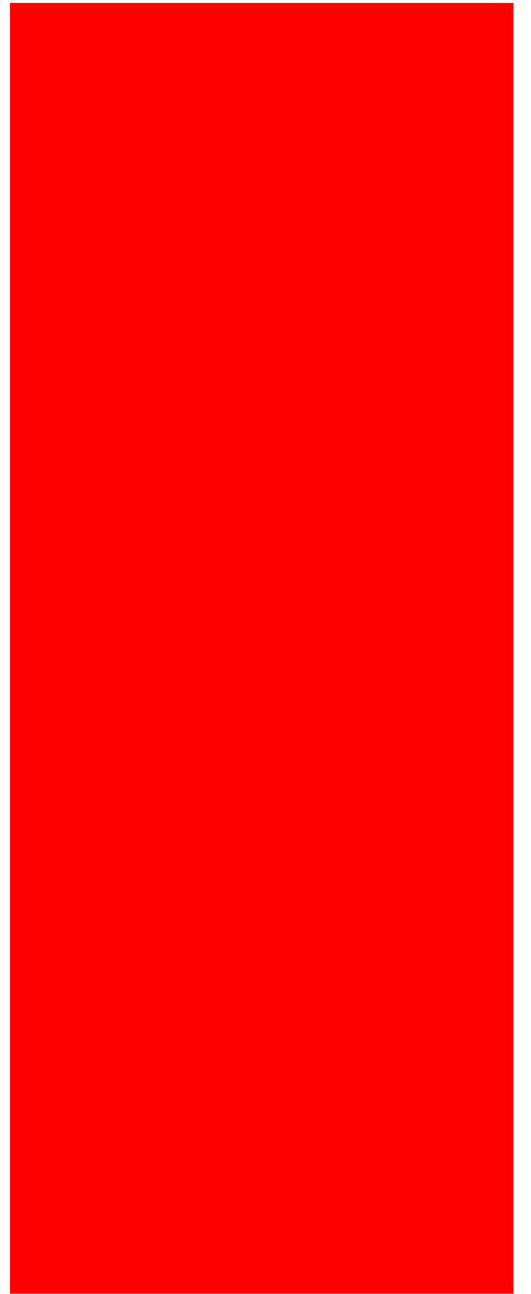


49 SECTION F – SERVICE
COORDINATION



50 F.1



Section F: Service Coordination (Section §14 of RFP)

F.1 DHH intends to provide CCNs with two years of historic claims data for members enrolled in the CCN effective the start date of operations. Describe how you will ensure the continuation of medically necessary services for members with special health needs who are enrolled in your CCN effective the start date of operations. The description should include:

- How you will identify these enrollees, and how you will use this information to identify these enrollees, including enrollees who are receiving regular ongoing services;
- What additional information you will request from DHH, if any, to assist you in ensuring continuation of services;
- How you will ensure continuation of services, including prior authorization requirements, use of non-contract providers, and transportation;
- What information, education, and training you will provide to your providers to ensure continuation of services; and
- What information you will provide your members to assist with the transition of care.

Transition/Service Coordination Experience

Aetna Better Health[®] and our affiliates are experienced in Medicaid and Children's Health Insurance Program (CHIP) managed care transitions, including the early identification, risk stratification and continuation of medically necessary services for Members with Special Health Care Needs (MSHCNs) and Children with Special Health Care Needs (CSHCNs). One of the hallmarks of our experience is our capability and capacity to provide Medicaid managed care to diverse and high-risk populations. We have developed systems, administrative infrastructure, and member-centered programs that meet the needs of our members while satisfying the budgetary requirements of Medicaid agencies.

We have a long history of effectively managing population-based health improvement programs that address the needs of the 20 percent of the population that is driving 80 percent of health care costs. We have developed a core competency in managing integrated health models for Medicaid and CHIP, including children with special health care needs and those in foster care, persons with developmental and physical disabilities and women with high risk pregnancies. Our approach focuses not only on clinical risk factors, but also on each member's functional status, social support structures and environmental conditions risks. In fact, an Aetna Better Health affiliate in Missouri recently received historical claims data from the state Medicaid agency to prioritize and identify members for a special project in a rural area of the state. We were successful in downloading data, developing a prioritized contact process, coordinating with Primary Care Providers (PCPs) in the area who serve these members and effectively identifying and outreaching to members for intervention.

A critical element of our experience is the seamless transition of members from Medicaid fee-for-service (FFS) programs to Medicaid Managed Care. Our proven risk assessment and care management strategies have led to early diagnosis and treatment, improved care coordination, increased quality and better outcomes for MSCHNs and CSCHNs. Aetna Better Health and our affiliates have actively managed care for members with special needs for the past 25 years.



MSHCNs in our care management program include women with high-risk pregnancies; members with multiple chronic conditions (e.g., mental health/developmental delay, mental illness and other chronic conditions). CSHCNs in our care management program include children suffering from high-risk conditions such as prematurity; ADHD; asthma; and children with serious or multiple chronic conditions (e.g. cystic fibrosis and epilepsy).

We are currently effectively managing care for over 111,950 MSHCN and CSHCN members as illustrated by the following table:

State	MSHCN / CSHCN Members
Arizona	41,500 ABD adults/children 8,900 DD children 15,716 SNP plan (dual eligibles) 8,900 LTC (special needs)
California	4,053 CSHCN
Delaware	7,800 ABD
Florida	1,100 ABD
Maryland	17,000 ABD
Pennsylvania	7,000 ABD
Total Number of Members	111,969

We coordinate services (e.g., obtain necessary physician appointments and critical durable medical equipment (DME)), and provide pre-admission and discharge planning. These services are essential to assist MSHCN and CSHCNs to manage their conditions and empower each member to live in the least restrictive setting. Aetna Better Health’s top priority is to provide each member with the right service, at the right time, at the right level of care.

Identification and Stratification

Aetna Better Health, after receipt and analysis of the two years of historic claims data for members enrolled in Aetna Better Health effective the start date of operations, will employ a stratification process to identify MSHCN, CSHCN and to facilitate members’ assignment to the appropriate risk level; providing member services, case and Disease Managers information to appropriately target members with the most significant need. The Medical Management Coordinator in collaboration with the Chief Medical Officer (CMO) will be responsible for overseeing the stratification process. Information we will focus on includes members:

- With prior authorizations that indicate hospitalization admissions
- Who, based on their claims pattern, may have a chronic disease (e.g., asthma, diabetes, congestive heart failure [CHF], chronic obstructive pulmonary disease [COPD])
- That are receiving or have recently (past 60 days) received home health care services
- With special health care needs (MSHCNs) and children with special health care needs (CSHCNs)

- Who have a gap in care based on comparing claim history to evidence based practice guidelines
- Who are recent NICU graduates
- Who have had three (3) or more ED visits in the last six (6) months
- Who have had three (3) or more inpatient admissions in six (6) months
- With five (5) or more prescriptions from different therapeutic classes
- With a recent (last 60 days) hospital admission and readmission within fifteen (15) days

Key to our stratification process is our General Risk Model (GRM).

The *General Risk Model (GRM)* has been developed to identify Aetna Better Health’s members who would benefit from enrollment in our DM Programs. The application prospectively identifies members who are at risk of becoming high utilizers of services and who have actionable gaps in care, or who present opportunities for more efficient medical management consistent with evidence-based guidelines.

The *GRM* processes information from a variety of sources and transforms it into a series of markers that measure both risk and opportunity. It then scores these markers and assigns a rank to every member, reflecting both the level of risk and potential opportunity for improvement. In addition to its risk algorithms, *GRM* identifies members who meet specific rules-based criteria for individual treatment interventions.

Aetna Better Health’s *GRM* program is proven technology for identifying members who have or are at risk of developing complex and/or chronic health care needs. *GRM* accomplishes this task through an internal diagnostic grouping process that evaluates over 15,000 ICD-9 codes and identifies specific chronic and acute conditions, including asthma, diabetes, chronic obstructive pulmonary disease (COPD), and congestive heart failure (CHF). The goal is to accurately identify a primary chronic care condition for each member if indicated in the claims data. The application funnels information from various sources into a member profile that allows our DM personnel to access a concise 12-month summary of activity. The 12 month summary provides our Health Coach Consultants (Disease Managers) with the ability to review a member’s entire administrative history (claims, prescriptions, authorizations, diagnosed conditions, laboratory results when available, enrollment history, and contact information), along with key data gathered through our web-based case management system. This is a powerful tool for integrating health data and facilitating the flow of information between all of the member’s caregivers. The information is stored in a database that has key linkages to our Actuarial Service Data Base (ASDB), making outcome reporting related to specific members available literally “on demand.” ASDB has the capacity to accept pharmacy utilization data from external systems and then distribute this vital information internally through *GRM*.

Aetna Better Health uses *GRM* to assist in identifying potential candidates for disease management. To accomplish this, *GRM* sorts, analyzes and interprets the following information:

- Claims history
- Pharmacy data
- Demographic information

- Identified gaps in care based on evidence-based guidelines
- Impact levels of the member's primary condition

GRM provides an empirically sound database that identifies members based on the following indicators:

- Predicted future cost/utilization of services
- Complicating co-morbid conditions
- Inappropriate patterns of care for chronic conditions (over-, under- and inappropriate utilization of services)
- Chronic conditions that are known to be responsive to evidence-based treatment guidelines
- Historical costs

GRM also promotes the facilitation of care coordination between all Medical Management functions (Concurrent Review, Prior Authorization, Case Management and Quality Management), and provides our DM personnel specific guidance as to where the member may have a potential gap in compliance with evidence-based care guidelines.

Determination of Total Risk Score

In order to assign each member a Total Risk Score, *GRM* will utilize the two years of historic claims data from Department of Health and Hospitals (DHH) – including physical, behavioral and pharmacy claims data. Our predictive modeling tool will transform these data into a series of markers (i.e., risk scoring elements) that show both the level of risk and opportunity for care improvement for each member and includes the following:

- ***Medicaid Rx.*** This pharmacy claims-based risk assessment tool uses the timeliest pharmacy data available for identification of a member's risk or health status identification. Medicaid Rx was designed and developed specifically for Medicaid populations.
- ***Compliance.*** A member's overall compliance with certain evidence-based treatment activities (HgA1c test for diabetics, flu vaccination) is assessed. A member with a claims history that indicates a gap in care, will be assessed to determine likely root causes and the Case Manager will develop a care plan to improve compliance.
- ***Co-morbidity.*** A member's co-morbidity burden based on the chronic condition identification and categorization methodology employed by GRM
- ***Impactability.*** A member's primary condition is assessed (using clinical input) as to the level of impact care management can have on the member's financial and clinical outcomes
- ***Recent Claims Cost.*** A rolling 12 months of claims cost (excluding trauma and maternity) is calculated for each member.

GRM combines the scoring elements described above to calculate a member's Total Risk Score and population rank for stratification purposes.

Determination of Member Risk Level

Utilizing the results from *GRM* members will either be placed in Integrated Care Management (ICM) or Disease Management (DM)¹. If the member has multiple co-morbid chronic conditions, is disabled with complicating medical factors or high-risk pregnancy, the member will be placed in ICM at the appropriate level of risk (low-risk, supportive and high-risk). If the member has a single chronic condition, the member will be assigned to DM. There are two levels of DM: high-risk and low-risk. A brief description of these programs and risk levels is provided below, along with a case example for each. These case examples are included to generally show the type of member that may fall into each of the risk levels.

ICM – Low-Risk to High-Risk Case Management Program

- **Population-based (low-risk care management)** – Individuals in this group typically have no complex medical or basic behavioral health conditions, will be successfully self-managing any chronic conditions and/or will be appropriately utilizing services (e.g., no high inpatient or emergency room utilization, no under- or over-utilization of prescriptions filled, no contra-indicated or duplicative medication therapy).
- **Low-Risk Care Management Case Example** – A representative case example of a member who may be assigned to population based services might be a 45-year old woman and the analysis of historical claims data indicates no evidence of a chronic condition, except for a past history of thyroid surgery. The claims data further indicated that five months ago she had an episode of influenza, which improved after three days, but on day five she experienced some shortness of breath and fever. She was diagnosed as having pneumonia and immediately started on antibiotics, and was able to be treated on an outpatient basis. She continued to improve and felt normal within two weeks. Data indicated that she was then re-evaluated a few weeks later and her PCP cleared her because of a normal X-ray.
- **Supportive Care Management** – Individuals in this category typically have a medical condition that the member is not successfully managing (e.g., a member with claims evidence they are having problems managing their asthma), an inpatient admission unrelated to preventable disease states or two (2) or more diseases (e.g., asthma and diabetes).
- **Supportive Care Management Case Example** – A representative case example of a member who may be assigned to supportive care management might be an 18-year old woman with a claims history of diabetes and asthma and is pregnant. Claims data indicates appropriate visits to her OB/GYN. Analysis of claims data indicates she is adhering to evidence based practice guidelines for diabetes (e.g., Cholesterol LDL Level, Dilated Retinal Eye Exam (DRE), HgbA1C, Urine Protein Microalbumin, blood pressure).
- **Intensive Case Management Services (high risk)** – Members in this group require the most focused involvement to optimize care and reduce future complications and adverse events. They typically will have complex medical conditions (e.g., chronic renal failure,

¹ Aetna Better Health has been successfully operating disease management programs in our Medicaid managed care health plans throughout the country since 1993 and has, through our affiliate, Schaller Anderson, L.L.C. (Schaller Anderson) operated an NCQA certified Disease Management Program for four targeted chronic diseases (i.e. asthma, congestive heart failure [CHF], chronic obstructive pulmonary disease [COPD] and diabetes) since 2006. Our experience has shown that disease management programs can be an effective strategy for improving the management of care for members with chronic conditions, resulting in improved health outcomes and cost savings.

advanced multiple sclerosis, high-risk pregnancy, hemophilia, chronic pain syndrome, bone or organ transplant, HIV/AIDS, cancer, Asperger's disorder, or pervasive developmental disorders) and/or behavioral health conditions (e.g., schizophrenia, bipolar disorder, autism spectrum disorder, substance abuse) or multiple chronic conditions (e.g., cardiovascular condition combined with severe depression), will be non-compliant with practice guidelines, will be inappropriately utilizing services (e.g., frequent emergency room visits, over utilization of drugs), will have several inpatient admissions within a six month period, and/or will not be utilizing their PCP/Patient-Centered Medical Homes (PCMH) effectively.

- **Intensive Case Management Case Example** – A representative case example of a member who may be assigned to high risk case management services is a 37-year old man who has crippling rheumatoid arthritis, anxiety, depression, and an unstable home situation. He intermittently needs to use a wheelchair when his arthritis flares up. His pharmacy claims history shows that he sporadically fills the six different medications he has been prescribed, although the data indicates that he does fill his pain medication prescriptions as directed. The data also indicates that he has a history of using the emergency room instead of seeing his PCP for his care needs. He has been hospitalized twice in the last six months and notes that he is getting more depressed because of his disabilities associated with the arthritis. He has no caregiver but does have a friend who occasionally transports him to his PCP or the pharmacy but his friend is not always available.

DM – High-Risk and Low-Risk

- **Disease Management Services (high risk)** – Member in this group have a specific chronic medical conditions [e.g., asthma, diabetes, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD)] with complicating medical conditions that may require interventions to assist the member in managing their disease state. Members with two or more conditions are typically in either supportive or intensive case management as described above.
- **Disease Management Services (high-risk) Case Example** – A representative case example of a member who may likely be assigned to high-risk disease management services is a 53-year old woman who the data indicated was diagnosed with diabetes about eight years earlier and analysis of test results indicate that this condition is currently controlled relatively well on two oral medications. Analysis of claims data further indicates that the member has severe allergies that are controlled with medication.
- **Disease Management Services (low- risk)** – Member in this group have a specific chronic medical conditions [e.g., asthma, diabetes, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD)] without complicating medical factors that may complicate the member in managing their disease state.
- **Disease Management Services (low-risk) Case Example** – A representative case example of a member who may likely be assigned to low-risk disease management services is a 21 year old woman with asthma that is relatively well controlled.

Aetna Better Health will continually evaluate the appropriateness of a member's assigned risk level and will reassign members to higher or lower risk levels depending on their care needs. Because of our sophisticated predictive modeling tool, *GRM*, and our in-depth experience

providing care management services to Medicaid populations, Aetna Better Health will be able to effectively perform risk assessment using the State's claims data.

Aetna Better Health will use the results from *GRM* to assign each member to one of the risk levels above. Based on the member's Total Risk Score, Aetna Better Health will rank each member from lowest to highest (with a higher score representing higher risk). The members with the highest Total Risk Scores will more than likely be assigned to the Intensive Case Management services group (high risk). Aetna Better Health will apply *GRM* to further stratify members into the Supportive, Disease Management or Populations based risk groups.

After initial program implementation in each GSA, Aetna Better Health will further evaluate the member's initial assigned risk level through:

- A review of the Health Risk Questionnaire (HRQ) that each member entering ICM or Disease Management will be asked to complete
- An assessment by RN Case Managers of each high and supportive risk level member's clinical, psychosocial, functional and financial needs (including discussions with member's family/caregiver, PCP and administration of standardized assessment tools)

These processes will allow us to validate that each member has been placed into the appropriate level of care prior to the development of a care plan. During the ongoing operational phase, Aetna Better Health will conduct a monthly stratification of all members and use *GRM* results to: 1) determine if the member's assigned risk level needs to be changed and 2) monitor the success of interventions as reflected by improvements in member risk scores.

Stratification Report

Aetna Better Health's Medical Management Coordinator will work with the Actuarial Services and Informatics teams to produce:

- An initial stratification report (90 calendar days after "go live" in each GSA)
- An ongoing quarterly stratification report (15 calendar days after the end of each calendar quarter)

Our stratification report will show how the member population has been stratified into the risk groups plus disease management and provide detail classification of the overall member population by rate code and breakdown of members by Parish, by disease states and co-morbid conditions.

Aetna Better Health will use the stratification report as an internal monitoring tool both at the individual member and program level.

- **Individual member level:** Case/Disease Managers will use the stratification report to assist in determining if the implemented care coordination services have been effective in improving a member's outcomes and if a member may need a higher or lower or higher level of care.
- **Program level:** Aetna Better Health will use the stratification report to assess the overall success of our care management services in improving clinical outcomes (i.e., member's health status) and reducing inappropriate costs. The report will be reviewed by Aetna Better

Health's QM/UM Committee each quarter to: 1) determine if there are opportunities for improvement and 2) as appropriate facilitate the implementation of any needed interventions.

Initial Contacts and Information Provided to Eligible Members

Aetna Better Health recognizes the initial contact process as a key first step in care management services leading to successful clinical and financial outcomes. Through the initial contact we will be able to:

- Educate the member about the benefits of the Coordinated Care Network (CCN) Program and care management program
- Encourage and facilitate member enrollment in the care/disease management program
- Establish the foundation for a working partnership between Aetna Better Health and the member
- Verify the selection/assignment of a PCP/PCMH by the member
- Collect basic health information (i.e., HRQ) from the member that is used to further assess the member's level of risk and health care needs

The Medical Management Coordinator, with supervision by the CMO, will oversee the initial contact process and will be supported in this effort by the Case Management Administrator/Manager, Quality Management Coordinator, Disease Management Coordinator, and Maternal Child Health/EPSTD Coordinator.

Aetna Better Health will mail each member a Welcome Packet. We will be able to distribute 10,000 new member packets per day and therefore, we do not foresee any problems in meeting DHH's distribution standards. The Welcome Packet will contain:

- Welcome letter highlighting major program features, providing Aetna Better Health contact information
- Welcome member newsletter
- Member Handbook containing all the information the member will need to access covered services appropriately and highlighting preventive care, case management, disease management and other services available to members
- Information regarding direct access to providers for members with special health care needs
- Member identification card
- Provider Directory (which will also be available in a searchable format on our website)
- The HIPAA Notice of Privacy Practices – Explanation of Enrollees' rights to access, amend, and request confidential communication of, request privacy protection of, restrict use and disclosure of, and receive an accounting of disclosures of Protected Health Information (PHI)

These materials will include:

- A description of the ICM model and Disease Management program including the benefits they offer to members and the role Aetna Better Health plays in delivering these services
- A description of a PCP/PCMH, including a discussion on the importance of their role in assisting in the management of a member's care and instructions on how to select an appropriate PCP/PCMH. Members will be asked to either submit the name of their



Better Health

PCP/PCMH they would like to use (and/or may be already using for regular care) or contact Aetna Better Health to establish a health care home.

- Instructions on the appropriate use of the Emergency Department (in the Welcome Newsletter and the Member Handbook)
- The toll-free phone number for Aetna Better Health and a description of the information that is available on our Web site
- Information on linguistic access, including the availability of LanguageLine[®] for telephone calls and other alternative formats such as large print for the visually impaired or Telecommunications Device for the Deaf (TDD)

The materials in the Welcome Packet will all be written at a sixth grade level in a manner that is easily understood and culturally sensitive. The materials will be available in English, with notations that the materials can be made available in Spanish and Vietnamese or additional languages if requested by the member, as well as in alternative formats and media (e.g., large print, audio CD).

Identification and Selection of PCP

It is our experience that a PCP and health care home model results in better patient outcomes, more efficient management, and ultimately will reduce health care costs, while providing members with quality health care. Our goal is to encourage all newly eligible members, especially those with moderate to high-risk levels to select a PCP/PCMH as soon as possible if the information from the Enrollment Broker does not include the member's selection. Should the member fail to choose, for new members in the initial enrollment groups in GSA A, B and C, we will either auto-assign a PCP or use the member's claims history to identify and assign a PCP/PCMH [if the claim history file is available on time].

Aetna Better Health's process for assigning members to PCPs.

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

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

If the member has not chosen a PCP, Aetna Better Health will automatically assign a PCP to the member within 10 days from enrollment into Aetna Better Health. Every attempt will be made to assign the member to a PCP with whom the member has a historical relationship. If there is no historical relationship, the member will be automatically assigned to a PCP who is assigned to an immediate family member enrolled in the CCN Program. If other immediate family members do not have an assigned PCP, automatic assignment will be made to a PCP with whom a family member has a historical relationship. If there is no member or immediate family historical usage, members shall be automatically assigned to a PCP using an algorithm developed by the proposer, based on the age and sex of the member and geographic proximity.

If the member is automatically assigned to a PCP, we will allow the member to change their PCP, at least once, during the first ninety (90) days from assignment to the PCP/PCMH without cause. From the ninety-first (91st) day, the member may be locked into the assignment to the selected PCP for a period of up to 12 months beginning from the original date the member was originally assigned to the PCP. If a member requests to change his or her PCP with cause, at any time during the enrollment period, we agree to grant the request.

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

Members with Special Needs

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

In order to help newly eligible members select an appropriate PCP/PCMH, Aetna Better Health will:

- **Identify Potential PCP/PCMH** – Using two years of historical claims data, Aetna Better Health will conduct an analysis of the providers the member has been using recently and for what type of care (e.g., routine source of care, specialty care). If the member's record on the eligibility file does not indicate that a PCP/PCMH was selected, Aetna Better Health will use analysis of the historical claims data along with the location of the member's residence to identify a potential PCP/PCMH. This analysis will be supported by GeoAccess.
- **Assist Members in Selection of PCPs/PCMH** – Our member, Care, Case and Disease Managers will assist member in the selection of a PCP/PCMH. This will be accomplished through the receipt of inbound calls from members and outbound calls made to the members as part of the assessment and care plan development process. During these calls Aetna Better Health staff will discuss the potential PCPs/PCMHs the member may want to select based on their current utilization patterns, verifying that the routine source of care identified through the claims data is accurate. Our staff will coach the member about the importance of the PCP/PCMH, the appropriate use of the emergency room and other health care services, the availability of community-based resources, and the importance of receiving primary, preventive, and periodic chronic care check-ups, if appropriate.
- **Outreach to Providers not in the Care Management Program** – If the member currently has a PCP/ that has not signed a participating agreement with Aetna Better Health our care/disease management staff will work with our provider services team to encourage the provider to become a part of our network. Should the provider decide not to participate as a contractor in our network we will negotiate a single case agreement to secure the member's

access to care/services. We will also see that the PCP/PCMH chosen is geographically convenient for the member.

Welcome Call

For all new members we will make a welcome call. Aetna Better Health places a high priority on outreach to and support for our members, beginning with the transition process. Our goal is to contact these members as soon as possible following enrollment to assist them in making a seamless transition into the CCN Program. Our Member Services, ICM or Disease Management staff works to make sure that there are no: a) interruptions in service, b) in care and c) concerns on the part of the member during the critical transition period. Our Welcome Call is an important part of the new member's introduction to all of the services and support available to them through Aetna Better Health.

Our Welcome Call:

- Welcomes each new member to our program and informs the member of the availability of oral interpretation and written translation services and how to obtain them free of charge;
- Identifies members who are pregnant or members with a chronic condition, or any special care needs and expedites transition to care that supports the individualized needs of each member;
- Identifies the member's current primary care provider relationship;
- Identifies the member's current and ongoing services needs;
- Educates members about health care benefits coverage and instructions on how to utilize services;
- Educates members about the important role of the PCP/PCMH in centralizing and coordinating care;
- Informs the member about the importance of making an initial appointment with his or her PCP for preventive care before the member requires care due to illness or condition and instructions about changing the PCP,
- Provides emergency numbers;
- Assists members with obtaining services, as needed, and
- Includes a statement of confidentiality.

During implementation for each GSA area we will complete new member welcome calls within twenty-one (21) business days of receipt of the enrollment file. Our standard operating procedure for making new member welcome calls is to use our interactive voice recognition (IVR) system. Our IVR process has proven to be successful with Medicaid populations in other states. We selected the IVR approach because of its high response rate and cost efficiency. As described below, the member always has the option of requesting to speak with an individual any time during the call. We will ask new members if they are pregnant, have a chronic condition or have a special health care need early in the call. The member responses will be documented in our web-based care management business application (Dynamo™). Each night record of these responses will be transmitted to Aetna Better Health's team for call back and intake processing. This Welcome Call is the beginning of a transition process that supports the member every step of the way in obtaining care.

The information obtained through the Welcome Call is another way that we identify and immediately support our new members. We will take the opportunity during this initial call to educate members and/or the member's family/caregiver, as appropriate, about benefits, the importance of finding a PCMH and how to select their primary care provider if they have not already done so. Depending upon the member's responses to the IVR, the member or the member's family/caregiver will be contacted by an Aetna Better Health Case Manager or Health Coach Consultant (Disease Manager).

Members stratified into *Intensive and Supportive* levels will also receive a separate Welcome Call from a Case Manager. The goal of this Welcome Call is to begin the assessment and care plan process.

We will make at least three telephone attempts on different days and at different times of day. If these attempts are unsuccessful, Aetna Better Health will mail the member a request to contact letter.

Interpretive Services for All Key Oral Contacts

Aetna Better Health is sensitive to communicating with our members and has standard operation procedures that include, but are not limited to:

- Access to a certified interpretation service through the Member Services Department via LanguageLine® Services
- Louisiana Relay Services to accommodate the hearing impaired
- Special assistance for cognitively impaired members or their caregivers as needed
- Our goal is to recruit Aetna Better Health staff who are bilingual

Targeted Outreach – Intensive, Supportive & Disease Management

A critical first step in the delivery of ICM and Disease Management process will be a comprehensive assessment and care plan. Our ICM priority will be to reach out to members stratified as *Intensive and then Supportive* risk levels. Our Disease Management team will prioritize outreach calls for those members stratified as high risk. *Low risk* members will receive a welcome letter and an explanation of the DM program.

To accomplish this in a timely fashion the following steps will be taken after initial contact with members assigned to the disease management or case management services group:

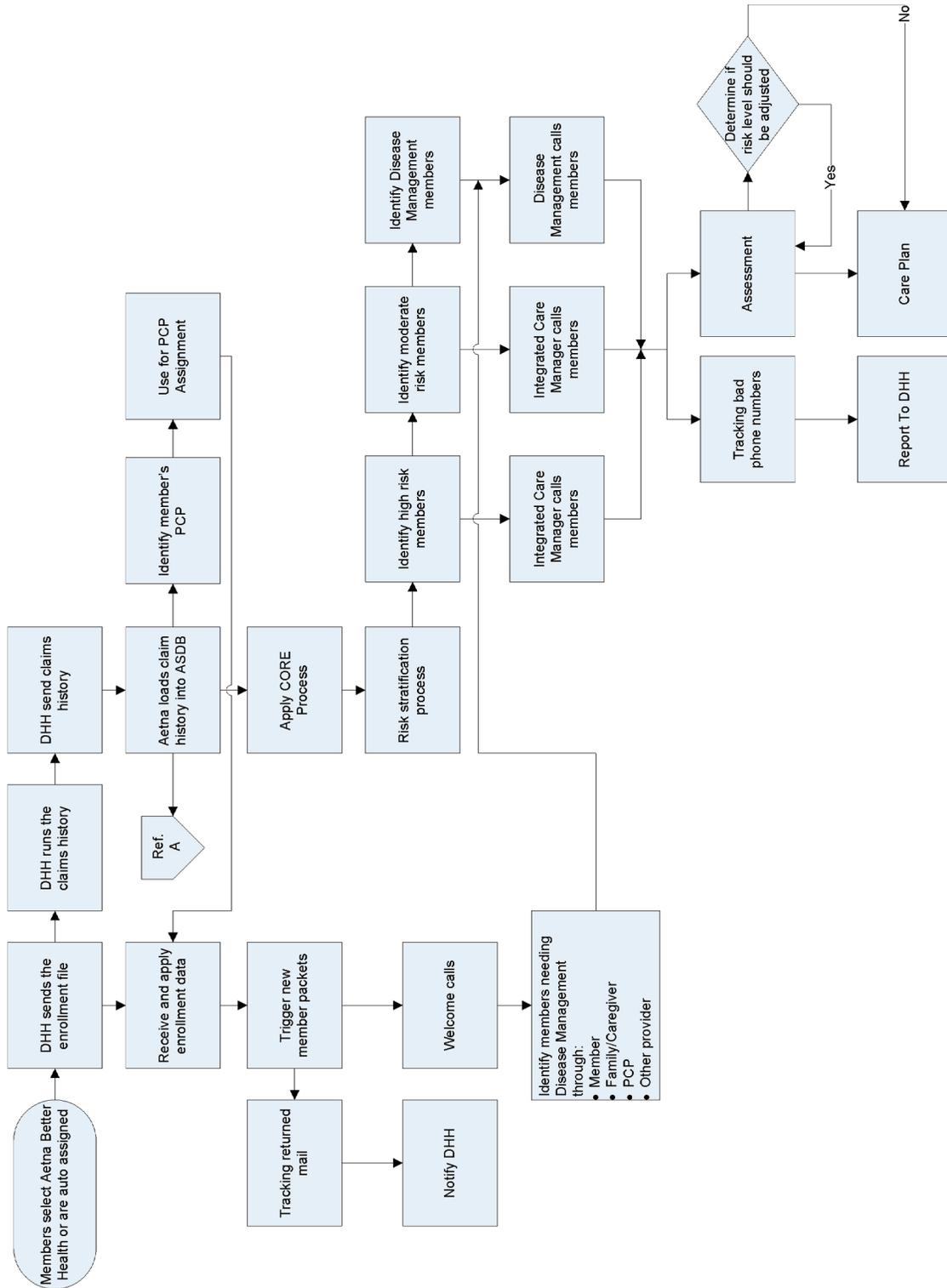
- A member of the ICM team will call members stratified into Intensive level of care. The purpose of this outreach is to welcome the member to ICM, explain the ICM process and the role of the Case Manager. Additionally, the ICM team will capture the initial assessment information and schedule the more detailed in-depth assessment of the member. Based on the outcome of the analysis of the historical claims data and the initial assessment information each member will be assigned a Case Manager with the appropriate training and experience to serve as the member's Case Manager.
- The ICM team will contact the member's PCP/PCMH to gather the PCP's insight for the assessment and plan of care. The RN Care Manager will also be available to address any concerns or questions that the PCP may have with regard to the member's assessment and



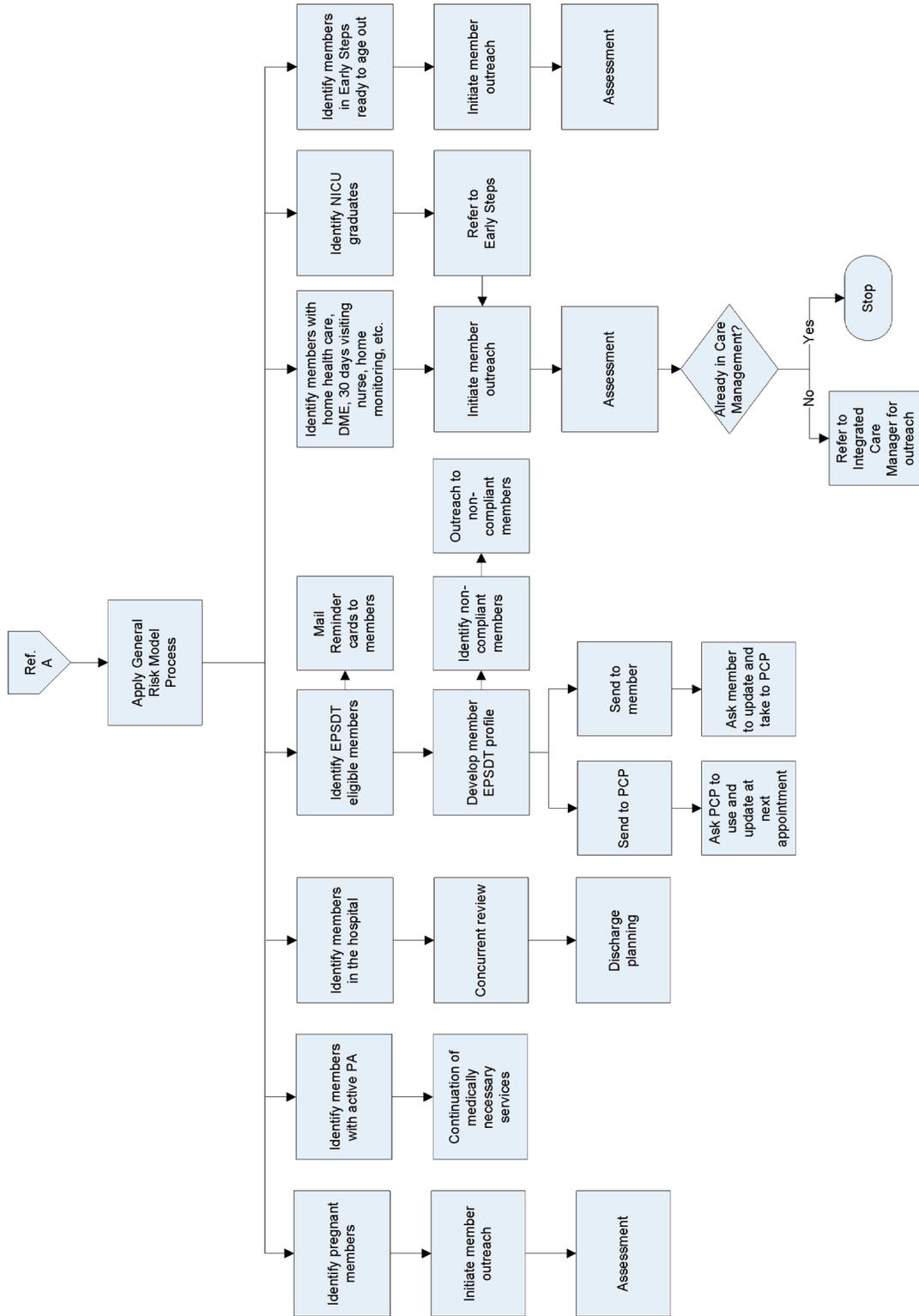
care plan. Aetna Better Health has protocols to guide the health care home and/or PCP to participate in the ICM process.

On the next pages we have included a flow chart that describes the Membership Enrollment and Stratification and Member Analysis. These flow charts provide an overview of our proposed solution to the process of identifying MSHCNs and CSHCNs. Our description extends beyond these members to the entire membership.

Membership Enrollment and Stratification



Member Analysis



Additional Information from DHH

To assist us in assessing and addressing the complete needs of each member, Aetna Better Health will request that DHH provide us with complete pharmacy history information, behavioral health information and open authorization for services. We will coordinate care with the carved out behavioral health vendor to provide each member with an integrated physical/behavioral health care plan.

Current and accurate member contact information will be imperative if Aetna Better Health is to be able to establish and maintain effective lines of communication with members. We have found this to be a continual challenge when working with Medicaid recipients as they tend to be a very mobile population with frequent address changes, may not have access to a phone or may simply not have any permanent domicile.

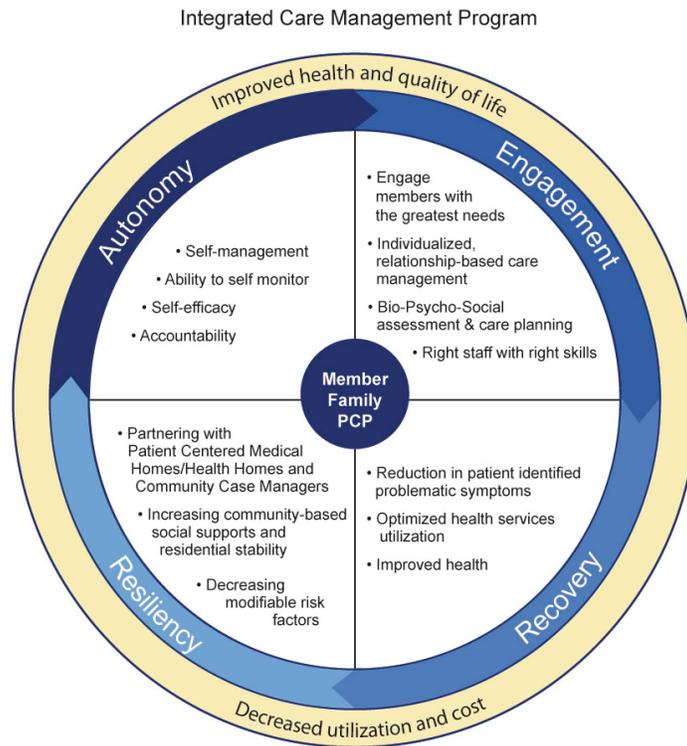
If we find that the contact information contained in the eligibility file is no longer correct (e.g., Welcome Packet is returned, phone number is out of service), Aetna Better Health will utilize additional strategies to locate the member. These may include, but are not limited to:

- Contacting the provider (e.g., PCP, clinic, pharmacy) from whom the member recently received services
- Contacting local community organizations, essential stakeholders or social service agencies with whom the member may be involved

Although not specifically classified as “information” in the truest sense of the word, we recommend that DHH and its agents meet with Aetna Better Health on a regular and consistent basis. This is one of our most significant lessons we have learned during our recent implementation and we consider it to be a best practice. We strongly urge DHH to frequently meet with Aetna Better Health during this process to identify and resolve issues as they happen.

Continuation of Services Through Integrated Care Management

Our ICM model assures a seamless continuation of services during and after the transition period, improving outcomes for MSHCNs/CSHCNs. ICM utilizes a holistic, member-centered approach that maximizes the integration of the members’ care by assigning an interdisciplinary care management team consisting of a medical director, registered nurse and/or licensed clinical social worker with current and valid state license and non-clinical team members. Each member with SHCN is assigned a Case Manager experienced in providing ICM services specific to the member’s condition. The Case Manager works closely with the member, PCP, and other service providers to assure that the member’s evolving needs are met with no interruption in care. Our ICM model is represented in the following graphic:



Continuity of Care

Continuity of care and member satisfaction is critical to our transition process. During the transition period, we will coordinate the services the member is currently receiving and will not replace providers or members unless absolutely necessary. Our key objective is that there will be no gap or inconsistencies in care for any member during the initial transition period [member moving from fee-for-service to Aetna Better Health]. For the first 90 calendar days, we will not require service authorization for the continuation of new members' medically necessary covered services, whether these services are provided by in-network or out-of-network providers. This also includes transportation services. Our utilization management staff will enter this approval into our prior authorization system to verify proper payment. Wherever possible, we will seek to contract with providers serving MSHCN and CSHCN members and bring them into our network as participating providers. We will obtain signed single case agreements from out-of-network providers, which will outline the requirements for continued service provision. Prior authorization of services from these providers beyond 90 calendar days of enrollment may be required.

Our approach to continuity of care throughout the initial transition period and thereafter requires that claims for covered health services will be denied on the grounds that a disease or physical condition existed prior to the member's eligibility date [no preexisting clause]. Services previously determined to be medically necessary, authorized, and scheduled will be honored by Aetna Better Health. Aetna Better Health puts our members' quality of care and continuity of care first in any decisions regarding transfers to in-network providers. Our protocols are basic, simple and are based on common sense. Our protocols are as follows:

- Pregnant members who have had a history of problem pregnancy, are having a problem pregnancy or are in their third trimester of care may continue to see their current provider through the birth of their babies if they so desire.
- Members receiving end of life care may also remain with their existing providers.
- Members receiving treatment for chronic or acute medical conditions (such as cancer, which includes chemotherapy, radiation therapy, or post-surgical follow-up) may continue care with the treating practitioner or provider(s) through the lesser of the current cycle or phase of active treatment or up to 90 calendar days for members undergoing active treatment for a chronic or acute condition or until completion of treatment whichever occurs first. Upon completion of treatment, our Case Manager will help the member choose an in-network practitioner or provider for future care.

Coordination of Services

Aetna Better Health will be responsible for the coordination and continuity of health care services for all members consistent. Aetna Better Health will develop and maintain effective care coordination, continuity of care, and care transition activities, using a continuum of care approach to provide health care services to our members. We will coordinate the delivery of core benefits and services with services that are reimbursed on a FFS basis by DHH (AKA carved out services). Aetna Better Health will make certain there are member-appropriate PCP choices within our provider network and that interaction with out-of-network providers serving our members during the transition period is timely. Our continuity of care activities will verify that the appropriate parties, including the member [and the member's family/caregiver] and PCP, are kept informed of the member's treatment needs, changes, progress or problems. Aetna Better Health will make certain that service delivery is properly monitored to identify and overcome any barriers to primary and preventive care that a member may encounter.

The Chief Executive Officer (CEO) will be responsible for Aetna Better Health's compliance with regulatory or contractual requirements for members transferring into or out of our Medicaid CCN Program due to member choice or open enrollment. The CEO delegates the Chief Medical Officer (CMO) to direct transition operations and to designate a transition Coordinator/Case Manager, who will oversee all transition activities, issues, and responsibilities.

Aetna Better Health maintains transfer-in procedures for the following:

- Identifying members who are transferring into our Medicaid CCN Program
- Assisting in coordinating care for members transitioning to Aetna Better Health who are receiving ongoing services or treatment of active and/or chronic high-risk conditions (e.g., chemotherapy, home dialysis, maternity care)
- Obtaining prior authorization files from DHH or the previous health plan, as applicable
- When necessary, requesting members' medical records and clinical information from practitioners in previous health plans
- Assigning a PCP/PCMH for newly enrolled members who have not already selected a primary care provider

- Forwarding information about enrolling MSHCNs or CSHCNs and high-risk [Intensive or High Risk disease management] members, as applicable, to their newly assigned PCP/PCMH, ancillary providers, and/or applicable internal departments and units
- Maintaining processes in Member Services and other appropriate departments to monitor new members' appointments for availability, accessibility, and timeliness
- Facilitating the transfer of pertinent medical records and the timely notification to members, subcontractors or other providers, as appropriate during transition
- Maintaining confidentiality of each member's medical records and personal health information during the enrollment transition

Continuity of care will include DME, home health care, prosthetics, orthotics, and other covered supplies or services. In the event a new member enrolling with Aetna Better Health is receiving Medicaid covered DME, prosthetics, orthotics and certain supplies and/or services the day before enrollment, whether those services were provided by DHH, another CCN or Medicaid fee-for-service organization (carve out vendor), Aetna Better Health will be responsible for the costs of continuing these services. The services will not require prior approval and can be provided by an in-network or out-of-network provider. Aetna Better Health will provide continuation of those services for up to 90 calendar days or until the member can be reasonably transferred without disruption, whichever is less. Aetna Better Health will also honor any prior authorization for DME, prosthetics, orthotics and certain supplies and/or services issued while the member was enrolled with DHH fee-for-service, in another CCN or the Medicaid fee-for-service organization (carve out vendor) for 90 calendar days after the member enrolls in Aetna Better Health.

Upon request by either the provider or the member, Aetna Better Health will continue to authorize out-of-network services being delivered by a qualified provider using a single-case agreement until we are able to arrange equally appropriate in-network services or arrange for the provider to join the Aetna Better Health network as a qualified participating provider.

Provider Information, Education and Training

Aetna Better Health will outreach to providers during initial orientation to advise them of MSHCN/CSHCN needs and work with the member, member's family, the member's current provider and our provider to effectively transition members into the CCN Program without any interruption or gaps in care.

We maintain written policies and procedures (P&P) concerning the initial and ongoing education and training of providers serving our members. We will provide training to all providers and their staff regarding the requirements of the Medicaid CCN Program, including limitations on provider marketing, continuation of services and identification of MSHCN/CSHCN members. We will educate and train the three types of providers who are treating our members: 1) contracted network providers; 2) providers who sign a single case agreement (SCA) with us; 3) out-of-network providers.

We consider provider education to be an important component in achieving and maintaining high performance standards across accessibility and availability measures. Our Provider Services Department will work with our CMO and Care Management staff to offer providers all of the support tools they need. We will send copies of our Provider Manual to all network providers within 30 days of their active network status. Our Provider Manual addresses the requirements

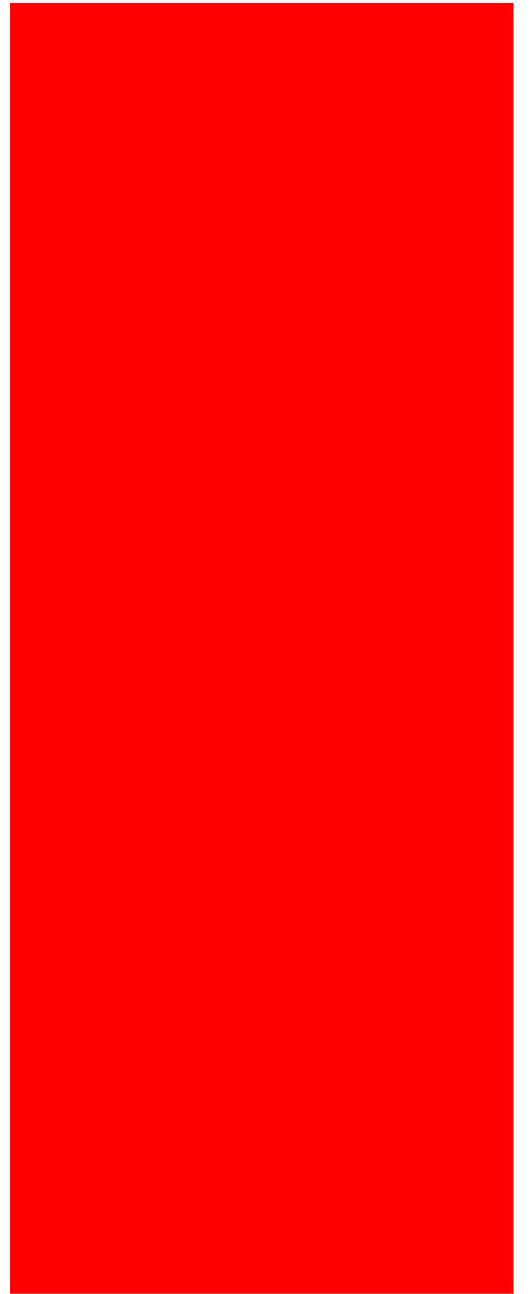
of the program with special emphasis on providing services for members with MSHCN/CSHCN. It also provides information on the application of best practice strategies and evidence-based clinical guidelines to improve the health of members and enhance their quality of life. Our provider manual will also be available on our website, along with our clinical practice guidelines and other useful information for providers.

We will conduct initial training within 30 days of placing a newly contracted provider, or provider group, on active status. We will also conduct ongoing training to assist providers to be in compliance with program standards and the contract. Our Provider Services Representatives will conduct initial and ongoing education regarding various topics, including providers' responsibilities for maintaining standards for availability and accessibility of care. We will offer provider education in various formats, including:

- **Provider Contract and Provider Manual** – The provider contract and provider manual each include requirements for appointment availability standards, after hours access requirements, clinical practice guidelines, cultural competency, billing practices and other information that will enable providers to serve our members. Providers receive these documents upon joining the network.
- **Initial Orientation** – Provider Services Representatives will provide initial education to providers upon joining the network, at onsite meetings where they review contents of the contract and provider manual, including clinical guidelines, best practices and other information helpful to network providers and their staff.
- **Routine Site Visits** – Our Provider Services Representatives conduct regular routine site visits with providers to assist providers and their staff in remaining current on and compliant with all contract requirements.
- **Website** – Our Provider Services Representatives provide training regarding the contents of and how to use Aetna Better Health's website. Providers can access the website to review information regarding standards, clinical guidelines, best practices and other information.

We will also inform and educate providers that have single case agreements (SCAs) with us and out-of-network providers concerning our quality of care, coordination of care and transition of care requirements.

51 F.2



F.2 Describe your approach to CCN case management. In particular, describe the following:

- Characteristics of members that you will target for CCN case management services;
- How you identify these members;
- How you encourage member participation;
- How you assess member needs;
- How you develop and implement individualized plans of care, including coordination with providers and support services;
- How you coordinate your disease management and CCN case management programs;
- How you will coordinate your case management services with the PCP; and
- How you will incorporate provider input into strategies to influence behavior of members.

Aetna Better Health's Integrated Care Management Model

Aetna Better Health[®] and its affiliates have more than 25 years of experience in providing effective case management services to Medicaid populations. This experience includes providing comprehensive care management services to Temporary Assistance for Needy Families (TANF), State Children's Health Insurance Program (SCHIP), Supplemental Security Income (SSI), Aged, Blind and Disabled (ABD), and Waiver populations (e.g., HIV/AIDS and long-term care eligible members). Within these member groups, we have expertise in working with special need groups such as developmentally disabled children, high-risk pregnant members, and other members/Children with Special Healthcare Needs (MSHCNs/CSHCNs). We understand the challenges of delivering health care and care management services in rural areas; for instance, in Arizona and Missouri we serve multiple counties that are rural and classified as medically underserved areas. The challenges of coordinating Medicaid services in rural areas are compounded when the membership is high-risk as are the long-term care members in Arizona. We have learned the skills and techniques necessary to adapt to these challenges and we look forward to demonstrating our expertise to the DHH for the Louisiana Medicaid CCN Program.

We have applied experience and skills in working effectively with members who have difficulty navigating the healthcare system due to health literacy issues, problems related to racial/ethnic health disparities, and the lack of social or environmental supports, including homelessness. We have expertise in meeting these challenges and in providing our members with high quality, coordinated care that meets their goals, fulfills their needs and contributes to the member and the member's family/caregiver taking greater responsibility for their health outcomes and disease state.

It is our experience that case management services and supports are best provided through an integrated approach. This is why we developed our Integrated Care Management (ICM) Model – ICM is a holistic and member-centered care management approach that has proven to be effective and efficient in meeting the needs of Medicaid members, members' families/caregivers and Primary Care Providers (PCPs)/Patient-Centered Medical Homes (PCMHs)/other providers. Our consolidated and ICM system includes utilization management (prior authorization, concurrent review and retrospective review) and quality management. Our approach incorporates

the processes of case management of members with complex and often comorbid diseases and care coordination (e.g., transition of care from hospital to home, continuity of care during new member enrollment, and reducing barriers to care by arranging services). We organize a member's care management team, building on the member's strengths to encourage and support the member in taking increased responsibility for their disease state.

Through our ICM Model, we coordinate and facilitate covered, medically necessary and cost-effective services that include the full range of core benefits and services. Our technique is to systematically identify, plan, obtain and monitor covered and medically necessary services for high-risk members with chronic or complex needs.

We will submit our ICM Model policies and procedures to DHH for approval within 30 days of contract execution, and annually thereafter. We will also submit any revisions to our policies and procedures for DHH consideration prior to making changes. Our Case Management Administrator/Manager, reporting to our Medical Management Coordinator, will oversee the ICM Model. Our ICM personnel will assess, plan, facilitate and advocate options and services to meet each member's needs. Our ICM protocols include:

- Early identification of members CSCHN/MSCHN members
- Timely assessment of each member's risk factors
- Proactively educate members about the value of a medical home (e.g., PCP/PCMH) and referral to a PCP or PCMH as appropriate
- Development of a holistic and member-centered care plan that is
 - Developed in collaboration with the member, the member's PCP/PCMH, specialists and other service providers
 - Accepted and approved by the member's Case Manager in a timely manner
 - In compliance with quality assurance and utilization management standards
- Referrals and assistance in accessing necessary providers in a timely manner
- Care coordination that links members to providers, core benefits, social, community and other support services as needed
- Quarterly monitoring of the member's progress and adjustments to the care plan as appropriate
- Continuity of care for newly enrolled members for up to 90 calendar days or until the member's care may be safely transferred
- Timely follow-up and documentation of outcomes
- A MSHCN or CSHCN is assigned a Case Manager experienced in providing ICM services specific to the member's condition or needs

Our ICM process begins with a comprehensive review and assessment of each member's strengths, needs, and disease state that results in the development of a mutually agreed upon, individualized and holistic care plan. The member, member's family/caregiver and PCP/PCMH are all involved in the assessment and care plan development process with an ICM Case Manager leading and encouraging the process. The ICM Case Manager monitors the member's progress and takes appropriate action if the member encounters barriers to achieving the care

plan's objectives. Our goal is to actively involve the member, the member's family/caregiver, the member's PCP/PCMH so that the right service is provided at the right time, and in the right setting.

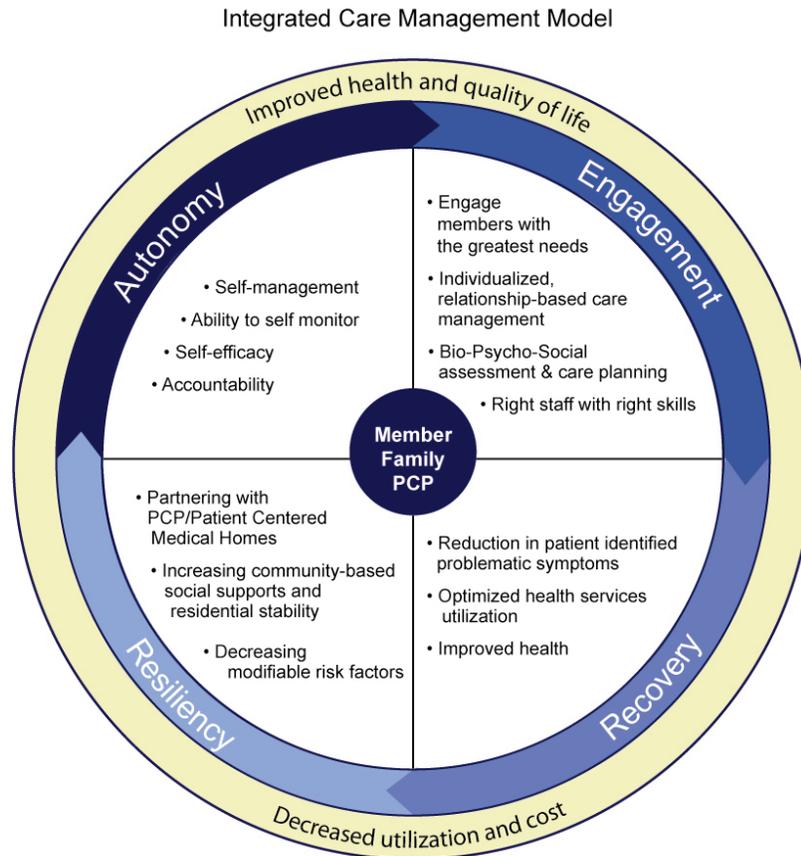
Member outreach and education are essential components in the success of our ICM Model. Educating members is a shared process that includes the member's PCP/PCMH. We have found that health literacy is a strong predictor of a member's ability to navigate the health system, access their benefits, understand written and oral instructions from providers, take prescription drugs correctly, and attend appointments. We create our member educational materials to meet members' needs, so all written materials will be in accordance with the DHH "Person First" Policy. Our communications are culturally sensitive and developed at a 6th grade reading/comprehension level.

ICM Guiding Principles

The foundation of our ICM approach to care management includes the following guiding principles:

- *Moving from disease focus to member focus*: evaluating every member for physical, behavioral and social risks to their current and future health
- *Identifying and employing the most effective intensity of evidence-based, plan-covered systems and services*: facilitating access to a continuum of services based on the intensity and complexity of each member's needs
- *Behavioral engagement for change*: using a single point of contact to engage each member in a plan that addresses their critical physical, behavioral and social needs to promote resiliency, recovery and optimal self-management
- *Teaming with the member and care providers to enhance care outcomes*: work as an interdisciplinary team that combines core competencies in physical and behavioral health within a systems framework to manage psycho-social complexity and challenging relationships with members and their families
- *Collaboration with plan sponsors to influence benefit design*: focus on coordinating and integrating fragmented services into a system of care that addresses each member's individual needs within the context of their family and cultural community

Our ICM approach has four key components as illustrated in the graphic on the following page.



ICM and CCN Case Management

In the following paragraphs, we address each of the elements necessary to fully describe how our ICM Model will address the specific requirements or populations described in the Request for Proposal (RFP).

Characteristics of Members in the ICM Model

Aetna Better Health’s ICM Model provides support and care management services to a wide variety of members. The program is specifically designed to be member-centered; therefore, we begin with the member. Members who participate in the ICM Model include women with high-risk pregnancies and members with multiple chronic conditions (e.g., diabetes with end stage renal disease, hypertension with adult sickle cell, cardiovascular disease with depression). The characteristic that best defines a member in our ICM Model is high-risk of inappropriately utilizing ED, hospital admissions, and readmissions that can be prevented through use of clinical practice guidelines. Our focus is to work with those members who have the greatest opportunity for improving their quality of life by increasing control and responsibility for their disease state. Part of our process in assessing members for participation in the ICM Model is determining their willingness to change. This characteristic is a high predictor of the member’s ability to adopt life-style changes and accept the advice and direction of their healthcare provider. Another primary characteristic is that the member has a difficult time in navigating the complex healthcare system and in understanding and applying healthcare directions. Overcoming health literacy problems is one of the greatest needs we find in our ICM members.

Members participating in our ICM Model include adults and children. Our approach is tailored to the individual's demographics, culture, and support structure. We find that many members in our ICM Model are homeless, lack support structures and deal with multiple chronic and/or disabling conditions. One of the unique and challenging aspects of members who participate in the ICM Model is that they are, at the same time, homogenous and dissimilar. By homogenous, we mean that each member deals with profound complex social, environmental, cultural, and medical situations. By dissimilar, we mean that each member addresses their circumstances in unique and compelling ways.

The number one characteristic of members participating in our ICM Model is their desire and willingness to take greater control of their care. Through the ICM Model, we give our members the tools, motivation, and support to achieve their goals.

Member Identification and Criteria

Aetna Better Health uses the following three methods to identify members who would benefit from ICM services:

- **Consolidated Outreach and Risk Evaluation (CORE) analysis** – We use a proprietary, evidence-based CORE process to analyze claims data to prospectively identify members who are at high medical risk
- **Referral** –Members may be referred to ICM from a variety of sources (e.g., case management, PCP, etc.)
- **Surveillance methods** – These include a variety of data or other informative elements that are used to supplement other member identification processes

CORE-Member Identification Method Number 1

Risk stratification is a key component of our ICM Model. We have successfully used risk stratification to maximize the effectiveness of our ICM Model by identifying members with the greatest opportunity for improvement (e.g., highest risk, highest cost, and experiencing poor health outcomes based on their condition).

Aetna Better Health further enhanced our ability to identify high risk members through the development and implementation of our Consolidated Outreach and Risk Evaluation (CORE) approach. In developing this tool, we used John Billing's work on Medicaid inpatient risk prediction as a blueprint, and then further enhanced his work to include emergency department use, which is a priority for all our Medicaid health plans. The resulting inpatient and emergency department models provide member-specific scores indicating the likelihood that the member will visit the emergency department or experience an inpatient admission in the next 12 months. Our CORE approach is based on the following:

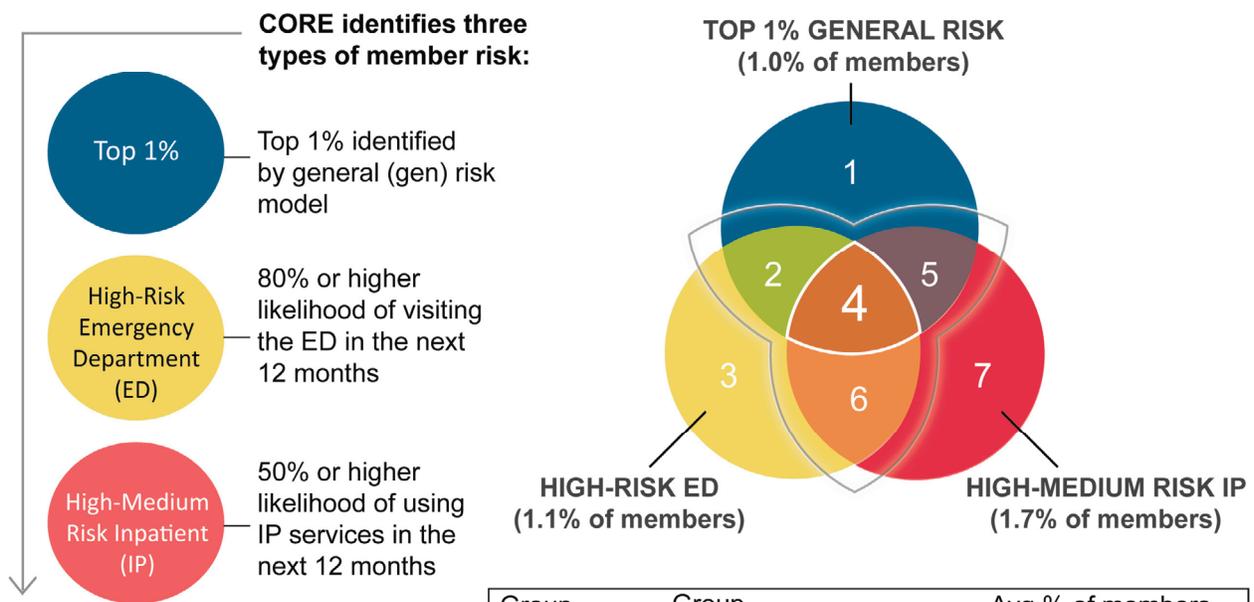
- Predictive modeling risk score in which the top one percent of members ranked by this score are considered high risk
- Emergency department risk score in which a logistic regression model assesses the likelihood of a member utilizing the emergency department in the next 12 months
- Members with a probability of 80 percent are considered high risk for an emergency department visit. Performance of this model is very good, with a positive predictive value of

72.1 percent. This means that 72.1 percent of the time, the predicted emergency department utilization actually occurs in the next 12 months.

- Inpatient admission risk score in which a logistic regression model addresses the likelihood of a member utilizing the inpatient hospital in the next 12 months. Members who have a probability between 50 to 69 percent are considered medium risk and 70 percent or more are considered to be high risk for an inpatient admit. (This excludes maternity admits.) Performance of this model is even better than the emergency department model, with a positive predictive value of 95.4 percent. This means that 95.4 percent of the time, the predicted inpatient utilization actually occurs in the next 12 months.

Members are placed within one or more of these three risk groups. In order to understand the significance of the overlap between these risk groups, the following diagram illustrates the overlapping relationships between the three different risk groups.

Aetna Medicaid’s Consolidated Outreach and Risk Evaluation (CORE) tool identifies members who will benefit most from our Integrated Care Management program. This tool uses acute care, pharmacy and long-term care (LTC) claims data to identify members at high risk for adverse future health outcomes.



Identifying highest risk members

This diagram shows three risk categories. The areas of overlap represent members at high risk (groups 2, 4, 5 and 6) for adverse health outcomes. Group 4 represents members at the highest risk, falling into all three risk categories.

Group #	Group name	Avg.% of members for typical health plan
1	Top 1% Gen risk ONLY	0.6%
2	Top 1% Gen risk / High-risk ED	<0.1%
3	High-risk ED ONLY	0.3%
4	High-med risk IP/Top 1% Gen risk/High-risk ED	0.2%
5	Top 1% Gen risk / High-med risk IP	0.2%
6	High-risk ED / High-med risk IP	0.6%
7	High-med risk IP ONLY	0.7%
Percentage of members not in CORE:		97.4%

Note: Percentages may not add up to 100% due to rounding

Each of the three overlapping circles in the CORE diagram represents a different predicted risk category; creating seven distinct risk groups:

- Group 1: Top one percent Predictive Modeling Only
- Group 2: Top one percent Predictive Modeling and High-Risk Emergency Department
- Group 3: High-Risk Emergency Department Only
- Group 4: Top one percent Predictive Modeling, High-Risk Emergency Department and High-Medium Risk Inpatient
- Group 5: Top one percent Predictive Modeling and High-Medium Risk Inpatient
- Group 6: High Risk Emergency Department and High-Medium Risk Inpatient
- Group 7: High-Medium Risk Inpatient only

Aetna Better Health compared members in these groups across a number of our affiliated Medicaid managed care health plans in other states and found remarkable consistency in the composition of each group in terms of demographics, cost, utilization, and prevalence of chronic disease. This model enables us to more precisely target and match members with appropriate levels of care management.

By combining the information from the CORE tool with other member information (i.e., Health Risk Questionnaire results), Aetna Better Health will assign members into the ICM Model at the most appropriate level of care management. We will target the highest risk members in the CORE for intensive case management. These members will generally have high medical and/or behavioral health complexity, frequent emergency department visits or hospital admits, and/or a high specialist to PCP/PCMH ratio. Members with moderate or lower relative risks will be assigned to supportive case management.

Referral – Identification Method Number 2

Identification may also occur through several sources or processes or that often involve provider referrals, internal referrals, self-referral, or a referral from other sources. These sources may include, but are not limited to:

- Self/member referral
- Member’s family/caregiver
- Member Services
- PCP/PCMH or other health providers who identify members in need
- Concurrent Review
- Prior Authorization
- Welcome Call
- Quality Management
- Maternal Child Health/EPSTD Coordinator
- Grievance and Appeals
- Referral from Carved-out Behavioral Health Vendor
- Review of Health Risk Questionnaire (HRQ) scoring
- Enrollee Special Needs Report (from the enrollment broker)

Surveillance Data – Identification Method Number 3

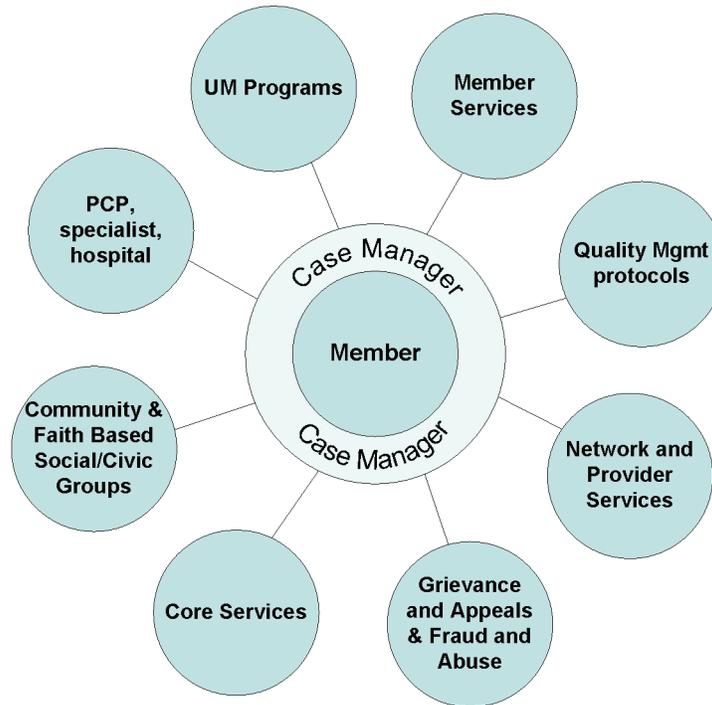
In addition to reviewing the results of CORE₂, we also consider surveillance data that may be available. Real time or surveillance data may include, but is not limited to:

- Information received as part of the referral to ICM (e.g., family/caregiver, PCP/PCMH, or other providers' concerns or issues)
- Enrollment transition information from each member's caregiver, PCP/PCMH or other provider as appropriate
- Identified gaps in a member's care as related to evidence-based practice guidelines by Care Considerations or other processes.
- Transition from EarlySteps – Individualized Family Service Plan (IFSP) review
- Discharge plan from an inpatient setting

Encouraging Member Participation

It is our experience that encouraging the member's and the member's family/caregivers' active participation in the assessment, care plan development, and care plan execution is of critical importance. The ICM approach was specifically developed to recognize and encourage member participation at each point in the case management process. Each Case Manager will receive training on the tools and techniques of encouraging and enhancing member participation in the assessment and care planning steps that make up the ICM Model.

Consistent with our ICM Model, the Case Manager places the member at the center of the care planning process. Motivational strategies such as reflective listening, normalizing, and decisional balancing will be used to engage the member and/or their representative in the assessment and care planning processes. This step facilitates active participation by the member and/or their representative during assessment and care plan development. Our Case Managers recognize and respect personal and cultural choices, and support informed decision-making by the member and/or their representative during the formulation of care plan goals.



Our ICM Case Manager actively involves the member and the member’s family/caregiver in completing the assessment and developing the care plan. The Case Manager collaborates with the member’s PCP/PCMH, specialty, or service providers, along with other individuals and organizations that are key to successful care plan development. Our experience has taught us that this step often strengthens the relationship between the member (and/or their family/caregiver) and the member’s PCP/PCMH. When completed, the care plan is discussed with the member and/or their family/caregiver. The member and the member’s family/caregiver have access to their care plan through our web-based care management business application (Dynamo™). This web-based care management business application (Dynamo™) is secure and user friendly. The member and the member’s family/caregiver, as appropriate, will receive instructions on how to access their care plan from their Case Manager. In addition, to encourage participation in the ICM Model, the member’s PCP/PCMH will also have web-based access to the member’s care plan through our web-based care management business application (Dynamo™). It is our experience that having access to the care plan is an important factor in the member using the care plan when visiting their PCP/PCMH and when making “life choices.”

Aetna Better Health’s ICM Model emphasizes building a trusting relationship between the Case Manager, the member, and the member’s family/caregiver or guardian, to facilitate identification of member’s goals, strengths, needs, and challenges. The care plan developed in collaboration with the member, member’s family/guardian, PCP/PCMH and other service providers offers: 1) the member and the member’s family or guardian with a clear understanding of their goals and agreement to the selected service options; 2) a summary of the member’s rights and responsibilities, including contact information and their complaint and appeals rights; 3) a point-of-reference for all Aetna Better Health personnel to facilitate coordination of members’ care; and 4) a road map for the member and the member’s family or guardian to navigate the complex healthcare system.

Assessing Members' Needs

ICM has written policy and procedures that govern the processes used for initially and periodically assessing members' service needs and describing the credential requirements of personnel performing assessments. Initial clinical assessments include, but are not limited to: Milliman Chronic Care Assessment; PHQ9; the Aetna Health Risk Questionnaire; PSC-17; SF10. Our culturally competent assessments are based on a holistic and member-centered approach. Periodic assessments occur quarterly. Members with intensive care management needs are reassessed on a monthly basis. These assessments serve as an opportunity to update the initial clinical assessments. Our ICM team's credentials include a Louisiana licensed Registered Nurse and Clinical Social Worker with a current and valid Louisiana license.

Our member assessment process is supported by our web-based care management business application (Dynamo™). This system supports the assessment process because many of the assessment forms, protocols and requirements are incorporated into the application and edit features prevent oversights, omissions or errors. In addition, our web-based care management business application (Dynamo™) enables personnel from other departments to review a member's assessment and other key administrative data (enrollment history, contact information, case management assessments and activities, diagnosed conditions, prior authorizations, medication history, laboratory results when available, discharge planning notes and claims history). This tool enables critical member information needed by other departments to be instantly available for decision-making and to support coordination of care.

A member receives an assessment from their Case Manager within five days of assignment to ICM. This assessment begins with the member's care plan, providing an opportunity for a comprehensive review of the member's medical situation necessary to develop a care plan. Aetna Better Health's Chief Medical Officer (CMO) and other key personnel (Member Services, Provider Services, Quality Management, Utilization Management (prior authorization, concurrent review) may be consulted as appropriate in the development of the member's assessment and care plan strategies necessary to meet the member's needs. As part of our assessment, the Case Manager will contact the member's PCP/PCMH and specialty providers to gather additional information necessary to complete the member's specialized care plan.

We use a holistic member-centered approach to assess the member and develop the member's individualized care plan. The Case Manager works closely with the member and the member's family/caregiver to determine the member's goals, as well as to identify their individual strengths and challenges. Often, these members have a difficult time identifying and internalizing their goals. Through the use of member engagement strategies, such as motivational interviewing, the Case Manager reinforces physicians' orders, educates the member and member's family/caregiver to improve health literacy, and encourages the member and the member's family/caregiver participation in the management of their condition(s).

Should issues in assessment process or in developing the care plan arise that require multi-disciplinary support, the Case Manager can take the case to our weekly "grand rounds" meeting. Grand rounds is a forum for a detailed review of the member's case and needs, with an emphasis on providing the Case Manager with care planning strategies. In preparation for the grand rounds, the Case Manager will contact the PCP/PCMH, behavioral health provider (from the carved out vendor), specialists, and other involved entities to gather additional information and

recommendations to consider during the grand rounds meeting, including member's behavioral health/medical history.

Care Plan Formulation

The Case Manager will use assessment results and the member's self-identified goals, along with the member's medical history and other information obtained during the assessment process, to formulate a care plan. Our Case Managers follow written policies and procedures that guide the use of assessment information to develop the care plan. Unlike other Medicaid managed care organizations, Aetna Better Health does not use system generated care plans. In the ICM approach, the member's care plan is individualized to each member's unique situation and medical needs. It is our experience that this holistic and member-centered approach is critical to involving the member and facilitating the member's commitment to the care plan.

The ICM Case Manager uses motivational strategies such as reflective listening, normalizing, and decisional balancing to engage the member and/or their representative in assessment and care planning processes. This facilitates active participation by the member and/or their representative during assessment and care plan development. Our Case Managers recognize and respect personal and cultural choices, and support informed decision-making by the member and/or their representative during the formulation of care plan goals.

As we described above, our ICM Case Manager actively involves the member and the member's family/caregiver in completing the assessment and developing the care plan. Active involvement of the member and the member's family/caregiver is critical to the development of the holistic and member-centered care plan. The Case Manager collaborates with the member's PCP/PCMH, specialty, or service providers, along with other individuals and organizations that are key to successful care plan development. Our experience has taught us that this step often strengthens the relationship between the member (and/or their family/caregiver) and the member's PCP/PCMH. When completed, the care plan is discussed with the member and/or their family/caregiver. The member and the member's family/caregiver have access to their care plan through our web-based care management business application (Dynamo™). The web-based care management business application (Dynamo™) is secure and user friendly. The member and the member's family/caregiver, as appropriate, will receive instructions on how to access their care plan from their Case Manager. In addition to encouraging participation in the ICM Model, the member's PCP/PCMH will also have web-based access to the member's care plan through our web-based care management business application (Dynamo™). It is our experience that having access to the care plan is an important factor in the member using the care plan when they visit their PCP and when making "life choices."

Aetna Better Health's Case Management Program emphasizes building a trusting relationship between the Case Manager, the member, and the member's family or guardian, to facilitate identification of member's goals, strengths, needs, and challenges. The care plan developed in collaboration with the member, member's family/guardian, PCP/PCMH and other service providers offers: 1) the member and the member's family or guardian with a clear understanding of their goals and agreement to the selected service options; 2) a summary of the member's rights and responsibilities, including contact information and their complaint and appeals rights; 3) a point-of reference for all Aetna Better Health personnel to facilitate coordination of members'



care; and 4) a road map for the member and the member’s family or guardian to navigate the complex healthcare system.

ICM Coordination with Disease Management

We have experience in coordination of care for members in our ICM Model with a wide range of health, behavioral health and disease management programs or activities. Aetna Better Health, together with its affiliates has successfully coordinated and facilitated the management and delivery of ICM, covered services and carved-out services for over 25 years. Disease management is provided by an affiliate of Aetna Better Health. This makes coordination a seamless and straightforward process.

Coordination of care and services between ICM, PCPs/PCMHs, other providers and our Disease Management Program is straightforward and seamless. Disease management services are provided by our affiliate, Schaller Anderson, LLC (Schaller Anderson). Since 2006, Schaller Anderson has provided an NCQA certified Disease Management Program for four targeted chronic diseases (i.e., asthma, congestive heart failure [CHF], chronic obstructive pulmonary disease [COPD] and diabetes). In 2009, Schaller Anderson developed a new Disease Management Program for depression and NCQA certified it in 2010. Our ICM Case Manager and Disease Manager will work consistently and closely with the member and the member’s family/caregiver and the PCP/PCMH to identify and coordinate services. Both the ICM Case Manager and the Disease Manager will have access to our web-based care management business application (Dynamo™) for purpose of coordinating care and services.

We use two outreach approaches in ICM – general and targeted outreach. General outreach informs/educates all our members and includes our Member Handbook, newsletters, and website. It is our standard operating procedure to make every effort to provide outreach information in an easily understood language and format. We inform our members that translations are available, at no cost, for non-English speakers. We take into consideration the special needs of our members and our materials are available at no cost to members in alternative formats. The purpose of targeted outreach is to contact individual members about benefits or programs that could improve their health or aid in meeting care plan goals. The following table describes the roles of key departments or personnel in targeted outreach.

Department or Position	Method to Identify Members Who Need Coordination	Outreach to Members for Disease Management (DM),
Maternal Child Health/EPSTD Coordinator	ID members during daily member contact Review EPSTD referral forms	Educate and refer member to DM
Member Services	ID members on calls	Educate and refer member to DM
Utilization Management	Review of prior authorization, concurrent or retrospective review	Educate and refer member to DM
Quality Management	Review of case, consult with PCP/PCMH or other personnel	Educate and refer member to DM
Actuarial Services	Analysis of CORE data	Refer to ICM for contact

Department or Position	Method to Identify Members Who Need Coordination	Outreach to Members for Disease Management (DM),
Grievance & Appeals	ID members during review of facts	Refer to ICM for contact
ICM Case Manager	ID members during assessment	Educate and refer member to DM
Provider Services	ID members during on-site visit, ID PCPs who need training	Educate and refer member to DM

Once we identify a member who may benefit from disease management, our approach is to contact the member to explain the value of these programs and guide the member through the process. The table above demonstrates there are several points where a member can be identified as needing a referral to disease management. We have policies and procedures governing referrals to Disease Management Programs. ICM Model team members receive initial and ongoing training on their responsibilities regarding this process and member contact is highly coordinated by the ICM Case Manager and other involved internal units. We use a variety of media and methods to contact our members with information about the value and importance of these programs. These include, but are not limited to, an informational/educational letter to members and their families/caregivers advising they could benefit from enrollment in one or more of these programs. We include information about the programs in their geographic area and promote the value of these programs. We also telephone members or their responsible party to reinforce our educational information and encourage participation. If internal reports continue to indicate the member or member’s family/caregiver has failed to enroll, we will reach out to the member’s PCP/PCMH to seek assistance.

The member’s PCP/PCMH has a critical role in our outreach, member education, and care coordination programs. The PCP/PCMH is aware of the member’s care plan and the role that disease management and other programs may play in meeting the member’s goals. Acting as a bridge, the PCP/PCMH often balances care between ICM, our providers, and our Disease Management Programs.

Through our web-based care management business application (Dynamo™), immediate notice of changes in data trends, from utilization management activities (prior authorization, concurrent review) and claim payment are available to inform the member’s Case Manager of changes in risk stratification. Our care coordination approach is to coordinate the services we provide with the services the member receives from disease management and other carve out providers. Our ICM, Maternal Child Health/EPSTD Coordinator, member services and provider service personnel will receive training regarding the disease management, and other carved out services. Members may also access disease management and other carved out services directly, by self-referral or they may be referred by other Aetna Better Health personnel.

The healthcare system is often fragmented and difficult to navigate for our CCN members. This is one of the reasons we developed our ICM process. We have designed ICM to assist and support our members who are in transition into, receiving care from or ending care at disease management or CCN case management. One of the reasons ICM is responsive is that our care coordination personnel have the training and experience to coordinate difficult care situations and respond to members who have complex medical needs, comorbid chronic illnesses, are high risk, or have special healthcare needs. We build the care coordination team around the needs of

the member and include the member, the member's family/caregiver, PCP/PCMH and other providers as necessary. The ICM and Disease Management Programs are integrated through the web-based care management business application (Dynamo™) into one seamless plan of care. During members' course of treatment, their level of care assignment, depending on the member's physical and behavioral health status, may be reduced to either supportive or population health services.

Coordinating Case Management with PCP/PCMH

Assessment and care plan development is an ongoing and fluid process between the member and the member's family and guardian, member's PCP/PCMH and the ICM Case Manager. We value the assessment and care planning process because it is member-centered, leads to consistency of services, provides for care in the most integrated setting, and promotes positive health outcomes for our members. We engage the member, the member's family or caregiver, PCP/PCMH and other providers to actively participate in the assessment and care planning process.

Aetna Better Health's ICM Case Managers will involve the member and the member's family/caregiver in completing the assessment and developing the care plan. The ICM Case Manager will collaborate with the PCP/PCMH, specialty, and service providers, along with other individuals and organizations are keys to successful care plan development. Our experience has taught us that this step helps to strengthen the relationship of the member and/or their family/caregiver with the member's PCP/PCMH to promote coordination of effective and efficient care.

Our ICM Case Manager will focus on keeping the member's PCP/PCMH, specialists and other providers up-to-date on the status of the member's care plan and any changes in the member's condition. Examples of case management communication, coordination and support include, but are not limited to:

- Obtaining and sharing pertinent medical records with the PCP/PCMH, specialist, and other providers actively providing services
- Following up with the PCP/PCMH and providers regarding medical records that were shared to coordinate changes in a member's care plan
- Informing the PCP/PCMH, specialists, and other providers of the member's most recent pharmacy fill history (if available from the carved out vendor)
- Facilitating safe transitions (e.g., from hospital to home) to maximize consistency of services and improve continuity of care
- Advocating on behalf of the member to improve accessibility of services, collaborate with stakeholders, and collaborate with involved entities on approaches to maximize the member's care plan
- Collaborating with the PCP/PCMH to meet the member's needs and avoid gaps in care
- Aetna Better Health, to improve coordination of care and communication, will recommend and support PCPs/PCMHs in developing electronic medical records

Influencing Members' Behaviors

Aetna Better Health is expert at working with providers to influence members' behaviors. We begin with a thorough orientation to our programs, clinical guidelines, care management processes and systems. Aetna Better Health will use a multi-pronged approach regarding provider initial and ongoing training. Our training program 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.

Aetna Better Health will deliver a comprehensive initial provider orientation to newly contracted providers and their personnel within 30 calendar days of the provider's contract effective date. 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.

In addition to initial provider orientation, our 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. Aetna Better Health 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 Aetna Better Health Provider Services Representatives. However, Aetna Better Health will supplement these routine site visits with ad hoc provider office visits, webinars, and provider forums.

All providers will receive information and training on how to work with our Case Managers, members, members' families and other providers to develop, implement and coordinate individualized care plans for members. Key topics covered by Provider Service Representatives during initial orientation include, but are not limited to:

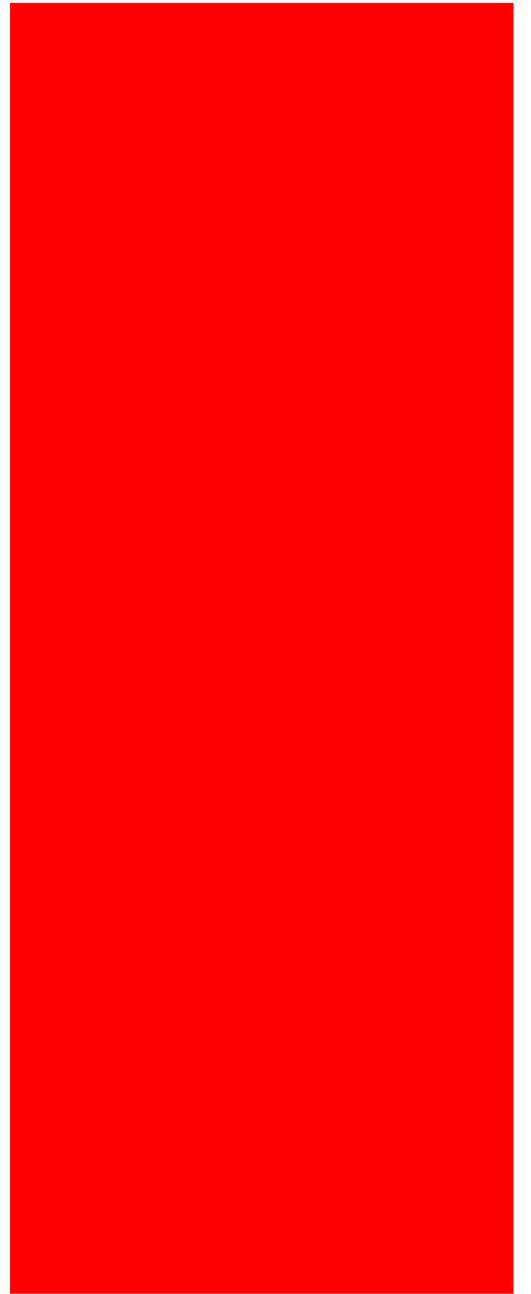
- DHH program standards
- State and federal guidelines, laws and regulations
- DHH subcontract provisions
- Utilization review programs (prior authorization, concurrent and retrospective review)
- Aetna Better Health's chronic care management program and identification of special needs of members
- ICM Model
- PCP/PCMH and other provider roles and responsibilities
- Aetna Better Health's website
- Aetna Better Health's process for communicating changes regarding program standards, laws and regulations, Aetna Better Health requirements
- Description of PCMH and requirements for recognition
- Core benefits and services provided by Aetna Better Health
- Emergency service responsibilities

- Medical necessity standards as defined by DHH and practice guidelines
- Practice protocols, including guidelines pertaining to the treatment of chronic and complex conditions
- Prior authorization and referral procedures
- Medical records standards
- Quality performance requirements
- Provider rights and responsibilities

Aetna Better Health actively encourages PCPs/PCMHs and other providers to offer input regarding best practices to influence a member's behavior and process for accepting responsibility for their disease state and health status. It is our experience that PCPs often know the triggers that motivate a member's [patient's] behaviors and can provide meaningful recommendations and ideas. We offer several approaches that enable providers to have direct input into our ICM Model. These approaches include, but are not limited to:

- Provider participation on our Quality Management/Utilization Management Committee where ICM strategies are discussed
- Provider forums with the CMO
- Provider CAHPS[®] survey
- ICM Case Manager contacting the PCP to discuss a member's medical condition/history and to obtain input for the care plan (to include strategies for member [patient] self-management)
- ICM Case Manager contacting the PCP to determine if there are specific causes for abrupt changes to a member's disease state or health outcomes
- Inviting the PCP to attend "grand rounds" to meet with the ICM team to discuss treatment plans, goals and care plan for a member (patient)
- The CMO meeting with PCP/PCMH/other providers, professional medical associations, advocacy organizations and members to refine community standards of care for inclusion in or modification of our ICM goals and standards

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F.3 Describe your approach for coordinating the following carved out services which will continue to be provided by the Medicaid fee-for-service program:

- **Dental**
- **Specialized Behavioral Health**
- **Personal Care Services**
- **Targeted Case Management**

During our 25-year history of Medicaid managed care experience, Aetna Better Health® and its affiliates have developed sound administrative and process techniques to improve the coordination of covered services. These techniques include proven approaches to effectively identify, manage, and coordinate carved out services. Based on our experience, we have designed these approaches to reduce the potential that a member may be unable to access a carved out service due to difficulties navigating the complex healthcare system. Our experience in coordinating care with and between carved out services in our 10 Medicaid managed care states is illustrated in the following table.

State	Behavioral Health	Dental	Early Steps ²	Personal Care Services
Arizona – Acute Care	X		X	X
Arizona – DD	X		X	X
California			X	X
Connecticut	X	X	X	X
Delaware			X	X
Florida			X	X
Illinois			X	X
Maryland	X		X	X
Missouri			X	X
Pennsylvania	X		X	X
Texas			X	X

Our experience is that case management activities are essential for Medicaid members with high risk and complicated comorbid conditions to take full advantage of both our covered services and the services available through carved out programs. Our overall program and approach is specifically designed to reduce the possibility that a member will be unable to obtain needed services from a carved out program.

As indicated previously, fragmentation of services and a lack of understanding on the part of the carved out vendor means that the responsibility for coordinating care often falls on the member and their family or caregiver. This creates numerous challenges for the member. We fully understand and appreciate how difficult it is for many of our members to navigate the complex healthcare system and our approach is designed to protect the member, act as the member’s advocate and to provide a management process to help avoid duplicate services and unnecessary cost. Our approach is to identify and avoid potential problems for members; these problems often include confusion regarding when and where to seek care; determining if a referral from the

² This is a common targeted case management program.

member's Primary Care Provider (PCP)/Patient-Centered Medical Home (PCMH) is needed; and if transportation is available to a carved out vendor. One of our approaches is to include information related to these issues in the Member Handbook and other materials as described below. We also will work constructively with DHH and the carved out vendor to develop the working relationship necessary to avoid the problems described above and to support each member gaining access to the covered and medically necessary services necessary to promote healthy lifestyles and improve quality of care.

Supporting Access to Care

Aetna Better Health and our affiliates have extensive experience in managing carved-out services for the programs identified by the State for this RFP. We have developed effective policies and procedures for collaborating with State agencies, carved out vendors and members (family and caregiver) to support access to care and to eliminate barriers.

We anticipate that timely pharmacy, dental and other claims from carved out vendors will be available to support our medical and risk management processes. These claims and associated authorization data [if applicable] will be imported and fully integrated into:

- *General Risk Model (GRM)*
- Active Health CareEngine® System and
- Our web-based care management business application (Dynamo™).

We will work with the DHH and its carved out vendors to develop protocols for obtaining utilization data as close to real time as possible. Timely, accurate and complete data is important for the validity of our risk management process and to facilitate intervention with a member or PCP/PCMH if necessary.

We will provide the member's PCPs/PCMHs, specialists and other practitioners with targeted communications about their members' usage of carved out services as information about these services is of vital importance to a physician in treating their patients. Our business application system (QNXT™) has the capacity to:

- Profile members' pharmacy, dental and behavioral health utilization
- Distribute pharmacy-related Care Considerations (generated by our affiliate's CareEngine® System) clinical decision support information to providers
- Assess member compliance with pharmacy regimens and enlist the provider's assistance when a member is not compliant or is at risk
- Advise our PCPs/PCMHs of psychotropic medication received by members with comorbid conditions [physical health and behavioral health]
- Depending on information available from the carved out behavioral health vendor about our members "in care" we are able to identify member's with a behavioral health diagnosis who are may not be "in care" and alert the behavioral health vendor to outreach to the member

We have experience successfully operating Medicaid managed care programs when both pharmacy and behavioral health services are carved out from the benefit package. We have developed techniques to integrate physical, behavioral health, dental, and PBM services so that care is seamless, unduplicated and transparent to the member. We know from experience that the

cost of care for members with chronic conditions is greatly impacted by a secondary behavioral health diagnosis or if the member fails to follow evidence based guidelines for prescription medicines. For example, our internal research and analysis shows that the cost of care for members with diabetes, on a per member per month basis, is 130 percent higher for those with at least one behavioral health condition (e.g., depression).

Outreach and Education Regarding Carved Out Services

Aetna Better Health views outreach and care coordination as critical components of our program to improve access to care for our Members with Special Healthcare Needs (MSHCN), Children with Special Healthcare Needs (CSHCN) members, pregnant members, members with chronic conditions and all other members. We define outreach as a communication process to educate or inform our members about carved out benefits, services or programs including, but not limited to Dental, EarlySteps, Personal Care Services, or Specialized Behavioral Health. We use two outreach approaches – general and targeted outreach. General outreach informs/educates all our members about carved out services – we include this information in our Welcome Newsletter, Member Handbook, member newsletters, web site, through our toll-free member service call center and/or inclusion of medically necessary services in the member’s care plan, if applicable. We will inform members on how to access carved out covered services and assist in coordinating these services either as part of each member’s comprehensive care planning or directly with the member’s PCP/PCMH. It is our standard operating procedure to make every effort to provide outreach information in an easily understood language and format. We inform our members that translations are available at no cost, for non-English speakers. We take into consideration the special needs of our members and our materials are available at no cost to members in alternative formats. The purpose of targeted outreach is to contact individual members about benefits or programs that could improve their health or aid in meeting care plan goals.

Our representatives, including but not limited to Member Services Representatives and Case Managers will assist members in accessing carved out services and programs. We assist members in identifying carved out providers, helping them to make appointments and following up to determine if the member requires additional assistance.

Coordinating Carved Out Services

Once we identify a member who may benefit from Dental, EarlySteps, Personal Care Services, Specialized Behavioral Health or other carved out services, our approach is to contact the member to explain the value of these programs and guide the member through the process to access and stay in care. We have policies and procedures governing internal referrals and our personnel receive initial and ongoing training on their responsibilities. Member contact is highly coordinated between our representatives (including Member Services Representatives, Provider Services, Grievance and Appeals, Quality Management, Utilization Management, Maternal Child Health/EPSTDT Coordinator and Case Managers) and each of DHH’s carved out programs and services. We will, prior to the date we become at risk for our members, establish a referral and communication plan with representatives from each carved out vendor and DHH.

The member’s PCP/PCMH has a critical role in our outreach, member education, and care coordination programs. Acting as a bridge, the PCP/PCMH assist in balancing the care between Aetna Better Health and other service providers to help avoid duplication of services, increase coordination, and improve outcomes. PCPs/PCMHs and other providers receive information

regarding carved out vendors from their Provider Services Representative, the Provider Manual; provider newsletters, our web site during new provider orientation and at regular provider training visits or education sessions.

The healthcare system is often fragmented and difficult to navigate for our MSHCN/CSHCN and other members (e.g., pregnant women with co-occurring substance abuse/behavioral health needs, members with chronic diseases). This is one of the reasons we developed our Integrated Care Management (ICM) process. We designed ICM to assist and support MSHCN/CSHCN and other members (e.g., pregnant women with co-occurring substance abuse/behavioral health needs, members with chronic diseases) accessing and remaining in care with carved out vendors. One of the reasons ICM is responsive is that our Care Managers have the training and experience to coordinate difficult care situations and respond to members who have complex medical needs, comorbid chronic illnesses, are high risk, or have special healthcare needs. We build the care coordination team around the needs of the member and include the member, the member's family/caregiver, the PCP/PCHM, and other providers in the process.

We will initially enroll any member receiving care and services for EarlySteps or Specialized Behavioral Health Care in the ICM intensive care program. However, during the member's course of treatment, their level of care assignment, depending on the member's physical and behavioral health status, may be reduced to either supportive of population health services. Our state-of-the-art IT system provides, through our web-based care management business application (Dynamo™), immediate notice of changes in data trends, from Utilization Management (UM) activities (prior authorization, concurrent review) and claim payment to inform the member's Case Manager of changes in risk stratification.

Our overall member service and care coordination approach is to synchronize the services we provide with the services the member receives from Dental, Early Steps, Personal Care Services, or Specialized Behavioral Health and other carved out services providers. This care coordination includes pharmacy (specifically for Specialized Behavioral Health Care coordination we notify the behavioral health carved out vendor of the member's current prescriptions and refill timeframes), inpatient/outpatient services, PCP/PCMH and specialty care and durable medical equipment (DME). Our representatives will follow-up with Dental, Early Steps, Personal Care Services, or Specialized Behavioral Health or other carved out programs to monitor that the member received the needed services or care.

Identification of Members Who May Need "Carved-Out" Services

Aetna Better Health, together with its affiliates has more than 25 years, has been coordinating and facilitating member access to "carved out" (fee-for-service) and programs. Our integrated systems and processes to identify members who may need a carved out service have been fine-tuned over time. These systems and processes are described below:

Early Periodic Screening Diagnosis and Treatment (EPSDT) Claims

In several states we receive and process both EPSDT claims and "tracking forms" from our PCPs. Our business application system (QNXT™) processes the EPSDT claim forms and produces reports to track member/provider compliance and to identify potential referral opportunities – based on the diagnosis code(s) the PCP entered on the claim. When the claim indicates a behavioral health or dental concern we coordinate with the member [and the

member's family/caregiver] the PCP and the carved out vendor for follow up on the diagnosis and potential referral.

Health Risk Questionnaire (HRQ)

When a member enters either our disease management or case management program a comprehensive health risk questionnaire is administered as part of the care plan development process. The results of the health risk questionnaire may indicate a need for a referral to a carved out vendor. Our Case Managers and Schaller Anderson's Disease Managers³ will receive self-disclosures from the member [family/caregiver] that often indicate a need for a referral to a carved out vendor. At the request of DHH, our HRQ can be modified to add questions regarding the member's need for carved out services.

General Risk Model (GRM) Reports

We use our *GRM* software to assist in identifying members, based on an analysis of claims data that may need a referral to a carved out vendor. *GRM* identifies members who currently have, or face risk of developing a condition that may require services of a carved out vendor. Monthly reports are generated and distributed to Aetna Better Health case management and disease management personnel; these reports can be customized to target member's diagnosis, service utilization, and pharmacy claims data. Since primary and secondary diagnoses are submitted on the claim our skilled technicians in our Informatics department can design monthly reports specifically related to certain diagnosis (e.g., behavioral health). The *GRM* software application analyzes complex data sets to identify members who may need outreach or assistance in accessing carved out services,

NICU Discharge Report

Our concurrent review nurse will alert our case management team of NICU admissions and discharges. We are aware that NICU discharge is a predictor of potential future health risks and these members often benefit from a referral the EarlySteps program for evaluation and assessment. The concurrent review alert also identifies a member [the child's parents] that may benefit from a referral to the behavioral health carve out vendor for assessment. The stressors associated with having an infant with a lengthy NICU stay transitioning home may indicate potential intervention by a behavioral health professional.

Pharmacy Utilization Reports

Depending on the availability of data from the carved out PBM, or if the PBM is producing and distributing pharmacy management reports, we have a standard set of reports that identify members who may be at risk for referral to the behavioral health carved out vendor. Our analytical framework considers several independent variables, including, but not limited to, the number of prescriptions the member fills in a quarter, source of the fills (emergency rooms versus pharmacy; multiple pharmacies for same drug, etc); type and frequency of fills (members with at least 10 scripts for narcotics from at least 10 different prescribers) and other factors that may indicate the member could benefit from a referral to a carved out vendor. Our advanced and comprehensive data analysis capabilities are an organizational strength – we transform raw data

³ Aetna Better Health has an agreement to use Schaller Anderson's NCQA certified disease management program. Both our case managers and Schaller Anderson's disease managers use our web-based care management business application system (Dynamo™) for ease of administering benefits and programs, including identification and coordination of members that may need a referral to a carved out vendor.

to actionable reports that improves quality of care, increases the effectiveness of care management, promotes positive member outcome and reduces overall cost.

Identification through Internal Aetna Better Health Process

Member Services

Aetna Better Health member services representatives (MSR) often have the first contact with members. Member or the member's family/caregiver often call our a MSR to request information regarding available care or services, for assistance in accessing care (selecting a PCP, changing PCPs, requesting transportation assistance, information about carved out services). The MSR documents each call in call tracking feature of our business application system (QNXT™) for future reference and depending on the nature of the call (i.e., the member is having an acute problem or incident) the MSR will initiate a three-way call to a) a case manger; b) the carve out vendor; 3) DHH or 4) 9-1-1 operator. It is our standard operating procedure to follow up with the member, the member PCP and the carved out vendor to make sure the member got into care and to determine if additional assistance is needed. If additional assistance is needed a Case Manager will get involved to support the member.

Provider Service Activities

Provider Service Representatives (PSR) receives inquiries from providers regarding members needing assistance or support from Aetna Better Health. Our Provider Assistance Program supports PCP and other providers to address the situation of members who continually fail to keep scheduled appointments. Our experience is that members who fail to keep scheduled appointments face several barriers that contribute to the problem. These barriers may include homelessness, lack of transportation, medical condition, and/or behavioral health/substance abuse issues. Regardless we take this referral from the provider to determine the root cause of the problem and either assist the member in selecting a new PCP, arrange transportation or refer the member to a carved out vendor. In addition, our PCPs and OB-GYNs often identify members with behavioral health/substance abuse needs in the course of providing routine primary and urgent care services and serve as a large source of referral to behavioral health carve out vendors. Our PSR will support/assist the provider and bring in a trained Case Manager to support/assist the member. We support and promote early identification of behavioral health and other problems as a method of helping the member to adopt the skills to take responsibility for their disease state.

The information and reports described above will be shared with either DHH or the carved out vendor according to agreement with DHH. Depending on DHH's or the carved out vendor's requirements, Aetna Better Health may assume additional costs for this information or reports and since these costs were not described in the RFP; we will discuss these costs in good faith with DHH to reach a contract amendment if applicable or appropriate.

Dental Care Coordination

Aetna Better Health will provide covered dental surgical services and emergency services, as well as laboratory or radiological services required to treat emergencies. We will work with DHH's carved out dental vendor, the member and the member's PCP/PCMH to coordinate the delivery of carved out dental services to members in a timely manner; especially those services identified as medically necessary during an EPSDT screen. Working in concert with the member, the member's PCP/PCMH and the carved out dental provider, we will support the

continuity and coordination of care for members who require covered dental care services, providing timely referrals, documenting these services in the member's medical records and coordinating overall care with the member's dental providers, with the permission of the member. Our Maternal Child Health/EPSTD Coordinator will take the lead on following up on members referred to the dental carved out vendor following a referral by the member's PCP from an EPSTD screen. Our experience is that coordination of referrals following a member's EPSTD screening may be difficult for many members, including CSHCNs. From our perspective, the members Case Manager [if applicable] and the Maternal Child Health/EPSTD Coordinator will work closely with the member and the member's family/care giver to facilitate the referral. Identifying barriers to care and coordinating the care/services to address these barriers is a key element of our care management approach.

Specialized Behavioral Health Coordination

Aetna Better Health will provide basic behavioral health benefits and services, including the highest level of screening, prevention, early intervention and referrals through members' PCP/PCMH. It is our experience that members with specialized behavioral healthcare needs require the highest degree of coordination and support to facilitate access to and continued use of behavioral health services and programs. We have experience working with CSHCN with co-occurring substance abuse or behavioral health needs. Another area of expertise is coordinating behavioral health services [basic or specialized] identified during an EPSTD screen. Aetna Better Health will reach out to the behavioral health carve out vendor and DHH to develop a comprehensive care coordination and referral management program that will provide the framework for ongoing activities. We fully understand the importance of establishing a coordinated system for managing care and services, especially basic and specialized behavioral health, identified during an EPSTD screen.

In many instances, members requiring specialized behavioral health care face multiple social and environmental challenges (e.g., homelessness, lack of family support structures). Our goal will be to identify those members and coordinate with the member, the member's PCP/PCMH, specialty providers, carved out behavioral health vendor and DHH to maximize the accessibility and availability of medically necessary covered services. Acting as the member's advocate, we will support and facilitate the transfer of medical records, pharmacy utilization records and care plans. We will support continuity and coordination of care for members who require specialized behavioral health services, providing timely referrals, documenting specialized behavioral health services in the member's medical records and coordinating overall care with the member's behavioral health provider, with the permission of the member.

Pregnancy and Substance Abuse

Aetna Better Health has processes in place to assist members with high-risk pregnancies to achieve better clinical outcomes. Alcohol, cigarette, and illicit drug use during pregnancy can cause poor pregnancy outcomes and early childhood behavioral and development problems. Due to these risks, all pregnant women are screened for current and past drug when we receive notice that a member is pregnant. We offer support and referral to smoking cessation programs with ongoing case management by our Case Managers to support the member. Members with a history of substance abuse are enrolled in intensive care management services in our ICM Model. The Case Manager will coordinate referrals to the carved out vendor and monitor the

member closely and assists in coordinating both the obstetrical care, the plan for baby post delivery and ongoing case management after delivery. The Case Manager's role is to facilitate referrals specific to the members needs (e.g., inpatient detoxification, or substance abuse counseling), coordinate services, monitor compliance with visits, assist in the selection of a pediatrician for the newborn and maintain the member in care management post partum to assure continued needs are met.

Personal Care Services Coordination

Aetna Better Health is experienced in coordinating the provision of personal care services (for EPSDT and long-term care) through Home and Community Based Services (HCBS) waiver programs under Section 1915(c) of the Social Security Act. We currently manage care for ABD members in five states, as well as 16,000 dually eligible individuals through Medicare Advantage Special needs plans. We will work with DHH's personal care services vendors to coordinate the delivery of personal care services to members in a timely manner. We will provide continuity and coordination of care for members (EPSDT eligible or long-term care related) who require personal care services, providing timely referrals, documenting these services in the member's medical records and coordinating overall care with the member's personal care services providers, with the permission of the member.

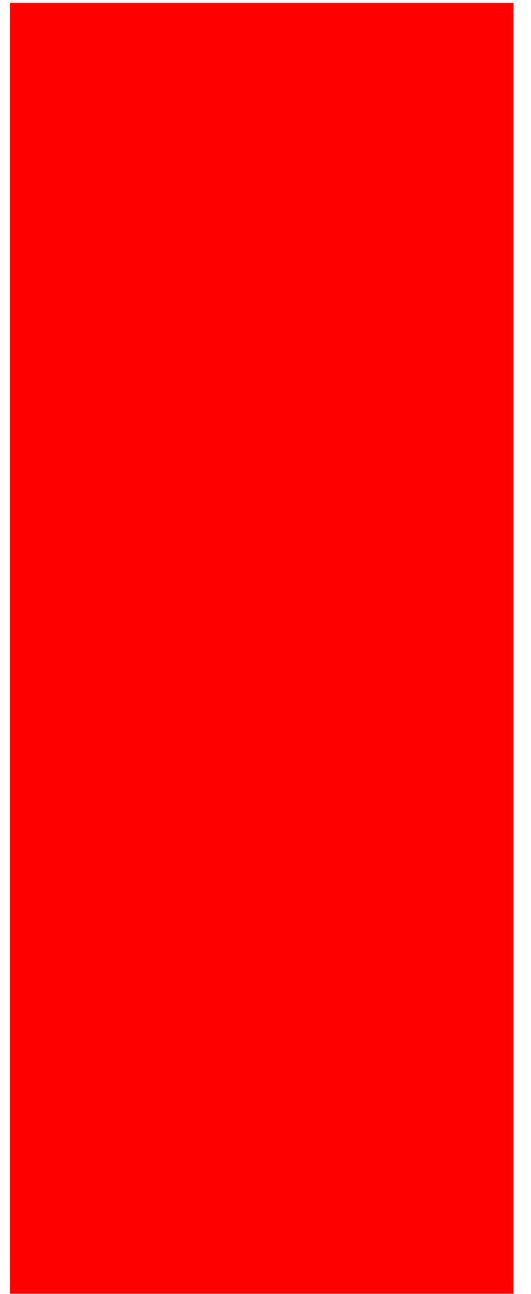
EarlySteps Program (Individuals with Disabilities Education Act (IDEA) Part C Program Services)

Aetna Better Health will coordinate care for members with special needs with DHH's program for family-centered, community-based, comprehensive, interagency service delivery system for infants and toddlers (birth through two) who are eligible for Part C services, and their families – through the EarlySteps program. Aetna Better Health and our affiliates have participated in referrals to and coordination with similar programs. As in our other States we will work with our member's family/caregiver to facilitate and support intake, development of the Individualized Family Service Plan (IFSP) and prepare the member for transition from the program.

After contract award our COO we will establish a working relationship to facilitate referrals, support coordination of care [as described in Chapter 9 of the EarlySteps Practice Manual, July 2010), assist in obtaining medical records, develop approaches to integrate the IFSP activities with the member's ICM care plan and prepare for transition of care (when the member reaches age 3). We will also assist in informing parents of premature infants (AKA NICU graduates) or infants with other physical risk factors associated with learning or developmental complications about the availability and value of the EarlyStep program.

We will help the member's family/caregiver with the initial referral, assist during the intake process and support the IFSP development process. Our ICM Case Manager will coordinate with the EarlyStep Intake Coordinator, Case Manager and provider as requested and necessary to support transfer of medical records and coordination of the member's CCN care plan with the IFSP.

53 F.4



F.4 For members who need home health services upon discharge from an acute care hospital, explain how you will coordinate service planning and delivery among the hospital's discharge planner(s), your case manager(s), your disease management staff member(s), and the home health agency. Further, explain how you will monitor the post-discharge care of enrollees receiving home health services in remote areas.

Introduction

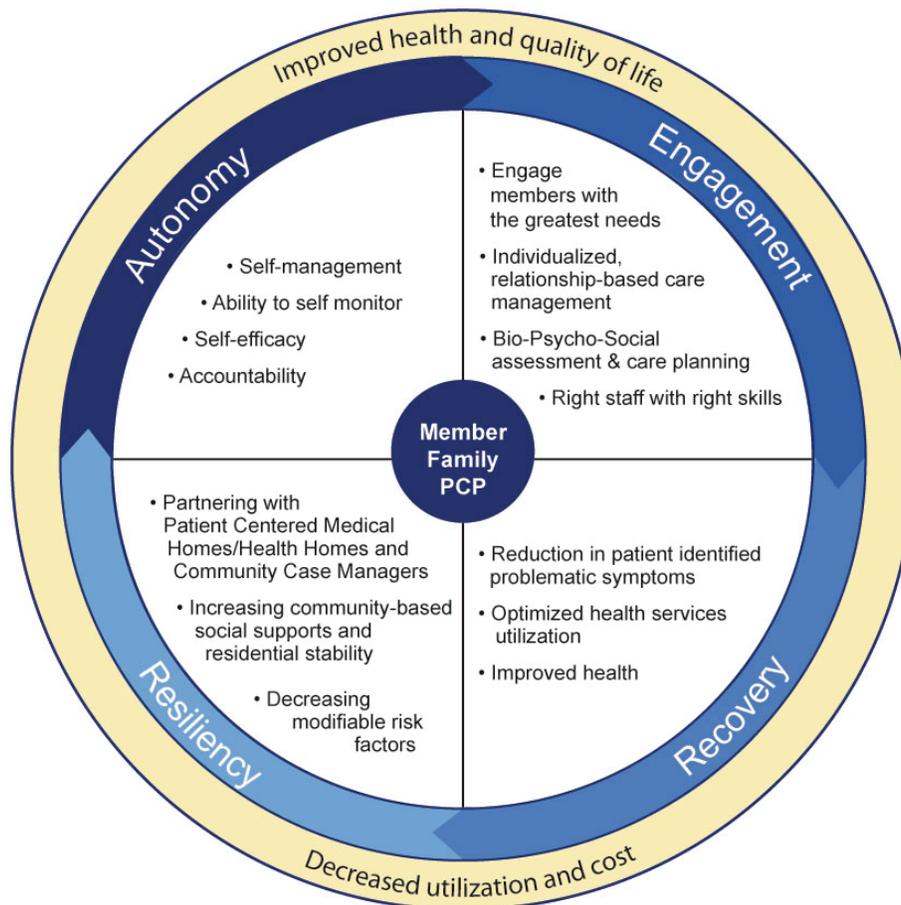
Aetna Better Health and its affiliates have been providing high quality, efficient and effective Medicaid managed care services for over 25 years. We are experienced in developing processes, programs and approaches to serve members who need home health services when discharged from an acute care hospital. For instance, our affiliate in Arizona, Mercy Care Plan, provides Medicaid managed care services for the Arizona Long Term Care System (ALTCS) and they coordinate home health care services for 8,560 members (June 1, 2011 enrollment). Mercy Care Plan also coordinates the full range of managed care services, including home health care services for about 9,000 Developmentally Disabled members. This applied experience coordinating home health services for these high risk members combined with facilitating home health care services for another 1.2 million members nationwide prepares Aetna Better Health to meet the needs of CCN members, DHH, hospital discharge planners and home health agencies in Louisiana.

Aetna Better Health offers three levels of home health care service coordination. These levels are:

Coordination of Home Health Care Services

Aetna Better Health's experience is that coordination of home health services is critical to avoid unnecessary hospital admissions or deterioration of the member's health care status. Our Integrated Care Management (ICM) approach promotes open communication between our members, their caregivers or other involved parties (e.g., (Primary Care Provider (PCP)/Patient-Centered Medical Home (PCMH), home health agency, Case Manager or specialty provider). By comprehensively addressing members' needs and involving the member's entire care team along the continuum of services, we help our members become more effective in managing their overall health, improve member and provider satisfaction, and improve healthcare outcomes. The graphic below illustrates our ICM approach:

Integrated Care Management Program



Home Health Care and ICM

It is our experience that members receiving home health services typically have chronic illnesses or injuries that require care from several providers and programs. This makes their care challenging to coordinate. Aetna Better Health’s ICM approach specifically serves members with complex medical needs. The ICM approach is to encourage appropriate use of services, coordinate care amongst the various members of the member’s care team to improve a member’s ability to self-manage their medical conditions.

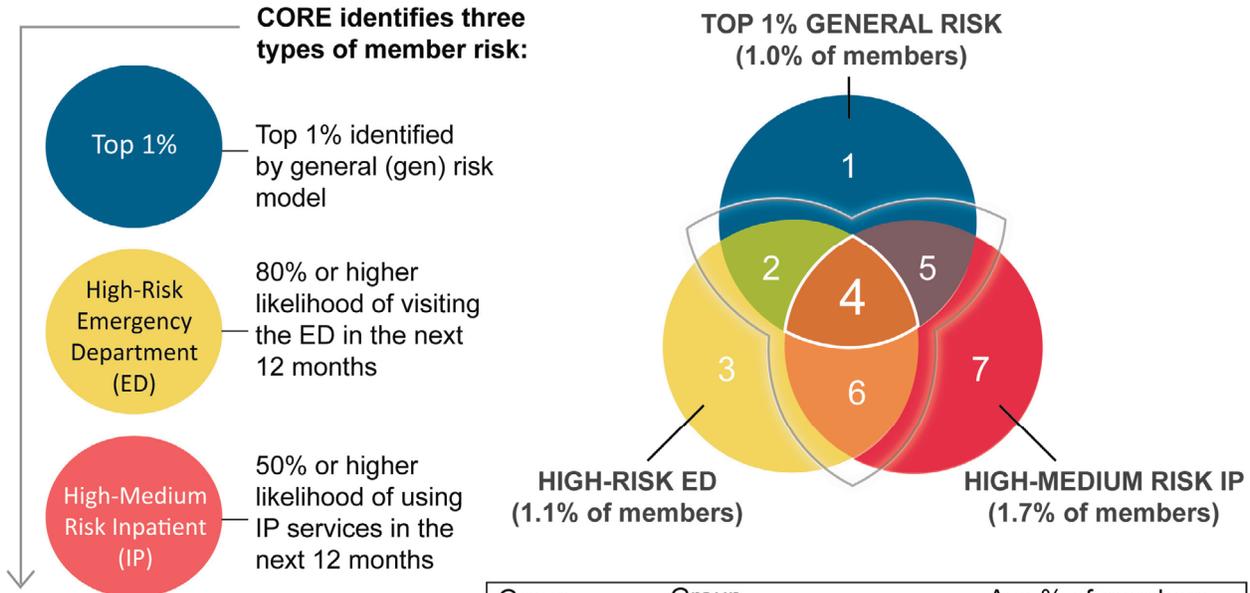
At the center of the ICM process is the Case Manager. The Case Manager’s role is critical because a Case Manager:

- Works closely with the member and the member’s family/caregiver to assist them in navigating through the complex health care delivery system;
- Coordinates services to avoid delays or gaps in care that often adversely affect health;
- Assist the member in scheduling PCP visits, arrange transportation and follow-up care with specialists and other care providers;

- Support discharge planning activities and coordinate service delivery post-discharge with the member's treating physician, home health provider, referral providers, the discharge planner, and hospital staff, as appropriate;
- Provide updated information related to the member's current status, compliance with care plan and updates regarding other services to the PCP or PCMH;
- Identify and avoid duplication of services;
- Facilitate safe care transitions from, and between, care settings, e.g., from a hospital setting to a home setting through collaboration with a member's treating provider, the hospital, and facility discharge planner, including assessment of least restrictive care settings which meet the ongoing medical needs of the member;
- Perform ongoing assessments of the member's service needs and adjust the care plan as appropriate;
- Coordinate disease management care and services to support planned interventions;
- Employ motivational skills to empower the member in taking an active role in the self-management of their disease; and
- Act as the member's advocate within Aetna Better Health, with the PCP or PCMH, and engage/link the member with community resources/stakeholders and healthcare providers.

Members with complex conditions are usually enrolled in ICM prior to their hospital admission. If a member needs to be enrolled in ICM when admitted to the hospital the Concurrent Review Nurse will refer the member to ICM. A member may self-refer, be referred by their care giver or PCP to ICM. Additionally, we also identify members through our Consolidated Outreach and Risk Evaluation (CORE) process. The graphic below outlines Aetna Better Health's CORE tool, which identifies members who can benefit from ICM.

Aetna Medicaid’s Consolidated Outreach and Risk Evaluation (CORE) tool identifies members who will benefit most from our Integrated Care Management program. This tool uses acute care, pharmacy and long-term care (LTC) claims data to identify members at high risk for adverse future health outcomes.



Identifying highest risk members

This diagram shows three risk categories. The areas of overlap represent members at high risk (groups 2, 4, 5 and 6) for adverse health outcomes. Group 4 represents members at the highest risk, falling into all three risk categories.

Group #	Group name	Avg. % of members for typical health plan
1	Top 1% Gen risk ONLY	0.6%
2	Top 1% Gen risk / High-risk ED	<0.1%
3	High-risk ED ONLY	0.3%
4	High-med risk IP/Top 1% Gen risk/High-risk ED	0.2%
5	Top 1% Gen risk / High-med risk IP	0.2%
6	High-risk ED / High-med risk IP	0.6%
7	High-med risk IP ONLY	0.7%
Percentage of members not in CORE:		97.4%

Note: Percentages may not add up to 100% due to rounding

Once a member is identified, a Case Manager is assigned to the member who collaborates with the member and their providers/caregivers in support of a care plan.

Case Managers adapt the intensity of care management to the member’s needs. The components of the ICM process changes and the role of the Case Manager is adjusted as the member moves from recovery toward self-management and autonomy. Case Managers are skilled at identifying adherence issues and changes in a member’s level of engagement, as such, if a member is having difficulty adhering to the care plan, the Case Manager intervenes quickly and assists the member in getting back on track. Case Managers are assisted and receive support from various medical management personnel. Examples of this support include innovative programs such as “grand rounds” sessions. Grand rounds provides the Case Manager an opportunity to leverage the collective strengths of the medical management team to produce the best possible outcomes for members. Grand rounds are staffed by a multi-disciplinary team (CMO, Medical Director, Case Managers and Managers of Medical Management) in order to discuss members who have

complex or comorbid conditions, are of high acuity, have high ED usage and are difficult to engage.

Care Plan Development

In a shared partnership with the member and the member's family/caregiver, the Case Manager facilitates development of a member-centered care plan. An important element of our ICM approach is the emphasis on building a trusting relationship between the Case Manager and the member and the member's family/caregiver to facilitate identification of member's goals, strengths, needs, and challenges. In performing this member-centered assessment and care planning the Case Manager applies their training, experience, and knowledge to identify and respond to the member's preferences, interests, needs, language, culture, and belief systems. Our Case Manager begins building the care plan based on the outcome of the holistic assessment and recommendations from the member's PCP and other care providers. Key to the care plan development is the involvement of the member and the member's family/caregiver in the identification of member-centered goals. The care planning process for a member who needs home health care post discharge from an acute care facility often begins while the member is still inpatient.

Our Concurrent Review Nurse and the member's Case Manager will meet with the member and the facilities discharge planner to develop, modify or refine the care plan to include home health care. The Case Manager may also consult, as appropriate, with a rehabilitative specialist, physical/speech/occupational therapist or other specialists to facilitate the development of the member's care plan. We have found that the facility's discharge planner and the member's treating physician often provide important information and guidance to facilitate the care planning process. This is part of our ICM process to prepare the member and the member's caregiver for the discharge and home health care services. The member's care plan is shared with the home health agency prior to the member's discharge to establish the scope of service, service requirements, the member's environment/situation and the role of home health services to help the member achieve their goals. Likewise the member's care plan becomes part of the disease management specifications and programs.

In order for the member to make an informed choice, the Case Manager provides the member and the member's family/caregiver information relative to the continuum of Aetna Better Health services, and community resources available to meet the member's goals/needs, including disease specific information, where applicable, through coordination with Aetna Better Health Disease Management staff. The Case Manager integrates the results of assessments, input from the member's PCP and other providers, observation of the member's environment, and consideration of the member's culture and values to develop the care plan.

The care plan is a valuable resource for the member because it indicates the member's rights and responsibilities, the agreed to services and plan of care, who the provider of care will be, and when the services are scheduled to occur (including scope, duration, intensity of each service). When the assessment and care plan development process is completed, the Case Manager provides the member or caregiver with a copy of the signed care plan. The care plan is available in our care management business application for the member and PCP to reference during the span of care.

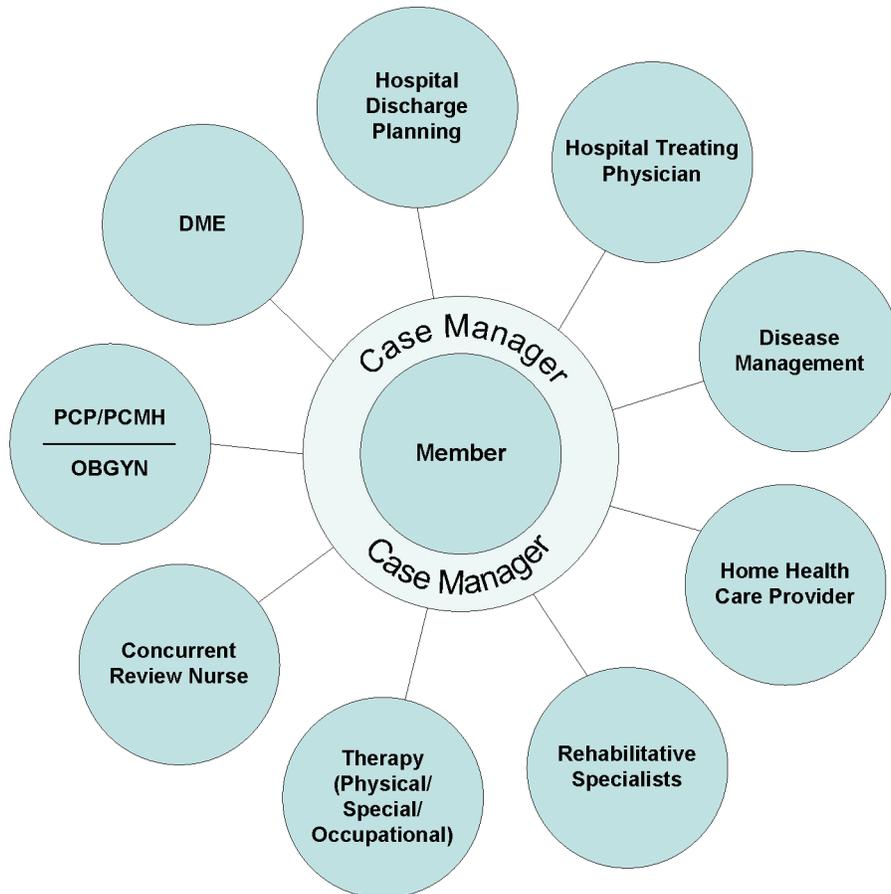
As indicated above, the ICM process is an ongoing and fluid process between the member, the Case Manager, the care team, and the treating provider for members discharged from an inpatient facility. Aetna Better Health values the assessment and care planning process because it is member-centered, leads to consistency of services, provides for care in the most integrated setting and promotes positive health outcomes for our members.

Coordination of Service Planning and Delivery

The Case Manager actively coordinates service planning and care delivery for the member's care plan. This coordination begins when the member is admitted, intensifies before and during discharge planning and is applied when the member is discharged. This approach provides the service and care the member needs to support discharge and maintain the member in their residence and is immediately available to the member and the member's caregiver.

Aetna Better Health engages several staff to manage the discharge process. The exact composition of this team varies depending on a member's needs. At a minimum, Aetna Better Health designates a full time Medical Director, Case Management staff, Concurrent Review staff, Prior Authorization staff, Disease Management staff and other Medical Management Coordinators who participate throughout various stages in the discharge planning process. The Louisiana Medical Director/Chief Medical Officer is a full-time employee, devoting at a minimum 32 hours weekly to the Louisiana operations. The Medical Director's efforts are complimented by other staff within the medical management area, including staff, which acts in the capacity of a Medical Management Coordinator. Combined, this staff provides timely medical decisions, comprehensive discharge planning and service delivery coordination, including arrangement of home health services to members in both urban and rural areas. The centerpiece of the service planning and delivery coordination is the member's care plan. The following graphic illustrates the coordination of service planning and delivery activities.

Coordination of Home Health Services – Post-Hospital Discharge



Care management at discharge is a person-centered, interdisciplinary process that includes member and family participation through all phases of the planning process as described earlier, including consideration of the following:

- Development of an individualized discharge plan, in collaboration with the member where appropriate, anticipating the member’s movement along the continuum of services;
- Ongoing collaboration between the member, family and the interdisciplinary care team, including the provision of verbal and written information on the range of services and available options in the member’s community;
- Documentation of each effort related to the above activities, including the member’s active participation in the discharge planning process;
- Scheduling of follow-up visits with PCP, specialists, home health, tests, and/or laboratory as applicable; and
- Important information concerning the discharge is documented, including information such as current admission and related test/laboratory results, medication

summary/dosages/frequency, diet and exercise plans, dates and times for scheduled follow-up visits, including home health care, red flags or other important happenings the caregivers and member should watch out for, i.e. ensuring the presence of action plan in case of complications, and checklist to confirm the member's understanding of the discharge instructions (Aetna Better Health uses a "teach back" method to confirm the member's understanding).

In addition to the above activities, the Member Services Department is available to members, member's families/caregivers and providers as a further resource to resolve any post-discharge challenges. Member services personnel receive training to facilitate handling of any call or issue, including identifying cases, which require further or immediate handling by other personnel in the medical management areas, such case management, disease management or discharge planning staff, in order to quickly resolve any member, member's family/caregiver or provider concern.

Monitoring Services

Monitoring of home health care and services is an important step and task of our Case Managers. The member's care plan will identify the necessary monitoring activities. Some monitoring activities assess if the member receives care as planned. This includes tracking the receipt of care by members post-discharge, including members living in remote/rural areas. These activities may include the following:

- Telephonic or home visit by a Case Manager
- Regular interaction with the member, e.g. at least once weekly for 30 days post-discharge, to prevent readmission and offer assistance such as needs assessment, education on the member's medical condition, coordination with Disease Management staff for ongoing management of the member's condition, verification that member is receiving care post-discharge, interaction with treating PCP or specialist to clarify treatment or request additional services, including scheduling assistance
- Needs assessment by Case Manager, Medical Management Coordinator or Disease Management staff concerning the following elements:
 - Durable Medical Equipment
 - Transportation
 - Social Services
 - Home Health
 - Medications reconciliation
 - Confirm available support system – caregiver, family
 - Depression screening, safety/fall evaluation (for certain members)
 - Educations provided (verbal or printed materials, if necessary)

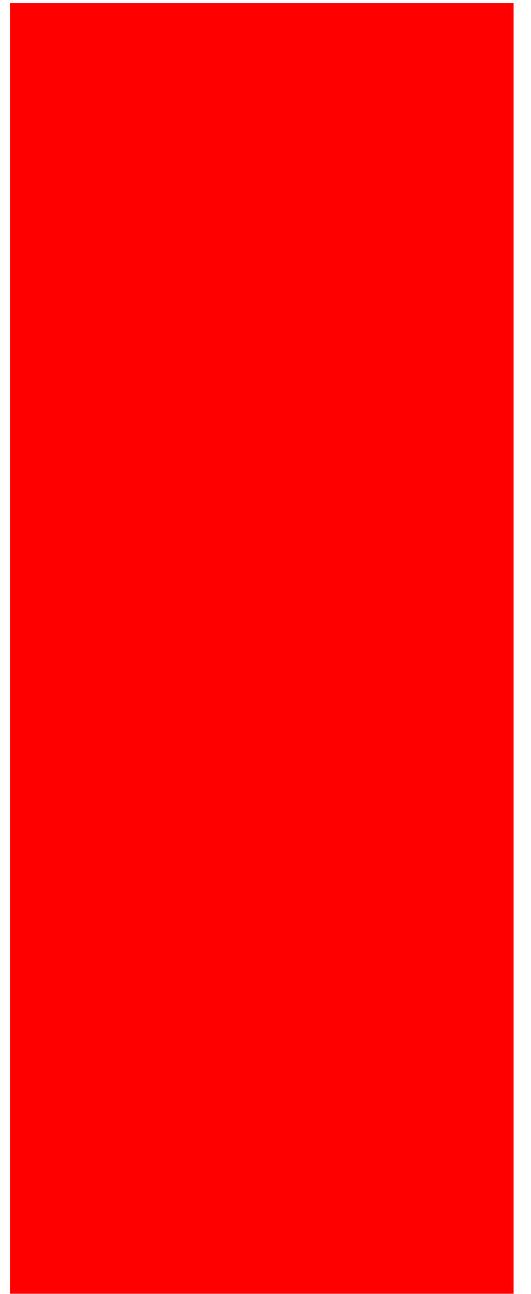
Network Development

Our network development efforts have produced a provider network for the State of Louisiana, which will be capable of providing covered and medically necessary services that meet the DHH standards prior to go live. Our network has the flexibility, capacity, and depth to meet the needs of those Medicaid populations enrolled in the coordinated care network, and presently, includes

home health capacity in each Louisiana parish. We continually monitor the number of contracted providers by provider type to provide on-going access to care. Although our Network Development Department has primary responsibility for network development, personnel from other departments work cooperatively to review results from provider monitoring tools and implement improvement activities that support a robust and accessible network in both urban and rural areas.

In the unlikely event that some providers become unavailable, such as in rural parishes, where the pool of providers could be sparse, Aetna Better Health defers to several mechanisms to provide the necessary access to care and services. One of the processes utilized by Aetna Better Health involves securing a single case agreement with an out-of-network provider, and making the financial and other arrangements necessary to facilitate the care interaction, i.e. identify the provider, identify the provider's availability, schedule the appointment, schedule transportation, and make arrangements for payment directly with the provider. In addition, if a service gap in a specific area of the State should exist, Aetna Better Health would work with contracted providers to explore expansion to cover the service area in need.

54 F.5



F.5 Aside from transportation, what specific measures will you take to ensure that members in rural parishes are able to access specialty care? Also address specifically how will you ensure members with disabilities have access?

Accessibility and Availability of Core Benefits and Specialty Care Services

Aetna Better Health[®] understands that adequate access to the full continuum of health care services [including community and faith based services] is a critical component to meeting our goal of providing the right service, at the right time and in the right setting. Aetna Better Health has experience building responsive and responsible networks to meet the needs of our members in rural areas. Our experience extends from home and community-based services to supporting members at risk of institutionalization (SNF) to developing network for basic core benefits/services. Our experience includes building Medicaid networks in the remote desert areas of Arizona, to the vast farmlands of Missouri and the expansive rolling hills of Pennsylvania. We take seriously the challenge of developing a comprehensive specialty network in rural Louisiana for members with disabilities, chronic disease(s) and special health care needs. Our network development teams and health plan leadership know Louisiana; our CEO, Pat Powers, has worked in Louisiana health care since 1978 and is leading our team in recruiting Louisiana talent with strong local experience and knowledge.

Aetna Better Health, together with its affiliates, has more than 25 years of Medicaid managed care experience, most of it in states with significant rural areas, we have developed best practices that guide our processes. These best practices are:

- Recruit and hire Network Development and Provider Services personnel that know the medical community where they will be working
- Respect the members and providers we serve and see network responsiveness from their point of view
- Understand the Medicaid payment structure [including fee-for-service payment rates] and the impact on provider practices and facility operations
- Recognize the cultural, ethnic and religious structure of the members and communities we serve
- Effective network design equals increased quality of care and more satisfied members and providers

Our network design always takes into consideration accessibility and availability standards. We start our network design process with an assessment of the service delivery structure in the communities we intend to serve. This understanding and appreciation is critical in recognizing gaps in care and in applying techniques to fill gaps. It is our experience that by involving the local provider and stakeholder communities, this process can lead to overall improvements in the health care system.

We began developing our local network by reaching out to providers that serve Aetna Inc's Louisiana national account members⁴ These providers are already credentialed according to our

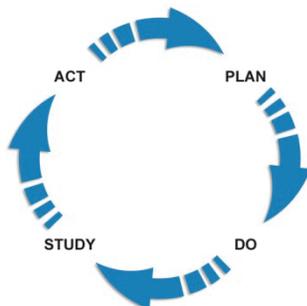
⁴ Neither Aetna Inc. nor any of its subsidiary companies are licensed to sell health insurance in Louisiana. But Aetna Inc. does serve national account members who reside in the State.

NCQA® certified credentialing process. To build on this foundation we reviewed the current DHH fee-for-service network to understand the existing care/service patterns. As a result of this review we developed a strategy to reach out to existing providers. Following our standard operating procedure, we began by involving FQHCs, RHCs, key provider groups, critical access hospitals and ancillary service providers throughout Louisiana. During our efforts we remained sensitive to the guidelines and standards established by the Civil Rights Act, Age Discrimination Act, Section 504 of the Rehabilitation Act of 1973, and Title II of the Americans with Disabilities Act. Aetna Better Health expects to continually expand our Medicaid network well after contract award – we know this effort is far from a one-time activity. We will evolve our network to meet member needs, respond to community situations (e.g., loss of a major provider) and adapt to changes in benefits or standards of care.

Network Adequacy

In designing, validating and managing our comprehensive network, we use GeoAccess software, the industry standard for monitoring the status of networks. It is especially valuable when comparing our network with where our members reside to determine compliance with DHH accessibility and availability standards. As a result of using GeoAccess software, we can analyze access of care standards based on a complex set of indicators including provider type, parish classification, and local geography. We perform GeoAccess analysis quarterly or more frequently if there are member or provider complaints – we analyze an area as small as a zip code or as large as an entire GSA. Our analysis typically includes maps showing member and provider addresses, summary information for a specific member or provider group, and comprehensive information (zip code, GSA, Parish or state). We routinely combine GeoAccess techniques and technologies with a host of other data and information to assist in network planning, analysis and expansion. These other data and information include, but are not limited to:

- Emergent, urgent, and routine appointment availability
- After hours audits
- Provider and member satisfaction surveys
- Analysis of provider inquiries or complaints and member grievances
- Feedback from provider site visits
- Input from other internal departments including our Integrated Care Management (ICM) case management
- Claims and encounter data
- Single case agreements by (i) parish; (ii) member and (iii) specialty



It is our standard operating procedure to continuously monitor the adequacy of our network to determine its effectiveness. Aetna Better Health uses the Plan-Do-Study-Act (PDSA) model to assess our progress in implementing a responsive, adequate and effective network. Our PDSA approach involves the network development and provider services units and leadership from Aetna Better Health’s entire organization. The PDSA model for continuous improvement

provides the framework for our approach to developing and implementing network interventions through the following steps:

- 1) Plan. Recognize an opportunity and plan a change.
- 2) Do. Test the change. Carry out a small-scale study.
- 3) Study. Review the test, analyze the results and identify what we've learned.
- 4) Act. Take action based on what we learned in the study step: If the change was ineffective, repeat cycle with a different plan. We incorporate successful interventions into our network development/management approach, using what we learned to plan new improvements, beginning the cycle again.

The leadership from Aetna Better Health's entire organization participates in the PDSA process. Supporting this process is our Service Improvement Committee, the QM/UM Committee and QMOC. Each of these committees includes cross functional and multidisciplinary leadership from across our operations. This means that member services, quality management, utilization management, grievance and appeals, and operations (e.g., claims, etc) are aware of and contribute to our network development plans and activities. This organizational commitment to meeting the needs of our members and providers is a hallmark of Aetna Better Health success in recruiting and retaining critical specialists in rural areas. As a example, through our Arizona affiliate, Mercy Care Plan, as of June 1, 2011, Mercy Care Plan provided Medicaid managed care services to over 300,000 TANF and CHIP and over 8,500 long-term care members.

Provider Networks in Rural Parishes

We recognize, and based on our experience, expect that designing and building networks in rural parishes of Louisiana can be difficult. Network development and maintenance is an ongoing challenge. Without a responsive provider network, our members are at risk due to delays in appointment availability and unreasonable travel distances. Additionally, care may be provided by well-meaning physicians who may lack the expertise and training to properly treat or monitor the member's condition(s). In the Aetna Better Health model, dependable access to care and services in rural areas is a right and not a privilege. We know firsthand the importance of making sure that each member has timely and appropriate access to the care and services they need. This is especially true for members with disabilities or chronic illnesses that often require more specialty care than other members – for these members access to care and services is more often about quality of life than convenience.

Aetna Better Health is aware that that medical economics have never been more difficult for physicians, provider groups and facilities today, especially for those who cannot take advantage of public subsidies. Most physicians, provider groups, and facilities today are under pressure from Medicaid, Medicare and commercial insurance payors to reduce cost, increase efficiencies, and improve quality. Economic realities are such that some providers simply must practice in urban areas to have an adequate supply of patients for their practice. Unfortunately, this often leads to a scarcity of providers in rural areas. Our experience is that these realities often have the greatest impact on certain specialties, such as perinatology, pediatric specialists, dermatology, orthopedics, and plastic surgeons. We have experience applying strategies to help overcome these barriers. These barriers are described below.

Matching Best Practices to Challenges

Aetna Better Health uses multiple approaches and tools to improve specialty provider recruitment and retention. These approaches are divided into three (3) strategic methodologies:

- 1) Bringing Technology Solutions to the Rural Providers
- 2) Being More Responsive and Easier to Do Business With
- 3) Short/Long Term Responsiveness – Example and Profile

We do not treat these approaches as being mutually exclusive. Our experience is that a mix of approaches is usually needed, the exact combination of which is dependent on the circumstances, situation, and environment at the local community level, we describe each of our strategies below.

Bringing Technology Solutions to Rural Providers

We are excited about the technology solutions we will bring to Louisiana. Our approach is to use these solutions to expand access to care for CCN members. We expect that Project ECHO will eventually expand access to care for all Louisianans living in rural parishes.

Project ECHO

Aetna Better Health is proud to report that we have had positive discussions with the Louisiana State University Medical School and the Tulane Medical School to bring Project ECHO to Louisiana. Project ECHO is a nationally and internationally recognized model for delivering timely access to specialty care for underserved and rural populations in a state. Using advanced video-conferencing technology, academic medical centers (AMCs) conduct periodic didactic lectures and teaching rounds where multiple local Primary Care Provides (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 will benefit our members by increasing access to diagnosis resources and 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 insufficient 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, Project ECHO has led to increased satisfaction among consulting primary care providers and has led to measurable improvements in the confidence in treating these complex conditions.

Project ECHO 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 staff at the University of New Mexico in a consultative relationship
- Build on the positive and fruitful 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). While Aetna Better Health is bearing the costs for implementing Project ECHO, the benefits will accrue to all members of the health system via the improved capabilities and expertise of local PCPs in the treatment of complex conditions.

The benefits of Project ECHO to the Louisiana 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 and duplicative testing and reduce the stress and cost of travel on the member and the member's family/caregiver
- Prevent costs of untreated diseases, e.g. liver transplants for untreated Hepatitis C cases

The basic building blocks of this approach are:

- Necessary elements of Project ECHO's effectiveness
 - Partnership with an Academic Medical Center (AMC)
 - Advanced video-conferencing technology
 - Reimbursement of the AMC for infrastructure and specialist costs

- Incentives for primary care providers to engage with the AMC, technological requirements for PCPs generally consist only of web cameras and an internet connection for participation.

Benefits of Project ECHO include:

- Rapid near real-time availability of specialists to effectuate timely support in the management of complex medical conditions
- Reduction in avoidable costs that derive from insufficiently timely or effective specialist management
- Reduction in transportation costs
- Improved communication and coordination of care between local primary providers and remote specialty providers
- Improved access to quality local primary care for members

TeleMonitoring

Aetna Better Health will implement a telemonitoring program with our CCN network. The advantage of telemonitoring in rural areas is that it reduces travel time for the member, provides the PCP/PCMH and/or specialty provider with timely information about the status of the member and promotes the use of evidence based practice guidelines. Through remote monitoring, certain biological signals, including blood pressure, pulse, blood oxygenation, weight and blood glucose levels are continuously monitored. Signals are transmitted to a monitoring facility where they are compared against desired parameters which are established in conjunction with clinicians responsible for a member's care, e.g., PCPs and specialists. As such, a specialist is able to monitor and assess certain information concerning their patient's care remotely, thus enabling the specialist to timely address warning signs and execute targeted interventions even if a member is unable to physically visit with the provider and before a condition can become serious or even life-threatening.

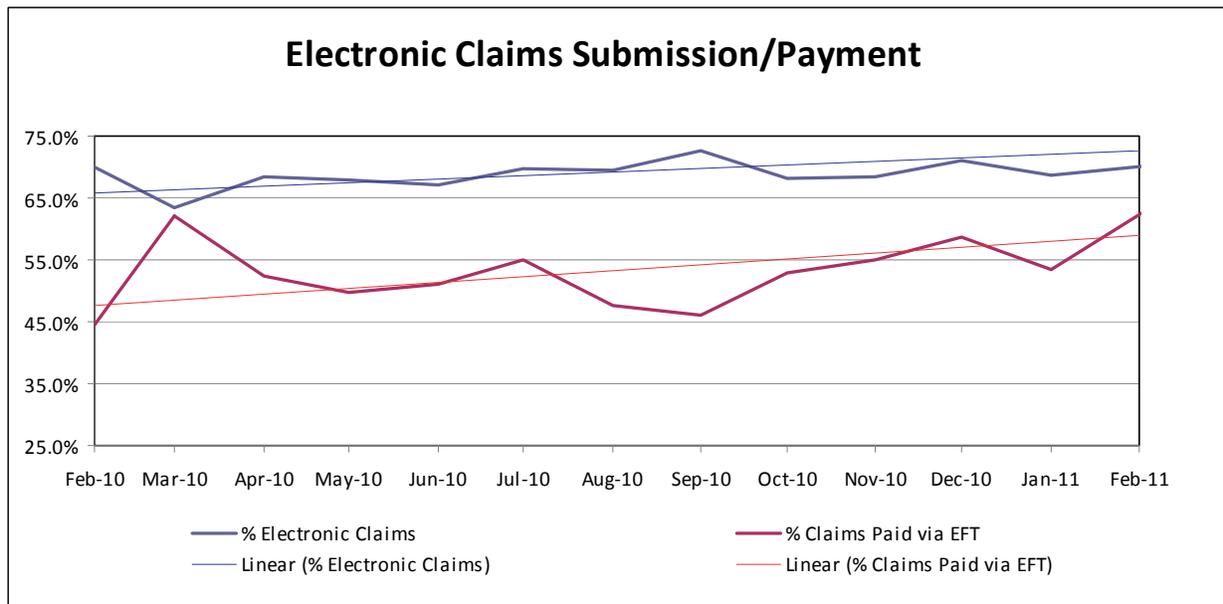
Telemonitoring capability, combined with proper self-management and educational supportive messaging and other outreach mechanisms utilized by our Case Managers, expands the capacity of the provider network such that members living in remote areas are also able to achieve timeliness of clinical interventions. Additionally, it also provides a real-time mechanism whereby a member can receive feedback concerning his/her disease states, and allows for active involvement by the member in his/her care plan. Furthermore, through collaboration with the Louisiana State University (LSU), Medicaid members whose providers are part of the LSU delivery system can access LSU's existing infrastructure for telemonitoring services thus further supporting access to ongoing care.

Technology support as described above has proven effective in attracting specialty providers to participate in Medicaid networks. Our experience is that these advancements themselves do not make it easier to recruit and retain specialty providers in our network. Under the direction of the Chief Operations Officer (COO), our Provider Services Manager will be responsible for assuring that provider services processes continually meet the needs of our provider community. Our departments including, but not limited to, provider services, member services, case management, and prior authorization, have direct contact with our providers and provide assistance in identifying challenges or barriers to servicing our rural specialty providers by communicating,

problem-solving, and strategizing to address the needs of our providers. We have learned that the following elements are also essential in the recruitment and retention of specialty providers.

Operational Responsiveness

To encourage rural specialty providers to join and remain in our network, we have improved our operational responsiveness. One of our key areas of focus is our claims payment system. The accuracy and timeliness of our claims adjudication process is a core competency of Aetna Better Health. To improve claim adjudication responsiveness we have increased our rate of accepting electronic claims and reimbursing providers using electronic fund transfers (EFT). This is best illustrated by the performance of our Arizona affiliate, Mercy Care Plan. As indicated in the table below, Mercy Care Plan has continually increased the rate it receives EDI claims submissions between February 2010 and February 2011. EDI claims submissions accounted for 70.4 percent of total claims submissions between February 2010 and February 2011. At the same time Mercy Care Plan’s EFT transactions rose to over 65 percent and that exceeded the minimum standard for Medicaid health plans in the state.



Our network providers also have access to Clear Claim Connection®. This is a web-based reference tool that providers can use to understand our clinical editing logic, thereby optimizing their claims submission accuracy. This enables the provider to better understand and apply the rules and clinical rationale affecting claim adjudication. Clear Claim Connection allows the provider to test a claim, especially a complex claim with complex coding combinations to avoid a denial by receiving responses from the system as the same edits are applied that are in our primary claims payment system (QNXT™).

Utilization Management Practices

Another area that providers generally identify as an area of concern is the red tape associated with the referral and authorization processes. Aetna Better Health has simplified our prior authorization processes to avoid unnecessary and ineffective prior authorization practices. The limited number of services that now require prior authorization are posted on our website and

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

- Member eligibility verification
- Panel roster review
- Searchable provider list
- Claim status search
- Remittance advice search
- Submit authorizations
- Search authorizations

We configure the portal to provide HEDIS^{®5} scorecard data, as well as alerts indicating when a member is due or past due for a HEDIS[®]-related service (e.g., well-child check-up, need for asthma controller medication, immunizations). This information is integrated within the application's provider panels/rosters. If a member is due or past due for a service, a "flag" appears next to the member's name, which, when clicked, permits providers to view a description of the needed service(s).

Our ICM process supports specialists in coordinating care and services for members with disabilities or chronic diseases. The member's ICM Case Manager works cooperatively and closely with the provider to support the member and facilitate the member's access to care and services.

We also provide standing prior authorization approvals, when required, for a span of appointments. The span of prior authorization, in most instances, aligns with clinical practice guidelines, the member's care plan, and/or the physician's orders.

Provider Communication

One of the key lessons we have learned from working with specialty and other providers in rural areas is that communication is extremely important to them. Our provider communications program recognizes and acknowledges that health care communication has become increasingly complex and demanding – our providers have to filter complex data, information, and messages from multiple sources every day. Our goal is to effectively and efficiently communicate with our providers to minimize any unnecessary disruption to care to our members. Our provider communication process will also facilitate and support our providers during this period of unprecedented budget shortfall. Our communication processes, methods and approaches are effective and efficient in having even the most difficult and complex message delivered to and understood by our providers.

⁵ HEDIS[®] is a registered trademark of the National Committee for Quality Assistance.

In addition, our provider communication strategy for recruiting and retaining rural specialists includes, but is not limited to:

- We meet with our providers during face-to-face provider visits, based on the provider’s preference, either quarterly or semi-annually.
- Our provider services representatives have experience and training on the CCN Program in the areas they serve.
- We deliver timely and accurate written communication to our providers that our providers find useful and interesting.
- Providers can obtain timely and accurate information about our programs and services from their provider services representative, our website or by calling our Provider Services Department.

Reduction of Administrative Burden

Medicaid managed care organizations, because of the detailed provider requirements we must administer, are infamous for being difficult to work with. Aetna Better Health reverses that trend. We simplify communication, reduce the burden to the provider and make it easy to get simple, direct and accurate answers. We offer expedited credentialing for certain specialists in accordance with DHH guidelines. Aetna Better Health makes provider training available in multiple modalities. Our protocol is to match the training topic with the training modality to make sure that the training approach supports the expected outcome (e.g., a change in provider behavior; acknowledge a new contract requirement, etc.).

Educational Modalities		
Live/virtual large group	Computer based training (CBT)	Quick Reference Guides
Live/virtual one-on-one	Interactive e-learning	E-mail
Simulation/role-based exercises		Health forums

Single Case Agreement

In the rare instance we are unable to obtain an agreement for a specialist in a rural area it is our standard operating procedure to arrange a single case letter of agreement with the appropriately trained and experienced provider. A single case agreement allows a member to receive the needed care or services from a specialist. Our Medical Management team arranges for medically necessary covered services by authorizing services to an out-of-network provider and facilitating transportation if there a provider is unavailable in a nearby location. Our Network Management Department will negotiate a single case agreement for the service. However, it is our standard operating procedure to never disrupt a member’s on-going 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. When out-of-network care is authorized, we share information regarding the member’s out-of-network utilization with the member’s PCP to facilitate continuity of care.

To proactively provide consistent access to services and avoid gaps, it is our standard operating procedure to recruit out-of-network providers with whom we have authorized care and/or executed a single case agreement. We continually assess use of out-of-network services to verify

that our network contains adequate numbers and types of specialty providers to serve our members, especially members with disabilities or chronic disease(s). Our Network Management Department uses this information to evaluate recruitment opportunities. For example, in our Texas affiliate, Aetna Better Health of Texas, although its home health network in a rural GSA met adequacy standards, needed a single case agreement with a specific home health care company, Accolade Home Health, to provide specific wound care services. Given Accolade's capability of providing unique services in rural locations for both adults and children, we executed a full provider agreement with Accolade to offer additional specialty services, increasing member choice on a regular basis.

Recruiting Specialists for Rural Parishes

In addition to analyzing out-of-network data, we perform quarterly GeoAccess analysis to monitor network adequacy. Our Network Management Department also reviews appointment availability/after-hours surveys and member complaint statistics to identify patterns and reports the results to our QM/UM Committee. We proactively use outcomes of these analytical efforts to enhance our network and avoid gaps

One of our approaches is to continuously monitor and recruit specialists who are new to the area or are expanding their practice. To help identify new providers, Aetna Better Health will work with, but our resources will not be limited to, the following organizations or groups:

- DHH (e.g., The Bureau of Primary Care and Rural Health (BPCRH)).
- The Louisiana Public Health Institute.
- Louisiana Certified Critical Access Hospitals.
- Louisiana's physician associations (e.g., Louisiana State Medical Society, Louisiana Osteopathic Medical Association, Louisiana Chapter of the American College of Cardiology).
- Louisiana State University, Medical School and Tulane University, School of Medicine.
- Louisiana Rural Health Association.
- Advocacy groups and participating providers [with DHH and/or Aetna Better Health] for referrals regarding providers to recruit. Advocacy groups are often a powerful and vital source of information about specialty providers in a committee and have often proven helpful in recruiting and retaining network physicians.

It is our standard operating procedure to continually re-contact providers that had previously declined to join our network, as circumstances may have changed and they may be willing to join our network. We will also help inform providers in rural parishes about the Louisiana State Loan Repayment Program. This program can be a powerful incentive to recruit eligible primary care practitioners and those who are specialty board certified or have completed a residency in family practice, osteopathic general practice, obstetrics/gynecology, internal medicine, pediatrics, psychiatry, or dentistry.

We will also use the two year claim history DHH will provide as we enter each GSA to identify specialty providers that are not participating in our network. These physicians may have established a strong physician/patient relationship with one or more of our members – we will

reach out to these providers, explain the changing circumstances, and offer them a participating contract.

Assessing Network Adequacy in Rural Areas

Aetna Better Health will evaluate network adequacy, i.e. network composition adequacy, including access to care for remote and rural areas, by reviewing various indicators, including GeoAccess studies, provider capacity, satisfaction surveys, and referrals to out-of-network providers and feedback from other departments. Results of these analyses drive our network recruitment efforts and other corrective actions to promote availability of specialty care in rural parishes. Additionally, Aetna Better Health's quality improvement area also reviews access to care reports detailing the results of access and availability monitoring activities related to travel distance, appointment and after hours availability, and provider a summary of any access to care complaints/grievances. If deficiencies or patterns of concern are identified, the QM/UM Committee will recommend corrective action as necessary to QMOC and then the Board so that concerns are resolved timely and in accordance with DHH standards.

Arranging Network Access for Special Needs members

Aetna Better Health is committed to arranging access to care for our members with disabilities, chronic disease(s) or who have special care needs. We facilitate access to care for these members, through our ICM Model – qualified members will have a Case Manager to support coordinating care and who works closely with the participating physicians, the member and the member's family/caregiver.

Individuals with special care needs can include people with diverse cultural and ethnic backgrounds, persons with physical disabilities or handicaps, e.g. visually or hearing impaired, individuals with mental illness or substance abuse addiction issues, pregnant women, the homeless, children, the elderly, or those with limited English proficiency (LEP) or reading skills, e.g. non-English speaking individuals. Targeted service arrangements may be required for these groups, including case management, counseling, home health care, translation or other outreach services, including arranging services at facilities with structural/physical adaptations to accommodate persons with disabilities, e.g. wheelchair access.

As stated previously, in contracting its provider network, Aetna Better Health takes into account compliance with Title II of the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973. Aetna Better Health is aware that no qualified individual with a disability should, by reason of their disability, be excluded from participation or be denied access to services, programs or activities and the services should be provided without regard to race, color, creed, sex, religion, age, national original ancestry, marital status, sexual preference, health status, income status, program enrollment or physical or behavioral disability. Additionally, Aetna Better Health is aware that other federal, state and local statutes and regulations also prohibit discrimination on the basis of disability and we are in full compliance with these requirements in other state Medicaid programs and we will remain compliant in Louisiana.

Facilities equipped to serve members with physical disabilities

Aetna Better Health plans and develops the provider network so that it is prepared to meet the needs of our members with physical accessibility needs and cognitive impairments. Aetna Better Health also identifies, engages and contracts with providers who can provide specialty services

in special care settings, and continually look for opportunities to supplement our provider network, such as contracting with mobile care units that bring specialty care to a home-bound member's residence. Aetna Better Health will also employ other strategies, such as contracting with non-office-based PCPs/PCMHs and specialists willing to provide services at a member's home.

Moreover, at Aetna Better Health, our provider network is expected to comply with the same requirements and make reasonable efforts to provide access for disabled persons or appropriate alternatives to accessing the care/specialty or primary care needed by our physically disabled populations. Aetna Better Health personnel conducts initial and ongoing provider site visits of highly utilized specialties, such PCP/PCMH offices, cardiologists, gynecologists and gastroenterologists, to review the site for physical access and find appropriate accommodations and equipment to serve populations with special needs. These provider site reviews are conducted on a regularly scheduled basis in accordance with our policies, since access to these sites is paramount to the success of our network activities and important for our members' safety and ongoing health needs. Reasonable expectations of the provider network, with respect to services for those with mobility impairments, is achieved through contractual obligations, and initial and ongoing Provider Service onsite reviews, which provide the following:

- Provider offices with exam tables that can be lowered to accommodate a patient in a wheelchair
- Provider offices that have wheelchair accessible entrances and restrooms
- Provider offices that are located on public transportation routes
- Guidance accommodations for people with vision disabilities, e.g., phones and elevators with Braille designated numbers for people with vision disabilities
- First and last appointment availability to accommodate diversified and other needs during a visit
- Maintenance of list of interpreters or computer aided real-time translation reporting services the member and/or the provider may access
- Verification of State licensure, including compliance with site access standards, e.g. elevator or ramp access for buildings situated on multi-level floors
- Compliance with the American with Disabilities Act Standards for Medical Facilities and local building codes, e.g. access to a restroom with handrails and sufficient space to maneuver a wheelchair
- Credentialing and recredentialing activities to complement the site visit and review of credentials
- Provider Services staff visits to meet ongoing needs

Assigning Members with Special Health Care Needs to Specialists

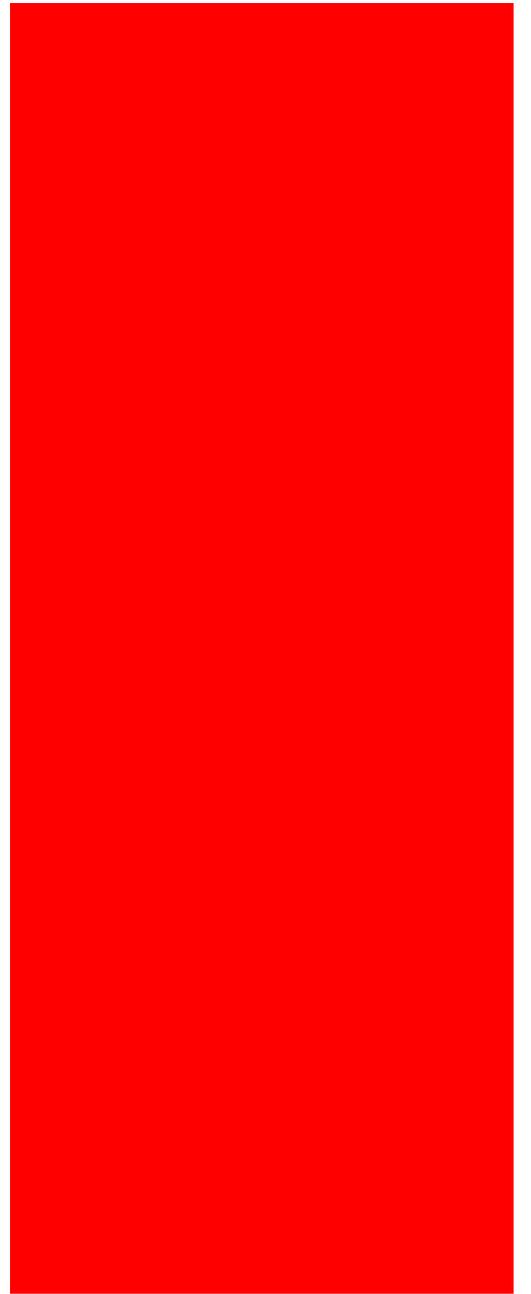
It is Aetna Better Health's practice to offer all members freedom of choice within the network in selecting a PCP/PCMH. Aetna Better Health personnel is trained on assisting members with selecting a PCP/PCMH upon enrollment and at any time that a member requests a change. In addition to traditional PCP provider types serving as PCP/PCMH, when needed, and upon request of the member and/or the provider or PCP/PCMH, we will permit selected medical

specialists to provide primary care and ongoing services to members. In these instances, the medical management staff coordinates with the member's current PCP/PCMH and the specialist to determine appropriateness of assignment. Aetna Better Health personnel has authority to approve appropriate requests based on disease state or complexity, e.g. paralysis, to facilitate effective and convenient medical services. Examples of members who may be assigned to a specialist include those with end stage renal disease, cancer, and HIV/AIDS. Pregnant members may also select or be assigned to a primary care physician specializing in obstetrics. Lastly, homeless members may select a homeless clinic (based on coordination, collaboration and availability of the clinic in the parish) as their PCP.

Utilization Managed for Populations with Complex Disability Health Care Needs

Aetna Better Health is aware that providing utilization management services for persons with disabilities takes a different approach. When applying utilization management protocols to this population, Aetna Better Health considers first the member and then the member's diagnosis, followed by the developmental stage or other factors of the disability, including co-occurring medical conditions. Aetna Better Health provides training and education to personnel regarding challenges surrounding persons with special needs so that sensitivity and understanding of the person as an individual facilitates their utilization management decisions. One such consideration, as mentioned earlier, provides allowing an member who needs a regular course of treatment to have direct access to that provider through standing referrals as appropriate for the member's condition and upon request of his/her treating providers.

55 F.6



F.6 Detail the strategies you will use to influence the behavior of members to access health care resources appropriately and adapt healthier lifestyles. Include examples from your other Medicaid/CHIP managed care contracts as well as your plan for Louisiana Medicaid CCN members.

Our Commitment to Helping Members Access Care

Aetna Better Health[®] is committed to helping members access health care resources appropriately. We believe having effective programs that encourage the adoption of healthy lifestyle habits is an investment that pays off in improved health outcomes for our members and meaningful cost savings for our clients.

Aetna Better Health considers access to care a high priority. We use a multi-disciplinary, coordinated and proactive approach to facilitate, evaluate, and manage access to care. Member Services representatives facilitate access to care by responding to member inquiries, answering questions about benefits and covered services, coordinating benefits for members with other insurance, arranging transportation to appointments, and assisting in resolving concerns and complaints.

How We Help Members Access Care

Aetna Better Health has programs in place to assist members in accessing adult preventive health/early detection, EPSDT, and maternity care services. We have provided general descriptions of these programs.

Access to Adult Preventive Health/Early Detection Services

Aetna Better Health conducts member and provider outreach activities to facilitate access to preventive health/early detection services. Our member outreach tactics include:

- Welcome calls to assist members with scheduling appointments
- Pre-recorded appointment reminder messages
- Monthly postcards and informational flyer mailings to reinforce and remind members of the importance of preventive care
- Educational member newsletters

Our members also have access to valuable information regarding preventive health care, the importance of wellness checkups for adults, periodicity and immunization schedules for children and wellness information on our website at www.aetnabetterhealth.com.

Provider outreach activities include distributing practice guidelines, posting prevention information and updates in the provider communications to our provider web portal, and ad hoc provider site visits.

Aetna Better Health routinely evaluates intervention activities to improve member access to preventive health/early detection services for effectiveness. Our evaluation tools include:

- GeoAccess analysis to identify potential areas to improve the accessibility and availability of services
- Member grievances and provider complaints, and

- Member and provider satisfaction survey data

The Provider Services Department analyzes the results of these monitoring tools and reports data to our Service Improvement Committee (SIC). The SIC identifies barriers to access to services and makes recommendations to refine or develop new interventions to overcome those barriers.

Access to EPSDT Services

Aetna Better Health provides EPSDT preventive health care services, including annual well child visits, adolescent well care, childhood immunizations, and adolescent immunizations to its members in accordance with the EPSDT periodicity schedule. Aetna Better Health actively conducts outreach to EPSDT members and their families to promote well-child services. We mail reminder cards to all EPSDT members' parents/ guardians about the need to schedule well-child visits, obtain age-appropriate immunizations, and dental care⁶ as set forth in the EPSDT periodicity schedule. We routinely make outreach calls to new members and the responsible party of EPSDT members who are past-due for their well child visits/immunizations to remind them about the importance of regular check-ups.

Access to Maternity Care

Maternity care services include prenatal care, post-partum care, and prenatal Case Management Services for all pregnant members. Due to the complexity of their needs, Aetna Better Health considers these members to be at increased risk of complications and automatically provides perinatal case management services to facilitate access to maternity care. Members receive case management services throughout their pregnancy and up to eight weeks postpartum.

Case management is Aetna Better Health's key strategy for improving high risk pregnant members' access to maternity care services and ultimately achieving positive birth outcomes. Our case management approach involves:

- Determining and evaluating the medical, social and psychological needs of the pregnant member
- Developing a care plan that identifies planned interventions and outcomes
- Implementing the care plan, which includes reviewing and monitoring of the effectiveness of the proposed interventions
- Modifying the care plan and proposed interventions, as necessary to continually meet the member's needs

Case History

The example below demonstrates that this model is effective in improving access to maternity care.

In 2010, Aetna Better Health's affiliate, in Arizona, Mercy Care Plan case management triage received a referral for a 22-year-old pregnant member. The Case Manager evaluated the member's needs and developed a care plan that involved teaching the member how to care for herself and providing additional support and care coordination throughout the pregnancy. Because of the member's complex needs, the Case Manager engaged the member multiple times

⁶ Aetna Better Health will discuss the best way to work with DHH and the dental carved-out vendor on the best way of educating the member and the member's family/caregiver.

per month to provide education and support, and facilitated transportation services. In following the PDSA model, the Case Manager continuously evaluated the effectiveness of interventions and modified the level of support, as determined by the member's needs. As a result of the increased level of case management, the member attended all prenatal appointments and delivered a full-term, healthy baby girl.

Educating Members to Adopt Healthy Lifestyle Behaviors

Aetna Better Health understands that education is one of the key factors influencing a member's behavior, including lifestyle choices. We take seriously our obligation to provide information about and connect members to programs and initiatives that promote the adoption of healthy lifestyles. Toward that end, we employ numerous strategies and resources to educate and influence our members to adopt healthy lifestyle behaviors.

Aetna Better Health and our affiliate health plans across the country use a variety of creative community outreach strategies to engage members in adopting healthy lifestyle behaviors. In addition to staffing a booth or having a similar presence at community health and wellness fairs to disseminate information about our own and local community prevention and wellness programs, such as smoking cessation, as appropriate, Aetna Better Health and our affiliates provide numerous sponsorships of community events whose mission translates easily into education about and an understanding of healthy lifestyle behaviors, such as

- Community walks to raise awareness about the benefits of healthy lifestyle behaviors in Arizona Free community swim parties in Missouri
- Creating a healthy behaviors calendar contest in Delaware, in which members age 16 and under submit artwork around healthy behavior themes to be judged for inclusion in the calendar that gets mailed all health plan households
- Educating members, also in Delaware, that they can use their WIC benefits at local farmer's markets and handing out free reusable grocery bags so members have a bag to fill with healthy, locally grown produce
- Using a community-based approach and a specially branded recreational vehicle to deliver prevention and wellness based messages and activities, such as healthy cooking demonstrations, in Maryland

Aetna Better Health uses educational materials to influence members to adopt healthy lifestyle behaviors, including, but not limited to:

- Member handbook
- Member newsletters
- Mailed reminders to schedule appointments for preventive screenings, such as annual wellness checkups, mammograms and cervical cancer screenings
- Annual flu shot reminders
- On-hold messaging
- New member welcome calls
- Krames On Demand (member-centered information that Case Managers can mail to members with condition- or wellness-specific information)

- Website

We intend to employ some or all of the above materials strategies for Louisiana CCN members, contingent upon DHH approval. All materials will comply with DHH requirements, including being written at or below a 6th grade reading level, and contain notations in Spanish and Vietnamese that members can acquire these materials in their language upon request by calling Member Services.

Additionally, Aetna Better Health's ICM Model includes components that emphasize the adoption of healthy lifestyle choices. For example, members enrolled in our Perinatal Care Management program are counseled about smoking cessation and assisted and supported with enrollment in substance abuse treatment programs as appropriate.

We also use Schaller Anderson's NCQA-certified disease management program to emphasize healthy behaviors in members with chronic health conditions. Examples include:

- Reminder calls emphasizing the importance of the use of maintenance medications for members with asthma, particularly following a visit to the ED
- Advice about appropriate nutrition, for members with congestive heart failure and/or coronary artery disease
- Guidance about appropriate exercise to build strength and endurance, for members with chronic obstructive pulmonary disease
- Text messaging reminders to make appointments for important tests such as an HbA1C screening, for members with diabetes

Another example of Aetna Better Health's emphasis on access to care and the adoption of healthy lifestyle behaviors is our Perinatal Care Management Program. Pregnant members are automatically enrolled into the program upon identification. They will receive regular contact from an assigned Case Manager, who will work to develop a collaborative relationship with them that will emphasize regular prenatal care, postpartum care, EPSDT services and healthy lifestyle behaviors. To support this effort, pregnant members also receive a booklet, at no cost to them, called "Taking Care of Yourself and Your New Baby." Developed by Aetna Better Health's clinical staff in collaboration with the marketing and communications team, the booklet provides a wealth of information about how to have a healthy pregnancy, emphasizes the importance of prenatal and postpartum care and then continues on to provide valuable information about the care of a newborn/infant through the first year. The booklet is provided in English and Spanish, written at a fourth-grade reading level, mailed to the member's household and is also available on the website for free download. (For Louisiana CCN members, the booklet will include a notation that it can be provided in Vietnamese, at no cost to the member, upon request.)

Examples from Other Medicaid Managed Care Contracts

EPSDT—Mercy Care Plan, Arizona

Aetna Better Health recognizes the important role EPSDT plays in improving the health outcomes of our members. We use specific strategies to promote the importance of the EPSDT program to our members to increase access to this important wellness initiative.

For example, Aetna Better Health’s affiliate, Mercy Care Plan in Arizona, furnishes EPSDT services to approximately 5,500 members with developmental disabilities through one of its four contracted lines of business with Arizona’s Medicaid agency, the Arizona Health Care Cost Containment System (AHCCCS). Effecting positive change with this particular member population is challenging because of social barriers to care, including lack of transportation and low health literacy. However, Mercy Care Plan has achieved a best-in-class EPSDT participation rate of 75 percent—20 percent higher than the state’s minimum performance standard.

Mercy Care Plan achieves this impressive statistic by promoting EPSDT services to members, performing outreach about the EPSDT program to members and providers, and monitoring the success of these activities. A summary of how this program works follows.

EPSDT Health Promotion Activities

Mercy Care Plan (MCP) defines health education as programs, services, and promotions designed to advise and inform members about wellness, healthy lifestyles, and the value of preventive care. MCP uses a combination of health promotion activities to improve our members and their responsible parties’ understanding of the EPSDT program. The purpose of MCP’s EPSDT program is to provide our members with available and accessible EPSDT services and to assist each member in utilizing these services. Examples of MCP’s promotion activities include:

General Educational Information. MCP defines member information materials as any material given to members, including but not limited to: member handbook, member newsletters, surveys, on-hold messaging, health-related brochures, and website content. Upon enrollment, each member receives a member handbook that includes information on the EPSDT program, child health guidelines and tips to keep children healthy. MCP’s member newsletters typically include articles about the value of the EPSDT program. MCP’s member services line educates callers, during their brief on-hold waiting periods, on various aspects of the EPSDT program. The member handbook, member newsletters and other information specific to EPSDT are included on MCP’s website for easy reference.

Population Specific Information. Mercy Care Plan’s Quality Management (QM) Prevention and Wellness (P&W) unit mails a variety of age-specific health materials to inform members and their responsible parties about the EPSDT program. Examples include 1) providing families of NICU graduates with general information about the Parent’s Evaluation of Development Status tool (or PEDS) to help families assess whether their infants are developing at an appropriate pace and to engage their child’s Primary Care Provider (PCP) if they have concerns; 2) providing a magnetic refrigerator immunization schedule to all responsible parties of children six months old; and 3) providing responsible parties for adolescent members a special “Get Vaxed” immunization flyer, targeted at teens.

Community Collaboration. MCP conducts community-based education at health fairs, where we distribute EPSDT information, appropriate health-related promotional materials and information about our PCP network. The Maternal Child Health/EPSDT Coordinator and QM staff work with local community organizations to improve the health status of Arizona’s children, including the Arizona Partnership for Immunization, South Phoenix Healthy Kids Partnership, and First Things First Regional Partnership Council.

EPSDT Outreach Activities to Members

MCP's EPSDT outreach strategy recognizes the importance of emphasizing and repeating messages about the value of EPSDT services to members/responsible parties. Our strategy includes:

General Reminders to Members. Our Prevention and Wellness (P&W) unit mails reminder cards to all EPSDT members/responsible parties. The content of the reminder cards includes the importance scheduling well-child visits, obtaining age-appropriate immunizations, and even parenting and safety tips tailored to the child's age. The scheduled mailings mirror what is set forth in the EPSDT periodicity schedule. Additionally, a pre-recorded, well-child reminder telephone call is made to two sets of responsible parties: 1) those who have children two and four months old and 2) those with children 12 years of age. These calls remind the responsible party to schedule an EPDST appointment.

Targeted Follow-up. Our P&W outreach specialists make calls to the responsible party of EPSDT-age members if the member is late in completing EPSDT appointment. During this call we take the proactive step of scheduling an appointment with the responsible party and the member's PCP office via three-way communication, along with arranging transportation.

Member Incentives. In accordance with AHCCCS policy, MCP offers gift certificates to responsible parties in two instances – when a 22-month-old child obtains any missing immunizations before the child reaches 24 months or when a well child visit is completed for a three-six year old member.

EPSDT Outreach Strategies for Providers

Mercy Care Plan's PCP education tools used to support the EPSDT program include the provider manual, network newsletters; supplying PCPs with monthly lists of members due for an EPSDT visit; and meeting with PCPs who provide care to a large number of EPSDT-eligible members. Other strategies include educating new PCPs about EPSDT requirements during the initial and each scheduled office visit and sending PCPs a list of NICU graduates. We analyze submission patterns of EPSDT forms to identify non-compliant providers and take necessary corrective action.

Monitoring Activities

In addition to ongoing reviews of quality and utilization data, MCP employs a variety of EPSDT-specific monitoring strategies to identify opportunities for improvement.

Ambulatory Medical Record Review (AMRR). MCP conducts AMRRs at PCPs' offices to assess their compliance with to monitor the provision of EPSDT services. After each AMRR MCP provides the PCP with feedback and education on any identified areas of concern. Poorly performing providers must implement a corrective action plan; we review the provider's compliance within 6 months.

EPSDT-Related Performance Measures. In addition to the AHCCCS-generated EPSDT performance results, MCP assesses its EPSDT performance and participation rates throughout the year, benchmarking its performance to the AHCCCS goals and the NCQA Medicaid 75th percentile. MCP produces a monthly report that shows EPSDT-related HEDIS^{®7} performance

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

- Distributing a booklet entitled “You and Your New Baby Book” to new mothers, emphasizing the importance of obtaining a postpartum checkup between 21 and 56 days following delivery. The booklet also includes information on newborn care, stages of development and EPSDT and immunization schedules.
- Reviewing the Emergency Department (ED) Utilization Report and Target Report to identify pregnant members accessing services through the ED.
- Working with providers to submit the completed Pregnancy Risk Assessment to Missouri Care within two days of an initial prenatal visit.
- Reviewing OB Observation Reports to identify pregnant members with complications.
- Reviewing daily Inpatient Census Reports to identify pregnant members hospitalized with complications.
- Performing postpartum assessments on all new mothers following discharge from the hospital.

Stakeholder Involvement and Participation

Central Region stakeholders participating with Missouri Care in its prenatal and postpartum care programs include, but are not limited to, the following:

- Members and, as appropriate, their parents and caregivers
- Providers, including PCPs and obstetricians
- Hospitals and clinics, including the University of Missouri Hospital and Clinic
- Subcontractors, such as laboratory, pharmacy and transportation providers
- Missouri state agencies (e.g., MO HealthNet)
- Local public health agencies (e.g., county health departments)
- Community resources (e.g., the WIC program)

The following are examples of Missouri Care’s collaborations to improve the quality of prenatal and postpartum care for our members:

- Progesterone Treatment (17P) Program: 17P is used only for pregnant women who have had a history of preterm labor before 37 weeks and are currently pregnant. Women being treated with 17P receive weekly injections beginning after week 16 and before week 20 of gestation and continue through week 36 of gestation (or delivery).
 - Missouri Care collaborated with a local pharmacy to allow providers to order 17P directly from the pharmacy. The pharmacy ships a one-month supply of four pre-filled syringes directly to providers, which enables them to administer 17P in their office. In addition, the pharmacy has a nurse on staff who may administer 17P in the pharmacy, if needed. Missouri Care’s perinatal Case Manager and Senior Medical Director have also hand delivered 17P to providers’ offices to accommodate long weekends and avoid supply issues. Missouri Care not require prior authorization for 17P treatments, which makes increases access to care for the members who need these treatments.
- Rosebud Program: This program assists Missouri Care with improving health outcomes and reducing costs associated with high risk pregnancies and infants. Working in collaboration with Missouri Care’s perinatal Case Managers, the Rosebud Case Manager provides

education and support to high risk pregnant members to identify and treat complications. The program has resulted in fewer preterm deliveries and fewer high risk infants. Missouri Care's partnership with the Rosebud Program generated potential NICU (Neonatal Intensive Care Unit) savings of approximately \$188,674 in CY 2008.

- Lutheran Family and Children's Services Program: This program works collaboratively with Missouri Care's perinatal case managers to improve the health outcomes of high risk pregnant women. Lutheran Family and Children's Services is a non-profit social service agency in Columbia, Missouri with social workers and nurses who provide case management services, including supportive counseling, childbirth preparation, mentoring, parenting skills, behavioral health screening, housing assistance and domestic violence protection, among others. The organization makes home visits along with providing nutritional/dietary counseling and even referrals for childcare when needed to support the high risk mother. Missouri Care coordinates activities with Lutheran Family and Children's Services during our bi-monthly case management meetings as part of its ongoing effort to improve member health outcomes and avoid costly NICU admissions.
- Intrauterine Growth Restriction (IUGR) Quality Study: A Missouri Care OB case manager teamed up with medical students to research the potential benefits of managing IUGR in an outpatient vs. inpatient setting. Their conclusion, published in *Modern Physician*, found that IUGR could be effectively managed in an outpatient setting. The University Hospital and Clinics subsequently adopted this policy and Missouri Care's high risk inpatient days per/1,000 decreased from 54/1,000 in 1999 to 24/1,000 in 2008.
- Father's Project Smoking Cessation Program: Missouri Care collaborated with University researchers to study the health behaviors of expectant fathers and develop a referral system for providers to use for members to access comprehensive tobacco/smoking cessation services.
- Baby Beep Smoking Cessation Program: Missouri Care collaborated with University nursing students to establish a support network for pregnant women who smoke. Case managers connect pregnant women with community resources that can help them stop smoking. Smoking among Missouri Care's pregnant members subsequently decreased from 36.8 percent to 35 percent.
- Boone County Local Public Health Agency Case Management of High Risk Pregnant Members: Missouri Care contracts with Boone County LPHA to provide face-to-face case management services, including home visits to high-risk pregnant members in Boone County.
- Induction of Labor Quality Study: In 2002, Missouri Care's OB case manager and two University of Missouri medical students formed a team to research the factors behind an increased rate of labor induction. The study's results led to the development of evidence-based physician protocols for the induction of labor.
- Community Resource Directory: Missouri Care worked in collaboration with the Division of Children's Services and Local Public Health Agencies to develop a comprehensive Resource Directory that enables case managers to quickly identify and refer members to appropriate community resources and services.

- WIC Referral Program: Missouri Care partnered with WIC staff to develop and implement a referral process for high risk pregnant and postpartum members and their children. This collaboration contributed to a decrease in “Failure to Thrive” hospitalizations following early case management intervention.

Case Histories

The following are examples of successful case histories involving Missouri Care’s perinatal case management team and Missouri Care members.

Case History 1

Missouri Care’s Perinatal Case Management Unit received a referral for a 25-year old carrying her first pregnancy. Among her risk factors was a history of depression and substance abuse, as well as a history of asthma. Initially, the member was resistant to being enrolled in case management. The Missouri Care case manager kept her interactions friendly and supportive and after several interactions, the member related that she was fearful of relapsing due to her current living situation. The case manager assisted the member to enroll in the CSTAR (Comprehensive Substance Abuse and Treatment) program to obtain the support she needed to remain drug free. Her pregnancy progressed well until the 30th week when she delivered a healthy, but very small, baby girl. The member was discharged, but her new daughter had to remain in the hospital. The case manager followed up with the member who talked excitedly about bringing her baby home. However, as the weeks continued, the daily trips to the hospital and the inability to “have a normal life” begin to take their toll. The member began to miss appointments with her case manager and did not keep her scheduled postpartum visit.

Missouri Care’s perinatal case manager contacted the case manager at the CSTAR program, hoping they had heard from the member, and found that the member was currently with her case manager. The member stated that she had quit visiting the hospital because she was not able to spend much time with her daughter and was not involved with her care. The case manager related that the member was unbathed and dressed in dirty clothes and had told her that she hadn’t eaten in several days. The perinatal case manager and the CSTAR case manager collaborated to have the member seen and evaluated for depression.

Ultimately, the member was diagnosed with postpartum depression and successfully treated. The perinatal case manager contacted the hospital staff and explained the member’s feelings. She was helped to spend more time with her baby and become more involved in the baby’s daily care. Six months after delivery she was able to bring her daughter home.

Case History 2

A 24-year old pregnant woman with three previous pregnancies, two miscarriages, Rh negative and pregnancy-induced hypertension enrolled in Missouri Care effective 2/2/08 with an estimated delivery date of 6/18/08. Missouri Care’s perinatal case manager completed an initial assessment and identified potential risk factors and unmet needs, reinforced the importance of notifying her OB about any symptoms, and instructed her when to present to the hospital for urgent and emergent symptoms.

The case manager also reviewed the possible options among Missouri Care’s network obstetricians, but the member did not wish to transfer care as she had already established a relationship with an out-of-network OB. The case manager then contacted the member’s OB to

arrange reimbursement. During monthly follow-up, the member reported that she had presented to the hospital for contractions and shortness of breath, edema in her upper and lower extremities and that her OB was aware of these developments. A few weeks later, the member reported that she was in the hospital with severe preeclampsia. She was induced the next day and delivered a healthy baby with a birth weight of 5 lbs 11 oz.

The member expressed her gratitude to Missouri Care’s case manager for providing education and support during her pregnancy. At the time of her postpartum assessment, the member reported that her blood pressure was under control and the baby was doing fine.

Case History 3

This case began as a referral from a member’s grandmother for behavioral health therapy. The member was 18 years old, pregnant, with a history of substance abuse and tobacco use. She lived in small rural community with no transportation. Missouri Care’s behavioral health case manager identified a therapist agreeable to the member and grandmother, scheduled appointments for therapy and arranged for transportation. The member was referred to the OB case manager. The member had not had any prenatal care, so an OB provider was identified and appointments were scheduled to coordinate with therapy appointments when possible. Transportation was arranged. The member was referred to a smoking cessation program and the CSTAR-Chemical and Substance Abuse Treatment Program. The OB case manager referred the member to WIC for nutritional counseling and supplemental dietary products. Our OB case manager provided information and referral to community resources, such as Resource Mother’s Teen Mentoring Support group and GED program, since the member had dropped out of school at age 16. The member was referred to birthing and breastfeeding classes, remained compliant with prenatal care and delivered a healthy term infant. The member continued to pursue her GED. She was diagnosed with depression and continues therapy with medical management. Both the member and grandmother were grateful for the resources and referrals.

Metrics and Outcomes

In 2009, Missouri Care reported HEDIS rates for Timeliness of Prenatal Care and Postpartum Care over the previous three years that were consistently above the statewide average as well as the NCQA 75th percentile, as reflected in the following tables. Our HEDIS 2008 rate for Postpartum Care actually exceeds the HEDIS 90th percentile benchmark of 70.62 percent.

Timeliness of Prenatal Care	2006	2007	2008
Missouri Care	89.05%	93.24%	91.11%
NCQA 75 th Percentile	88.10%	88.70%	88.56%
Statewide Average	56.28%	79.88%	77.95%

Postpartum Care	2006	2007	2008
Missouri Care	66.91%	71.56%	70.83%
NCQA 75 th Percentile	65.90%	65.50%	65.69%
Statewide Average	50.15%	61.69%	58.86%

Our Plan for Louisiana CCN Members

Aetna Better Health applauds DHH's emphases on access to appropriate care and the adoption of healthy lifestyle behaviors. We believe that these strategies, when fully deployed within the Louisiana CCN population, will significantly improve members' health outcomes and subsequently lead to greatly reduced health care costs for DHH.

The following section represents an overview of our proposed member health education plan for Louisiana CCN members for Years 1 through 3 of our contract.

Aetna Better Health intends to support these efforts by implementing a multi-year education plan with our CCN member population, as shown below.

Year 1

- The importance of a PCP/Patient-Centered Medical Home (PCMH)
- Importance of preventive care
- Importance of prenatal care to prevent low birth weight/premature birth
- Diabetes prevention and management

Year 2

- Year 1 initiatives continue, plus the following:
- Cancer (according to the Louisiana Public Health initiative website, Louisiana is found to have cancer rates that outpace the national average. For Louisiana residents, the most frequently diagnosed cancers are lung at 16 percent, prostate, 16 percent, breast, 14 percent, colon and rectum, 12 percent, and urinary bladder, 4 percent. The five-year period between 2000 and 2004 brought 105,082 diagnoses of invasive primary in Louisiana residents, or an average of 21,016 cases per year. Specifically, Louisiana's incidence rates for tobacco-related cancers such as lung, oral cavity, kidney, and pancreas are also higher than U.S. rates, and are preventable)
- Smoking cessation (see cancer notes, above)
- Childhood obesity (relates to Year 1 efforts at diabetes prevention)

Year 3

- Years 1 and 2 initiatives continue, plus the following:
- Asthma

The strategies and tactics that follow should be considered a launching pad, as we continually assess our membership, factors that may be barriers to success for them, and which strategies we are employing are most effective. All strategies, tactics and programs are subject to DHH review and approval prior to implementation.

Perinatal Care Management

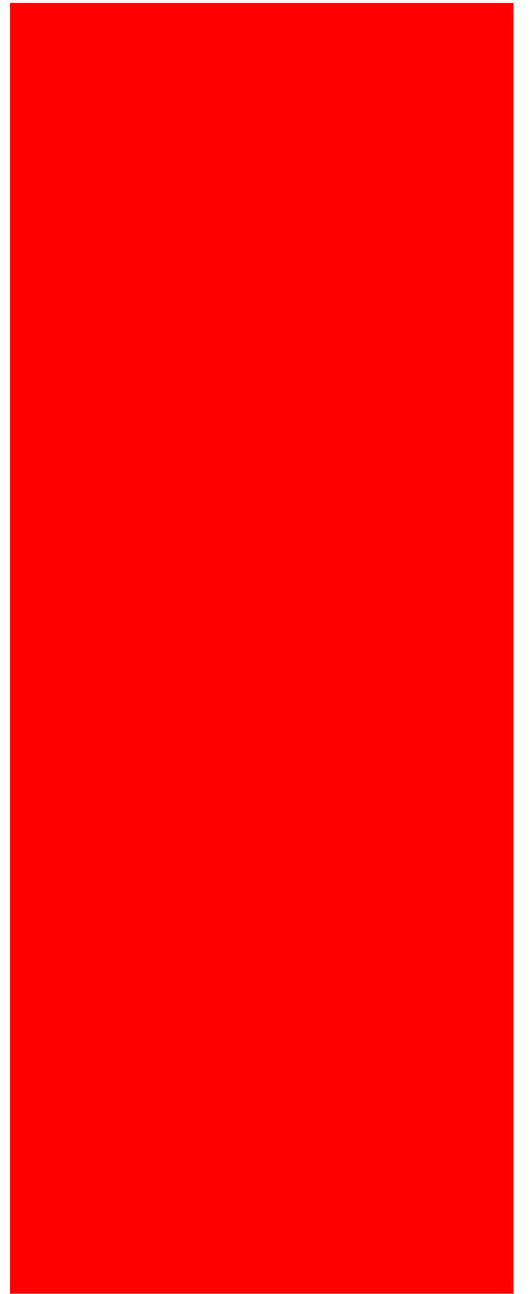
Aetna Better Health will automatically enroll all pregnant members, upon identification, into our Perinatal Case Management program. As part of our Intensive Care Management, or ICM program, the Perinatal Care Management program will address concerns and issues facing the

“whole” member: physical, behavioral and social, to help the member have a healthier pregnancy, with the goal of a full-term delivery of an infant with a healthy birth weight.

Perinatal care management will emphasize accessing prenatal care at the right time, developing a relationship with the member’s PCMH provider, selecting the appropriate PCMH for the newborn, the importance of regular EPSDT visits as the baby grows and the ongoing adoption of healthy lifestyle choices so that health care outcomes remain positive for the entire family.

Outreach, education and encouragement to members to engage in healthy pre and post-partum care includes referrals to substance abuse treatment, smoking cessation, domestic violence support services, counseling for pregnant teenagers and post-partum outreach for all pregnant members. Outreach is provided during each trimester for non high-risk members in order to identify potential high-risk conditions as they occur later in pregnancy.

56 F.7



F.7 Many faith based, social and civic groups, resident associations, and other community-based organizations now feature health education and outreach activities, incorporate health education in their events, and provide direct medical services (e.g., through visiting nurses, etc.). Describe what specific ways would you leverage these resources to support the health and wellness of your members.

Strategies to Leverage the Existing System

Aetna Better Health[®] together with its affiliates has approached our managed care programs from an integrated perspective for more than 20 years. We have a core competency in managing integrated health models for Medicaid populations and we excel at integrating physical, behavioral health, and community-based programs for our members. Our model is holistic and Member-centric, with an emphasis on meeting the individual needs of our Members aligning care directly in their home communities where they have existing care support relationships. In every state where we do business, we focus on our Members' health and well-being using the critical components of positively influencing behavior changes, relationship building, and involvement with community and social systems that wrap around the Member to enhance their self-efficacy and promote positive health outcomes.

For years, our focus has been on the establishment of a Patient-Centered Medical Home (PCMH), prevention and wellness services, and community-based support systems to manage the full continuum of care for our Members as part of a coordinated system of care. This includes using community-based support systems that directly provide covered services to Medicaid members, e.g. Federally Qualified Health Centers, and those that provide non-covered services, e.g. nutrition programs promoting balanced meals. Aetna Better Health has developed a workforce that understands the Louisiana community, its faith based ministries, and extensive community health resources and leadership. Aetna Better Health has developed, implemented, monitored, and managed Medicaid networks throughout the country, and has processes in place that focus on integrating and collaborating with community service providers.

To effectively leverage the existing community resources, Aetna has identified internal and public health objectives in an effort to align these with community-based organizations and systems available to Louisiana residents. These objectives include but are not limited to: Wellness, prevention, disease management, healthy lifestyles, and prenatal care. Our outreach efforts center on these goals and also include efforts, which emphasize member education, and continuously invoke the value of member engagement. The establishment of broad-based community partnerships is an effective tool for improving health. Examples of community-based partnerships under consideration include the following groups:

- Public and private health associations
- Advocacy organizations
- Civic groups and other nonprofit organizations
- Schools and universities
- Public Health entities
- Churches and faith-based organizations

- Local and state governments
- Hospitals, clinics and physicians

Aetna Better Health anticipates developing collaborative partnerships with community, advocacy and faith-based organizations, such as those listed above, for the purpose of outreach and education, which promotes healthy behaviors and better health outcomes and as more fully described on the following pages.

Identifying Community Based Services and Resources: Community Based Resource Directory

Aetna Better Health relies heavily on existing community resources to see that our members receive needed health and support services. To this end, we will compile an extensive Community Resource Directory to assist Case Managers and Member Service staff in identifying and contacting community-based organizations and resources for our members. These guides will include names of organizations, website, contact information and other information for a host of community resources. The guides will be arranged so that they can be printed by Aetna Better Health staff, communicated to members in writing or available via an Internet download. Aetna Better Health will organize guides by Geographic Service Area to see that member referrals are geographically appropriate.

The following community-based organizations and resources, most of which have locations throughout the state of Louisiana and its various parishes, are examples of organizations that will be included in Aetna Better Health's Community Resource Directory (Additional and specific examples of agencies and programs are listed in a table that follows):

- Area Agencies on Aging (e.g., The Office of Aging and Adult Services, Louisiana Aging and disability Resource Center)
- Early Head Start/Louisiana Head Start Association
- The Special Supplemental Food Program for Women, Infants and Children (WIC), including the LA Commodity Supplemental Food Program
- Vaccines for Children (VFC) (Coordinated through the offices of primary care physicians, FQHCs, school based health clinics, rural health clinics and other local certified health departments throughout the various parishes in LA)
- Community Mental Health Centers, including behavioral health programs in metro schools sponsored by such agencies as the Children's Bureau and Family Services of Greater New Orleans
- Parish Health Units throughout LA
- Rural Health Clinics throughout the various LA parishes
- Federally Qualified Health Centers throughout the various LA parishes
- Meals on Wheels and similar support organizations (including faith-based entities providing nutritional support and other Louisiana meals-on-wheels programs which include senior meal programs)
- Home and Community-Based Service providers
- Alcohol and substance abuse support groups (e.g., Alcoholics Anonymous)

- Support groups and volunteer programs (e.g., Senior Corps’ Foster grandparent and Senior Companion programs, and the Louisiana Association of Community Action Partnerships such as the A.S.S.I.S.T. Agency)
- University Health Programs (e.g. Tulane University School of Medicine Children’s Health Fund)
- Faith Based Resources (e.g., St. Augustine Catholic Church and Lakeland Baptist Church who provide head start, FEMA, employment, community food banks, aging and other community resources or referrals)
- Specialized disease associations and agencies, including:
 - American Heart Association
 - American Lung Association
 - United Cerebral Palsy
 - March of Dimes
 - Association for Retarded Citizens
 - Muscular Dystrophy Association
 - National Alliance for the Mentally Ill

For an example an existing community resource guide available to Louisiana residents, which Aetna Better Health may reference when assembling its Community Based Resource Directory. This guide is available to the general public at <http://www.dhh.louisiana.gov/publications.asp> and describes the community resources that families with children and/or youth with special health care needs living in Jefferson, Orleans, Plaquemines, or St. Bernard Parishes might find helpful. The information listed intends to guide both families and professionals regarding available program services, how to contact the program, if the program has eligibility criteria, and if the family needs to have a Medicaid community referral or a physician referral for inclusion.

Aetna Better Health’s Community Resource Directory for Louisiana, which is under development, will also be available on our website for easy access for members, care-givers, providers and other stakeholders. It will be updated on an ongoing basis and will include website links to information to empower members to conduct their own research and outreach efforts directly with parent organizations of the referenced community-based resources.

Summary of other Community-Based Programs under Consideration

Community-Based Organization	Type of Program	Description of Services
Department of Health & Hospitals The Louisiana Public Health Institute	Teen Pregnancy	<ul style="list-style-type: none"> •Personal responsibility education and teen pregnancy prevention programs. •The project implements and evaluates teen pregnancy prevention evidence-based interventions in twelve sites throughout Orleans Parish.

Community-Based Organization	Type of Program	Description of Services
<p>(in partnership with the U.S. Department of Health and Human Services, Office of Adolescent Health)</p>		<p>The project targets high-risk youth, aged 14-19, to address the gaps in sex education and prevention services.</p> <ul style="list-style-type: none"> •The “Becoming a Responsible Teen” aspect of the program is designed to give teens skills to delay sexual involvement and reduce exposure to HIV and services African-American New Orleans youth ages 14-19. •The “Safer Sex” program component will target females ages 14-19 who are seeking treatment for sexually transmitted infections.
<p>The Institute of Women and Ethnic Studies (IWES)</p>	<p>Women's Health Issues</p>	<ul style="list-style-type: none"> •Dedicated to improving the physical, mental and spiritual health and quality of life for women of color and their families, especially those who are socio-economically disadvantaged. • Provides information, education, and communication projects and training opportunities that promote health awareness and activism, especially in relation to mental health, HIV/AIDS awareness and prevention and peer education to women and youth.
<p>Central Louisiana Area Health Education Center (CLAHEC)</p>	<p>Reduce HIV/STDs among adolescents Teen Pregnancy</p>	<ul style="list-style-type: none"> • Offer a variety of education based services to meet the needs of health care providers and consumers in the 17-parish region served. • Provides the “Be Proud! Be Responsible!” teen pregnancy prevention education program to cadets in the Louisiana National Guard Youth Challenge Program (LNGYCP), which targets at-risk adolescents. • The goal of the program is to give members knowledge to help them change behaviors that will result in a reduction in HIV and STDs among adolescents, and a reduction of unplanned pregnancy among adolescents.
<p>Sisters Informing, Healing, Living, and Empowering (e-SiHLE) (in partnership with Tulane University)</p>	<p>Reduce HIV/STDs among adolescents Teen Pregnancy</p>	<ul style="list-style-type: none"> • The program is an Internet pregnancy prevention for older teenage girls, under a partnership with Tulane University utilizing social media the outreach too. • An evidence-based program to reduce the risk of HIV and STDs among African-American adolescent females. •The program used Social Cognitive Theory (SCT) and the Theory of Gender and Power to guide the design and implementation of the intervention. Social Cognitive Theory addresses both the psychosocial dynamics facilitating health

Community-Based Organization	Type of Program	Description of Services
		<p>behavior and the methods of promoting behavior change.</p> <ul style="list-style-type: none"> •The gender-relevant theoretical framework of the Theory of Gender and Power highlights social processes prevalent in the lives of African-American female adolescents that contribute to risk in sexual relationships.
<p>Mary Amelia Douglas-Whited</p> <p>Community Women's Health Education Center</p> <p>(in partnership with Tulane School of Public Health)</p>	<p>Wellness and Outreach</p> <p>Health Education</p>	<ul style="list-style-type: none"> • Seeks to enhance women's health and well-being through our work in community capacity building; leadership development, health education, advocacy and research • Example: Family Health Fair - Cowen High School, New Orleans, family-focused health fair hosted by Americorps Volunteers and staff at Cowen High School. Various topics addressed. •Provide accurate and clear health information to the women and families of New Orleans. The Mary Amelia Center conducts outreach through health fairs and local events and by providing wellness talks through our Jane Wilson Smith Wellness Talk series •When attending a health fair or community event the following is provided: •Free health education print materials; Information about the center, including copies of latest newsletter, an educator to answer questions about the material provided.
<p>Department of Health & Hospitals</p> <p>Office of Public Health – Parish Health Units</p> <p>School-Based Clinics</p> <p>Preventive Health Services Louisiana's Section of Maternal and Child Health (MCH)</p>	<p>Preventive care</p> <p>Prenatal care</p>	<ul style="list-style-type: none"> •Improve health and opportunities of Louisiana's women, infants, children, and families through approaches that are preventive, evidence-based, and evaluated. •Programs target women of childbearing age, infants, children, and youth in Louisiana, and are designed to see that these individuals have access to high quality primary and preventive health care services

Community-Based Organization	Type of Program	Description of Services
<p>Providence Community Housing</p>	<p>Homelessness</p>	<ul style="list-style-type: none"> •Mission is to foster healthy, diverse and vibrant communities by developing, operating and advocating for affordable, mixed-income housing, supportive services and employment opportunities for individuals, families, seniors and people with special needs. •Goal is to bring home 20,000 victims of Katrina by rebuilding and/or developing 7,000 units of housing - both single-family homes and apartments.
<p>Catholic Charities, Archdiocese of New Orleans</p>	<p>Food & Nutrition</p>	<ul style="list-style-type: none"> •Food For Families program •Food For Families provides nutritional food boxes to pregnant women and post-partum mothers, infants and children under six years of age who are not receiving WIC assistance, and seniors who are 60 years old or older and meet Federal Income Guidelines. •The program also educates clients about good nutrition by providing nutritional information that includes easy to make recipes using commodity foods, caloric intake, how to stretch food dollars and eat a healthy diet.
<p>Parish assistance offices and work development programs</p> <p>Louisiana Workforce Commission</p> <p>Community Action and Support Agencies</p> <p>Department of Labor</p> <p>Department of Health and Hospitals</p> <p>Community and/or Technical College Systems</p> <p>Louisiana Public Health Institute</p> <p>Catholic Charities</p>	<p>Workforce Development</p>	<p>Aetna Building Louisiana Employment (ABLE) is a workforce development program created by Aetna Better Health to bring value for the state of Louisiana and Medicaid recipients by reducing the number of individuals on case assistance while providing long-term stability in the workforce through training and experience.</p> <p>Aetna Better Health will leverage our CCN Program start-up and ongoing job creation opportunities to create jobs for all TANF recipients receiving cash assistance. We will work with a third party vendor to assist us in recruiting eligible individuals for the ABLE through communications with workforce development agencies.</p> <p>Aetna Better Health will interview, assess and hire TANF recipients receiving cash assistance</p>

Community-Based Organization	Type of Program	Description of Services
		<p>who apply for the following positions with the following hiring goals:</p> <ul style="list-style-type: none"> • Member Services Representatives (1 ABLÉ for every 3 department positions) • Receptionist • Prior Authorization Representative (1 ABLÉ for every 4 department positions) <p>Aetna Better Health will provide workforce and job specific training throughout their first 60 to 90 days and ongoing as needed to include:</p> <ul style="list-style-type: none"> • Use of technology and Aetna Better Health tools • Soft skills - how to work with difficult customers, ask probing questions and how to have good phone etiquette • Business conduct and integrity • Effective business writing • Business etiquette (which would include proper attire) <p>Aetna Better Health will pay ABLÉ staff a minimum of \$30,000 in addition to an annual bonus and the opportunity to earn merit pay increases if performance expectations are met.</p> <p>Aetna Better Health's ABLÉ commitment:</p> <ul style="list-style-type: none"> • We will strive to create a diverse work force and inclusive team environment • Hire, train, educate and work to retain ABLÉ staff • Report on program success to DHH • Encouraging advancement (i.e. lateral to learn new skills sets or upward for promotion) • Providing training to build professional and life skills.
<p>Department of Health & Hospitals</p>	<p>Immunizations</p> <p>Sexually Transmitted Disease</p> <p>Family Planning</p>	<p>Contract with OPH to offer these services in their more than 70 Parish Health Units.</p>

Community-Based Organization	Type of Program	Description of Services
	Weight management	
Office of Public Health – Parish Health Units	Immunizations Sexually Transmitted Disease Family Planning Weight management HIV/AIDS education	Contract with OPH to offer these services in their more than 70 Parish Health Units.
Louisiana Health Care Quality Forum	Population health HIE PCMH initiatives	Work together to better understand the population health needs of Louisiana’s Medicaid population Support state-wide HIE efforts Support PCMH initiatives and collaborate on best practices

Care Delivery through Significant Traditional and Community-Based Providers

Aetna Better Health views the provision of covered services through affiliated, community-based providers as necessary and essential in accomplishing the public health goals of our community. We traditionally assume an expanded and involved role, working with community-based organizations, and will call upon our extensive experience with the following organizations:

- Community Mental Health Centers (CMHC)
- Area Agencies on Aging
- Federally Qualified Health Centers/Community Health Centers (FQHCs)
- Homeless shelters
- School-based health centers
- Rural Health Clinics (RHCs)
- Parish Health Unit (PHU) through OPH
- Prenatal clinics

The following table describes the types of arrangements we have with community-based organizations in other states to improve the quality of care for our Members.

Community-Based Organization	Type of Arrangement and Description of Services
State Department of Health and Office of Public Health's Parish Health Units	<ul style="list-style-type: none"> •Contract for state laboratory, immunization and family planning services •Collaborative arrangement for providing information to the immunization registry •Pregnancy education •Education and support services to families that have young adults with developmental disabilities •Tuberculosis and lead screening •Dental sealants •AIDS counseling and testing <ul style="list-style-type: none"> • Perinatal home visits • Weight management education and counseling
Community Mental Health Centers	<ul style="list-style-type: none"> •Contract for a wide variety of direct care services, including services provided by paraprofessionals and care for addiction and substance abuse •Collaborative arrangements with CMHC Case Managers •Collaborative arrangements to provide wrap-around services to support high risk behavioral health member and their families •Coordination and treatment planning relevant to regional State-operated Hospitals
Homeless Shelters	<ul style="list-style-type: none"> •Identification of social, economic and transportation issues and solutions to aid in the care management process •Collaborative arrangements to support wrap-around services to support the basic needs of the Medicaid so the medical and behavioral health services can be successful
Federally Qualified Health Centers/Rural Health Centers	<ul style="list-style-type: none"> •Contract for a wide variety of direct care services, including services provided by paraprofessionals (i.e., physician extenders) •Collaborative arrangement to provide educational and preventive services •Assisted in the development of co-location to have BH providers on site, trying to address the member's entire spectrum of care. It is very important that we think of the member's holistically.
Faith-Based Organizations	<ul style="list-style-type: none"> •Collaborative arrangement to provide emergency shelters for Members •Coordinate case management and referrals for substance abuse treatment when appropriate
Social Services Centers	<ul style="list-style-type: none"> •Collaborative arrangement to provide educational and preventive services to young adults in school •Coordination of care between the school-based setting and network providers outside of school settings

Community-Based Organization	Type of Arrangement and Description of Services
	<ul style="list-style-type: none"> •Identification and coordination of services for young adults whose individual education plans include medical, developmental and behavioral services
Pre-natal Clinics	<ul style="list-style-type: none"> •Collaborative arrangement to assist in the early identification of pregnant Medicaid •Coordination of perinatal case management

Aetna Better Health values the important role that community-based organizations and safety net providers play in serving vulnerable populations. Throughout our more than 20-year history of serving special needs populations under a managed care model, we have collaborated effectively with these organizations to verify that Members are able to access needed services in an appropriate setting. Our approach and strategy is to contract with safety net providers that have traditionally served Members, including but not limited to Federally Qualified Healthcare Centers, Rural Health Clinics, Parish Health Units, and Community Mental Health Centers. We understand and will proceed with program development recognizing that FQHCs, RHCs PHUs, CMHCs and other local community health resources are key to an integrated care model. The safety net provider’s mission, experience and locations warrant their key role in maintaining effective services for the Medicaid populations in both urban and rural areas.

Aetna Better Health has initiated contacts with and will continue to develop working relationships with these providers. In preparation for our proposal submission, Aetna Better Health has already met with non-contracted agencies and their representatives throughout the Louisiana parishes to discuss the services they provide and how they work and interface with other community organizations and safety net providers. We have reached out to the Office of Public Health, RHCs, FQHCs, public hospitals and other safety net providers to inquire about contracting and working with them. It is our intent to contract and develop a strong working relationship with all of these entities.

Providing for our special population health needs is often complex and cannot be taken out of the context of the community in which Members live and work. Aetna Better Health fosters collaborative relationships with community-based resources to assist members in accessing care, including preventive care and services. We track and collaborate on health care services provided by local health departments, federally qualified health centers, rural health clinics, school based clinics and other providers and coordinate our internal efforts by means of a Memoranda of Understanding (MOUs) or other written agreements that stipulate our mutual responsibilities and obligations. Our MOU providers are also responsible for establishing a system for coordinating care and sharing critical medical information with Primary Care Provider (PCPs)/PCMHs, make reasonable efforts to avoid duplication of services, educate members on managed care, promote follow-up with the PCP/PCMH and provide Aetna Better Health with appropriate medical records.

Working with community-based organizations and safety net providers will facilitate the important contributions that these organizations offer, including:

- Assessing community needs

- Monitoring access to health care
- Filling gaps in available care resources in urban and rural areas
- Advocating on behalf of vulnerable individuals
- Offering access to quality health care services, including specialty services
- Providing their special expertise and perspective derived from extensive experience in working with this population

We recognize and appreciate the value that our stakeholder partnerships bring to delivering and coordinating health care services for our members and adhere to the following:

- Inviting advocacy groups to advise Aetna Better Health on key decisions and processes
- Recognizing that delivering managed care in rural areas requires flexible partnering with community stakeholders.
- Ensuring that community-based providers and agencies receive timely, accurate and complete information about Aetna Better Health's role and support in coordination of services to members.

Examples of our commitment and work with Community-Based Resources and Organizations in states we currently serve include:

Community Based Service Providers

Partnership with Lutheran Family and Children Services

We work collaboratively with Lutheran Family and Children's Services to improve the health outcomes of high risk pregnant women. Lutheran Family and Children's Services is a non-profit social service agency in Columbia, Missouri, with social workers and nurses who provide case management services, including supportive counseling, childbirth preparation, mentoring, parenting skills, behavioral health screening, housing assistance and domestic violence protection, among others. This organization makes home visits along with providing nutritional/dietary counseling and even referrals for childcare when needed to support the high risk mother. Missouri Care coordinates activities with Lutheran Family and Children's Services during our bi-monthly case management meetings as part of our ongoing effort to improve member health outcomes and avoid costly Neonatal Intensive Care Unit admissions.

Partnership for Enhanced Delivery of Services (MO-PEDS)

In 2003, Missouri Care initiated a partnership with MO-PEDS (now known as the Family Resource Services program) to help identify and coordinate the services and support needed for families of Children with Special Health Care Needs (CSHCN). The objective is to improve the quality of care for rural and underserved CSHCN by increasing the availability of comprehensive care coordination in Missouri Care's 18 counties. The Family Resource Services program is based on the health care home model of care in which a family support specialist partners with the member, the member's caregiver, PCP, treating specialists and Missouri Care's nurse case manager to coordinate care and provide access to needed services.

Missouri Care and the Missouri Foundation for Health provided funding for MO-PEDS from 2003-2006. Because Missouri Care believes that a sustainable commitment to reaching vulnerable children is core to our mission, we continue to provide financial support for the program in partnership with the University of Missouri Department of Child Health and the

Thompson Center for Autism and Neurodevelopmental Disorders (the only autism center in the State and currently the home of Family Resource Services). Missouri Care and Family Resource Services recently collaborated with DHSS staff to develop a standard tool to assess the presence of a viable health care home, this tool is now being used by DHSS staff.

Parents served by the partnership report significant improvement in satisfaction with care coordination and access to behavioral health services as a result of the intervention. They also note decreases in family burdens, caregiver strain, parents' missed work days, children's school absences and utilization of ambulatory services.⁹

Partnership with School Nurses

Aetna Better Health has a long history of working in partnership with school nurses and other school personnel and we have published a quarterly school nurse newsletter since 2004. We also work with schools in providing EPSDT services to students. For example, in 2004 and 2005 we partnered with a school to contact members in the district who had not received EPSDT screenings and invited them to access services during the back-to-school fair. We also worked with two additional school districts to provide EPSDT services in the schools. In addition, our staff has visited schools to make presentations on various health education topics, and provided school nurses with additional health education resources.

State and Local Public Health Agency Partnership

Partnership with WIC

On a semi-annual basis, we generate a list of members from birth to age five (children eligible for WIC) and share them with the participating WIC offices in an effort to identify which members are currently enrolled in WIC. We then mail letters to eligible members who are not enrolled in WIC to explain the benefits of the program and encourage them to join.

For members who are already enrolled in WIC, we identified any child who has not had an EPSDT exam during the past year. We then generate a colorful flyer about the importance of EPSDT services and place them in the members' files at the county WIC office. When members come in for their next visit, they are given the flyer and educated by the WIC nutritionist on the importance of yearly EPSDT services. The WIC office also notifies us when a member has received a flyer and our quality management nurse follows up to reinforce the importance of EPSDT exams and to see if an appointment has been scheduled. To date, we have found that members enrolled in WIC are more likely to receive an EPSDT exam than those who are not.

Co-Case Management Partnership with Local Public Health Agencies

We have experience working with Local Public Health Agencies (LPHA) to co-case manage members with high risk pregnancies. Nurses at the LPHA complete a risk appraisal for all our members who are pregnant and notify our perinatal Case Manager by completing and faxing a Pregnancy Risk Screening form. Monthly progress notes and encounters are shared between our perinatal Case Manager and LPHA nurses for co-case management.

⁹ Farmer, JE, Clark, MJ, Sherman, A, Marien, W.E, & Selva, T.J., "Comprehensive Primary Care for Children with Special Health Care Needs in Rural Areas," *Pediatrics* 116 (2005): 649-656.

Sponsorships/Events

Aetna Better Health is committed to supporting organizations and events that are compatible with improving the health and well being of children and families. We anticipate participating in the following community activities through educational outreach, health screenings and sponsorships:

- Child Development Program Spring Family Fair
- Public school system sponsored health and back to school festivals
- DHH outreach events
- Baton Rouge Blues Festival
- Festival Internationale de Louisiane in Lafayette
- St. Anthony and St. Pius X Blessing of the Fleet Festival in Lafitte
- Cajun French Music Association Festival in Lake Charles
- Marshland Festival in Lake Charles
- Bayou Classic
- FestForAll – Baton Rouge
- Rapides Parish Fair
- Angola Prison Rodeo
- Local health fairs
- Faith based health fairs and educational events

The following are examples of our commitment to sponsorship and event member activities in the states we currently serve:

Sponsorship of Daniel Boone Little League Challenger Baseball Team

Missouri Care sponsors a little league in which kids with disabilities can play, compete and have a good time, whether in wheelchairs, forearm crutches or other forms of DME. Missouri Care's mascot, "Stripes the Tiger," attends the games and runs the bases with the kids. A number of our staff members join in the action as well. Missouri Care very proudly displays a trophy commemorating our involvement in this very special activity.

Swim Parties

Swim Parties are an integral part of our community outreach effort and have become our signature community event. We pay the admission fee for everyone to enjoy a summer evening of fun at the local pool. Only our members receive an invitation, but Swim Parties are widely advertised as open to members, non-members, their friends and families. The parties give us an opportunity to show our members we appreciate them and to educate the community about healthy living.

Swim Parties provide us and other organizations with an opportunity to disseminate safety information (bike, water and fire safety, insect bites, etc.) to families in a fun and friendly environment. We encourage each pool's lifeguard staff to present an in-water safety demonstration and we invite participation from community organizations concerned with safety (e.g., law enforcement, fire department, hospital emergency room, Red Cross, local health

department, etc.). These organizations have been very supportive in providing a great opportunity for kids to look at the rescue vehicles, talk to the crews about safety issues and acquire age-appropriate printed information.

Community Based Departments Collaboration

Office of Public Health Parish Health Units (PHUs)

Many Medicaid members are presently served by Parish Health Units and our contractual efforts to service population. These programs are important to Aetna Better Health's efforts to provide comprehensive, wellness and preventive-focused services such as immunizations, health awareness information, health screenings, family planning, perinatal home visits, weight management, breast cancer awareness, and AIDS counseling and testing and communicable disease investigations. Aetna Better Health will build upon our contractual relationship with PHUs by promoting their involvement in providing PCMH support, disease management services and access that geographically complements our service area. Although our initial contract relationship is just a beginning, we envision establishing mutual work teams with local PHUs to examine an expanded role in serving Aetna Better Health's Medicaid populations. PHUs will serve as a priority care centers for members seeking a PCMH and the PHU's capacity and interest supports the continuous and consistent principles of a PCMH offering a full-range of primary care services. In addition, our PCMH alignment with PHUs will focus on enhancing access to needed medications and the creation of prevention and disease management functions within the centers designed to address special needs of our Members.

Community Mental Health Centers

Aetna Better Health recognizes Community Mental Health Centers (CMHCs) serve a critical role in providing key behavioral and substance abuse health services. As such we welcome the opportunity to work with CMHCs to serve as a PCMH to facilitate better coordinated care for Louisianans with complex chronic health conditions and significant behavioral health care needs. CMHCs are integral to the ongoing interface of behavioral health and medical services and is consistent with our efforts to provider our members with individualized, integrated care. This is particularly true for segments of the population such as seriously mentally ill Members whose primary service provider falls to the CMHC.

Aetna Better Health envisions a collaborative relationship in working with CMHCs to achieve the program improvement and service development goals expressed by the Department of Health and Hospitals. While we understand that behavioral health care is carved-out as a service consideration, it is still important to establish collaborative relationships between Aetna Better Health and CMHCs and where a CMHC can act in the capacity of PCMH, Aetna Better Health is committed to nurturing that relationship and the associated services rendered to our members. Specifically, there will be a joint effort to provide linkages with our network PCMHs (if the CMHC is not acting in a PCMH capacity); cooperative efforts to enhance cultural competency and service access; collaborative case management and coordination strategies to more broadly provide supportive services, such as employment, housing and social services for mentally ill Members.

Care Management

Aetna Better Health offers a set of capabilities and expert care management competencies that are tied to a unique integrated care model. We have developed and perfected care and safety net

service coordination programs designed specifically to work with Medicaid populations and those members accustomed to receiving covered services through community-based resources. Further, our policies and procedures can be customized to a Member's specific circumstances utilizing an individualized plan of care tailored to each individual's needs. Our ICM approach focuses on the entire spectrum of each Member's health care needs ensuring physical and behavioral health and social well being are addressed by focusing on behavior change, relationship building, and by engaging and activating community and healthy social support systems. As part of our efforts to enhance Member resiliency and self-efficacy, we assess each Member in terms they can easily understand that reflect their values, desired care outcomes and stage in life.

To accomplish this, our care management team collaborates across all health care disciplines and works in partnership with:

- Members
- Primary care providers
- Specialists
- Hospitals (inpatient/outpatient)
- Behavioral health providers –even though carve out
- Dental providers –even though carve out
- Community-based organizations and other stakeholders

Member Education and Dissemination of Information Related to Community-Based Resources

Information regarding established community partnerships will be distributed to the members in a variety of mechanisms and through several staff and mediums, as further described below. Initially, upon enrollment and subsequently upon request of the member or as member support needs are identified, information regarding these resources will be made available to members through the member Welcome Packet, the member Internet portal, through member services and care management staff and through organization highlights in the member newsletters. Aetna Better Health will educate network providers via the Provider Manual, mailings, the Provider Internet portal and direct communications (e.g., during monthly provider services visits and webinars). Additionally, other supplementary strategies to communicate with members and Providers regarding the availability of community-based services include:

- Aetna Better Health hires deploys a locally-based Community Outreach Team that will work hands on with community organization and stakeholders to develop relationship and partnerships recognizing that it is important to reach members by non-traditional means such as providing CCN information at pawn shops, payday loan establishments, hair salons, casinos and other locations within the community.
- Aetna Better Health's CEO oversees the Community Outreach Team is committed to being highly involved in community organizations and associations across the state.
- Aetna Better Health supplements the online portals and printed directory materials with educational and training events, community forums and special notices.

- Aetna Better Health uses care coordination, Member Service representatives, care Management and other medical management staff to “target” members for community-based services, works with the member’s Primary Care Physician (PCP)/PCMH to find appropriate medical and social resources, which compliment the member’s care plan.
- Aetna Better Health sponsorships and participation of community-events such as health fairs and health screenings.

Member and Community Advisory Council

Aetna Better Health together with its affiliates effectively manage Medicaid programs across the nation that support, respect, and encourage consumer and community input. Throughout the years, we have learned that consumer and community input into the operations and management of our programs, including input related to care providers and community-based services, is vital in an integrated and member centered care model. We understand Medicaid Members frequently have unique health care needs. We also understand the unique challenges of Medicaid populations in accessing service such as poor English and health literacy, lack of transportation and childcare, and lack of telephone services. Health literacy and proficiency with the English language may create additional challenges. We also recognize the experience of community organizations and other advocates in treating Medicaid populations. As such, we provide members, their caregivers, advocates, and community organizations with access to a Member Advisory Council whereby they can talk to our staff about key ways in which the programs offered by Aetna Better Health may be improved.

Member Advisory Councils provide various parties and entities an opportunity to openly communicate with Aetna Better Health regarding their preferences for care settings, and share their experiences regarding network providers, care improvement programs, community-based services and other Aetna Better Health interactions. Our Member Services Director, working closely with our Community Outreach staff and Quality Management Coordinator, will have the overall responsibility to verify development and ongoing management of a meaningful consumer input initiative. These individuals will be responsible for presenting consumer input to the Aetna Better Health management team and Quality Assessment Performance Improvement (QAPI) Committees (e.g., Service Improvement Committee, Quality Management/Utilization Management Committee and Quality Management Oversight Committee) for review. Based on the review of this feedback, we will identify opportunities for improvement and make changes needed to improve our operations and management of the program.

Under the leadership of the Member Services Director we will implement a comprehensive community input forum that will be designed to establish ongoing Member, caregiver, and community input to support the success of Aetna Better Health programs as well as ongoing feedback on quality improvement strategies to continuously improve the overall effectiveness of our program operations and management. The goals of this initiative will include, but are not limited to, the following:

- Promotion of individuality, dignity, independent living and wellness for our Members
- Support of a person-centered, rights-based approach to care for our Members
- Identification and elimination of barriers to holistic care for our Members

- Training opportunities for Aetna Better Health staff and providers on topics such as cultural competency and sensitivity training, the importance of health literacy
- Gaining feedback from Members and their caregivers to verify best practices and maximize the quality of Members' lives

In selecting consumers and other entities to participate in the Member Advisory Council, Aetna Better Health will choose members that are fairly representative of the diversity of Members and communities we serve. These members will be selected in several ways including, but not limited to, the following:

- Outreach to community organizations or consideration of community or advocacy interest in participation
- Aetna Better Health staff (especially Care Manager) nominations
- Member or caregiver responses to announcements in our Member communications such as "on-hold" recorded messages, Member newsletters and Member handbook, outbound calls to potential members.
- Provider nominations

Connecting Members with Community Based Resources

Examples of the tools we will use to meet this goal are promotion of self-management by the members and hands-on intervention through ICM Model, and more specifically, through a member's assigned case manager (CM). Our CMs will assist the member in developing effective problem-solving skills, including the ability to identify barriers to appropriate care and develop the necessary strategies to access needed services or community resources. Avenues for accomplishing this will include teaching problem-solving skills to members, incorporating problem-solving skills in member interactions or encouraging inclusion of goals related to problem solving in the member's care plan. Through our member educational materials we will also strive to increase their awareness of services available in their local community, including how to access any State available resource guides.

For some members, the Case Managers may need to take a more hands-on role in connecting the member to needed services and resources. In addition to other responsibilities and service coordination activities of CMs, this may involve:

- Providing information to the member on available community resources, e.g., support groups, special education program on nutrition, location of the food stamp or local health department office
- Assisting the member in accessing the resource, e.g., enrolling them in a community support program, helping them with a social service application
- Working with the member's assigned PCP/PCMH to facilitate the member's access to appropriate providers and/or community resources

Work with the Community through the Aetna Foundation

Founded in 1972, the Aetna Foundation is the independent charitable and philanthropic arm of Aetna, Inc. Our mission is to promote wellness, health, and access to high-quality health care for everyone, while supporting the communities we serve.

Aetna's support for programs promoting diversity has deepened through our emphasis on increasing racial and ethnic health equity, while continuing to strive to advance diversity as an engine for change, and as a tool for increasing opportunity. Since 1980, more than \$379 million has been awarded in grants and sponsorships, with over \$30 million directed toward racial and ethnic health equity since 2001.

Examples of awards and initiatives that demonstrate our commitment to diversity include:

- A \$30,000 award to the **Foundation for Health Coverage Education** is funding the Spanish translation of the CoverageForAll.org website (www.coverageforall.org) which provides the uninsured with access to information about their health coverage options.
- In Chicago, a \$300,000 award to the **Center for Healthcare Equity** at the Institute for Healthcare Studies at Northwestern University Feinberg School of Medicine is supporting research and community outreach projects and other initiatives to stimulate improvements in health care equity and overall quality of care for all populations.
- A \$175,000 grant to the **National Council of La Raza (NCLR)** supported The Health Career Pathways Initiative, an educational program targeting Latino communities and administered in collaboration with local community-based partners to recruit and train individuals for careers as health care professionals. The award enabled expansion of the program in Chicago and four additional cities.
- A \$75,000 grant to **Dress for Success** will support the first Aetna Health and Wellness Initiative through their Professional Women's Group program, helping to expand the program by including information on nutrition, fitness and other lifestyle changes.
- In New York City, a \$70,000 award to the **Museum for African Art** will support "Active Body, Active Mind." Targeting senior citizens, the program aims to stimulate mental and physical activity, promote healthy eating, and make walking both entertaining and engaging while viewing exhibitions at the museum.
- A \$50,000 grant to **Project Access of New Haven, Inc.** in Connecticut is supporting a program designed to increase access to, and coordination of, specialty care for the uninsured. The program will also address existing health care disparities and fragmented care associated with low health literacy.
- A \$50,000 award to the **Martin Luther King Jr. Center** in Atlanta supported the Health and Wellness Forum and Salute to Greatness Awards Dinner. The forum, which targets youth, adults and educators, addressed health issues like childhood obesity, diabetes, HIV/AIDS, asthma and other health disparities.
- A \$40,000 award to the **Fund for Public Health New York, Inc.** is supporting the Text4Baby Program, a free service that delivers important health information to pregnant women and new mothers living in underserved communities by sending text messages to mobile phones. Subscribers receive three text messages each week, in English or Spanish, each one tailored to the mother's stage of pregnancy and/or the age of her baby.

Serving a Diverse Marketplace

We are committed to engage these communities through a number of meaningful efforts. These include the following:

Multicultural/multilingual partnerships

We focus our efforts on grassroots strategies that better address the needs of a changing marketplace. This is accomplished by supporting community events, working with a diverse array of community leaders and organizations, and working with States like Louisiana to manage the health of their Medicaid recipients.

Strategic granting

Aetna and the Aetna Foundation have a distinguished legacy of providing grants to support numerous community-based efforts that improve the quality of life in under-served communities. Specifically, Aetna and the Aetna Foundation have awarded over \$379 million in grants and sponsorships since 1980.

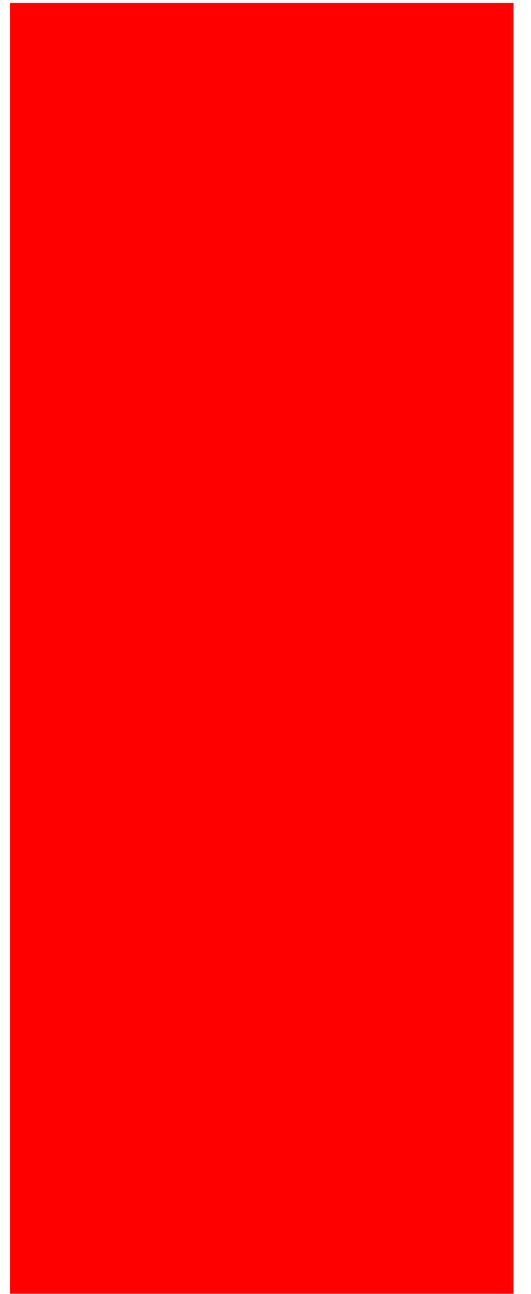
An important component of this giving has been to reduce health care disparities and create greater equality in access to health care for all. We have provided over \$30 million in these critical grants since 2001. Going forward, this will continue to be a significant focus of our community investments.

Employee volunteering and giving

Aetna's employees significantly increase the impact of our grant-making through an extraordinary commitment to serving the communities in which we live and work. Aetna employees have contributed over 1.9 million volunteer hours since 2003, with over 317,000 volunteer hours in 2009 alone. This commitment has improved the lives of communities across the country through a variety of grassroots projects, such as disaster relief, disease research, human rights, community building, little league teams, education, the environment and animal welfare. Further, Aetna employees, retirees and directors contributed \$4.4 million in 2009 through our Giving Program.

As America has advanced through both prosperous and challenging times, one trend has remained constant: Aetna has chosen to reach steadfastly into the community with a spirit of partnership, funding, and volunteers. As we step into the future, we look forward to continuing our efforts to make a difference in the world of health care, in all communities and for all people.

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F.8 Submit a statement of any moral and religious objections to providing any services covered under Section §6 of RFP. If moral and religious objections are identified describe, in as much detail as possible, all direct and related services that are objectionable. Provide a listing of the codes impacted including but not limited to CPT codes, HCPCS codes, diagnosis codes, revenue codes, modifier codes, etc. If none, so state. Describe your plans to provide these services (e.g. birth control) to members who are entitled to such services.

Aetna Better Health, Inc., a Louisiana corporation, d/b/a Aetna Better Health has no moral or religious objections to providing any services covered under Section 6 of the RFP.