications, including any previous QOC provider issues and making a recommendation regarding re-credentialing of the provider. The CPC forwards its recommendation to the Medical Director responsible for the final determination regarding continuation of the provider's credentials. The Medical Director has final authority. Providers have the right to request a Fair Hearing should they disagree with the credentialing decision.

Examples of Handling Issues with Noncompliance

Below are some examples of concerns Aetna Better Health identified regarding noncompliance with contract requirements and how we addressed the concerns:

Example One – Complaints Received about a Provider

Aetna Better Health's Quality Management (QM) Department received multiple complaints from members about the level of service and care provided by one of our contracted providers. In addition to addressing these concerns as each were identified, we reviewed the trended volume of complaints for the provider received within a rolling 12 month period and found that the number for him was four times greater than that of his peers. Our QM Department performed

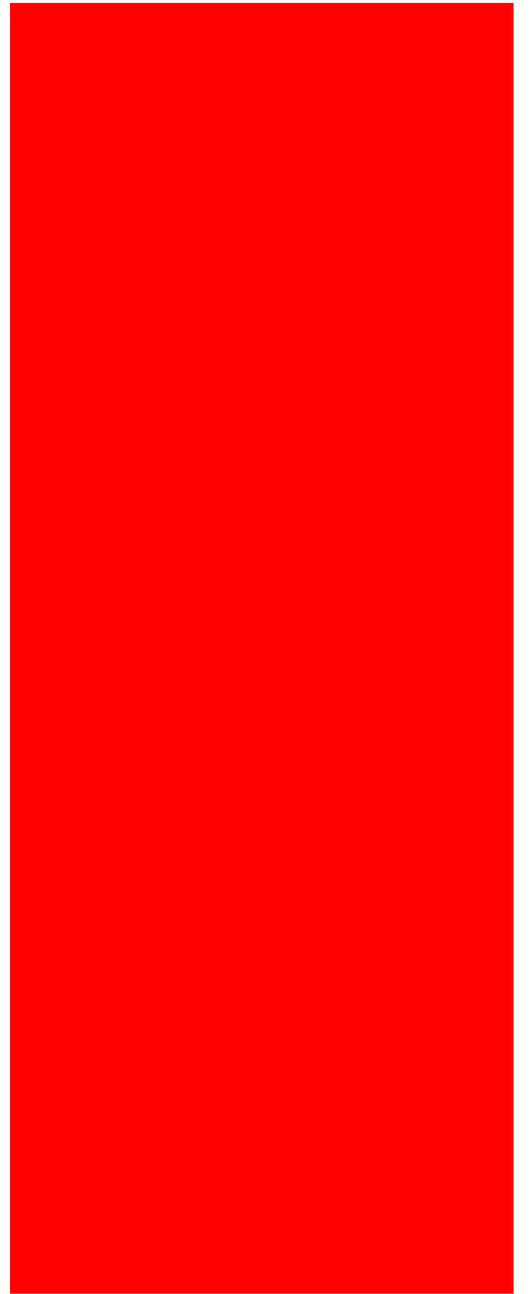
research to further identify the reasons for the complaints and took various follow up actions, as follows:

- Gathered reports to determine the details of each case and categorized the complaints by type.
- Gathered a list of Care Considerations that Aetna Better Health had sent to the provider during this time frame.
- Set up a series of meetings with the provider and various Aetna Better Health personnel members to discuss the concerns. During the first meeting we introduced key contacts from Aetna Better Health and reviewed questions or concerns from the provider and personnel.
- Conducted a follow up meeting within the next few weeks to include personnel from the Provider Services Department, the Medical Director and Quality Director. We discussed key details surrounding the member complaints we received and shared provider practice comparisons (without sharing member details for other providers). During this meeting we suggested possible ways to reduce the complaint volume. We reviewed programs and initiatives that Aetna Better Health offers to assist them in managing patients and provided contact names for Aetna Better Health personnel that can assist with non-compliant members if necessary
- Aetna Better Health set up a follow-up meeting in approximately three months to revisit the practice and office personnel. In the meantime, Aetna Better Health developed monthly reports to determine if there was improvement and/or changes and shared results with the provider at the follow-up meeting. Results showed a decreasing trend of complaints and Aetna Better Health continues to monitor the provider to verify sustained improvement.

Example Two – Provider Submitting Claims Incorrectly

A provider in our Medicaid Delaware plan had an issue with electronic claims submission upon submitting claims to Aetna Better Health for the first time. The provider’s EDI vendor submitted the claim to Aetna Better Health where we voided the claim on our end. The provider assumed we did not receive the claims and continued to resubmit them again and again. The provider contacted their Provider Service Representative who conducted research regarding the problem, and found that claims were not being accepted because something was missing on each claim such as NPI, TAX ID number, or the address or name was different than the set-up that we have in our system claims processing system. Our Provider Service Representative then ran a claims query to capture all the claims that were affected by this particular trend, contacted the EDI vendor to verify that the information they have regarding the provider is accurate and matches our system information, and set up a meeting with the provider to review their submitted claims and associated concerns. Our Provider Service Representative re-educated the provider regarding appropriate submission of claims and how to work with Aetna Better Health in instances where claims are denied or not paid as expected. Once we verified that each system was set up appropriately and that the provider understood how to complete the claims form, the Provider Service Representative facilitated the reprocessing of claims by Aetna Better Health and followed up with the provider to verify that all claims issued had been resolved.

69 G.11



G.11 Describe in detail how you will educate and train providers about billing requirements, including both initial education and training prior to the start date of operations and ongoing education and training for current and new providers.

Aetna Better Health[®] has a long history of successfully implementing new health plans where we have transitioned providers from fee-for-service to managed care programs. Our most recent experiences include transition of our Missouri, Florida, Pennsylvania and Illinois health plans. As part of these transitions, we have offered extensive training programs for providers regarding how to appropriately submit claims and have experienced minimal grievances and claims disputes. One reason for our success is that we offer multiple tools to providers to educate them regarding our program, measure status through various monitoring tools, and follow up with providers to validate their comfort and understanding with our processes.

We will use a multi-pronged approach in Louisiana regarding provider's initial and ongoing training about billing requirements. Our training program includes assistance from personnel across Aetna Better Health and is offered in various settings using a variety of materials. It is designed to provide a comprehensive orientation to providers who join our network prior to the start of operations as well as to those who join our network after operations have begun. Our training program continues thereafter with ongoing education on a routine basis to currently contracted providers. Below is a description of the Aetna Better Health personnel involved in provider training regarding billing requirements and our initial and ongoing provider education programs, including the settings offered and resources we provide regarding billing requirements.

Oversight and Personnel Involved in Training Regarding Billing

Aetna Better Health's Chief Operating Officer (COO) oversees our provider education and training programs with involvement of personnel from multiple departments on how to address provider billing and claims issues. In particular, personnel from the Provider Services, Claims Processing, Claims Inquiry and Claims Resolution, Grievance and Appeals, and our call center departments receives particular training in how to identify concerns regarding billing and facilitate resolution throughout the organization.

In addition, Aetna Better Health has a Provider Claims Educator who serves as an important resource for providers and internal departments. Reporting to the Provider Services Manager, the Claims Educator is responsible for educating contracted and non-contracted providers regarding all provider contract requirements, including proper claims submission, electronic claims transactions and access to Aetna Better Health provider resources. The Claims Educator fully integrates claims education between our grievances, claims processing and provider services systems to facilitate the exchange of timely information between Aetna Better Health and providers. The Claims Educator also interfaces with Aetna Better Health's call center to compile, analyze, and disseminate information from provider calls; identify trends and guide the development/implementation of strategies to improve provider satisfaction; and communicates frequently with providers by telephone and on-site to facilitate effective communications. Upon identifying concerns with provider claims, internal personnel notify our Provider Services Department who works with our Claims Educator to assist the provider.

Initial and Ongoing Provider Education

Our training program includes participation from the Aetna Better Health personnel mentioned above and is offered in various settings using a variety of materials, as described below.

Initial Provider Orientation

Our education process begins during the initial recruitment phase where we discuss Aetna Better Health and Louisiana Medicaid program requirements, including billing requirements. Upon joining our network, Aetna Better Health will deliver a comprehensive initial provider orientation to newly contracted providers and their personnel within 30 days of placing the newly contracted provider on active status. The training materials and mechanisms we use will be the same regardless of whether a provider joins prior to the start of operations or after. The mechanisms we will use to deliver initial provider orientation both prior to and after the start of operations and the training materials we will use are described below.

Mechanisms to Deliver Initial Provider Orientation

Aetna Better Health will deliver formal training to newly contracted providers through the following three primary mechanisms, all of which allow for detailed training regarding provider billing requirements:

- 1) One on One Provider Interactions
- 2) Community Provider Forums
- 3) Webinars

One-on-One Provider Interactions – Aetna Better Health provides one-on-one training with individual practices in their offices within 30 days of placing the newly contracted provider on active status. This setting will be particularly useful for large institutions, large community-based PCP and specialty practices, and those provider offices that cannot attend a webinar or provider forum. This training mechanism will be available to newly contracted providers who join prior to or after the start of program operations and can be arranged at times that fit the provider's schedule. During these sessions we arrange for training regarding the process for submitting claims, how to address questions about claims, and how to use our claims tools and automated systems. Our Provider Services Representatives are available to assist the provider and provide detailed instructions on what the provider needs to do.

For example, our Provider Service Representatives educate providers on how to use our online systems, such as Clear Claim Connection®, a provider reference tool that helps providers optimize their claims submission accuracy. Currently there are 2300 provider groups registered in our Arizona Medicaid plan to use this web-based tool that helps providers to understand Aetna Better Health's clinical editing logic. Use of the tool allows them to better understand the rules and clinical rationale affecting adjudication. Providers access Clear Claim Connection® through Aetna Better Health's web portal via secure login. Various coding combinations can then be entered to determine why, for example, a particular coding combination resulted in a denial. The provider may also review coding combinations prior to claim submission, to determine if applicable auditing rules and clinical rationale will deny the claim before it is submitted.

Community Provider Forums - Aetna Better Health will schedule several Provider Forums in locations central to provider offices and will invite the local office personnel to attend. We will

schedule provider forums over the course of several weeks on different days of the week and at different times to accommodate providers' schedules and encourage maximum attendance. Provider forums will be available to newly contracted providers both prior to and after the start of program operations.

Webinars - Aetna Better Health will conduct interactive training sessions that leverage the flexibility provided by the internet while still allowing real-time personal interaction. Prior to the start date of operations, we will schedule webinars over the course of several weeks on different days of the week and at different times to accommodate providers' schedules and encourage maximum participation. The providers will be able to attend the webinar from their office and the webinars will feature both voice and video capability. We will continue to conduct Webinars after the start of operations to orient newly contracted providers.

Materials Used and Topics Covered During Initial Provider Orientation

Regardless of the training delivery mechanism, Aetna Better Health will deliver formal initial provider orientation to newly contracted providers using a comprehensive PowerPoint presentation augmented by Aetna Better Health's Provider Handbook and a Provider Orientation Kit. The PowerPoint presentation includes detailed information about the Department of Health and Hospitals (DHH) program standards and Aetna Better Health requirements (including information contained in our Provider Handbook). The Provider Orientation Kit contains several 1-2 page documents outlining key topics of interest to providers. The presentation, Provider Handbook and Provider Orientation Kit include detailed information regarding billing requirements. The training will be delivered by our Provider Services Representatives who will review contents of the Provider Handbook, Provider Orientation Kit, and our Web based Provider Directory. Provider Services Representatives will end the orientation session with a question and answer period and explain that further information and instructions are also available on our website.

Contents covered by Provider Service Representatives during initial orientation regarding billing requirements include:

Functions of key departments including Provider Services, Network Development and Contracting, Member Services, Quality Management, Medical Management, and Claims, and how to contact those departments directly with specific questions

Provider handbook contents, specifically reviewing Claims Payment, Encounter Submission and Claims Dispute

- Claims submission, including electronic claims, data validation, remittance advice and encounters policies and procedures
- Claims edits and correct coding guidelines
- Interest payments
- Electronic Funds Transfer
- Provider claim disputes
- Reimbursement including process for dual eligible members
- Coordination of Benefits and Third Party Liability requirements
- Electronic tools, including our website, electronic funds transfer, data interchange and remits

Better Health

- Eligibility verification (process for verifying online)
- Availability of online claims inquiry/monitoring and electronic prior authorization submission
- Performance measure results
- Medical review criteria and practice guidelines
- Reimbursement information
- Provider Orientation Kit, which includes the overall training PowerPoint presentation as well as forms and information regarding
 - Quick Reference Guide
 - Benefit Grid
 - Authorization Form
 - Provider Dispute Form
 - Aetna Better Health Contact List
 - Transportation
 - Specialty Medication

Ongoing Education and Training for Current and New Providers

Aetna Better Health's initial provider orientation program will be offered to newly contracted providers who join prior to the start of program operations or thereafter. Training mechanisms, materials, and content will be the same regardless of when they join (except for updates to materials to reflect changes in program requirements). Aetna Better Health will work with newly contracted providers to review all billing requirements and verify that they understand how to comply with program policies, billing procedures, and standardized billing forms and formats. The Provider Handbook and Provider Orientation Kit will include additional information and requirements regarding billing for the provider's reference.

In addition to initial provider orientation, Aetna Better Health Provider Services personnel will conduct regularly scheduled ongoing education sessions with contracted providers as well as ad hoc education sessions as needed. Provider Services Representatives cover a variety of topics during routine office visits, such as updates or changes to program standards, laws, regulations, and billing requirements. Mechanisms for ongoing education will mainly be through regularly scheduled provider office visits by Provider Services Representatives. However, Aetna Better Health will supplement these routine site visits with ad hoc provider office visits, webinars, and provider forums.

Aetna Better Health will also provide updates and additional information regarding billing requirements through dissemination of materials such as provider newsletters, bulletins, mailings, notifications sent with the provider's claims remittance advice, and updates to our website. For example, our Provider Services Representatives may schedule ad hoc visits with certain providers who have questions regarding or difficulty with billing requirements. Provider Services Representatives will also be available by telephone and email to answer questions that may arise between visits and provide information.

In addition to access to Provider Services Representatives, providers can also contact Aetna Better Health's toll-free telephone line with questions regarding provider billing requirements. The provider access component of the toll-free telephone line will be staffed by Aetna Better Health provider representatives between the hours 7am -7pm Central Time daily. This telephone help line will have personnel to respond to Provider questions in all areas, including prior billing requirements.

Identifying Additional Education Needs

We use the above settings and materials to proactively educate providers regarding billing requirements. In addition, we also gather feedback from the various avenues and tools listed below to identify when an existing provider may be in need of additional training. In these instances, we arrange for follow up and education by our Claims Educator and/or Provider Service Representative, and use the feedback when developing initiatives for network providers regarding education and training.

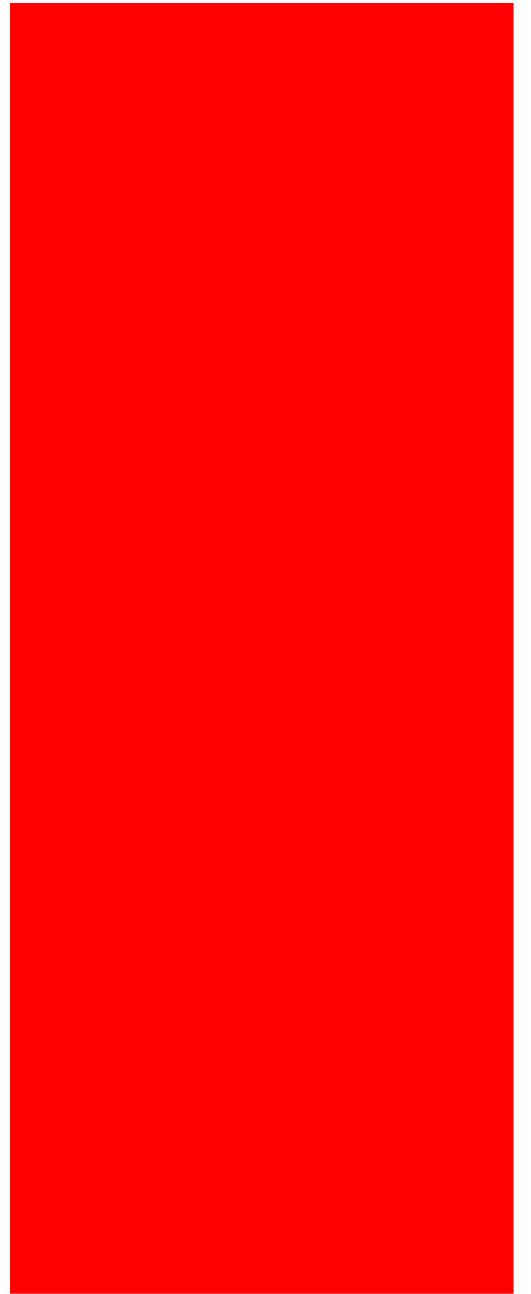
- Claims Reports - we may identify who continually submit claims that are denied. We arrange contact from our Claims Educator and/or Provider Service Representative to discuss the concerns and help provider understand that claims payment process
- Calls to our Claims Inquiry and Claims Research (CICR) Department - Providers who call our CICR Department may request status on claims payment and instructions regarding claims submission. Our CICR may recognize the need for additional training to the provider and will notify our Claims Educator and/or Provider Service Representative to follow up with the provider.
- Provider Claims Disputes – the provider may file a dispute in response to a claim denial. Upon researching the reasons for the denial, we determine from our research that the provider submitted claims incorrectly and provide additional training to support the provider
- Clearinghouses – Providers may have difficulty with claims submission through the clearinghouse. In these case, our Claims Educator and/or Provider Service Representative will assist the provider
- Provider Site Visits – As mentioned above, Aetna Better Health's Provider Service Representative receive feedback from providers during routine site visits and have an opportunity to identify and re-educate providers regarding billing requirements. Our Provider Service Representatives facilitate contact with our Claims Educator as needed.
- Provider Satisfaction Surveys – Aetna Better Health will conduct annual provider satisfaction surveys which include questions regarding satisfaction with our operational processing including billing/claims.

During the initial go-live period for each GSA, we expect to experience a higher level of provider inquiries about claims since it will be the first time that Louisiana providers will be working with us. We expect that our proactive training sessions will cover the vast majority of provider questions and concerns but know that certain providers will contact us for assistance. Aetna Better Health will be prepared to assist providers and will have resources available from 7:00am to 7:00pm Central Time. On an ongoing basis, we will monitor the effectiveness of our provider training programs regarding billing requirements using the above tools and will make adjustments as necessary. Our Service Improvement Committee (SIC), a multidisciplinary



committee that reviews data regarding service operations with Aetna Better Health, will use data from the above sources and recommend additional training initiatives that will affect our providers on an individual or network-wide basis.

70 G.12



G.12 Describe how you will educate and train providers that join your network after program implementation. Identify the key requirements that will be addressed.

Aetna Better Health® has an extensive provider communication and education program that begins when providers join the network and continues on an ongoing basis thereafter. We have experience across our other Medicaid plans (most recently to include Missouri, Florida, Pennsylvania and Illinois) with transitioning providers from a fee-for-service to a managed care environment. In addition to initially transitioning providers, we continually recruit providers and enhance our network on an ongoing basis.

Overseen by our Chief Operating Officer, our provider education program involves participation from personnel from multiple departments, such as Aetna Better Health Provider Services, Quality Management, Utilization Management, Claims Processing, Claims inquiry and Claims Resolution, Grievance and Appeals, and our call center. Provider Service Representatives lead the training process with providers, continually communicating with providers and facilitating interactions between providers and various internal departments. Provider Services Representatives use a multi-faceted approach to educate providers regarding key Department of Health and Hospitals (DHH) and Aetna Better Health requirements, offering training sessions across a variety of settings using various education materials as described below.

Initial Provider Orientation

Aetna Better Health will deliver a comprehensive initial provider orientation to newly contracted providers and their personnel within 30 days of the effective date of a provider joining our network. We have established policies and procedures regarding initial (and ongoing) provider education and do not panel members to our providers until they have completed our initial orientation process. The mechanisms we will use to deliver initial provider orientation, training content and training materials we will use are described below.

Mechanisms to Deliver Initial Provider Orientation

Aetna Better Health will deliver formal training to newly contracted providers primarily through three primary mechanisms: one on one provider interactions, community provider forums, and webinars.

One-on-One Provider Interactions – Aetna Better Health will provide one-on-one training with individual practices in their offices. This setting will be particularly useful for large institutions, large community-based PCP and specialty practices, and those provider offices that can not attend a webinar or provider forum. It will also be useful as our network becomes more mature, when we will no longer have large numbers of providers/provider groups joining our network at once. This training mechanism can be arranged at times that fit the provider’s schedule.

Community Provider Forums - Aetna Better Health will schedule periodic Provider Forums in locations central to provider offices and will invite the local office personnel to attend. We will schedule provider forums over the course of several weeks on different days of the week and at different times to accommodate providers’ schedules and encourage maximum attendance.

Webinars - Aetna Better Health will conduct interactive training sessions that leverage the flexibility provided by the internet while still allowing real-time personal interaction. We will schedule webinars over the course of several weeks on different days of the week and at different times to accommodate providers' schedules and encourage maximum participation. The providers will be able to attend the webinar from their office and the webinars will feature both voice and video capability.

Key Requirements Addressed During Initial Provider Orientation

Regardless of the training delivery mechanism, Aetna Better Health will deliver formal initial provider orientation to newly contracted providers and their personnel using a comprehensive PowerPoint presentation augmented by Aetna Better Health's Provider Handbook and a Provider Orientation Kit. The PowerPoint presentation includes detailed information about DHH program standards and requirements of the provider's contract with Aetna Better Health (including information contained in our Provider Handbook). The Provider Orientation Kit contains several 1-2 page documents outlining key topics of interest to providers. The training will be delivered our Provider Services Representatives who will review contents of the Provider Handbook, Provider Orientation Kit, and our web-based Provider Directory. Provider Services Representatives will end the orientation session with a question and answer period.

Key topics covered by Provider Service Representatives during initial orientation include, but are not limited to:

- Overview of Aetna Better Health and our administrative structure
- Role of the Provider Services Department and other key departments
- Contact information for Aetna Better Health departments
- DHH program standards including subcontract provisions
- PCP and other provider roles and responsibilities
- Description of Patient-Centered Medical Home and requirements for recognition
- Benefits, and description of both covered and non-covered services
- Copayments and cost sharing, when applicable and how they are applied
- Electronic tools, including the website, electronic funds transfer, data interchange and remits, eligibility verification
- Utilization review programs (prior authorization, concurrent and retrospective review, medical necessity standards, referrals, medical records standards, practice protocols)
- Quality Management programs (including chronic care management program and identification of special needs of members, provider profiling process)
- Transportation process and contact information
- Provider assistance program
- Policies and procedures regarding the provider complaint system, including how to file a complaint with Aetna Better Health and how the complaint will be reviewed
- Description of Aetna Better Health's member grievance system including how a provider may file a grievance on behalf of a member and the associated timeframes

- Process for submitting inquiries and requests for information
- Claims submission protocols, including information regarding clean claims
- Aetna Better Health prompt pay requirements
- Limitations on provider marketing
- Provider Contract
- Provider Handbook
- Provider Orientation Kit

Provider Service Representatives provide a Provider Handbook and Provider Orientation Kit to complement the training. The Provider Handbook includes additional detail regarding the orientation topics. Documents included in the Provider Orientation Kit are listed in the following table:

Provider Orientation Kit Document	Description
Aetna Better Health Provider Welcome Letter	The Aetna Better Health Provider Welcome Letter will be inserted into the Provider Orientation Kits welcoming Providers to our network.
Aetna Better Health Provider Quick Reference Guide	The Aetna Better Health Provider Quick Reference Quick Reference Guide is a snapshot of the Provider Handbook. – Key items like, claims, prior authorization, etc.
Aetna Better Health Benefit Grid	The Aetna Better Health Benefit Grid outlines a portion of the benefits we offer to our members.
Aetna Better Health Prior Authorization Form	The Aetna Better Health Prior Authorization Form is used by Providers when asking for medical Prior Authorization.
Aetna Better Health Provider Dispute Form	The Aetna Better Health Provider Dispute Form is used in the event a Provider is dissatisfied with Aetna Better Health.
Aetna Better Health Contact List	The Aetna Better Health Contact List is a document comprised of our contact information as well as our vendors.
Transportation Quick Reference Guide	This document outlines the policies and procedures for obtaining non-emergent non-ambulance transportation.
Curascripts Specialty Medication Form	The CuraScript Prior Authorization Form is used to request specialty medications dispensed/delivered by CuraScript; prior authorization requests for CuraScript specialty medications are reviewed by Aetna Better Health.
Curascripts Provider Letter	The CuraScript Provider Letter is a letter describing CuraScript and Aetna Better Health's prior authorization process for reviewing specialty medications.

Ongoing Education and Training

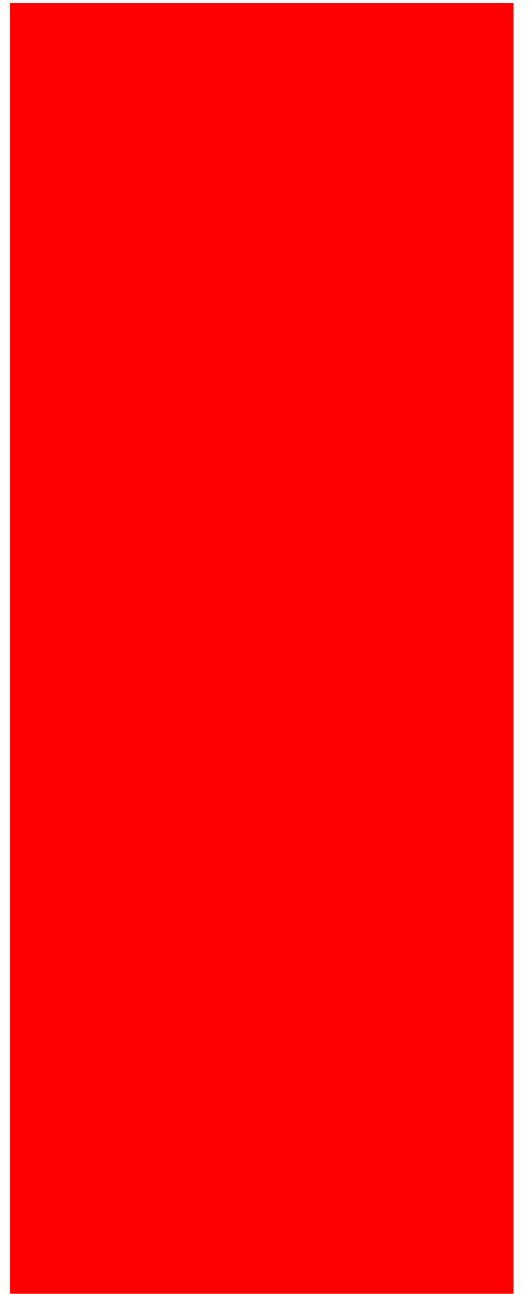
In addition to initial provider orientation, Aetna Better Health Provider Services personnel will conduct regularly scheduled ongoing education sessions with contracted providers as well as ad

hoc training sessions as needed. Provider Services Representatives cover a variety of topics during routine office visits and reinforce the information provided during initial orientation. Provider Service Representatives will also communicate updates or changes to program standards, laws, regulations, and Aetna Better Health requirements. Mechanisms for ongoing education will mainly be through regularly scheduled provider office visits by Provider Services Representatives. However, Aetna Better Health will supplement these routine site visits with ad hoc provider office visits, webinars, and provider forums.

Aetna Better Health will also provide updates and additional information regarding DHH program and Aetna Better Health requirements through dissemination of materials such as provider newsletters, bulletins, mailings, notifications sent with the provider's claims remittance advice, and updates to our website. Provider Services Representatives will also be available by telephone, email and surface mail to answer questions that may arise between visits and provide information.

In addition to access to Provider Services Representatives, providers can also contact Aetna Better Health's toll-free telephone line with questions. The provider access component of the toll-free telephone line will be staffed by Aetna Better Health provider representatives between the hours 7am -7pm Central Time daily. This telephone help line will have personnel to respond to provider questions in all areas.

71 G.13



G.13 Describe your practice of profiling the quality of care delivered by network PCPs, and any other acute care providers (e.g., high volume specialists, hospitals), including the methodology for determining which and how many Providers will be profiled.

- **Submit sample quality profile reports used by you, or proposed for future use (identify which).**
- **Describe the rationale for selecting the performance measures presented in the sample profile reports.**
- **Describe the proposed frequency with which you will distribute such reports to network providers, and identify which providers will receive such profile reports.**

A top priority of Aetna Better Health is to effectively manage our provider network to deliver the highest quality care to our members. We are committed to continuously improving the efficiency and effectiveness of the care our network provides. Central to our success in providing quality care is our relationship and collaboration with the clinicians and community service providers who care for our members. In this rapidly changing era of health information, we recognize that sharing actionable and meaningful health information with providers is absolutely critical and essential to ensuring success in driving quality outcomes. To this end, we continually refine and expand our Provider Profiling efforts in order to give providers the most accurate and timely information possible.

An integral component of our quality efforts is the utilization of detailed Provider Profiles. Profiles serve as the key clinical tool to track trends related to cost, quality and utilization while also serving as a check on care accountability. The profiles are dynamic and provide clinicians with a transparent benchmark for their performance as measured among their peers. Our profile development process takes into consideration the following features under the direction of the Chief Medical Officer (CMO):

- Multi-dimensional assessment of a provider's performance
- Clinical and administrative indicators of care that are accurate, measurable, and relevant to the enrolled population
- Provider, group, and Service Area benchmarks for areas profiled, where applicable, including the Department of Health and Hospital's (DHH's) performance measures
- Feedback to providers regarding the results of their individual performance, practice performance (where indicated) and the overall performance of the provider network

Additional objectives of our Provider Profiles include:

- Maximize point of care effectiveness and efficiency in all care settings
- Share accurate, actionable health information that clinicians and care providers can use to support clinical decision-making and prioritization of care
- Provide individually tailored services that promote care at the right time, in the right setting

- Serve as a key tool to support our Patient-Centered Medical Home (PCMH), Pay for Performance (P4P) and other provider quality and value-based purchasing efforts. For P4P efforts, we will often use a combination of quality (i.e. HEDIS) and utilization (admits, ED visits, etc.) measures depending on the local plan needs
- Encourage transparency, best practices and evidence-based care strategies that optimize outcomes and take costs into consideration
- Improve the member and provider experience of care and increase member engagement and self-management capabilities
- Provide a transparent tool for the health plan's medical leadership to intervene with a provider when the care trends are off target
- Track care across settings to prevent unnecessary utilization of Emergency Department care and prevent unnecessary readmissions
- Share HEDIS or other DHH required performance measures

Provider Profile and Quality Oversight

Aetna Better Health's Board has ultimate responsibility for our Quality Management Program and outcomes which includes Provider Profiling. The Board delegates day-to-day management of our Quality Management Program to the Chief Executive Officer (CEO), who delegates responsibility and authority for our Quality Management Program to the CMO. The CMO, with the support from Quality Management and Provider Services, has the responsibility and authority to oversee our Provider Profiling processes. The CMO reports profiling status to the Quality Management/Utilization Management (QM/UM) Committee, which makes decisions regarding next steps with individual providers and provides information to our Quality Management Oversight Committee (QMOC). Chaired by the CMO, the QMOC is responsible for identifying clinical indicators, developing provider initiatives, assessing the results of Provider Profiles, developing quality improvement initiatives and monitoring provider progress on corrective action plans.

Provider Profiling serves as an important Quality Assurance and Performance Improvement (QAPI) monitoring and evaluation tool for improving the quality of care delivered to our members. We proactively work with our providers to revise profiles to verify the information we provide is useful and aligns with improving care. In all of our Aetna Better Health affiliated plans, the Provider Profiling process has effectively improved PCP performance related to well-care visits and behavioral health screenings during standard office visits; increased the use of generic medications; and improved compliance with disease specific clinical practice guidelines. We expect our profiling process in Louisiana to result in similar positive trends.

The QMOC determines the performance criteria, goals and thresholds for action for monitoring the utilization and quality of care. We select quality measures based upon their relevance to the populations we serve and the providers administering care. The Quality Management Coordinator and the CMO review and revise performance measures at least annually to evaluate provider performance data to:

- Identify aberrant outcomes/trends
- Review the effectiveness of initiatives

- Propose new or additional initiatives
- Evaluate network and provider performance against DHH's performance measures

We take any recommendations to revise the parameters to our QM/UM Committee for review and our QMOC for approval.

Profiling Methodology, Process and Experience

Aetna Better Health has extensive experience in delivering Provider Profiles, which contain health information with specifically tailored data set, throughout our Aetna Better Health affiliated Medicaid managed care programs. We will apply this experience as we implement our profiling process in Louisiana. In our other Aetna Better Health affiliated Medicaid managed care programs, we issue Provider Profiles tailored to meet the needs of each Aetna Better Health affiliated program. When determining which metrics to include in a Provider Profile there are a few key considerations. First, we examine the requirements of the State Medicaid program. For example, this may include adding P4P measures in our Provider Profile. Next, a key consideration is determining the primary care quality measures that are the most meaningful to providers and members including, but not limited to HEDIS measures. Finally, we obtain additional information from providers and stakeholders to determine the community's specific health needs. We then consider this feedback when developing a coherent profile data set.

Current Provider Profiles

Aetna Better Health uses two primary Provider Profiles for PCPs. The first is a broad profile that captures key utilization metrics including inpatient, emergency department and pharmacy information. The second is a HEDIS-based profile; this profile captures HEDIS specific or other metrics that align to support key clinical improvement areas. We send profile reports quarterly to providers either electronically or via mail depending on provider preference. Examples of these profiles are included in Appendix T. Additionally, please see a copy of the Physician Quality Measurement Report Sample in Appendix T.

PCMH Profiles

As a result of our PCMH efforts we have developed a profile to support PCMH expansion. The PCMH Profile represents our latest and most exciting data set designed to capture metrics and care elements to measuring a PCMH's impact on care outcomes. In our PCMH efforts, we have received excellent feedback from our provider community lauding the report as a useful, succinct and relevant tool in guiding their care decisions.

The PCMH Profile has two sections--the first section details specific Provider Profile data (HEDIS) and the second details key utilization data. Included in the PCMH Profile are the following metrics:

- An overview of Emergency Department (ED) visits, hospitalizations, generic pharmacy utilization, and medical cost per member per month, comparing a practice (and its individual providers) to overall Aetna Better Health performance
- A "Compliance" summary that includes an overview of how well the practice and their individual physicians are performing on quality/HEDIS metrics, along with comparisons to Aetna Better Health overall performance

- A "Trends" summary which includes historical, month-by-month ED visits, hospitalizations (inpatient admits), and medical cost
- A list of members including member detail/drilldown information and ED visits and inpatient admits for members over the last three months

Aetna Better Health selected the PCMH Profile measures based on evidence-based research regarding PCMH evaluation and guidelines, provider feedback and our past experience in delivering Provider Profiles. The PCMH profile is currently sent monthly to our participating pilot sites. While the PCMH profile is aligned with our current profiling needs, we understand that the use of information by Medicaid agencies and health plans is an evolving process. Our profiling processes and measures are aligned as part of a dynamic process as our providers continue to use profile information to improve their practices, we will adjust our profiles to meet their needs to provide for timely and accurate information to support member care and services. Although our current PCMH profile serves as a critical starting point, we are continually refining the process and assessing new capabilities to stay in step with future provider needs and requirements by Medicaid agencies.

Louisiana Profiling Requirements

Aetna Better Health has several options for provider profiling that we will utilize to enhance the care of our members in Louisiana. We have developed a provider profiling format that accommodates the specific data elements required by DHH. Upon receiving approval by DHH and gathering actual provider data, we will be prepared to populate and distribute these reports by the second quarter of 2012. Building upon our profiling efforts described above with the PCMH Profile, we are developing a single Primary Care Provider (PCP) Profile consistent with DHH's needs for Family Practice, Internal Medicine, and Pediatric providers and a specialized profile for OB/GYN providers. The PCP Profile will be made available to clinicians via a web portal where each provider can securely access their specific profile information. The PCP Profile will include the following information:

- Utilization of out-of-network providers
- Specialty referrals/1,000
- Emergency Department visits/1,000
- Inpatient admits/1,000
- Laboratory services/1,000
- Percent Generic Prescribing Rate
- High-End Diagnostic Radiology/1,000

For our initial profile efforts we have selected the quality metrics outlined in the chart below based on the following factors: our previous experience with profiling metrics, appropriateness by provider, our experience with national HEDIS measures; provider experience and feedback on which measures are most meaningful, ability to gather the specific metric data accurately and consistently to report back to providers; ability to consistently aggregate the information and tie to outcomes that could support other components of our programming such as P4P. Further, we would like to capture those metrics that are consistent with our current PCMH efforts and focus on measures that providers will find useful in practice.

Family Practice/Internal Medicine/Pediatrics
Well Child Visits in Years 3, 4, 5, 6 of Life (incentive-based)
Adults' Access to Preventive/Ambulatory Health Services (incentive-based)
Adolescent Well-Care Visits (incentive-based)
Children and Adolescents Access to PCP
Use of Medication of People With Asthma
Annual Number of Asthma Patients With One Asthma-related Visit
Appropriate Testing for Children with Pharyngitis
Well Child Visit in First 15 Months of Life
Comprehensive Diabetes Care- Hgb A1c (incentive-based)
Comprehensive Diabetes Care
Chlamydia Screening (incentive-based)
CHF Admission Rate
Adult Admission Rate
Cholesterol Management for People With CAD
OB/GYN
Chlamydia Screening (incentive-based)
Breast Cancer Screening
Cervical Cancer Screening
Prenatal and Postpartum Care (Timeliness of Prenatal Care and Postpartum Care) (depends on global billing)

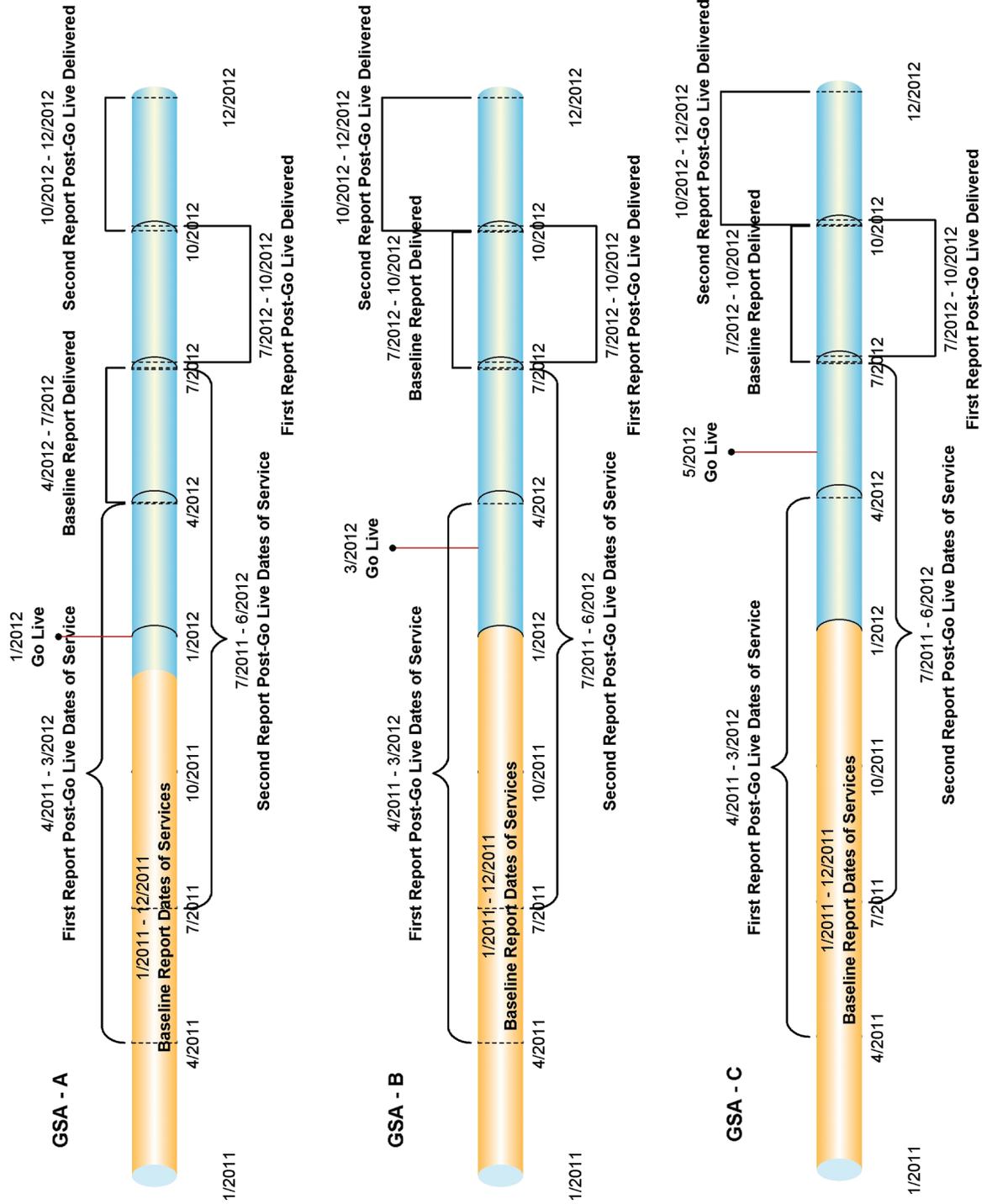
Please see Appendix T for a copy of the PCP Profile Report.

Timeline

Aetna Better Health will establish baseline profile data using the past two years of data for each Geographic Service Area (GSA). In order to have meaningful data, results and profile reports that the state and provider can use, we recommend the following timeline for delivery for the PCP Summary Profile (all estimates assume timely and complete provision of historical data by the State, including subsequent claims run out):

- Baseline calendar year 2011 information (based on State historical data) to be provided in Q2, 2012 for GSA A and Q3, 2012 for GSAs B and C

Thereafter we will provide quarterly updates based on the most recent *12 months* of data allowing for three months of claims run-out. This means that the PCP Profile provided in Q2, 2012 for GSA A will include data from January 2011 - December 2011. Then the PCP Profile provided in Q3, 2012 for GSA A will include data from April 2011-March 2012 and so on from this point forward. The PCP Profile will be delivered quarterly to providers. Below is a graph showing this timeline:



Timeline for OB/GYN Profiles

As noted above, we currently have a comprehensive OB/GYN profile that we utilize for all Aetna Better Health affiliated plans. We will use the OB profile for Louisiana as well with the addition of the additional quality metrics noted above. We will distribute the OB profile in accordance with the same timeline as that listed above for our PCP Profile, allowing for the capture of historical and new claims data into the report. Please see Appendix T for a sample of the OB Profile Report that shows the data elements:

Based upon our experience, the PCP, OB and PCMH profiles are the most critical profile reports to provide during the first year of operations. During this time we will concentrate efforts on working cooperatively with providers to develop a meaningful, supportive relationship where we use data as a key management tool. Our experience demonstrates that when profiles and other tools contribute to improved practice patterns, we are best able to increase quality, reduce costs and improve overall system performance. We will work with DHH to develop a schedule for the implementation of specialist and hospital profiles. In the interim, Aetna Better Health will manage specialist and hospital performance using our day-to-day utilization management processes.

Specialists and Hospitals

Aetna Better Health has experience producing meaningful and effective Provider Profiles for its high volume specialists and hospitals in other Aetna Better Health affiliated programs. As mentioned above, our primary focus during the first year will be on the creation of PCP, PCMH and OB profiles. Thereafter we will provide profiling data for specialists and hospitals. Hospital profile measures will include:

- Admits/1,000, days/1,000, average length of stay,
- 30 day readmission rates,
- Percent of hospital stays that are only one day, percent of hospital stays for ambulatory care sensitive conditions

Below is a sample of our Hospital Profile Report from one of our existing Medicaid plans:

HOSPITAL NAME	Hospitalizations				
	Admits	ALOS	% 1 Day Stays	ALOS w/o 1 Day Stays	30 Day Readmit Rate
HOSPITAL A	651	4.7	12.9%	5.2	15.5%
HOSPITAL B	203	3.6	7.9%	3.8	9.3%
HOSPITAL C	55	2.8	40.0%	3.9	20.0%
HOSPITAL D	49	5.0	36.7%	7.4	10.6%
HOSPITAL E	43	4.9	30.2%	6.5	10.5%
HOSPITAL F	16	3.8	18.8%	4.4	21.4%
TOTALS	1,017	4.4	15.3%	5.0	14.2%

State Summary Profile Report

In accordance with Louisiana's requirements, we will deliver State Summary Profile reports to DHH on a quarterly basis. These reports will coincide with the availability of the provider reports (i.e. for the PCP profiles they would be available in Q2 2012). The State Summary Reports will include all of the metrics included in the provider reports at the group level as well as overall summary statistics across all practices by specialty. In the State Summary Report, practices will be grouped by specialty (Family Practice, Internal Medicine, Pediatrics) with summary statistics at the specialty level. Please see Appendix T for a sample of the State Summary Profile Report.

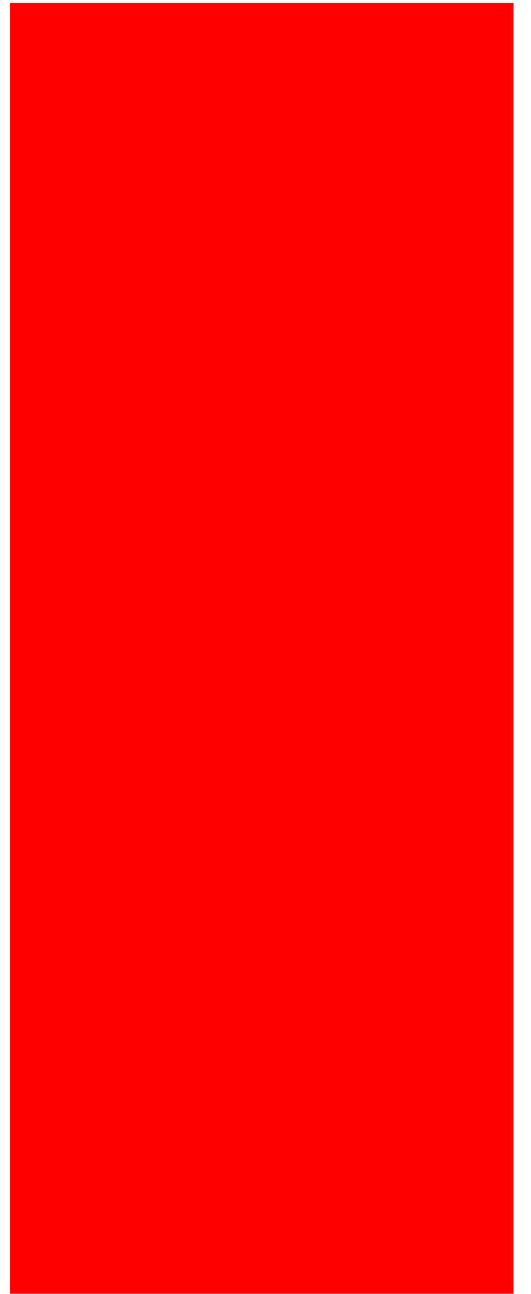
Communication with Providers

Aetna Better Health will prepare profiles on a quarterly basis. We will inform providers on the profiled measures, methodologies to generate scores, and best practices through our Provider Newsletter. We also provide our methodology in further detail in our provider handbook and discuss the process during our provider site visits. Our reports include a description of the data sources used, the methodology, and the efforts we took to verify the validity, accuracy, and reliability of the data utilized. We compare individual performance with an aggregate "like practitioner groups" within the health plan, as well as to external benchmarks when they are available. Reports and explanations include information relevant to develop action plans/intervention strategies that are fact-based to improve utilization, quality and member satisfaction.

We compare each provider's performance to that of their primary specialty peers to identify best practices as well as opportunities for improvement. Aetna Better Health reviews profile results and communicates best practices to the provider as well as other network providers. We also identify providers who have outlying performance, and follow up with providers who fall significantly below their peers, working together with the providers to improve their performance. For providers who are identified for corrective action based on their profile results, we may produce profiles more frequently to track their progress toward identified goals.

Under the leadership of our CMO, Provider Services Representatives contact providers whose performance falls below the established threshold in any area of quality, service or utilization to develop action plans specific to performance goals. The CMO determines timeframes for improvement based on the time required to demonstrate change and continues to follow up with the providers to verify that improvement milestones are met. The CMO reports the status to the QM/UM Committee, which makes decisions regarding next steps with the provider (i.e. remove from corrective action, limit the provider's panel, or recommend for termination) and provides information to our QMOC. We then conduct follow-up visits with these providers to monitor their progress on action plan items. Providers who have continued unacceptable performance are referred to the Aetna Credentialing and Performance Committee for appropriate action.

72 G.14



G.14 Describe the process for accepting and managing provider inquiries, complaints, and requests for information that are received outside the provider grievance and appeal process.

Aetna Better Health has developed and implemented a formal process to receive, manage, and respond to provider inquiries, complaints, or requests for information in a timely, complete, and accurate way. While multiple departments respond to questions and resolve issues, our provider relations department assumes primary responsibility to oversee this process. Located in Louisiana, our Provider Services Manager and team of representatives coordinate communications regarding provider inquiries, complaints, and requests for information.

Aetna Better Health values its providers and has written policies and procedures (hereinafter referred to as P&Ps) to support and govern our process to receive, manage, coordinate and respond to provider inquiries, complaints, or requests for information. It is Aetna Better Health's P&P that all employees receive adequate training/information, encourage providers to submit inquiries, complaints, or requests for information, and that we shall never retaliate (formally or informally) against a provider for submitting an inquiry, complaint, or request for information. Our executive management team (Chief Executive Officer (CEO), Chief Operating Officer (COO) and Chief Medical Officer (CMO)) support the continued enhancement of our processes to encourage, receive, manage, and respond to inquiries, complaints, or requests for information, and our processes are utilized by all Aetna Better Health personnel.

Aetna Better Health has three primary inquiries, complaints, or requests for information goals:

- a) Reinforce open, two-way communication channels between providers and Aetna Better Health
- b) Assuring the accurate, complete, and timely resolution of provider inquiries, complaints, or requests for information
- c) Applying lessons learned from provider inquiries, complaints, or requests for information to systematically identify areas of concern and implement improvements to our processes or operations

Our COO is accountable and responsible for meeting these goals. The COO is supported by personnel from multiple areas, including but not limited to our:

- 1) Network development and Provider Services Departments;
 - Compliance
 - Fraud and abuse
 - Case management
 - Member services
 - Medical management (Quality and Utilization Management)
 - Claims management
 - Grievance and Appeals.

Our COO provides the leadership to effectively manage the inquiries, complaints, or requests for information process. This includes, but is not limited to, having the organizational, operational and administrative systems in place that are capable of recognizing, receiving, managing, and responding to inquiries, complaints, or requests for information. Aetna Better Health provides initial and ongoing training of personnel from all organizational areas on the importance of inquiries, complaints, or requests for information; P&Ps related to inquiries, complaints, or requests for information; and steps the employees should take to recognize, respond or forward (to the Provider Services Department) and document the receipt of inquiries, complaints, or requests for information.

Our Provider Services Department takes provider inquiries, complaints and requests for information Monday through Friday from 7 a.m. to 7 p.m. In the rare instance all of our PSR are busy with other provider calls, the provider will be asked to leave a voice mail. We will return the providers call before the end of the business day or the next business day. If a provider calls after normal business hours they will be invited to leave a voice mail and a PSR will return the call the next business day. It is our standard operating procedure to log voice mail calls in our call tracking system for inventory management.

Aetna Better Health's Departmental Roles

Aetna Better Health offers multiple resources to our providers to initiate inquiries, complaints, and requests for information. Providers primarily contact is usually their Provider Service Representative (PSR) to ask questions or to resolve issues or complaints. The PSR works with Aetna Better Health personnel across the organization to facilitate resolution of providers' inquiries, complaints, or requests for information. Providers may also contact other Aetna Better Health departments directly to resolve certain matters. Personnel from the following departments receive, document and resolve items directly with providers and offer additional assistance or education as appropriate:

Member Services – member eligibility verification, PCP assignments and changes, general claims status, and other basic matters

Medical Management – Utilization Management (Prior Authorization, Concurrent Review), Case Management, Disease Management³, provider profiling results, and technical assistance

Quality Management – quality of care concerns, credentialing/re-credentialing, ambulatory record review results, EPSDT, special program referrals, abuse or neglect of a member, and maternity care program issues

Compliance – fraud and abuse reporting

Claims Inquiry/Claims Review (CI/CR) – our Claims Management call center for providers to request one-on-one discussion regarding our adjudication of a claim – CI/CR representatives are trained in all aspects of our claims system, Louisiana CCN core benefits, contract requirements and claims adjudication processes. The CI/CR number is in the Provider Manual, Provider

³ Aetna Better Health utilize its affiliates (Schaller Anderson, LLC) NCQA® disease management programs for diabetes, asthma, congestive heart failure, chronic obstructive and pulmonary disease (COPD) for the Louisiana CCN program.

Newsletters, and website and on every remittance advice. The CI/CR representative records vital information about the provider's inquiry in our call tracking system QNXT™

Aetna Better Health uses a centralized business application (QNXT™) to accept, manage, and respond to provider inquiries, complaints, and requests for information. Our QNXT™ system allows employees to capture, review, track, and research information and thereby supports overall consistency in responses and uniformity of information distributed to providers. Our case/disease management teams use our web-based care management business application (Dynamo™) to record and track a uniform and member specific history and record of contacts and coordination. These data systems improve our capacity to effectively respond to provider inquiries, complaints, and requests for information.

Training

Aetna Better Health Employee Training

Personnel in Provider Services, Provider Contracting, Claims, Medical Management, Member Services and Quality Management participate in an initial training program when they join Aetna Better Health and annually thereafter or as necessary to improve effectiveness and efficiency of operations. We maintain a record of employee attendance at initial and on-going training events. Our training programs include a component on managing and responding to provider inquiries, complaints and requests for information that focuses on the importance of documenting information, categorizing topics within the QNXT™ call tracking module, documenting the resolution, and the role of our committee structure [Service Improvement Committee, Quality Management/Utilization Management Committee (QM/UM) and QMOC] in the resolution process. We provide initial and ongoing training to departmental personnel who handle provider calls so that the information they disseminate is accurate and consistent.

Network Provider Training

During the provider orientation site visit and regular visits, PSRs provide training for providers regarding how to submit inquiries, complaints, and requests for information. Training includes the role of various Aetna Better Health departments, and how and under what circumstances providers should contact other departments directly to initiate and resolve an inquiry, complaint, or request for information. PSRs also provide written training materials to providers, such as the Provider Manual, and refer providers to resources located on our website. We maintain a record of provider attendance at initial and on-going training events.

Provider Inquiries, Complaints, and Requests for Information

The telephone numbers of our Louisiana-based Provider Service Department are prominently displayed in our Provider Manual, Provider Newsletters, website, and other written communication. Providers also receive instructions on using AboveHealth®. AboveHealth® is our secure HIPAA-compliant web portal for Aetna Better Health's providers. Designed to foster open communication and facilitate access to a variety of data in a multitude of ways, this secure, ASP-based application synchronizes data on a daily basis with QNXT™ through data extract and load processes, allowing providers to perform several on-line functions, including, but not limited to:

- Member eligibility verification
- Review of assigned [linked] members (roster)

- Searchable provider list
- Claim status search
- Remittance advice search
- Submit prior authorization requests
- Search status of prior authorizations requests

Aetna Better Health's objective is to receive and resolve provider inquiries, complaints, and requests for information in a timely, accurate, and complete manner to assist our providers in effectively meeting the needs of our members. The Provider Services Department tracks and trends provider issues and uses the data to verify prompt, accurate, and complete resolution so that service improvement action plans may be developed and implemented. The Provider Services Manager reviews daily and weekly call tracking reports to identify outstanding items and monitor performance. The Provider Services Manager uses the daily report to assist representatives in closing items or to provide additional training as necessary. Weekly reports are reviewed to identify the timeliness, completeness, and accuracy of closed responses and to track progress of open items. Documentation of provider issues and issue resolution is provided to DHH upon request.

We accept provider inquiries, complaints, or requests for information from providers who may access Aetna Better Health at any point within our organization. A provider may contact any Aetna Better Health employee with a provider inquiries, complaints, or requests for information and trust that whenever, however and whoever receives the inquiry, complaint, or request for information, the provider will receive an accurate, complete, and timely [at the time of initial contact or within 30 days; but in no event greater than 90 days] response. Personnel from all our departments receive training regarding provider inquiries, complaints, or requests for information.

Receiving Provider Inquiries, Complaints, and Requests for Information

PSRs receive provider inquiries, complaints, and requests for information by incoming calls, written communication, e-mail and information received by other Aetna Better Health departments. Aetna Better Health personnel record the following information in the call tracking QNXT™ module:

- Date and time of the contact;
- Provider's name, address, telephone number, email address and ID number (if known);
- Description of the inquiries, complaints, and requests for information;
- Outcome, including date resolved and provider notification (if applicable);
- Status and projected resolution timeframe (if not resolved during initial contact);
- Action plan for resolution (including details regarding if the item was forwarded to another department for research);
- Identification of actions/corrective action(s) to resolve the issue; and
- Final resolution – including date resolved and provider notification. Regardless of how the inquiry, complaint, or request for information is received, employees from the department

that received the item documents the following information into the QNXT™ call tracking module:

- Resolution including date resolved and notification to the provider.

Provider Complaint Escalation

In the rare instance the provider's inquiries, complaints, and requests for information is not resolved at the initial point of contact, and depending on the reason why the provider contacted the Provider Services Department, the PSR has an established escalation P&P. At any point in the call a provider may request escalation and the PSR will implement the escalation P&P. The first point of escalation is usually the PSR's Supervisor or Manager. Escalation is supported, depending on the issue or concern, to the COO or the CMO.

Managing Provider Inquiries, Complaints, and Requests for Information

Incoming Calls

Aetna Better Health's objective is to resolve provider inquiries, requests for information, and complaints during the initial call to limit the administrative burden to the provider. In some limited instances, Aetna Better Health may need to conduct research or enlist assistance from other departments and as a result, a resolution may not occur at the time of the initial call. In these instances, the representative who received the call will provide an estimated timeframe for resolution - within 30 days but no later than 90 days - and will keep the provider aware of our progress.

At times, PSRs forward items regarding quality of care concerns directly to the quality management, case management or disease management for follow up and resolution. Likewise, employees from other departments may forward issues to the Provider Services Department if they are unable to assist the caller. In these instances, a PSR will respond to the provider within three business days with the resolution or estimated timeframe for resolution (within 30 days, but no later than 90 days). PSR track provider inquiries, complaints, and requests for information on a daily basis and take action as necessary and appropriate until they are resolved.

Written Communication

PSR respond to emails and letters from providers regarding inquiries, complaints, or requests for information in writing within three (3) business days of receipt. The communication activities are documented in the call tracking module of QNXT™. If the representative is unable to resolve the matter within the timeframe, the PSR informs the provider of the need to conduct further research and the expected timeframe for resolution. The representative follows up with the provider and provides a resolution within thirty 30 business days, but no later than 90 days.

Handling Provider Communications Involving Members

The Provider Services Department tracks provider communications regarding members including but not limited to, quality of care issues, abuse [physical], neglect, or fraud and abuse. The PSR will immediately refer any suspected case of physical abuse to medical management and the appropriate parishes' Office of Child Protective Services, 24 Hour Emergency Hotline , In addition to tracking the information in the QNXT™ call tracking system, the resolution process for provider issues of this nature includes the following:

- Providing an acknowledgement letter to the individual(s) reporting the issue
- Documenting all steps in the investigative and resolution process

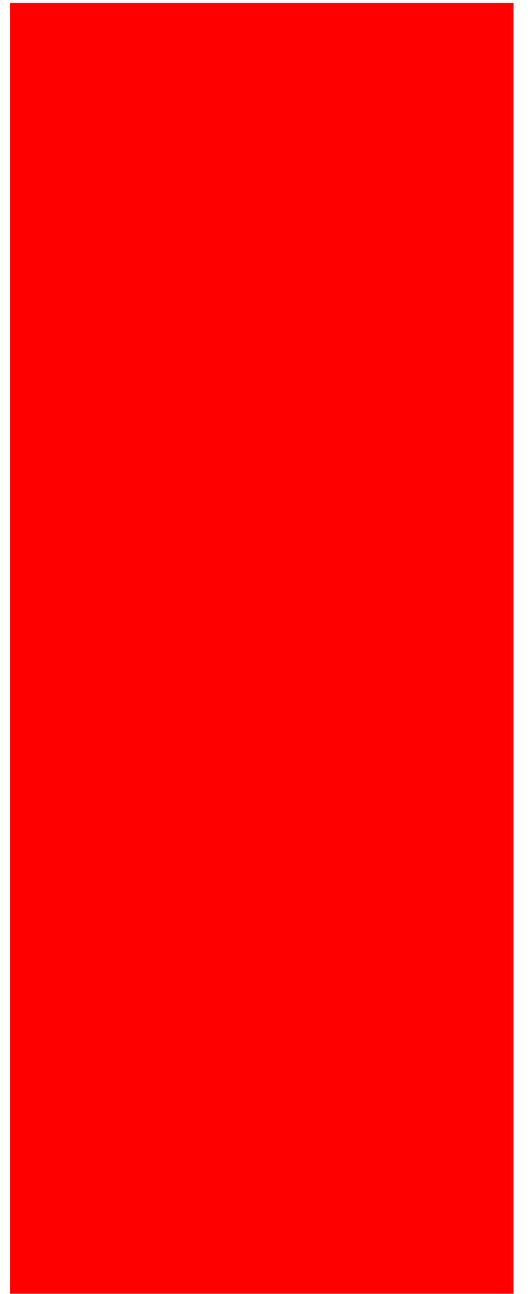
- Contacting the member to identify and assist in obtaining needed health care services
- Providing a closure/resolution letter to the member to make sure the member has an understanding of the resolution and contact information for Aetna Better Health should they have any questions or concerns

Performance Improvements

To identify patterns and trends related to provider complaints, inquiries, and requests for information, our Provider Relations Director analyzes the effectiveness of the steps taken to resolve provider issues. The Provider Relations Director reports the data trends and improvement initiatives to the Service Improvement Committee (SIC) for research and cross-functional coordination. The SIC discuss issues, performs research, gathers preliminary data and identifies end-to-end root causes identification. The goal of SIC is to identify service initiatives and other actions that will improve the provider's experience with Aetna Better Health. The result of these efforts are report to the Quality Management/Utilization Management (QM/UM) Committee. The QM/UM Committee is our principal forum to systematically identify, discuss, and resolve issues that impact both members and providers. Committee members review trended data, approve recommended intervention activities, identify improvement activities, assign action plans, and monitor action plans to completion. The committee also utilizes results from provider inquiries, complaints, and requests for information to make recommendations regarding the quality and appropriateness of care provided to our members, provider and employee training, and operational improvements.

Open two-way communication with our providers is a priority for Aetna Better Health. Our goal is to cultivate a strong working relationship with each of our providers; listening and responding to provider's inquiries, complaints, and requests for information is important is forging this relationship. We have developed a flexible, responsive and respectful approach to effectively and efficiently respond to and resolve provider's issues and concerns.

73 G.15



G.15 Describe in detail your proposed approach to providing non-emergency medical transportation (NEMT) services, including, at a minimum:

- **What administrative functions, if any, you will subcontract to another entity;**
- **How you will determine the appropriate mode of transportation (other than fixed route) for a member;**
- **Your proposed approach to covering fixed route transportation;**
- **How you will ensure that pick-up and delivery standards are met by NEMT providers, including training, monitoring, and sanctions;**
- **How you will ensure that vehicles (initially and on an ongoing basis) meet vehicle standards, including inspections and other monitoring;**
- **Your approach to initial and ongoing driver training;**
- **How you will ensure that drivers meet initial and ongoing driver standards;**
- **How your call center will comply with the requirements specific to NEMT calls; and**
- **Your NEMT quality assurance program (excluding vehicle inspection).**

Aetna Better Health[®] provides non-emergency medical transportation (NEMT) services to members who lack transportation to and from covered services. Aetna Better Health has arranged for NEMT services through a vendor, Medical Transportation Management (MTM). We have worked with MTM in our Aetna Better Health affiliated health plan in Illinois and are familiar with their capabilities for providing timely and quality access to NEMT services. In addition to providing services to members who lack transportation, we also make transportation services available to members in instances where we are unable to meet the geographic access standards for a member, regardless of whether the member has access to transportation.

Our Member Services Manager oversees the delegation and management of our transportation process. They perform delegation oversight activities to validate that MTM can initially provide services in accordance with Department of Health and Hospitals (DHH) and Aetna Better Health NEMT policies and procedures, and that MTM continues to provide appropriate services on an ongoing basis. We will conduct a preassessment review of MTM prior to the operational start date and on an annual basis thereafter. During that review, we will verify that MTM has policies and procedures in place and appropriate processes to manage these functions. Our Medical Management Coordinator oversees our delegation management functions and delegates review of arrangements to the Quality Management/Utilization Management (QM/UM) Committee. Aetna Better Health will present information collected during our audits to the QM/UM Committee for analysis and review, and develop recommendations or implement correct action plans as appropriate.

Aetna Better Health has worked closely with MTM to review their capabilities in managing the NEMT needs of our Louisiana members. Below is a description of their capabilities, including:

- The administrative functions we subcontract to MTM

- How MTM determines the appropriate mode of transportation for members
- MTM's approach for covering fixed route transportation
- How MTM meets pick up and delivery standards
- How MTM verifies that vehicles meet vehicle standards
- MTM's approach to initial and ongoing driver training
- How MTM verifies that drivers meet initial and ongoing driver standards
- How MTM's call center will comply with requirements specific to non-emergency medical transportation calls
- MTM's quality assurance program

Administrative Functions Subcontracted

Aetna Better Health will subcontract the following administrative functions MTM:

- Claims payment
- Network adequacy
- Customer service
- Reporting
- Credentialing (ensuring the NEMT Providers meet requirements)

Determining the Appropriate Mode of Transportation

To help MTM's customer service representatives (CSRs) assign the most appropriate mode quickly, MTM's system (called the NET Management System) will automatically track all transportation requests and keep a history of each. The system will track the information gathered during each call and refer the CSR to this when receiving future requests from the member. Any documents supporting transportation decisions are scanned using document imaging software and are maintained on file.

When an eligible member or their representative calls to schedule transportation services, the CSR will determine if the member had been previously authorized for a specific mode. If the member has been authorized and has a current certification on file, the CSR will arrange the trip pending eligibility approval. For new callers, the CSR will inquire if the member has any special needs that would affect transportation services, such as the use of a mobility device, cane, or walker. The CSR will be authorized to schedule the trip, as long as the member is able to use public transportation. This will always be the mode of first consideration. If the member requests a higher mode or has special needs requests (i.e., escort or attendant services, door-to-door service, etc.), the CSR will refer the request to a Case Manager for a Level-of-Need (LON) determination.

Assigning the Most Appropriate, Cost Effective Mode

MTM verifies that members will be placed on the most appropriate, cost-effective mode of transportation with their LON assessment process. This efficient, effective process for reviewing and documenting the medical necessity of requested modes of transportation or levels of service was designed by MTM's clinical personnel and their business analysts to provide the most thorough method possible. When MTM applies this process to previously unmanaged

transportation programs, MTM is able to effectively reduce per-trip cost by approximately 25 percent.

As previously mentioned, in assigning the appropriate level of service, MTM's first mode of choice will always be public transit. Under our LON process, all members requesting a higher mode of transportation than public transit will be required to undergo the LON assessment. Next, MTM will assign paratransit services as appropriate, followed by ambulatory sedan/van (curb-to-curb, then door-to-door) or wheelchair transportation (curb-to-curb, then door-to-door). Door-to-door services will only be assigned following thorough assessment resulting in certification documenting that the member has a physical, sensory, mental, developmental, or cognitive disability that requires such services for the safety of the member. MTM will also authorize stretcher and non-emergency ambulance when the member's needs dictate these modes, and refer exceptional transportation services such as air travel, lodging, meals, and transportation for visitation purposes when a member must travel a great distance for treatment.

After the Case Manager speaks with the member about their needs, the Case Manager will fax the member's medical provider requesting an evaluation of the member's cognitive and physical abilities via a LON form. MTM works closely with the medical community to verify their understanding of our LON procedures and the importance of their swift response in order to provide complete resolution in a timely manner.

Aetna Better Health's and MTM's foremost concern is member safety at all times. MTM collaborates directly with the medical community through their LON process to provide the most appropriate mode of transportation meeting the member's capabilities. To further detail this process, their LON assessment will take into consideration the following when assigning the least costly, most appropriate mode of transportation:

- Public transit (fixed and deviated route): Please see the section below regarding our approach for covering fixed route transportation.
- Mileage reimbursement: If a member is ambulatory and has access to a personal vehicle owned by the member or a family member/friend, we will approve mileage reimbursement as an appropriate mode. The Case Manager will handle these trips and predetermine the mileage prior to authorizing reimbursement. MTM's system automatically provides the direct mileage for a trip when the Case Manager enters the origination and destination addresses by accessing the integrated Geographical Information System (GIS) mapping. The member must then complete and return the trip log.
- ADA paratransit services: If a member is certified for ADA services, in concurrence with Aetna Better Health, MTM will arrange their transportation directly with the ADA provider and arrange for the appropriate reimbursement, either via token/pass or direct reimbursement to the ADA provider.
- Special needs requiring higher modes: If the healthcare provider submits a LON form which indicates the need for a higher mode of transportation due to a qualifying medical reason, such as the member is physically or mentally disabled to the degree that accessing public transit could result in a health or personal risk, the Case Manager will authorize the most appropriate form of transportation based on the physical and cognitive abilities of the member. This mode will most commonly consist of demand response transportation services,

but may occasionally include air travel. MTM will also seek volunteer services to conduct these modes of transportation. MTM applies the following LON rules in making such determinations:

- A member who is ambulatory or can transfer out of their mobility device without assistance and has no cognitive disabilities receives shared van/sedan/taxi transportation with curb-to-curb service depending on availability
- A member who is ambulatory or can transfer out of their mobility device with assistance and has severe cognitive disabilities receives shared van/sedan transportation with door-to-door services
- A member who is in a mobility device, does not require assistance, but cannot transfer into a vehicle and has no cognitive disabilities is assigned curb-to-curb wheelchair transportation
- A member who is in a mobility device, is not able to transfer, and has cognitive limitations receives door-to-door wheelchair transportation
- A member who must remain in a supine (lying down) position due to a medical condition receives stretcher van services
- A member who is supine and needs medical assistance such as intravenous line administration during transport receives non-emergency ambulance services
- Exceptional transportation requests: Requests for air ambulance, commercial air, commercial bus, commercial train, meals and lodging, etc., are handled individually through transport completion by a specialized Case Manager

Approach for Covering Fixed Route Transportation

As fixed route is the most cost-effective mode of transportation, this will be the first mode of choice. MTM's NET Management System enables the CSR to determine immediately if the member's pickup and drop-off location are within a half mile from a fixed route stop. MTM's system will not assign transportation to a provider if the trip distance is less than ½ mile, unless the member cannot travel the distance independently. Similarly, MTM will only assign public transit to members if they live within ½ mile of public transit stop, unless they arrange for transportation to and from the stop. If the member indicates an inability to use public transportation due to medical reasons, the CSR will advise the member that their healthcare provider must submit medical verification. The CSR will transfer the call to a Case Manager, who will obtain the healthcare provider's name, telephone number, and fax number. The Case Manager will then fax a LON form to the healthcare provider directly from the NET Management System. Using the form, the healthcare provider will indicate whether or not the member has a valid medical reason for not being able to utilize public transit. If the provider indicates the member can walk to the fixed route stop and successfully navigate the fixed route system, a Case Manager will contact the member to inform them that they are approved to use public transit, except for special needs trips such as chemotherapy, high-risk pregnancy, and dialysis. If the member still does not wish to use public transit, the trip is denied and they are informed of their appeal rights. If the healthcare provider decides the member is eligible for a higher mode of transportation, the member will be assigned to that mode.

Verifying that MTM Meets Pick Up and Delivery Standards

MTM monitors transportation provider on-time performance through their 100% trip reconciliation process. In accordance with Louisiana standards, Aetna Better Health requires MTM to schedule transportation such that the member arrives on time but no sooner than one hour before the appointment. Similarly, Aetna Better Health requires that the members will not have to wait more than one hour after the conclusion of treatment for transportation home, nor be picked up prior to the completion of treatment. MTM providers must record their pick-up and drop off times and submit driver logs to MTM for payment authorization. Trip Reconciliation personnel carefully review the trip logs to identify any inconsistencies, and document inconsistencies to track provider performance. MTM holds contracted transportation providers to high standards, expecting at minimum a 90% on-time performance threshold. If at any time a transportation provider is delayed, the member is contacted and kept informed of the issue. Also, if needed, MTM sends an alternate transportation provider. MTM Quality Service Coordinators closely monitor the overall complaint percentage and the number and nature of complaints concerning transportation providers. Where warranted, transportation providers are placed under corrective action plans (CAPs). CAPs are reviewed for performance improvement. If noticeable actions have not been taken and performance has not improved, other measures may be taken, such as reducing transportation provider's available capacity in our system, closing them to new trips until compliance has been met, or termination from the network.

Verifying that Vehicles Meet Standards

It is MTM's policy to conduct vehicle inspections of all provider vehicles that will service the contract prior to its execution, annually, and periodically throughout the year. MTM's procedures call for complete vehicle inspections for all subcontracted transportation providers to verify that vehicles meet Aetna Better Health's requirements and MTM's Transportation Provider Guidelines, and to verify that member safety and comfort features are in good working order (i.e., brakes, tire tread, signals, horn, seat belts, air conditioning/heating, etc.). If MTM determines that any vehicle is substandard, they may request that the vehicle be repaired, that the vehicle be removed from service until repaired, or that the vehicle permanently be removed from service depending on the severity of the issue. MTM validates that all vehicles undergo their stringent credentialing process. Required information for credentialed vehicles includes:

- Regular maintenance documentation
- Safety inspection documentation for each vehicle
- Accident/incident report
- Current insurance card
- Vehicle registration
- Safety equipment

It is the transportation provider's responsibility to maintain all vehicle records. The provider must keep all vehicle credentialing information up-to-date via MTM's Transportation Provider Web Portal.

Approach to Initial and Ongoing Driver Training

MTM requires various training activities for drivers to verify they are able to respond appropriately to specific NEMT and Aetna Better Health-related issues. Adequate driver training is a critical component to verifying member satisfaction and safety. To validate that drivers receive this necessary training, MTM requires transportation providers to submit proof of completed training, along with proof that training was obtained from a reputable resource, for each of their drivers via MTM's Transportation Provider Web Portal. MTM's Vice President of Safety, Training, and Security, along with MTM's Network Management personnel, will help to facilitate this training either in-person or via WebEx online sessions. MTM's driver training program includes:

- Basic first aid and defensive driving
- Overview of passenger assistance techniques, including sensitivity training proper loading, unloading, and mobility device securement procedures and emergency procedures
- Techniques for diffusing tense situations
- HIPAA guidelines and requirements
- Orientation on client and MTM procedures
- Tips on working with MTM and our processes
 - Receiving trip assignments
 - Calling in member no-shows
 - Recording pick-up and drop-off information appropriately
 - Billing and trip reconciliation
 - Collecting pick-up and drop-off information, including member signatures.

Upon training completion, the transportation provider must upload information pertaining to the specific training received, driver's signature, and date of completion. All required training must be completed within 90 days of the driver's hire date, and providers are required to develop and maintain an annual Driver In-Service Schedule to verify ongoing training of drivers.

Verifying that Providers Meet Initial and Ongoing Driver Standards

Throughout the life of each provider's subcontract with MTM, the transportation provider and MTM's Network Management Department maintain all driver information. All drivers are re-credentialed annually. Required information for credentialed drivers includes:

- Copy of current Driver's License
- Defensive Driver Training documentation
- Basic first aid training documentation
- Emergency Procedures training documentation
- Passenger Assistance training documentation
- Annual driver In-Service training documentation
- Wheelchair Securement training documentation (if applicable)
- Drug Free Workplace Policy (signed by driver)

- State Driver History Check (renewed on an annual basis), typically referred to as DMV, DRV, or MVR reports
- National Criminal Background Checks (renewed on an annual basis)
- Driver Performance Evaluation and Review (when applicable)

Network Management personnel work with each transportation provider to see that the provider maintains and submits all current credentialing records. When a piece of credentialing information expires, MTM's NET Management System will automatically alert their Network Management Department. In addition to alerting Network Management, the system will send the transportation provider an alert that will pop up upon logging into the Transportation Provider Web Portal. This alert will notify the transportation provider of which credentials are set to expire for the applicable driver. All credentials must be renewed annually. If, despite being notified of the pending expiration the transportation provider does not update the credential, a member of MTM's Network Management Department will contact the provider. If a credential expires for any driver, that driver will not be allowed to transport any member until the credential is updated in the database.

Call Center Compliance with Requirements Specific to NEMT Calls

One of MTM's greatest strengths as a transportation broker comes from their background in managing customer service center (CSC) operations. With six CSCs across the country that operate under the highest standards, MTM has proven that they have the capabilities necessary to manage call intake for NEMT services.

Hours of CSC Operation

To provide optimum service for Aetna Better Health members, the CSC will have regular business hours of 7:00 a.m. to 7:00 p.m., Monday through Friday. MTM can adjust the CSC hours of operation based on the needs and requirements of Aetna Better Health. By calling our Aetna Better Health-dedicated toll-free telephone line, members or their representatives will have the ability to schedule transportation services. In addition to maintaining sufficient, appropriate staffing to handle calls during regular business hours at each of our CSCs, Aetna Better Health will also maintain capable personnel to take in after-hours calls at their corporate CSC.

As well as receiving service from a dedicated CSC, Aetna Better Health members will receive 24/7/365 access to high quality service through MTM's state-of-the-art corporate CSC. After-hours, Sunday, holiday, and back-up support will be provided through this location as needed.

Training Local CSC Personnel

The number one priority of MTM CSRs will be to provide professional, prompt, and courteous customer service to all Aetna Better Health members and their representatives. To verify this quality level of service, MTM has developed a comprehensive training program that teaches their employees to treat all callers with dignity, respect, and keep information confidential. With their two week training program consisting of the following topics, MTM verifies for Aetna Better Health that all incoming calls for NEMT services will be handled in a timely, responsive, and courteous manner:

- Background on the NEMT industry and Medicaid

- Scheduling services in compliance with Aetna Better Health and MTM regulations
- MTM’s Cisco system and other CSC equipment
- MTM’s NET Management System
- Confidentiality, including HIPAA safeguards and compliance
- Cultural diversity, sensitivity, and CLAS standards
- Using the LanguageLine® and TTY/TDD services
- Customer service soft skills, phone etiquette, and professionalism, especially when working with
- Members with special needs or managing difficult behavior
- Active listening, documentation, and restating trip details before concluding the call
- Aetna Better Health-specific requirements and protocols, and MTM policies and procedures through the Operations and CSR Training Manuals. In addition to initial training, CSRs will receive ongoing training through MTM’s online video library, periodic training sessions with their supervisors, and periodic call monitoring and reviewing.

Monitoring CSC Personnel

MTM Call Center Managers, Customer Service Supervisors, and Team Coaches will be responsible for monitoring CSRs for proper performance and duty execution, and will be on the CSC floor to answer any questions or solve any problems CSRs may have. In addition, MTM has a thorough live and recorded call monitoring review process, in which a supervisor will audit the following:

- Timeliness of answering and completing calls
- Accuracy of information acquired during intake
- CSR professionalism, sensitivity, courtesy, and responsiveness to the member’s needs
- Accuracy of trip scheduling

Meeting Limited English Proficiency (LEP) Needs

MTM provides CSRs with the training necessary to handle culturally diverse, limited English proficiency (LEP) populations with sensitivity and active listening. In addition, MTM abides by Culturally and Linguistically Appropriate Services (CLAS) standards; hires bilingual CSRs; and utilizes the Language Link for all languages not spoken by their CSRs.

CLAS Standards Govern Cultural Sensitivity

To verify all members receive high quality service, MTM takes an additional step in providing high quality service to LEP individuals by educating personnel on cultural competency. The U.S. Department of Health and Human Services Office of Minority Health has issued standards for CLAS to improve access to healthcare services. MTM promotes sensitivity and communication styles that respect cultural diversity. In general, CLAS standards address:

- Training
- Initial and ongoing organizational self-assessments
- Management accountability/oversight mechanisms to provide culturally and linguistically appropriate services

MTM has adopted the CLAS standards that apply to NEMT management, and tailored them appropriately to the industry, effectively promoting sensitivity and communication styles that respect cultural diversity.

Hiring Bilingual CSRs to Meet LEP Needs

MTM will seek to hire bilingual CSRs to improve communication with LEP members. These languages may include Spanish and any other language specified by Aetna Better Health. One example of MTM’s ability to successfully hire bilingual CSRs comes from their Minneapolis/St. Paul, Minnesota operations. To meet the varying language needs of members in this service area, MTM hired CSRs with language skills in Spanish, Hmong, Filipino, and a variety of other languages.

Using Telephonic Interpretation Services to Meet LEP Needs

To meet the needs of LEP individuals, MTM will utilize a professional telephonic interpretive services company that uses certified language interpreters to accommodate the needs of those who speak a language other than English. MTM currently uses this service as part of a number of their contracts.

TTY/TDD Services for the Hearing and Speech Impaired

In addition to meeting LEP needs, MTM also has the capabilities to meet the needs of other populations who experience communication barriers. MTM will process calls for hearing or speech impaired members through TTY (teletype) and TDD (Telecommunication Device for the Deaf) services. By using these services, MTM can effectively see that all Aetna Better Health populations, regardless of their specific needs, will not experience communication barriers with MTM.

Proven Louisiana MCO Call Center Capabilities

MTM provides quality customer service in Louisiana and across their book of business. MTM’s phone statistics for a Louisiana MCO in March 2011 fall within the measures set forth by the Louisiana Administrative Performance Measurement Set, as depicted in the following table:

Louisiana MCO Phone Statistics—March 2011		
Statistic	Results	Louisiana Administrative Performance Measurement Set Requirements
Average Speed to Answer	10 seconds	30 seconds or less
Abandonment Rate	1.78%	5% or less
Percentage of Calls Answered in 30 Seconds or Less	90.22%	At least 90%

MTM Quality Assurance Program

In all areas of MTM’s business, their goal is to exceed average performance standards and continue to build on their reputation as a leader in quality NEMT management. To verify they meet this goal, make continuous quality improvements, monitor performance metrics, and continue to provide the highest quality transportation services, MTM designed our

comprehensive Quality Management (QM) Program. MTM will work with Aetna Better Health to develop and/or customize performance measurements for Louisiana during the first year and beyond as needed.

MTM's QM Program uses performance metrics and thresholds to evaluate compliance with MTM's standards and client protocols. MTM collects data from their various operations Departments—Quality Management, Network Management, Customer Service, Care Management, and Client Services—then compares the data to established goals and thresholds. Then, MTM's Quality Management Committee (QMC) receives and trends each threshold, or predetermined level of performance.

Aetna Better Health's QM/UM Committee will review reports from MTM and approves MTM's Quality Assurance program. MTM's Vice President for Clinical Operations, who oversees MTM's Quality Assurance Program, will attend Aetna Better Health's quarterly QM/UM committee meetings to discuss status and concerns regarding MTM's services to Aetna Better Health members.