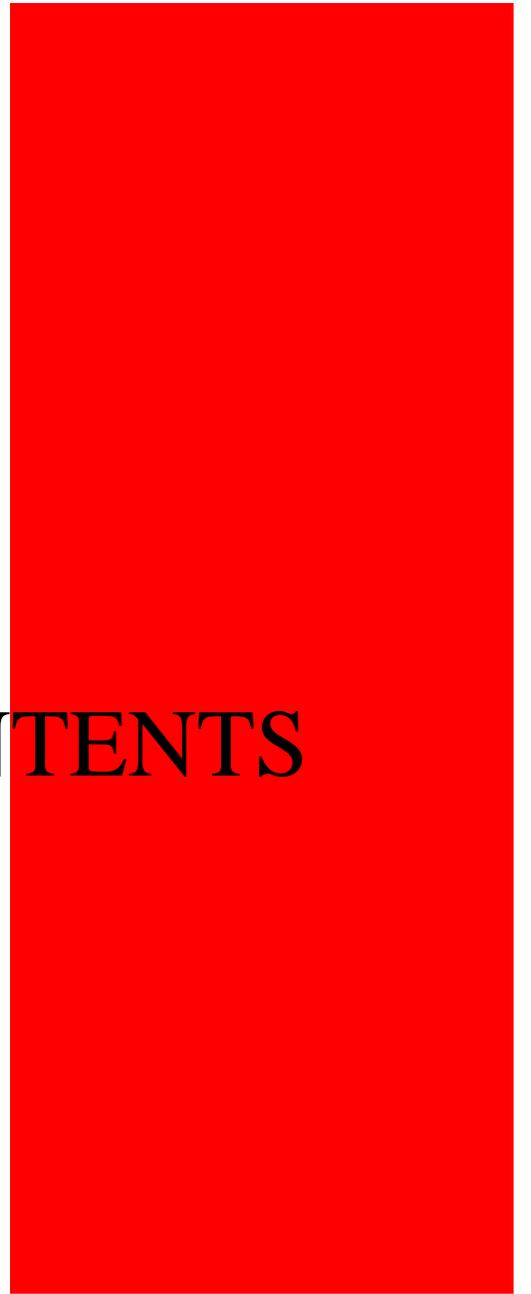
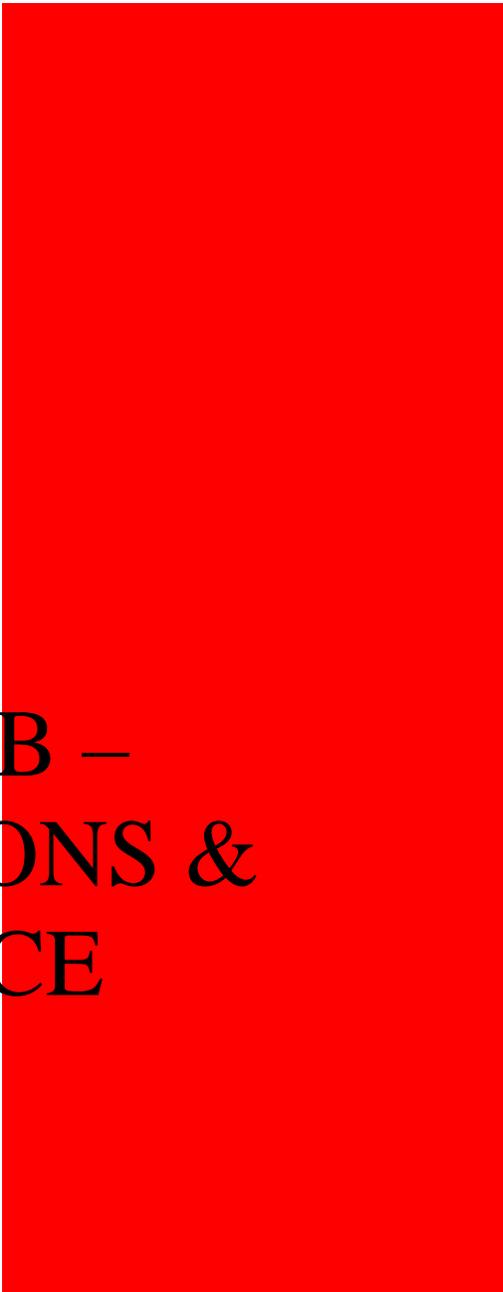


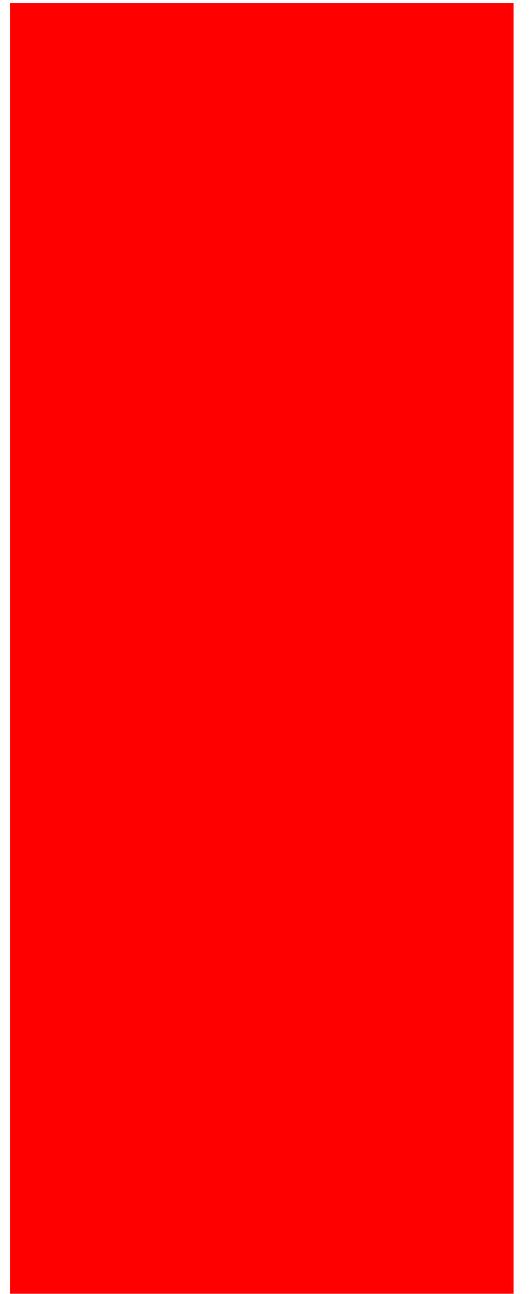
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2 SECTION B –  
QUALIFICATIONS &  
EXPERIENCE

3 B.1



## **PART II: TECHNICAL APPROACH**

### **B. Qualifications and Experience (Sections §2, §3 and §4 of the RFP)**

**B.1** Indicate your organization's legal name, trade name, *dba*, acronym, and any other name under which you do business; the physical address, mailing address, and telephone number of your headquarters office. Provide the legal name for your organization's ultimate parent (e.g. publicly traded corporation).

Describe your organization's form of business (i.e., individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and detail the names, mailing address, and telephone numbers of its officers and directors and any partners (if applicable). Provide the name and address of any health professional that has at least a five percent (5%) financial interest in your organization, and the type of financial interest.

Provide your federal taxpayer identification number and Louisiana taxpayer identification number.

Provide the name of the state in which you are incorporated and the state in which you are commercially domiciled. If out-of-state, provide the name and address of the local representative; if none, so state.

If you have been engaged by DHH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; if not, so state.

#### **Legal Name/d/b/a**

Our legal name is Aetna Better Health, Inc., a Louisiana corporation, d/b/a Aetna Better Health<sup>®</sup> ("Aetna Better Health").

#### **Headquarters Physical and Mailing Address**

Following is the physical and mailing address for Aetna Better Health:

Aetna Better Health, Inc.  
5615 Corporate Blvd., Suite 400B  
Baton Rouge, LA 70808

#### **Phone Number**

Aetna Better Health's phone number is: (225) 992-4490

#### **Legal Name of Ultimate Parent**

Aetna Inc. is the ultimate parent of Aetna Better Health, Inc., a Louisiana corporation, d/b/a Aetna Better Health ("Aetna Better Health").

#### **Form of Business**

Aetna Better Health, Inc., a Louisiana corporation, d/b/a Aetna Better Health ("Aetna Better Health") is a wholly-owned subsidiary of a publicly-traded corporation, Aetna Inc. Aetna Better Health is wholly owned by Aetna Health Holdings, LLC, which is wholly owned by Aetna Inc., a publicly traded corporation. Aetna Better Health was incorporated in Louisiana in July 2010 and is a for-profit corporation. Our ultimate parent, Aetna Inc., is also a for-profit corporation.



Aetna Better Health is a licensed HMO in the State of Louisiana, effective June 2011. Aetna Better Health will administer the Louisiana Medicaid Coordinated Care Network (CCN) Program under an Administrative Services Agreement with Schaller Anderson, LLC (Schaller Anderson), which holds a third party administrator license in the State of Louisiana. Aetna Better Health is a wholly owned subsidiary of Aetna Health Holdings, LLC, which is a wholly owned subsidiary of Aetna Inc., a Fortune 500 company. Schaller Anderson is also a wholly owned subsidiary of Aetna Health Holdings, LLC. Aetna has been serving the health and insurance needs of Americans since 1853 and has established a solid financial foundation for our operations. Aetna Inc.'s total revenues for 2010 exceeded \$34 billion dollars; A.M. Best continued to rate Aetna's financial strength as A (Excellent) and affirmed an A+ (Excellent) long-term credit rating for Aetna, Inc.

To review Aetna Inc.'s corporate structure and the lines of responsibility and authority in the administration of Aetna Better Health's business as a health plan, please refer to Appendix C for a copy of Chart A organizational chart.

**Officers and Directors**

Following are the names, addresses and phone numbers of our officers and directors:

Name	Title	Address	Phone Number
Thomas L. Kelly	Director and President	4645 E. Cotton Center Blvd., Bldg. #1 Phoenix, AZ 85040	602-659-1631
Frederick R. Hatfield	Director	4645 E. Cotton Center Blvd., Bldg. #1 Phoenix, AZ 85040	602-659-1603
Coleen Kivlahan, M.D.	Director	4645 E. Cotton Center Blvd., Bldg. #1 Phoenix, AZ 85040	703-331-5602
Janet M, Stallmeyer	Director	4645 E. Cotton Center Blvd., Bldg. #1 Phoenix, AZ 85040	602-910-1812
Elaine Rose Cofrancesco	Vice President and Treasurer	151 Farmington Avenue, Hartford, CT 06156	860-273-5784
Robert Kessler	Vice President and Secretary	4645 E. Cotton Center Blvd., Bldg. #1 Phoenix, AZ 85040	860-273-1051
Stephen G. Martino	Vice President	980 Jolly Road, Blue Bell, PA 19422	215-775-6321



Name	Title	Address	Phone Number
David W. Braun	Assistant Controller	980 Jolly Road, Blue Bell, PA 19422	215-775-5174
Kevin J. Casey	Senior Investment Officer	151 Farmington Avenue, Hartford, CT 06156	860-273-3708
Jennifer A. Palma	Principal Financial Officer and Controller	980 Jolly Road, Blue Bell, PA 19422	215-775-5001

**Health Professionals with a Five Percent Financial Interest**

No health professional has a financial interest of five percent or more in Aetna Better Health.

**Taxpayer Identification Number**

The federal taxpayer identification number for Aetna Better Health is: 80-0629718.

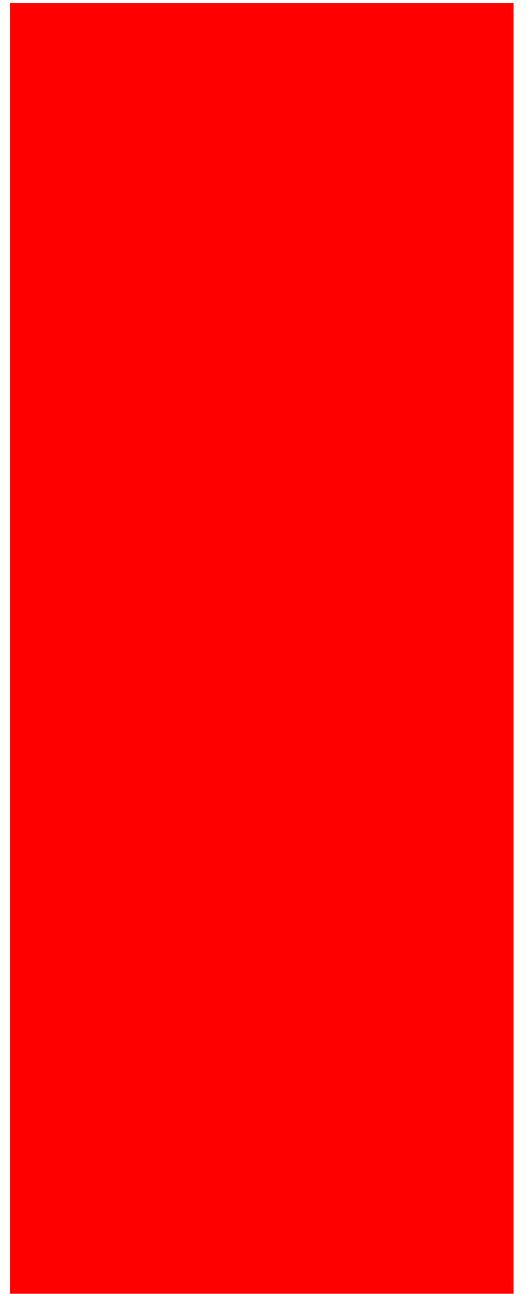
**State of Incorporation and Domicile**

Aetna Better Health, Inc. d/b/a Aetna Better Health (“Aetna Better Health”) is incorporated and domiciled in the State of Louisiana.

**Engagement with DHH in the Past 24 Months**

Aetna Better Health has not been engaged by the Department of Health and Hospitals in the past 24 months.

4 B.2



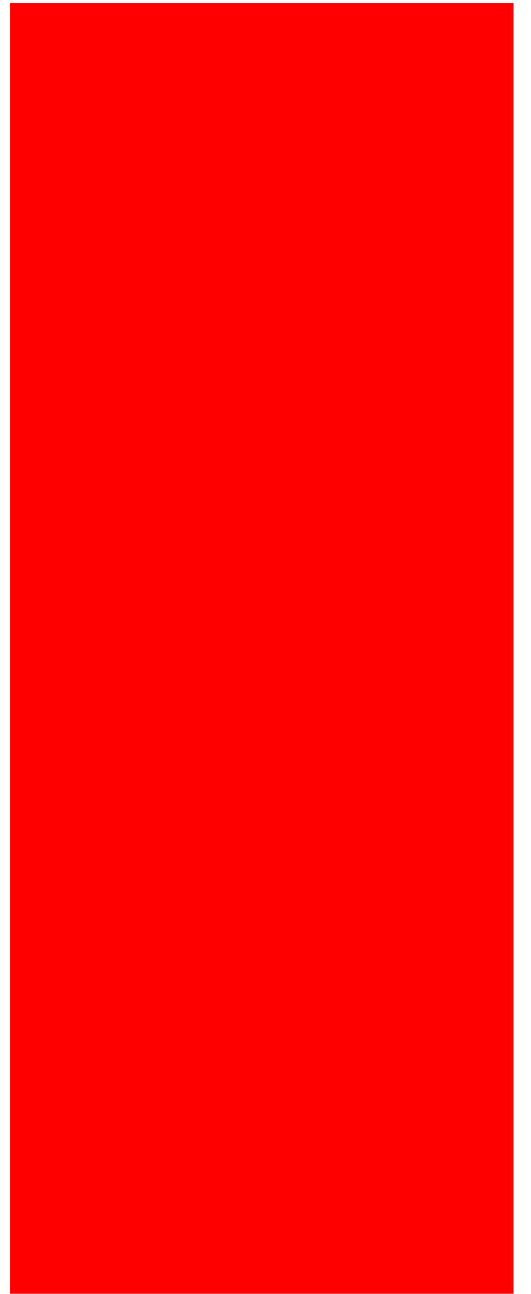
**B.2 Provide a statement of whether there have been any mergers, acquisitions, or sales of your organization within the last ten years, and if so, an explanation providing relevant details. If any change of ownership is anticipated during the 12 months following the Proposal Due Date, describe the circumstances of such change and indicate when the change is likely to occur. Include your organization's parent organization, affiliates, and subsidiaries.**

Aetna Better Health, Inc., a Louisiana corporation, d/b/a Aetna Better Health (“Aetna Better Health”) was incorporated in the State of Louisiana in July 2010, and licensed to do business as an HMO in the State of Louisiana in June 2011. There has been no merger, acquisition or sale of Aetna Better Health, Inc. d/b/a Aetna Better Health (“Aetna Better Health”) within the last ten years, and we do not anticipate any change of Aetna Better Health ownership during the next 12 months following the Proposal Due Date.

Aetna Inc. acquired Medicaid leader, Schaller Anderson, LLC (Schaller Anderson) and all its affiliates in July 2007. Upon acquisition of Schaller Anderson, Aetna placed all of its Medicaid operations under Schaller Anderson management, which reports to Aetna’s division of National Accounts, Aetna Global Business and Medicaid. Schaller Anderson and its affiliates form the core of Aetna Medicaid operations.

Aetna is continually looking for ways to reduce expenses by merging entities within the Aetna family of companies and has merged several entities within the Aetna organization over the last 10 years. Aetna is also continually evaluating acquisitions that present strategic growth opportunities and has acquired several companies over the last 10 years for this purpose and to better service our existing and new customers. Aetna has not had any sales that were material during the last 10 years.

5 B.3



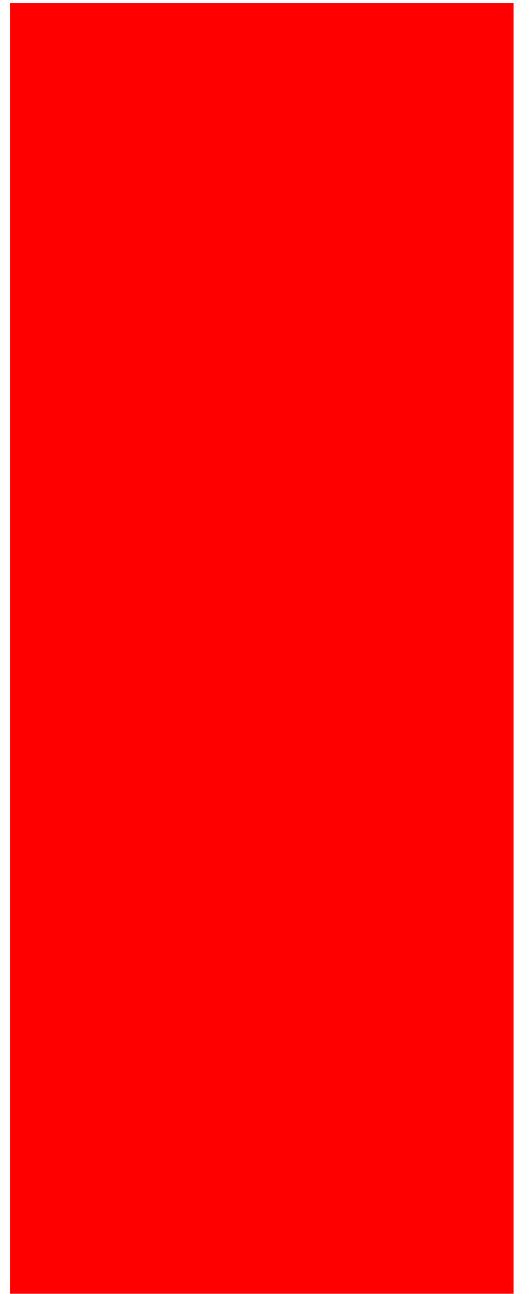
**B.3 Provide a statement of whether you or any of your employees, agents, independent contractors, or subcontractors have ever been convicted of, pled guilty to, or pled *nolo contendere* to any felony and/or any Medicaid or health care related offense or have ever been debarred or suspended by any federal or state governmental body. Include an explanation providing relevant details and the corrective action plan implemented to prevent such future offenses. Include your organization's parent organization, affiliates, and subsidiaries.**

It is Aetna Better Health, Inc.'s, a Louisiana corporation, d/b/a Aetna Better Health's® ("Aetna Better Health's") policy and procedure that Aetna Better Health shall not employ or contract with an individual, agent, independent contractor or subcontractor who has been convicted of, pled guilty to, or pled *nolo contendere* to any felony and/or any Medicaid or health care related offense or have ever been debarred or suspended by any federal or state governmental body.

Other than as set forth below, neither our parent organization, affiliates and subsidiaries nor any of its employees, agents, independent contractors or subcontractors have ever been convicted of, pled guilty to, or pled *nolo contendere* to any felony and/or any Medicaid or health care related offense or have ever been debarred or suspended by any federal or state governmental body.

In April 2010, the Centers for Medicare & Medicaid Services (CMS) imposed intermediate sanctions on Aetna suspending the enrollment of and marketing to new members of all Aetna Medicare Advantage and Standalone Prescription Drug Plan contracts, effective April 21, 2010. The sanctions related to compliance with certain Medicare Part D requirements, primarily those relating to changes in the drugs covered by certain plans from 2009 to 2010. The suspension did not affect current Medicare enrollees who stayed in their existing plans. CMS lifted the sanctions on June 13, 2011. We take our obligations to our members and plan sponsors seriously, and our priority is to help make sure that our members have access to covered benefits.

6 B.4



**B.4 Provide a statement of whether there is any pending or recent (within the past five years) litigation against your organization. This shall include but not be limited to litigation involving failure to provide timely, adequate or quality physical or behavioral health services. You do not need to report workers' compensation cases. If there is pending or recent litigation against you, describe the damages being sought or awarded and the extent to which adverse judgment is/would be covered by insurance or reserves set aside for this purpose. Include a name and contact number of legal counsel to discuss pending litigation or recent litigation. Also include any SEC filings discussing any pending or recent litigation. Include your organization's parent organization, affiliates, and subsidiaries.**

There is no pending or recent litigation against Aetna Better Health, Inc., a Louisiana corporation, d/b/a Aetna Better Health ("Aetna Better Health").

Aetna Inc. and its subsidiaries/affiliates are routinely involved in non-material litigation regarding the administration of health, life, disability and dental plans. Most of this litigation involves a single claim for benefits or payment for provider services.

Pending litigation and recent litigation may be discussed with legal counsel:

John E. Neugebauer, Esq.  
Aetna  
980 Jolly Road  
PO Box 1180  
Blue Bell, PA 19422  
Phone: (215) 775-5939

All material litigation is reported in Aetna's public filings. Following is the litigation proceeding section from Aetna's Form 10-K, filed February 25, 2011.

## **Litigation and Regulatory Proceedings**

### ***Out-of-Network Benefit Proceedings***

We are named as a defendant in several purported class actions and individual lawsuits arising out of our practices related to the payment of claims for services rendered to our members by health care providers with whom we do not have a contract ("out-of-network providers"). Other major health insurers are also the subject of similar litigation or have settled similar litigation. Among other things, these lawsuits allege that we paid too little to our health plan members and/or providers for these services, among other reasons, because of our use of data provided by Ingenix, Inc., a subsidiary of one of our competitors ("Ingenix").

Various plaintiffs who are health care providers or medical associations seek to represent nationwide classes of out-of-network providers who provided services to our members during the period from 2001 to the present. Various plaintiffs who are members in our health plans seek to represent nationwide classes of our members who received services from out-of-network providers during the period from 2001 to the present. Taken together, these lawsuits allege that we violated state law, the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the Racketeer Influenced and Corrupt Organizations Act and federal antitrust laws, either acting alone or in concert with our competitors. The purported classes seek reimbursement

of all unpaid benefits, recalculation and repayment of deductible and coinsurance amounts, unspecified damages and treble damages, statutory penalties, injunctive and declaratory relief, plus interest, costs and attorneys' fees, and seek to disqualify us from acting as a fiduciary of any benefit plan that is subject to ERISA. Individual lawsuits that generally contain similar allegations and seek similar relief have been brought by a health plan member and by out-of-network providers.

The first class action case was commenced on July 30, 2007. The federal Judicial Panel on Multi-District Litigation (the "MDL Panel") has consolidated these class action cases in the U.S. District Court for the District of New Jersey under the caption *In re: Aetna UCR Litigation*, MDL No. 2020 ("MDL 2020"). In addition, the MDL Panel has transferred the individual lawsuits to MDL 2020. Discovery is substantially complete in MDL 2020, several motions are pending, and briefing on class certification has been completed. The court has not set a trial date or a timetable for deciding class certification or other pending motions. We intend to vigorously defend ourselves against the claims brought in these cases.

We also have received subpoenas and/or requests for documents and other information from, and have been investigated by, attorneys general and other state and/or federal regulators, legislators and agencies relating to our out-of-network benefit payment practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against us with respect to our out-of-network benefit payment practices.

### ***CMS Actions***

Effective June 13, 2011 CMS lifted its April 21, 2010, CMS imposed intermediate sanctions on us, suspending the enrollment of and marketing to new members of all Aetna Medicare Advantage and Standalone PDP contracts. The sanctions related to our compliance with certain Medicare Part D requirements. The suspension does not affect our current Medicare enrollees who stay in their existing plans. CMS has granted us a limited waiver of these sanctions to allow us to continue to enroll eligible members into existing, contracted group Aetna Medicare Advantage Plans and Standalone PDPs through March 31, 2011. As a result of these sanctions, our 2011 Medicare membership was adversely affected because we did not participate in the 2010 open enrollment for individual 2011 Medicare plans which occurred between November 15, 2010 and December 31, 2010. We are cooperating fully with CMS on its review and are working to resolve the issues CMS has raised as soon as possible. If the CMS sanctions remain in effect or we fail to obtain extensions of the limited waiver through the end of those sanctions, our Medicare membership and operating results could be adversely affected.

CMS regularly audits our performance to determine our compliance with CMS's regulations, our contracts with CMS and the quality of services we provide to our Medicare members. CMS uses various payment mechanisms to allocate and adjust premium payments to our and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information maintained and provided by health care providers. We collect claim and encounter data from providers and generally rely on providers to appropriately code their submissions and document their medical records. Medicare Advantage plans and PDPs receive increased premiums for members who have certain medical conditions identified with specific health condition codes. Federal regulators review and audit the providers' medical records and related health condition codes that determine the members' health status and the resulting

premium payments to us. CMS has instituted risk adjustment data validation (“RADV”) audits of various

Medicare Advantage plans, including two of Aetna’s contracts for the 2007 contract year. Although these two audits are ongoing, we do not believe that they will have a material impact on our operating results, financial position or cash flows.

We believe that the OIG also is auditing risk adjustment data, and we expect CMS and the OIG to continue auditing risk adjustment data for the 2007 contract year and beyond. Aetna and other Medicare Advantage organizations have provided comments to CMS in response to CMS’s December 2010 proposed RADV sampling and payment error calculation methodology by which CMS proposes to calculate and extrapolate RADV audit payment error rates for, and determine premium refunds payable by, Medicare Advantage plans. Our concerns with CMS’s proposed methodology include the fact that the proposed methodology does not take into account the “error rate” in the original Medicare fee-for-service data that was used to develop the risk adjustment system and that retroactive audit and payment adjustments undermine the actuarial soundness of Medicare Advantage bids. CMS has indicated that it may make retroactive contract-level premium payment adjustments based on the results of these RADV audits, which could occur as early as 2011. CMS’s premium adjustments could be implemented prior to our, or other Medicare Advantage plans, having an opportunity to appeal the audit or payment error calculation results or methodology. We are unable to predict the ultimate outcome of CMS’s final RADV audit methodology, other audits for the 2007 contract year or subsequent contract years, the amounts of any retroactive refunds of, or prospective adjustments to, premium payments made to us, or whether any audit findings would cause a change to our method of estimating future premium revenue in bid submissions to CMS for the current or future contract years or compromise premium assumptions made in our bids for prior contract years. Any premium refunds or adjustments resulting from regulatory audits, including those resulting from CMS’s selection of its final RADV audit methodology, whether as a result of RADV or other audits by CMS or OIG or otherwise, could be material and could adversely affect our operating results, financial position and cash flows.

#### ***Other Litigation and Regulatory Proceedings***

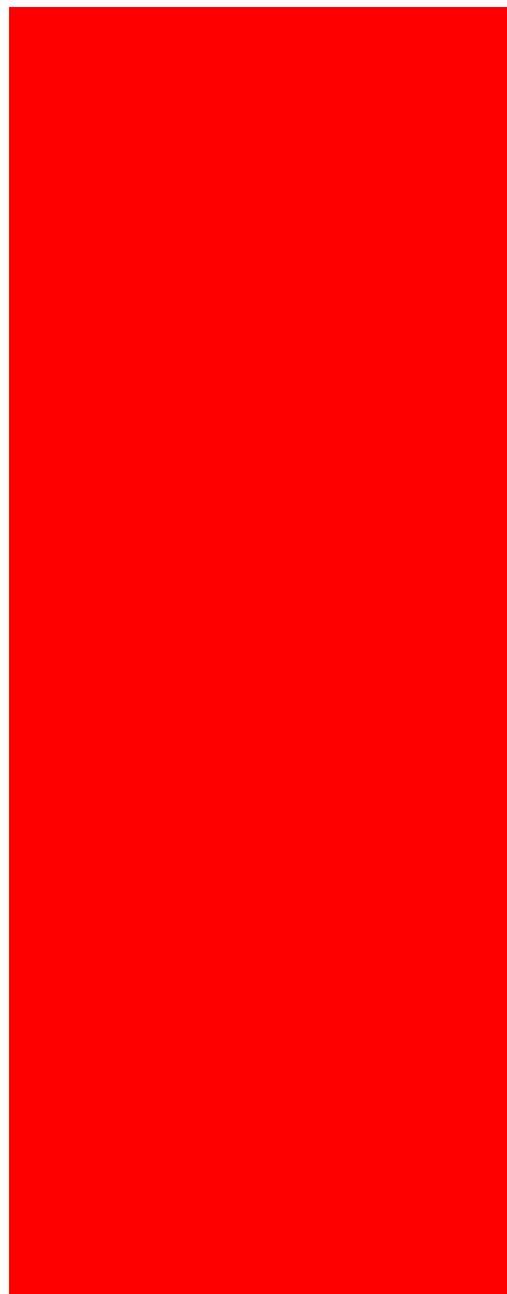
We are involved in numerous other lawsuits arising, for the most part, in the ordinary course of our business operations, including employment litigation and claims of bad faith, medical malpractice, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay medical and/or group insurance claims (including post-payment audit and collection practices), rescission of insurance coverage, improper disclosure of personal information, patent infringement and other intellectual property litigation and other litigation in our Health Care and Group Insurance businesses. Some of these other lawsuits are or are purported to be class actions. We intend to vigorously defend ourselves against the claims brought in these matters.

In addition, our operations, current and past business practices, current and past contracts, and accounts and other books and records are subject to routine, regular and special investigations, audits, examinations and reviews by, and from time to time we receive subpoenas and other requests for information from, CMS, various state insurance and health care regulatory authorities, state attorneys general, the Center for Consumer Information and Insurance

Oversight, the Office of the Inspector General, the Office of Personnel Management, committees, subcommittees and members of the U.S. Congress, the U.S. Department of Justice, U.S. attorneys and other state and federal governmental authorities. These government actions include inquiries by, and testimony before, certain members, committees and subcommittees of the U.S. Congress regarding certain of our current and past business practices, including our overall claims processing and payment practices, our business practices with respect to our small group products, student health products or individual customers (such as market withdrawals, rating information, premium increases and medical benefit ratios), executive compensation matters and travel and entertainment expenses, in connection with their consideration of health care reform measures, as well as the investigations by, and subpoenas and requests from, attorneys general and others described above under “Out-of-Network Benefit Proceedings.” There also continues to be heightened review by regulatory authorities of and increased litigation regarding the health care benefits industry’s business and reporting practices, including premium rate increases, utilization management, complaint and grievance processing, information privacy, provider network structure (including the use of performance-based networks), delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices and claim payment practices (including payments to out-of-network providers). As a leading national health care benefits company, we regularly are the subject of such government actions. These government actions may prevent or delay us from implementing planned premium rate increases and may result, and have resulted, in restrictions on our business, changes to or clarifications of our business practices, retroactive adjustments to premiums, refunds to members, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible loss of licensure or suspension from participation in government programs, including the actions taken by CMS that are described above under “CMS Actions.”

Estimating the probable losses or a range of probable losses resulting from litigation, government actions and other legal proceedings is inherently difficult and requires an extensive degree of judgment, particularly where the matters involve indeterminate claims for monetary damages, may involve fines, penalties or punitive damages that are discretionary in amount, involve a large number of claimants or regulatory authorities, represent a change in regulatory policy, present novel legal theories, are in the early stages of the proceedings, are subject to appeal or could result in a change in business practices. In addition, because most legal proceedings are resolved over long periods of time, potential losses are subject to change due to, among other things, new developments, changes in litigation strategy, the outcome of intermediate procedural and substantive rulings and other parties' settlement posture and their evaluation of the strength or weakness of their case against us. We are currently unable to predict the ultimate outcome of, or reasonably estimate the losses or a range of losses resulting from, the matters described above, and it is reasonably possible that their outcome could be material to us.

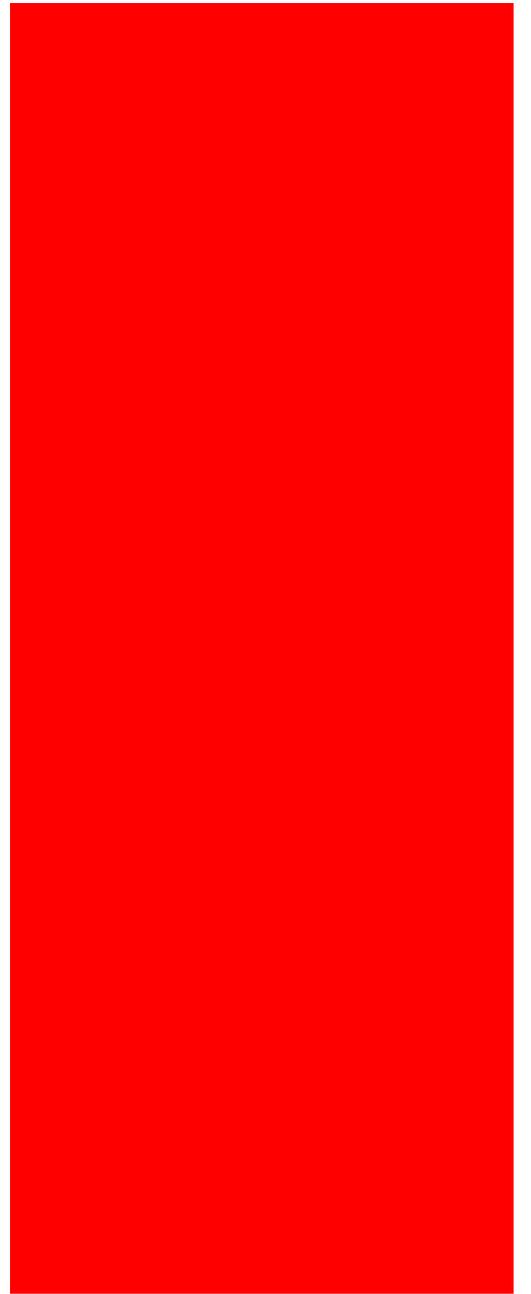
7 B.5



**B.5 Provide a statement of whether, in the last ten years, you or a predecessor company has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. If so, provide an explanation providing relevant details including the date in which the Proposer emerged from bankruptcy or expects to emerge. If still in bankruptcy, provide a summary of the court-approved reorganization plan. Include your organization's parent organization, affiliates, and subsidiaries.**

Neither Aetna Better Health, Inc., a Louisiana corporation, d/b/a Aetna Better Health (“Aetna Better Health”), or its ultimate parent company, Aetna Inc., or any of its affiliates and subsidiaries has filed for bankruptcy or insolvency proceedings in the last 10 years.

8 B.6



**B.6 If your organization is a publicly-traded (stock-exchange-listed) corporation, submit the most recent United States Securities and Exchange Commission (SEC) Form 10K Annual Report, and the most-recent 10-Q Quarterly report.**

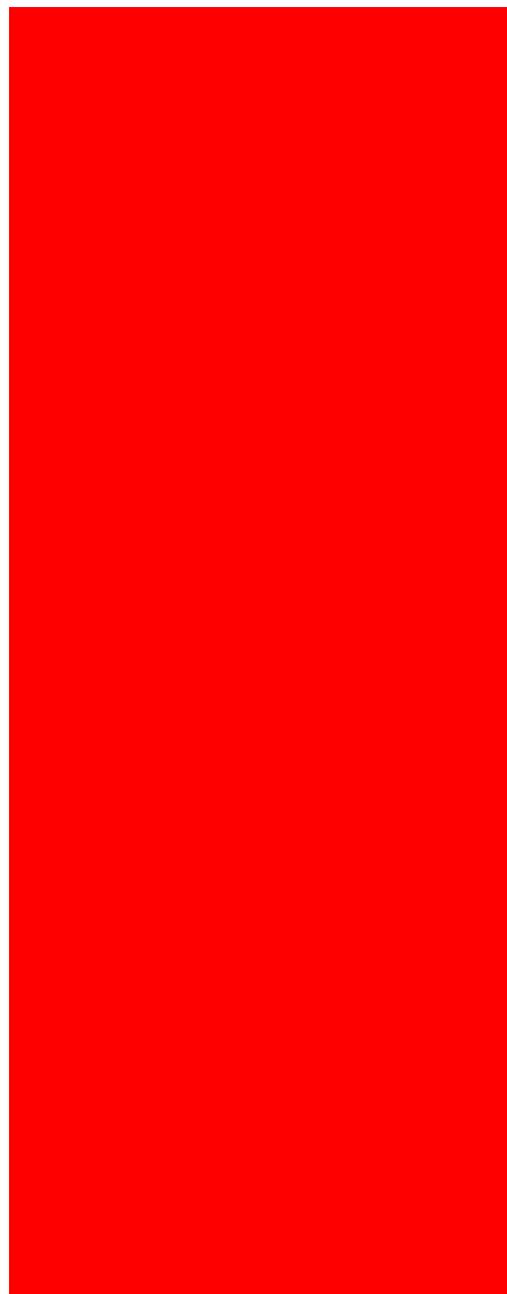
**Provide a statement whether there have been any Securities Exchange Commission (SEC) investigations, civil or criminal, involving your organization in the last ten (10) years. If there have been any such investigations, provide an explanation with relevant details and outcome. If the outcome is against the Proposer, provide the corrective action plan implemented to prevent such future offenses. Also provide a statement of whether there are any current or pending Securities Exchange Commission investigations, civil or criminal, involving the Proposer, and, if such investigations are pending or in progress, provide an explanation providing relevant details and provide an opinion of counsel as to whether the pending investigation(s) will impair the Proposer's performance in a contract/Agreement under this RFP. Include your organization's parent organization, affiliates, and subsidiaries.**

Aetna Better Health, Inc., a Louisiana corporation, d/b/a Aetna Better Health (“Aetna Better Health”) is a wholly-owned subsidiary of a publicly-traded corporation, Aetna Inc. Aetna Better Health, Inc. d/b/a/ Aetna Better Health is wholly owned by Aetna Health Holdings, LLC, which is wholly owned by Aetna Inc. (Aetna), a publicly traded corporation.

There have not been any Securities Exchange Commission (SEC) investigations, civil or criminal, involving our organization, our parent organization, affiliates and subsidiaries in the last 10 years.

For Aetna's Securities and Exchange Commission Form 10K, 2010 Annual Report, and the most recent 10-Q Quarterly Report, please see Appendix A.

9 B.7



**B.7 If another corporation or entity either substantially or wholly owns your organization, submit the most recent detailed financial reports for the parent organization. If there are one (1) or more intermediate owners between your organization and the ultimate owner, this additional requirement is applicable only to the ultimate owner.**

**Include a statement signed by the authorized representative of the parent organization that the parent organization will unconditionally guarantee performance by the proposing organization of each and every obligation, warranty, covenant, term and condition of the Contract.**

### **Financial Reports**

Aetna Better Health, Inc., a Louisiana corporation, d/b/a Aetna Better Health (“Aetna Better Health”) is a wholly-owned subsidiary of a publicly-traded corporation, Aetna Inc. Aetna Better Health is wholly owned by Aetna Health Holdings, LLC, which is wholly owned by Aetna Inc., a publicly traded corporation. Please see Appendix B for the most recent detailed financial reports for our ultimate owner, Aetna Inc.

### **Unconditional Performance Guarantee**

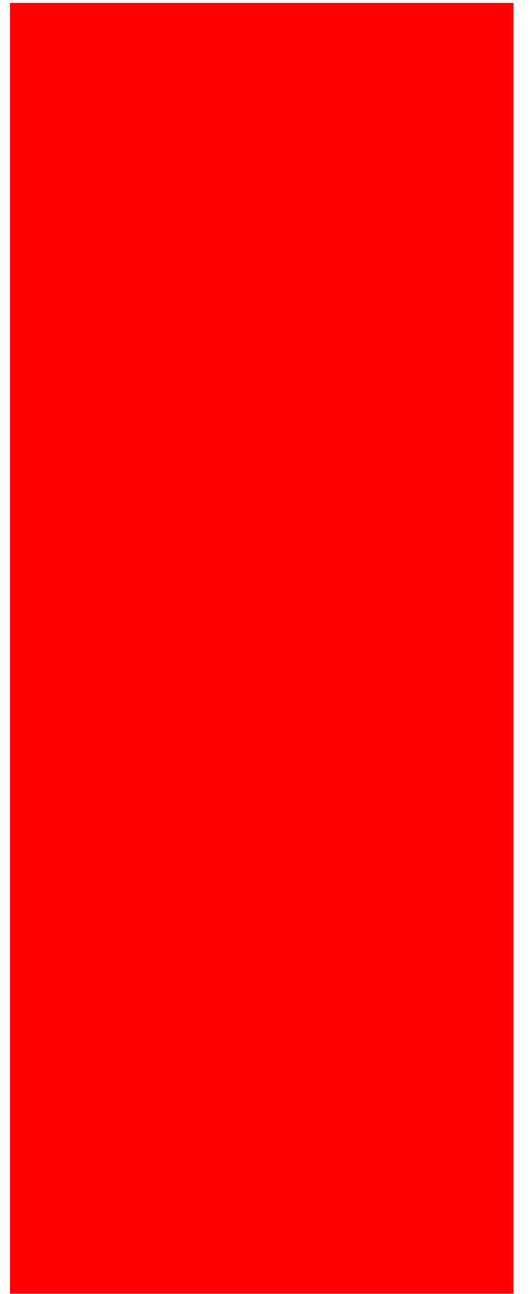
Aetna Health Holdings, LLC will unconditionally guarantee performance by Aetna Better Health in each and every obligation, warranty, covenant, term, and condition of the contract executed by the parties. There is no maximum limit to the financial support that will be provided by Aetna Health Holdings, LLC.

To review Aetna Inc.’s corporate structure and the lines of responsibility and authority in the administration of Aetna Better Health’s business as a health plan, please see Appendix C for a copy of Chart A organizational chart.

### **Unconditional Performance Guarantee**

Please see Appendix B for a signed statement of unconditional performance guarantee from our parent company, Aetna Health Holdings, LLC.

10 B.8



**B.8 Describe your organization's number of employees, client base, and location of offices. Submit an organizational chart (marked as Chart A of your response) showing the structure and lines of responsibility and authority in your company. Include your organization's parent organization, affiliates, and subsidiaries.**

### **Number of Employees**

Our top team of experienced implementation/transition experts is already in place and ready to begin implementation activities upon contract award. Should a contract for GSA A, B and C be awarded to Aetna Better Health, we project hiring up to 180 full-time Louisiana employees to staff this office, but reserve the right to adjust staffing according to membership.

### **Client Base**

The following table provides information for each State Medicaid or State Children's Health Insurance Program (SCHIP) Program for which we are contracted, either directly with a State client or indirectly through a sponsoring organization, to coordinate managed health care services. Our integrated medical management capabilities, provider network and strong administrative services are fully embedded in a variety of delivery systems, including fully capitated health plans, complex care management and administrative services organizations.



Part Two: Technical Proposal  
Section B: Qualifications and Experience

Client Name & Address	Prime or Subcontractor	Contract Size		Contract Details	
		Average Monthly Covered Lives*	Capitated	Duration	
<b>Arizona (Mercy Care)</b>					
Department of Economic Security Div. of Developmental Disability 2200 N. Central, Suite 207 Phoenix, AZ 85004	Subcontractor	ABD: 8,850 Total: 8,850	Yes	6 years Contract expires October 2011	1985 Original Contract Start Date
<b>Contact Information</b> <b>Name:</b> Louetta Coulson, Administrator of Health Services <b>Telephone:</b> 602-238-0928, ext 6012 <b>E-mail:</b> <a href="mailto:lcoulson@azdes.gov">lcoulson@azdes.gov</a>					
<b>Scope of Services:</b> Manage and coordinate medical services including inpatient, outpatient and ancillary services; Medicare wraparound for dual eligibles. Behavioral health services are carved out we coordinate care with the vendor.					
<b>*Covered Population:</b> Individuals enrolled with the Division of Developmental Disabilities who are diagnosed with severe chronic disability appearing before age of 18, who are diagnosed with cognitive difficulties, cerebral palsy, epilepsy, autism, or for children 0-5 who are mentally delayed.					



Part Two: Technical Proposal  
Section B: Qualifications and Experience

Client Name & Address	Prime or Subcontractor	Contract Size		Contract Details
		Average Monthly Covered Lives*	Capitated	
<b>Arizona (Mercy Care Plan AZ)</b>				
State of Arizona AHCCCS Administration 701 E. Jefferson Phoenix, AZ 85034 <b>Contact Information</b> <b>Name:</b> Elizabeth Stackfleth <b>Telephone:</b> 602-417-4796 <b>E-mail:</b> <a href="mailto:elizabeth.stackfleth@azahcccs.gov">elizabeth.stackfleth@azahcccs.gov</a>	Subcontractor	TANF: 292,189 *** ABD: 41,534 Total: 333,723 *** The TANF number includes dual eligible members, 15,716, already reflected on the Mercy Care Advantage Page	Yes	5 years Contract expires October 2013 May 2002 Original Contract Start Date
<b>Scope of Services:</b> Manage and coordinate medical services including inpatient, outpatient and ancillary services; Medicare wraparound for dual eligibles. Behavioral health services are carved out we coordinate care with the vendor. <b>*Covered Population:</b> TANF, Aged, Blind and Disabled (ABD)				



Part Two: Technical Proposal  
Section B: Qualifications and Experience

Client Name & Address	Prime or Subcontractor	Contract Size		Contract Details	
		Average Monthly Covered Lives*	Capitated	Duration	
<b>Arizona (Mercy Care Advantage AZ)</b>					
CMS Div of Medicare Health Plans 90 7th Street Suite 5-300 (5W) San Francisco, CA 94103 <b>Contact Information</b> <b>Name:</b> Virginia (Ginnie) Brooks <b>Telephone:</b> 415-744-3696 <b>E-mail:</b> <a href="mailto:vbrooks@cms.hhs.gov">vbrooks@cms.hhs.gov</a>	Subcontractor	SNP/Duals: 15,716  Total: 15,716	Yes	Annual Renewal  January 2006  Original Contract Start Date	
<b>Scope of Services:</b> Medicare Advantage, Special Needs Program (SNP) contractor with CMS. Provide and coordinate all Medicare covered services and benefits  <b>*Covered Population:</b> Individuals eligible for both Medicare and Medicaid (aka dual eligibles).					



Part Two: Technical Proposal  
Section B: Qualifications and Experience

Client Name & Address	Prime or Subcontractor	Contract Size		Contract Details	
		Average Monthly Covered Lives*	Capitated	Duration	
<b>Arizona (Mercy Care Plan AZ)</b>					
State of Arizona AHCCCS Administration Arizona Long Term Care System(ALTCS) 701 E. Jefferson Phoenix, AZ 85034	Subcontractor	LTC: 8,867 Total: 8,867	Yes	5 years Contract expires October 2011	May 2002 Original Contract Start Date
<b>Contact Information</b> Name: John Black Telephone: 602-417-4055 E-mail: <a href="mailto:john.black@azahcccs.gov">john.black@azahcccs.gov</a>					
<b>Scope of Services:</b> Manage and coordinate services for members residing in skilled nursing facilities, assisted living facilities and home and community-based settings with acute care and behavioral health services, including case management.					
<b>*Covered Population:</b> Aged Blind and Disabled (ABD), and Supplemental Security Income (SSI) who meet criteria for institutional placement.					



Part Two: Technical Proposal  
Section B: Qualifications and Experience

Client Name & Address	Prime or Subcontractor	Contract Size		Contract Details	
		Average Monthly Covered Lives*	Capitated	Duration	
<b>Arizona (Mercy Healthcare Group)</b>					
Healthcare Group of Arizona Healthcare Group Administration 701 E. Jefferson Phoenix, AZ 85034	Subcontractor	HCG: 3,813 Total: 3,813	Yes	9 years (Annual renewal increments) Contract expires August 2011	May 2002 Original Contract Start Date
<b>Contact Information</b> Name: Carla Kot Telephone: 602-417-6743 E-mail: <a href="mailto:carla.kot@azahcccs.gov">carla.kot@azahcccs.gov</a>					
<b>Scope of Services:</b> Manage and coordinate medical services including inpatient, outpatient and ancillary services; Medicare wraparound for dual eligibles. Behavioral health services are carved out we coordinate care with the vendor.					
<b>*Covered Population:</b> Healthcare coverage for working uninsured.					



Part Two: Technical Proposal  
Section B: Qualifications and Experience

Client Name & Address	Prime or Subcontractor	Contract Size		Contract Details	
		Average Monthly Covered Lives	Capitated	Duration	
<b>California</b>					
CalOptima 1120 West La Veta Avenue Orange, CA 92868 <b>Contact Information</b> Children's Hospital Orange County (CHOC) Health Alliance <b>Name:</b> Kerri Ruppert Schiller <b>Telephone:</b> 714-532-8451 <b>E-mail:</b> <a href="mailto:kschiller@choc.org">kschiller@choc.org</a>	Subcontractor	TANF: 86,826 CHIP: 18,156 ABD: 4,053 Other: 729 Total: 109,764	Yes	15 years  Current contract expires August 2012  October 1995 Original Contract Start Date	
<b>Scope of Services:</b> Manage and coordinate acute care services including inpatient, outpatient and ancillary services. Behavioral health services are carved out; we coordinate care with the vendor  <b>Covered Population:</b> TANF, CHIP and ABD					



Part Two: Technical Proposal  
Section B: Qualifications and Experience

Client Name & Address	Prime or Subcontractor	Contract Size		Contract Details	
		Average Monthly Covered Lives	Capitated	Duration	
<b>Connecticut</b>					
State of Connecticut, Department of Social Services 25 Sigourney Street Hartford, CT 06106	Prime	TANF: 95,565 CHIP: 4,825 Other(Charter Oak): 4,218 Total: 104,608	Yes	6 years	Three year contract with three, 1-year extensions. Current term ends 6/30/11
<b>Contact Information</b> <b>Name:</b> Mark Schaefer, Interim Director <b>Telephone:</b> 860-424-5067 <b>E-mail:</b> <a href="mailto:mark.schaefer@ct.gov">mark.schaefer@ct.gov</a>					
<b>Scope of Services</b> Manage and coordinate acute care services including inpatient, outpatient and ancillary services. Behavioral health services are carved out; we coordinate care with the vendor					
<b>Covered Population:</b> HUSKY A (TANF), and HUSKY B (CHIP), Charter Oak (State program covering 19 to 64-year-olds)					



Part Two: Technical Proposal  
Section B: Qualifications and Experience

Client Name & Address	Prime or Subcontractor	Contract Size		Contract Details	
		Average Monthly Covered Lives*	Capitated	Duration	
<b>Delaware (Risk)</b>					
Delaware Medicaid & Medical Assistance 1901 N. Dupont Highway Lewis Building New Castle, DE 19720	Prime	TANF: 68,463 CHIP: 3,986 ABD: 7,835 Other (Expanded): 20,655 Total: 100,939	Yes	6 years  Contract expires 6/30/11 with option to extend contract until 6/30/2012	July 2004  Original Contract Start Date
<b>Contact Information</b> Name: Mary Marinari, MCO Liaison Telephone: 302-255-9548 E-mail: <a href="mailto:mary.marinari@state.de.us">mary.marinari@state.de.us</a>					
<b>Scope of Services:</b> Manage and coordinate acute care and behavioral health services including inpatient, outpatient and ancillary services.					
<b>*Covered Population:</b> TANF, CHIP, and ABD					



Part Two: Technical Proposal  
Section B: Qualifications and Experience

Client Name & Address	Prime or Subcontractor	Contract Size		Contract Details	
		Average Monthly Covered Lives	Capitated	Duration	
<b>Illinois</b>					
Illinois Integrated Care Program Illinois Department of HealthCare and Family Services 201 South Grand Springfield, Illinois 62763 <b>Contact Information</b> Michelle Maher Bureau Chief Bureau of Managed Care 217-524-7478	Prime	Membership unavailable due to new contract starting May 2011.	Yes	3/1/2011	5 year contract with option to renew for a total of 10 years  March 2011 <i>Original Contract Start Date</i>
<b>Scope of Services:</b> Manage and coordinate services for members residing in skilled nursing facilities, assisted living facilities and home and community-based settings with acute care and behavioral health services, including case management.					
<b>Covered Population:</b> ABD (adults and older adults with disabilities) Older Adults and Adults with Disabilities who are eligible for Medicaid but are not eligible for Medicare.					



Part Two: Technical Proposal  
Section B: Qualifications and Experience

Client Name & Address	Prime or Subcontractor	Contract Size		Contract Details	
		Average Monthly Covered Lives	Capitated	Duration	
<b>Florida</b>					
Integral Health Plan, Inc .D/B/A Integral Quality Care 4630 Woodland Corporate Blvd Tampa, FL 33614	Subcontractor	TANF: 11,262 ABD: 1,075 Total: 12,337	No	1 year  Current contract expires August 2012	March 2010  Original Contract Start Date
<b>Contact Information</b> Name: Richard Akin Telephone: 239-658-3138 E-mail: <a href="mailto:rbakin@aol.com">rbakin@aol.com</a>					
<b>Scope of Services</b> Manage and coordinate acute care services including inpatient, outpatient and ancillary services. Behavioral health services are carved out; we coordinate care with the vendor.					
<b>Covered Population:</b> TANF and ABD					



Part Two: Technical Proposal  
Section B: Qualifications and Experience

Client Name & Address	Prime or Subcontractor	Contract Size		Contract Details	
		Average Monthly Covered Lives	Capitated	Duration	
<b>Maryland</b>					
Maryland Physicians Care 509 Progress Drive Linthicum, MD 21090	Subcontractor	TANF: 112,820 CHIP: 11,560 ABD: 16,909 Other (PAC): 18,302 Total: 159,591	Yes	13 years	State automatically renews contract every year. July 1997 Original Contract Start Date
<b>Contact Information</b> Name: Raymond Grahe, Chairman Telephone: 301-790-8102 E-mail: <a href="mailto:ragrahe@meritushealth.com">ragrahe@meritushealth.com</a>					
<b>Scope of Services</b> Manage and coordinate acute care services including inpatient, outpatient and ancillary services. Behavioral health services are carved out; we coordinate care with the vendor					
<b>Covered Population:</b> TANF, CHIP, ABD and Primary Adult Care (PAC) – PAC is for low income adults age 19 and over who meet the minimum income requirements. PAC benefits cover cost of prescriptions, primary care, mental health care and other limited services.					



Part Two: Technical Proposal  
Section B: Qualifications and Experience

Client Name & Address	Prime or Subcontractor	Contract Size		Contract Details	
		Average Monthly Covered Lives*	Capitated	Duration	
<b>Missouri (Risk)</b>					
MO HealthNet (Missouri Medicaid) 615 Howerton Court P.O. Box 6500 Jefferson City, MO 65102	Prime	TANF: 45,203 CHIP: 5,381  Total: 50,584	Yes	13 years  Current contract expires June 2012	March 1998  Original Contract Start Date
<b>Contact Information</b> <b>Name:</b> Susan Eggen, Assistant to Deputy Director <b>Telephone:</b> 573-526-2886 <b>E-mail:</b> <a href="mailto:Susan.M.Eggen@dss.mo.gov">Susan.M.Eggen@dss.mo.gov</a>					
<b>Scope of Services</b> Manage and coordinate acute care and behavioral health services including inpatient, outpatient and ancillary services.					
<b>Covered Population:</b> TANF, CHIP and foster children					



Part Two: Technical Proposal  
Section B: Qualifications and Experience

Client Name & Address	Prime or Subcontractor	Contract Size		Contract Details	
		Average Monthly Covered Lives	Capitated	Duration	
<b>New Hampshire</b>					
New Hampshire Medicaid Care Coordination Pilot 53 Regional Drive, Suite 201 Concord, NH 03301 <b>Contact Information</b> <b>Name:</b> Katie Dunn, Director <b>Telephone:</b> 603-271-5254 <b>E-mail:</b> <a href="mailto:Kdunn@dhhs.state.nh.us">Kdunn@dhhs.state.nh.us</a>		Prime	TANF: 104,209 ABD: 18,375 Total: 122,584	No	3 years  <i>Current contract expires June 2012</i>  January 2007 <i>Original Contract Start Date</i>
<b>Scope of Services</b> Provide enhanced care coordination (ECC) and administrative services for Medicaid recipients. The ECC pilot program was established to provide efficient and effective primary and secondary medical/behavioral health care, focused on prevention and the establishment of a medical home, was delivered to Medicaid recipients. The programs' two areas of focus are enhanced care coordination and medical administrative services/ utilization management.					
<b>Covered Population:</b> TANF and ABD					



Part Two: Technical Proposal  
Section B: Qualifications and Experience

Client Name & Address	Prime or Subcontractor	Contract Size		Contract Details	
		Average Monthly Covered Lives	Capitated	Duration	
<b>Pennsylvania</b>					
State of Pennsylvania Department of Public Wealth (DPW) of the Commonwealth of Pennsylvania	Prime	TANF 35,817 ABD: 6,858 Total: 42,675	Yes	1 year  Current contract expires December 2015  April 2010 Original Contract Start Date	
<b>Contact Information</b> <b>Name:</b> Vivienne Elby-Bowers, Aetna Core Team Manager <b>Telephone:</b> 717-772-6289 <b>E-mail:</b> <a href="mailto:VELBYBOWER@state.pa.us">VELBYBOWER@state.pa.us</a>					
<b>Scope of Services</b> Manage and coordinate acute care services including inpatient, outpatient, pharmacy and ancillary services. Behavioral health services are carved out; we coordinate care with the vendor.					
<b>Covered Population:</b> TANF, SSI and dual eligibles under 21					



Part Two: Technical Proposal  
Section B: Qualifications and Experience

Client Name & Address	Prime or Subcontractor	Contract Size		Contract Details	
		Average Monthly Covered Lives	Capitated	Duration	
<b>Pennsylvania (Risk)</b>					
Commonwealth of Pennsylvania Department of Insurance Office of CHIP and Adult Basic 1142 Strawberry Square Harrisburg, PA 17120	Prime	CHIP: 29,800 Total: 29,800	Yes	17 years <i>Currently in negotiations with state for another three year contract</i>	1993 <i>Original Contract Start Date</i>
<b>Contact Information</b>					
<b>Name:</b> Lowware Holliman, Division Chief					
<b>Telephone:</b> 717-783-1437					
<b>E-mail:</b> <a href="mailto:lholliman@state.pa.us">lholliman@state.pa.us</a>					
<b>Scope of Services</b>					
Provide all managed care medical services including inpatient, outpatient and ancillary services; Coordinate behavioral health services					
<b>Covered Population:</b> CHIP					



Part Two: Technical Proposal  
Section B: Qualifications and Experience

Client Name & Address	Prime or Subcontractor	Contract Size		Contract Details
		Average Monthly Covered Lives*	Capitated	
<b>Texas (Risk)</b>				
Texas Health and Human Services Commission Health Plan Operations, H-320 11209 Metric Blvd., Bldg H Austin, Texas 78758	Prime	TANF: 50,232 CHIP: 12,708	Yes	4 years  Contract expires August 2013  September 2006 Original Contract Start Date
<b>Contact Information</b> <b>Name:</b> Rudy Villarreal, Health Plan Manager <b>Telephone:</b> 512-491-1466 <b>E-mail:</b> <a href="mailto:Rudy.Villarreal@hpsc.state.tx.us">Rudy.Villarreal@hpsc.state.tx.us</a>		Total: 62,940		
<b>Scope of Services:</b> Manage and coordinate all acute care and behavioral health services including inpatient, outpatient and ancillary services				
<b>*Covered Population:</b> TANF and CHIP				



Part Two: Technical Proposal  
Section B: Qualifications and Experience

Client Name & Address	Prime or Subcontractor	Contract Size		Contract Details
		Average Monthly Covered Lives*	Capitated	
<b>Texas – Parkland (ASO)</b>				
Texas Health and Human Services Commission Health Plan Operations, H-320 11209 Metric Blvd., Bldg H Austin, Texas 78758 <b>Contact Information</b> <b>Name:</b> Rudy Villarreal, Health Plan Manager <b>Telephone:</b> 512-491-1466 <b>E-mail:</b> <a href="mailto:Rudy.Villarreal@hsc.state.tx.us">Rudy.Villarreal@hsc.state.tx.us</a>	Subcontractor	TANF: 155,355 CHIP: 42,350 Total: 197,705	No	12 years Contract expires August 2013 December 1998 Original Contract Start Date
<b>Scope of Services:</b> Manage and coordinate acute care services including inpatient, outpatient and ancillary services. Behavioral health services are carved out; we coordinate care with the vendor <b>*Covered Population:</b> TANF and CHIP				



### **Location of Office**

Aetna Better Health's office is located at:

Aetna Better Health, Inc.  
5615 Corporate Blvd., Suite 400B  
Baton Rouge, LA 70808  
Phone: (225) 992-4490

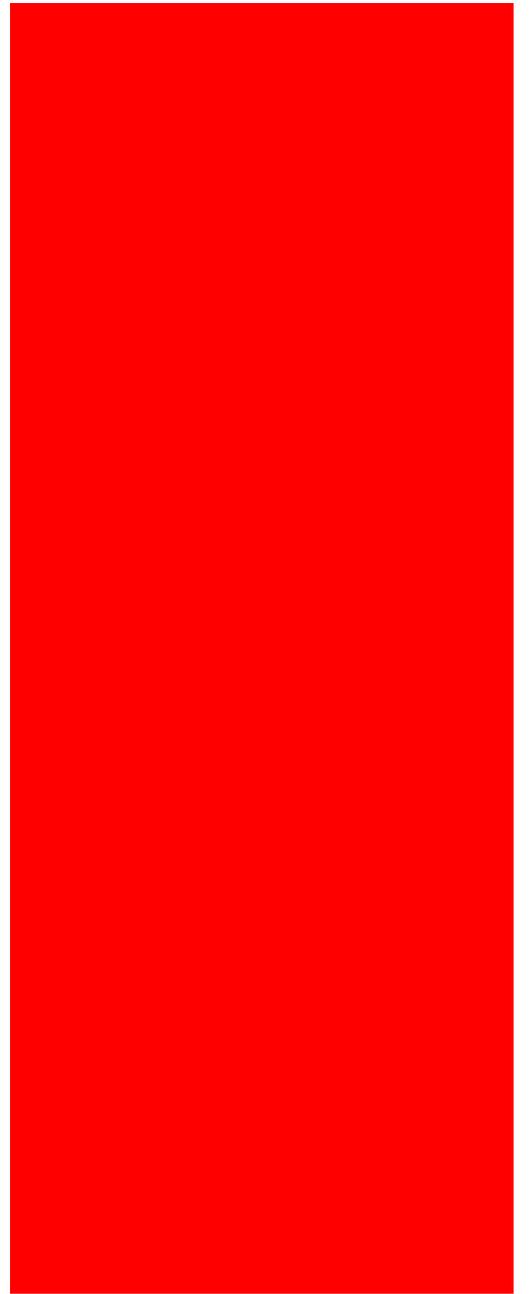
### **Organizational Charts**

Aetna Better Health is a wholly-owned subsidiary of a publicly-traded corporation, Aetna Inc. Aetna Better Health is wholly owned by Aetna Health Holdings, LLC, which is wholly owned by Aetna Inc., a publicly traded corporation. Please see Appendix C for Chart A: Corporate Structure and Lines of Responsibility and Authority. Chart A illustrates Aetna Better Health's position in Aetna Inc.'s structure and the lines of authority and responsibility within our company. It also illustrates the cohesive Aetna Medicaid service organization represented by our parent company, affiliates and subsidiaries.

### **Corporate Structure and Lines of Responsibility and Authority**

Please refer to Appendix C, which illustrates the corporate structure and lines of responsibility and authority for Aetna Better Health's parent company, affiliates and subsidiaries.

11 B.9



**B.9 Provide a narrative description of your proposed Louisiana Medicaid Coordinated Care Network project team, its members, and organizational structure including an organizational chart showing the Louisiana organizational structure, including staffing and functions performed at the local level. If proposing for more than one (1) GSA, include in your description and organizational chart if: 1) the team will be responsible for all GSAs or 2) if each GSA will differ provide details outlining the differences and how it will differ.**

### **Coordinated Care Network (CCN) Network Project Team Designed to Deliver Results**

Aetna Better Health, Inc., a Louisiana corporation, d/b/a Aetna Better Health (“Aetna Better Health”) together with our affiliates has a 25 year history of successfully serving Medicaid populations throughout the nation under a managed care model. We currently own or administer Medicaid programs in 10 states (Arizona, California, Connecticut, Delaware, Florida, Illinois, Maryland, Missouri, Pennsylvania and Texas), serving more than 1.3 million enrollees. We also provide care management services to Medicaid recipients in New Hampshire. We have significant experience building organizations from the ground up, utilizing our proven methodologies for completing start-up activities and maintaining ongoing operational staffing. We already have in place the organizational, operational, managerial and administrative systems capable of fulfilling all contract requirements.

Aetna Better Health is committed to hiring qualified, experienced individuals who will be well trained on the specifics of their respective job responsibilities. Our experienced personnel will support the Department of Health and Hospital’s (DHH) mission to protect and promote health and access to medical, preventive and rehabilitative services for citizens of the State of Louisiana. We will provide timely, quality services and utilize all available resources to serve our members in the most effective manner. Aetna Better Health has created a clearly defined, yet flexible staffing plan designed to adjust to the evolving needs of the Louisiana Medicaid CCN Program and to address all requirements found in this Request for Proposal (RFP). The same experienced team will be responsible for the implementation of all GSAs – GSA A, B and C and we will use the same proven strategies, methodologies and operational efficiencies for all GSAs.

Our project team has over 332 years of health care experience, including 117 years of Medicaid managed care experience. Our project team has expertise in successfully transitioning members from a fee-for-service (FFS) environment to Medicaid managed care in multiple states through model that delivers results in key areas including:

- Improved coordination of care
- A patient-centered medical home (PCMH) for Medicaid recipients
- Better health outcomes
- Increased quality of care as measured by metrics such as HEDIS<sup>®1</sup>

<sup>1</sup> HEDIS is a registered trademark of the National Committee for Quality Assurance

**Better Health**

- Greater emphasis on disease prevention and management of chronic conditions
- Earlier diagnosis and treatment of acute and chronic illness
- Improved access to essential specialty services
- Outreach and education to promote healthy behaviors
- Increased personal responsibility and self-management
- A reduction in the rate of avoidable hospital stays and readmissions
- A decrease in fraud, abuse, and wasteful spending
- Greater accountability for the dollars spent
- A more financially sustainable system
- Net savings to the State

***Administrative Efficiency and Financial Stability***

Aetna Better Health works closely with states, especially when they are experiencing financial challenges to develop innovative and strategic solutions, helping Medicaid members to get the right care, at the right time, and at the right level of care while simultaneously controlling costs.

We are committed to the states we serve and investing in those communities. Our history clearly demonstrates that once we enter into a contractual relationship with a state, we are committed to making the services we deliver effective for both the state and Aetna Better Health. We have been recognized as a good conservator of taxpayer dollars. We have earned this recognition because we avoid duplicate and unnecessary services, we monitor and control fraud and abuse, and we promote the enrollee taking control of their own health care. This means that we are mindful and concerned about wasting taxpayer dollars.

Our strategy is to build upon and enhance the State of Louisiana's existing infrastructure. One of the major concerns that Medicaid agencies have when converting from fee-for-service to managed care is the impact that change has on the existing provider network. Our approach, strategy, and commitment are to initially contract with the State's provider network and to identify any gaps in care. Equally important is working closely with those State agencies that contribute to the Medicaid program and to make sure their programs and services are recognized and used. We are aware of the State's investment in its programs and services and we will, through our programs, assist the State in achieving a good return on investment.

**Successful Implementation Experience**

A critical component in our overall implementation plan is the successful transition of members into the Medicaid managed care CCN Program without any interruption in or gaps in service. We have significant experience in achieving the seamless transition of members from Medicaid fee-for-service (FFS) programs into efficient Medicaid managed care programs. The following table illustrates examples of our transition experience. Please note that each one of these transitions was performed on time and without disruption to members' care.

***Member Transition/Coordination***

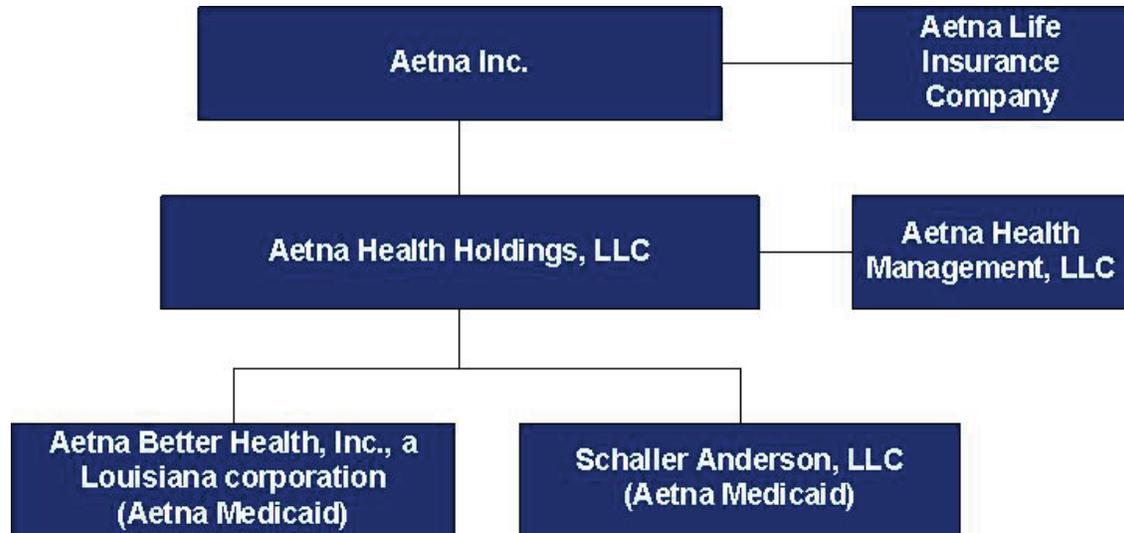
<b>State (Program) Year</b>	<b>Previous Program and Enrollees</b>	<b>Services Performed During Transition</b>	<b>Transition Period</b>
<b>Arizona</b> (Arizona Long Term Care Program) 2005	Managed Long-Term Care Health Plan 4,000 at-risk members transitioned	<ul style="list-style-type: none"> <li>● Transition planning for frail, elderly and older adults with disabilities</li> <li>● Institutional and HCBS assessment</li> <li>● Continuity of care including service authorizations, medication maintenance and review of member care plans</li> </ul>	4 months
<b>Delaware</b> (Delaware Medical Assistance Program) 2004	Fee-For-Service 90,000 members transitioned	<ul style="list-style-type: none"> <li>● Continuity of care including service authorization and medication maintenance</li> <li>● Risk stratification, including Health Risk Questionnaire (HRQ)</li> <li>● Member Primary Care Provider (PCP) selection</li> <li>● Member assessment and care planning</li> <li>● Provider network training</li> <li>● Member education and outreach</li> </ul>	60 Days
<b>Missouri</b> (Northwest Missouri ASO) 2008	Fee-For-Service 42,000 members transitioned	<ul style="list-style-type: none"> <li>● Continuity of care including service authorization and medication maintenance</li> <li>● Risk stratification, including Health Risk Questionnaire (HRQ)</li> <li>● Member PCP selection</li> <li>● Member assessment and care planning</li> <li>● Provider network training</li> <li>● Member education and outreach</li> </ul>	90 Days
<b>Missouri Expansion</b>	Managed Care	<ul style="list-style-type: none"> <li>● Continuity of care including service authorization, dental,</li> </ul>	90 Days

State (Program) Year	Previous Program and Enrollees	Services Performed During Transition	Transition Period
2009	4,900	<ul style="list-style-type: none"> <li>and vision</li> <li>• Risk stratification, including Health Risk Questionnaire (HRQ)</li> <li>• Member PCP selection</li> <li>• Member assessment and care planning</li> <li>• Provider network training</li> <li>• Member education and outreach</li> <li>• Review for gaps of current care plan</li> <li>• Assisted providers transfer medical records</li> <li>• Facilitating the authorization of needed services.</li> </ul>	
<b>Florida</b> 2010  (Integral was a brand new plan approved by the state in March 2010 with new membership starting in April 2010 (owned by Collier Health Services). The majority of members were Medipass members (state Medicaid plan))	Fee-For-Service 63 on go-live  (received 9,000+ Collier members on 5/1 (state mandatory assigned))	<ul style="list-style-type: none"> <li>• Continuity of care including service authorization and medication maintenance</li> <li>• Risk stratification, including Health Risk Questionnaire (HRQ)</li> <li>• Member PCP selection</li> <li>• Member assessment and care planning</li> <li>• Provider network training</li> <li>• Member education and outreach</li> <li>• Facilitating the authorization of needed services</li> </ul>	90 Days
<b>Pennsylvania</b> 2008	Fee-For-Service 6,353  Total initial enrollment 50,000 (approximately)	<ul style="list-style-type: none"> <li>• Continuity of care including service authorization, medication maintenance, vision and dental</li> <li>• Transition of care coordination</li> <li>• Risk stratification, including Health Risk Questionnaire</li> </ul>	90 Days

State (Program) Year	Previous Program and Enrollees	Services Performed During Transition	Transition Period
		(HRQ) <ul style="list-style-type: none"> <li>● Member PCP selection</li> <li>● Member assessment and care planning</li> <li>● Provider network training</li> <li>● Member education and outreach</li> <li>● Assisted providers transfer medical records</li> <li>● Facilitating the authorization of needed services</li> </ul>	
<b>Illinois</b> 2011	Fee-For-Service 1,394 September 2011 20,000 (expected)	<ul style="list-style-type: none"> <li>● Continuity of care including service authorization and medication maintenance</li> <li>● Risk stratification, including Health Risk Questionnaire (HRQ)</li> <li>● Member PCP selection</li> <li>● Member assessment and care planning</li> <li>● Provider network training</li> <li>● Member education and outreach</li> <li>● Assisted providers transfer medical records</li> <li>● Review all available member information during transition (e.g. disease manager, case manager, family members, stakeholders, etc.)</li> <li>● Monitor continuity and quality of care</li> <li>● Review current placement of members (e.g. ICF, nursing home, etc.)</li> <li>● Encouraging out-of network providers who are currently</li> </ul>	90 Days

State (Program) Year	Previous Program and Enrollees	Services Performed During Transition	Transition Period
		treating our Enrollees to enter into provider network agreements <ul style="list-style-type: none"> <li>● Facilitating the authorization of needed services</li> <li>● Identification of members who are currently under treatment for acute and chronic health conditions and/or need special assistance during the transition of care process</li> </ul>	

**Aetna Better Health’s Corporate Structure**



The above organizational chart illustrates Aetna Better Health’s corporate structure, lines of responsibility and authority. Our ultimate parent, Aetna Inc. (Aetna) is a publicly traded corporation and the parent organization of the Aetna group of companies. Established in 1850, Aetna Inc. is one of the nation’s leading diversified health care benefits companies, serving more than 36 million people with information and resources to assist them in making their own decisions about their health care. Aetna Health Holdings, LLC (Aetna Health Holdings) is a Delaware limited liability holding company, and is wholly owned by Aetna. Aetna Better Health Inc., a Louisiana corporation, together with its affiliates form the core of Aetna’s Medicaid business and have collectively provided access to health care coverage to Medicaid enrollees across the nation for 25 years. Schaller Anderson, LCC (Schaller Anderson), acquired by Aetna, Inc. in 2007, one of the nation’s leading Medicaid managed care companies, has brought access to health care to traditional Medicaid populations (TANF and SCHIP), as well as special needs populations, including older adults and adults with disabilities since 1986. Our affiliate, Schaller Anderson, will serve as Aetna Better Health’s third party administrator in Louisiana.

Our Aetna Medicaid business has provided access to health care coverage to Medicaid members across the nation for more than 25 years. As part of the Aetna Medicaid business unit, Aetna Better Health, together with its affiliates, currently owns or manages TANF and SCHIP benefits for more than 1.3 million members in 10 states.

**CCN Program Organization Charts**

The following organizational charts illustrate the Aetna Better Health Louisiana Medicaid CCN Program structure comprised of numerous diversified areas that will administer the Louisiana Medicaid CCN Program. The Aetna Better Health CCN team will be led by our Senior Vice President/Market Lead Central Region, Janet Stallmeyer, who will work in collaboration with our Chief Executive Officer (CEO), Patrick C. Powers, to develop

and implement a comprehensive, quality-driven program. Ms. Stallmeyer brings over 30 years of experience in the development, management and operation of Medicaid organizations, integrated delivery systems and medical groups. She provides oversight to Aetna Medicaid plans in the central region of the United States as well as those in the northeastern states.

Our organizational structure was created and designed to meet the specifications of the Louisiana Medicaid CCN Program. We have sufficient experienced organizational leadership to serve the evolving needs of our members. Our personnel is experienced in meeting the expectations and needs of our members and possesses expertise in developing and implementing effective solutions to health care challenges for Medicaid populations.

**Aetna Better Health Key Departmental Functional Responsibilities**

Following is an overview of key departmental functional responsibilities for the CCN Program.

Department	Functional Responsibilities
<b>Claims Processing</b>	Supports and achieves provider satisfaction through the timely and accurate adjudication of Louisiana Medicaid CCN claims, coordination of third party resources or coordination of benefits, and payment recoupment.
<b>Disease Management</b>	Disease management programs addressing asthma, cardiovascular disease, congestive heart failure, chronic obstructive pulmonary disease and diabetes will be provided by our affiliate, Schaller Anderson's NCQA-certified disease management program.
<b>Financial Functions</b>	Supports financial control of treasury functions for the Louisiana Medicaid CCN Program including developing financial statements and other indicators of financial performance, overseeing claims payments to providers, and developing, maintaining and reporting of consistent organizational methodologies of accounting.
<b>Member Services</b>	Provides timely and accurate responses to inquiries about the Louisiana Medicaid CCN Program, including telephone calls received through the Member Services hotline, written correspondence, and claims questions from our provider network, requests to re-issue ID cards, demographic changes, eligibility verification, and confirmation of provider assignment or changes.
<b>Management Information Systems</b>	Provides technical system support to the Louisiana Medicaid CCN Program including hardware, software, and network communications that enable operational functions including enrollment/eligibility, provider data maintenance, encounter/claims processing, financial, utilization management/quality improvement, reporting, interface, and third party resource (TPR) subsystems.
<b>Provider Services/ Provider Network Development</b>	Develops, maintains and enhances relationships with CCN providers, facilities, behavioral health services, and ancillary providers that have experience meeting the diverse and complex needs of health plan members and works together with them to provide a quality, comprehensive care package.

Department	Functional Responsibilities
<b>Quality Improvement</b>	Provides consultation and support to departments and committees serving the Louisiana Medicaid CCN Program to help verify that activities designed to improve the processes by which care and services are delivered to members are coordinated and effective in achieving established performance standards. Plans and implements a standardized and comprehensive quality improvement program throughout the organization that is responsive to the health care needs of the health plan and conducts investigations into potential quality of care concerns identified through Utilization Management activities or complaints.
<b>Reporting</b>	Verifies compliance with CCN contract requirements and deliverables, regulatory agency requirements and requests, and complaints and appeals processes.
<b>Utilization Management</b>	Develops and oversees processes and implementation of prior authorization, concurrent review, retrospective review, and case management functions. Monitors, analyzes, trends and reports utilization data and works with the management team to develop targets, budgets and policies and procedures for the Louisiana Medicaid CCN clinical program development and management.

**Phase I: Implementation Project Team**

Aetna Better Health’s top team of Medicaid managed care experts will manage the seamless transition of members to an effective and efficient Medicaid managed care model during the implementation period and initial start-up operations. This team of experienced individuals is already in place and will begin serving the CCN Program upon contract award. The proposed team has more than 117 years of health care experience managing successful implementations in 10 states: Arizona, California, Connecticut, Delaware, Florida, Illinois, Maryland, Missouri, Pennsylvania and Texas.

Our Louisiana-based Chief Executive Officer (CEO), Patrick C. Powers, will manage both the implementation and ongoing operations for the Louisiana Medicaid CCN Program. Mr. Powers possesses substantial in-depth experience as a CEO and President of several major national networks, has served as an advisor to numerous health care and managed care companies and has played an active leadership role in the Louisiana health insurance industry for more than 25 years. A Baton Rouge native, he has lived in the State and served Louisiana citizens for the vast majority of his career. He will be supported by our Senior Vice President/Market Head Central Region, Medicaid, Janet Stallmeyer, who will serve as Administrator for the CCN Program. She brings more than 30 years of experience in successful implementation and operation of innovative Medicaid and Medicare programs to her oversight of the CCN Program. On a day-to-day basis, Mr. Powers will also be supported by Chief Operating Officer (COO) Ruth Sirotnik, who has over 10 years of experience in overseeing Medicaid managed care plan operations for Aetna Better Health and our affiliates.

All key personnel are in place and all are full-time, experienced personnel dedicated to serving our members. Aetna Better Health’s most experienced team of Medicaid managed care experts will manage the seamless transition of members to an effective and efficient Medicaid managed care model during Phase I: implementation and initial start-

up operations. This team will remain in place for a period of nine months or more, as required to manage members' successful transition to the CCN Program and begin initial operations. During this period, our Chief Executive Officer and his personnel will be recruiting from among the local Louisiana talent pool, as well as a national talent pool of experienced Medicaid managed care executives, to smoothly transition certain key positions to Louisiana-based personnel.

Our phased-in transition/operations approach has been extremely successful in Medicaid managed care implementations we have conducted in other states. It enables us to draw upon the best national and local resources to develop a Medicaid managed care organization specifically designed to meet the needs of each geographical area. We are experienced in both urban and rural area transitions and have expertise in meeting the challenges presented by both. Our top team manages the transition, trains ongoing personnel and remains available for consultation and assistance throughout the life of the contract.

Should we be the successful bidder for GSA A, B and C, we anticipate staffing levels of approximately 180 full-time employees, with staffing levels contingent on membership growth. We anticipate that our Administrator, Janet Stallmeyer, and our Chief Executive Officer, Patrick Powers, will remain in place throughout Phase I and Phase II: implementation and ongoing operations. They will continue to be supported by the resources of Aetna Better Health's affiliates throughout the contract.

### **Phase II: Ongoing Operations Project Team**

Following initial implementation and start-up, and until permanent personnel are hired and fully trained and transitioned, some key positions will transition from our national Medicaid managed care implementation experts to Louisiana-based positions. This model enables us to draw from the top national pool of talented Medicaid managed care experts available through Aetna Better Health for initial implementation and start-up. We will recruit from our own broad-based pool of talent in diverse areas, as well as from top talent in Louisiana. For ongoing operations, the following positions will be based in the State of Louisiana:

- Chief Executive Officer
- Medical Director/Chief Medical Officer
- Compliance Officer
- Grievance System Manager
- Contract Compliance Officer
- Quality Management Coordinator
- Maternal Child Health/EPSTD Coordinator
- Medical Management Coordinator
- Provider Services Manager
- Provider Claims Educator

Each of these key positions will be supported both short-term and long-term by our expert Phase I implementation team. They will receive extensive training on the Louisiana Medicaid CCN Program prior to transitioning into their ongoing roles.

Aetna Better Health will inform the Department of Health and Hospitals (DHH) in writing within five business days when a key staff member in one of the positions listed below transitions out of the CCN Program, leaving a fully trained key staff member in place. This notification will provide the name and contact information for the new key staff member. Aetna Better Health will replace any of the key personnel with a person of equivalent experience, knowledge and talent. The name and resume of the new employee will be submitted as soon as the new hire has taken place, along with a revised organization chart complete with key personnel time allocation. The replacement of the Administrator/CEO/COO or Medical Director/CMO will be submitted to the DHH for prior written approval.

Our ongoing local team of Louisiana key personnel will be supported by our national Aetna Medicaid organization and have access to these resources. This depth and breadth of diversified support will enable our core Louisiana CCN Program ongoing operations team to draw upon over 25 years of Medicaid managed care experience in making decisions and developing processes to serve the evolving needs of our members in Louisiana.

### **Key Personnel**

The following table illustrates the experience that our highly qualified key personnel bring to the CCN Program:



Part Two: Technical Proposal  
Section B: Qualifications and Experience

CCN Contract Functions	Names and Corporate Titles	Years of Medicaid Experience	Years of Health Care Experience	Implementation Experience
Administrator	Janet Stallmeyer, M.B.A. Senior Vice President/Market Head, Central Region, Medicaid	8 years 6 months	19 years 3 months	Oversight of all Medicaid implementations for Aetna Better Health and affiliates in the Central Region and northeastern states
Chief Executive Officer	Patrick C. Powers, B.A., C.P.A. Chief Executive Officer <sup>2</sup>	1 month	25 years 8 months	Involved in multiple start-ups including PPO network development in Covington, LA; HIPAA compliance packages for over 100 provider practices/organizations; expansion of Managed Comp into 7 new regions, including New Orleans; expansion of Gulf South Health Plans, Inc.; transition of multiple General Health, Inc. operating systems into 1 integrated system; launch of Baton Rouge Ambulatory Surgical Services outpatient surgery center
Chief Operating Officer	Ruth Sirotnik Vice President, Account Management	10 years	23 years 2 months	Two implementations in Florida and Delaware
Medical Director/Chief Medical Officer	John Esslinger, M.D., M.M.M. Chief Medical Officer	6 years	22 years 1 month	One implementation in Georgia, oversight of securing provider contracts, communication with key stakeholders, etc.
Chief Financial Officer	Lauren Edgington, M.S. Chief Financial Officer	8 years 5 months	8 years 5 months	1.6 years of implementation experience with transitions of populations to Medicaid managed care in Florida and Illinois
Compliance Officer	Patricia Simpson, M.B.A. Director, Medicaid Policy and Program Administration	10 years 10 months	18 years 2 months	Experience in five implementations, in Connecticut, Florida, Pennsylvania, Illinois, and Delaware

<sup>2</sup> \* The filings required by the Department of Insurance for Mr. Powers to serve as the CEO of Aetna Better Health have been submitted to DOI and are pending. Per DOI Regulation 66, approval is anticipated within 30 days, and certainly well in advance of the CCN go-live date of January 1, 2012. In the interim, Mr. Tom Kelly, who has been approved by the DOI to serve as the interim CEO of Aetna Better Health, will execute any documents required to be signed by the CEO.



Part Two: Technical Proposal  
Section B: Qualifications and Experience

CCN Contract Functions	Names and Corporate Titles	Years of Medicaid Experience	Years of Health Care Experience	Implementation Experience
Grievance System Manager	Patrice Jackson, B.S. Grievance System Manager	4 years 9 months	7 years 8 months	Experience in four implementations, in New Hampshire (ASO), Illinois, Florida and Pennsylvania
Business Continuity Planning and Emergency Coordinator	Terry L. Newnan Director, Systems and Technology	22 years 3 months	22 years 3 months	Experience with five implementations
Contract Compliance Officer	Lisa Baird, CPC-I, CPC-H Director of Implementation	13 years 8 months	22 years 7 months	Experience with two implementations in Illinois and Pennsylvania; coordination and execution of all Implementation team activities
Quality Management Coordinator	Arda Curtis, R.N., B.S., C.P.H.Q.	16 years 9 months	41 years	Experience with one Aetna Better Health implementation in Florida; extensive Medicaid experience.
Performance/Quality Improvement Coordinator	Arda Curtis, R.N., B.S., C.P.H.Q.	16 years 9 months	41 years	Experience with one Aetna Better Health implementation in Florida; extensive Medicaid experience.
Maternal Child Health/EPSTD Coordinator	Daniel P. Jansen, M.S.A., M.S.W., C.P.H.Q.	10 years 8 months	29 years	Not Applicable
Medical Management Coordinator	Mark Douglas, J.D., M.S.N., F.N.P., R.N. Director of Clinical Project Coordination	19 years 1 month	19 years 1 month	Experience with one implementation in Illinois
Provider Services Manager	Jason Rottman, B.S. Chief Operating Officer	13 years 11 months	16 years 7 months	Experience with two implementations in Illinois and Maryland oversight of development and implementation of Provider Database, credentialing application, and electronic data exchange with the State



Part Two: Technical Proposal  
Section B: Qualifications and Experience

CCN Contract Functions	Names and Corporate Titles	Years of Medicaid Experience	Years of Health Care Experience	Implementation Experience
Member Services Manager	Taira Green-Kelley, B.A. Regional Vice President	11 years 7 months	15 years	Experience with three implementations in Illinois, Missouri Kansas lead responsibilities for Member Services Department, community and advocacy outreach, marketing, hiring management and personnel, oversight and development of department, set-up and training, etc.
Claims Administrator	Von Young, B.A. Associate Special Projects Officer	6 years 7 months	19 years 2 months	Experience with one implementation in Texas, drafted BNA and organized team
Provider Claims Educator	Jason Rottman, B.S. Chief Operating Officer	13 years 11 months	16 years 7 months	Experience with two implementations in Illinois and Maryland oversight of development and implementation of Provider Database, credentialing application, and electronic data exchange with the State
Case Management Administrator/Manager	Melody Dowling, M.S.W., L.C.S.W.	9 years 5 months	15 years 11 months	Experience in two implementations in Missouri and Illinois
Information Management and Systems Director	Gregory Krause, M.B.A. Management Information Systems Manager	12 years, 10 months	12 years 10 months	Over 12 years of experience in state implementations managed by Aetna Medicaid companies, including the AZ ALTCS and CHIP implementations
Implementation Manager	Lisa Baird, CPC-I, CPC-H Director of Implementation	13 years 8 months	22 years 7 months	Experience with two implementations in Illinois and Pennsylvania; coordination and execution of all implementation team activities
	<b>Total Years of Experience</b>	<b>229</b>	<b>418</b>	

### **Administrator**

Janet Stallmeyer, M.B.A., is the designated Administrator for Aetna Better Health in Louisiana. Ms. Stallmeyer's background includes more than 30 years of successful complex corporate and managed care contract administration experience. Her past professional accomplishments, stemming from her in-depth knowledge of the Medicaid and Medicare systems and service delivery for special populations, has resulted in the successful transition and/or implementation of innovative programs throughout her career. She currently provides oversight to Aetna Medicaid plans in the central region of the United States as well as those in the northeastern states.

The Administrator's primary responsibilities will include, but not be limited to, the following:

- Oversee the operation of the Louisiana Medicaid CCN Program, in conjunction with the Chief Executive Officer (CEO), verifying adherence to program requirements and timely responses to the Department of Health and Hospitals (DHH)
- Administrator or designee will participate in the DHH's committee for CCN administrative simplification
- Accountability for the oversight and management of all health plan operations through the design and implementation of financial controls, management information systems including electronic medical records, best practice health care services, human resource policies and procedures, facilities management, and comprehensive marketing programs
- Delivering leadership and technical expertise to develop and improve health plan leadership skills and performance
- Directing operations to confirm that all services are delivered in a timely, cost-effective and quality manner
- Conducting a strategic review of operations and implementing a member engagement strategy focusing on state customer relationships
- Verifying compliance with State and federal requirements including reporting and operational standards
- Providing leadership, team building, and personnel development to confirm creation of a multi-disciplined, culturally diverse team

### **Chief Executive Officer**

Patrick C. Powers, B.A., C.P.A., is the designated Chief Executive Officer (CEO) for Aetna Better Health in Louisiana. Mr. Powers possesses substantial in-depth experience as a CEO and President of several major national networks, has served as an advisor to numerous health care and managed care companies, and has been featured as a key speaker at seminars and conferences that serve the medical community. Mr. Powers has played an active leadership role in the Louisiana health insurance industry for more than 25 years and is a Baton Rouge native, having lived in the State and served Louisiana citizens for the vast majority of his career. Part of his experience includes developing national disaster plans, leading an employers' coalition, and developing and implementing a statewide managed care organization consisting of a health maintenance organization, preferred provider organization, third party administrator and Utilization Management company, which resulted in a membership of 14,000 within six months after becoming operational.

The CEO's primary responsibilities will include, but not be limited to, the following:

- Serving as the primary contact for the DHH
- Oversight of the day-to-day operation of the CCN, verifying adherence to program requirements and timely responses to the DHH, working with and reporting to the Administrator
- CEO or designee participates in the DHH's Committee for CCN Administrative Simplification
- Oversight of initial development and all ongoing operations of the CCN
- Product development, network contracting, executive counseling and market development
- Development and oversight of strategic planning process
- Responsibility for strategy and all operations of the CCN, including Utilization Management and Quality Management
- Verify compliance with the terms of the contract, including securing and coordinating resources necessary for such compliance
- Receiving and responding to all inquiries and requests related to the contract, in the timeframes and formats specified after mutual consultation
- Attending and participating in regular Administrator/CEO/COO meetings or conference calls, as well as Regional Advisory Committees (RACs) for managed care (the CEO may designate key personnel to attend a RAC if the CEO is unable to attend)
- Making best efforts to promptly resolve any issues identified either by Aetna Better Health or the DHH that may arise and are related to the contract
- Meeting with the DHH representative(s) on a periodic or as needed basis to review performance and resolve issues

### **Chief Operating Officer**

Ruth Sirotnik is the designated Chief Operating Officer for Aetna Better Health. She will work with the Administrator and Chief Executive Officer to oversee day-to-day operations. Ms. Sirotnik has over 23 years in the health care industry and 10 years of experience with Medicaid programs. Under her leadership, a new Schaller Anderson Medicaid program was implemented in the state of Florida. Her responsibilities include:

- Oversight of the day-to-day operation of the CCN Program, verifying adherence to program requirements and timely responses to DHH, working with and reporting to the Chief Executive Officer
- Participating in DHH's Committee for the CCN Administrative Simplification
- Oversight of initial development and all ongoing operations of the CCN Program
- Oversee the implementation of effective processes for the attainment of operational, financial and budgetary goals of the unit
- Direct the activities of a group of managers, integrate execution of these activities across these managers
- Responsible for decision making as to significant matters that impact financial reporting and accounting policy matters, both on a GAAP and statutory basis, as well as overseeing operational aspects of addressing such issues
- Evaluate and analyze the accounting and reporting aspects (GAAP/statutory) of key business strategies
- Oversee the implementation of effective processes for achieving business goals
- Represent the company on issues of importance (e.g., accounting and regulatory standards setters, professional groups, community organizations, etc.)
- Build effective teams across the organization and assist in confirming appropriate staffing and development for personnel succession
- Partner with controller to executive short and long range strategic plans
- Integrate execution among various other units

### **Medical Director/Chief Medical Officer**

John Esslinger, M.D., M.M.M., is the designated Medical Director/Chief Medical Officer (CMO) for Aetna Better Health in Louisiana. Dr. Esslinger is an accomplished physician and medical executive. He has extensive experience in providing clinical leadership within two major health insurance companies, a privately held disease management company, and as part of a hospital executive administrative team. He has demonstrated success in highly matrixed organizations that have undergone significant change or growth. Dr. Esslinger possesses excellent communication and management skills, with an ability to identify critical business needs and implement plans to achieve objectives.

The Medical Director/CMO's primary responsibilities include, but are not limited to, the following:

- Development, implementation and medical interpretation of medical policies and procedures including, but not limited to, service authorization, claims review, discharge planning, credentialing and referral management, and medical review included in the grievance system
- Administration of all medical management activities of the CCN Program
- Serving as director of the Utilization Management Committee and as chairman or co-chair of the Quality Assessment and Performance Improvement Committee
- Providing clinical expertise and business direction in support of medical management programs to promote the delivery of high quality, constituent responsive and cost-effective medical care
- Determining clinical coverage based on medical necessity
- Participating on the Peer Review's Medical Advisory Committee (MAC), Quality Oversight Committee (QOC) and in clinical care reviews
- Consulting with other Aetna Better Health medical directors with behavioral health expertise
- Leading the clinical personnel in the coordination of quality, cost-effective care on behalf of members utilizing their available benefits
- Providing clinical expertise and business direction in support of effective medical management programs through participation in clinical team activities in the execution of Precertification, Concurrent Review/Discharge Planning, Case Management, Disease Management, Quality Management, Disability Management and Clinical Claim Review
- Providing clinical guidance in operating effective medical programs to promote quality of care for members and in reviewing potential lapses in the quality of care
- Acting as the lead business and clinical liaison with network providers and facilities to support effective execution of the medical services programs by the clinical teams
- Participating in Quality Management activities at regional and market levels, including those necessary to meet NCQA and URAC standards
- Proactively using data analysis to identify opportunities for quality improvement and to positively influence the cost-effective delivery of quality care
- Leveraging the use of predictive modeling and medical cost forecasting capabilities to improve decision making relative to medical cost spending

- Responsible for predetermination reviews and original and standard reviews of claim determinations, performing appeals of claim and predetermination issues and providing clinical, coding and reimbursement expertise
- Acting as medical leader for providers, regulatory and accrediting agencies, and the community
- Engaging providers and facilities in our mission to deliver cost-effective quality care to our members
- Demonstrating the ability to work within and lead teams to manage company business objectives
- Confirming consistent and disciplined design and execution of medical management programs
- Active involvement in all major Clinical and Quality Management components of the CCN
- Oversight of medical management activities that meet the strategic needs of business segments and plan sponsors
- Design and implementation of medical policies, goals, and objectives
- Provides professional leadership and direction within the medical management department
- Uses data analysis to identify opportunities for quality improvement and to positively influence practice patterns
- Leads Quality Management activities at regional and market levels including those necessary to achieve NCQA accreditation
- Acts as critical medical leader for external providers and plan sponsors, including regulatory and accrediting agencies
- Supports sales and marketing efforts including participation in key marketing activities and presentations

### **Chief Financial Officer**

Lauren Edgington, M.S., is the designated Chief Financial Officer (CFO) for Aetna Better Health in Louisiana. Ms. Edgington's background encompasses over a decade of finance, operations, business process, and technology experience. She has been the key player in facilitating the merger of two large public program entity licenses in New York, and has proven herself an effective multi-site manager with the ability to match complex business needs with effective business solutions and demonstrable reduction of operating costs. Known for applying increased automation, facilitating profitable growth and building a strong, integrated organization, her vast expertise in these areas will be invaluable in this undertaking.

The CFO's primary responsibilities will include, but not be limited to, the following:

- Overseeing the budget, accounting systems and financial reporting implemented by the CCN Program
- Verifying financial performance, budgeting, forecasting and cost containment
- Collaborating with regional CFOs to verify consistent and accurate reporting across all Medicaid business
- Confirming that all regulatory and state reporting are submitted accurately and timely
- Identifying and executing on medical expense opportunities to drive local market strategies to achieve performance and quality targets
- Evaluating facilities and utilization to identify emerging trends and research outlier facilities and/or utilization
- Presenting plan performance to the Board of Directors monthly, and highlighting key trend drivers as well as impact of state budget deficit discussion
- Collaborating with state Medicaid programs through the routine rate setting process to identify cost saving opportunities to help balance Budgets
- Working closely with corporate finance on new business development and implementation

### **Compliance Officer**

Patricia Simpson, M.B.A., is the designated compliance officer for Aetna Better Health in Louisiana. Ms. Simpson has been responsible for the oversight, administration and coordination of Medicaid policies, programs and compliance at Schaller Anderson for over six years. She has shared her significant experience with the medical community by serving as a subject expert in panel discussions and seminars, and has managed and trained personnel on a nationwide level. Ms. Simpson also possesses in-depth experience in development and monitoring of performance measurement reporting systems and processes that identify, investigate and report fraud and abuse.

The Compliance Officer's primary responsibilities will include, but not be limited to, the following:

- Oversight of fraud and abuse program to prevent and detect potential fraud and abuse activities per state and federal regulations
- Execution of provisions of the compliance plan, including investigation of unusual incidents and implementing corrective measures when necessary
- Implementation of new Medicaid health plans
- Oversight and management of compliance/regulatory related audits
- Monitoring of health plan contract management and performance and management of compliance reviews and internal audits
- Serving as privacy officer for the Medicaid line of business which includes monitoring all privacy related activities, coordination of personnel training, and responding to internal/external inquiries regarding any privacy issues
- Oversight and coordination of all compliance and regulatory activities for eight Medicaid health plans nationwide
- Development and review of policies and procedures
- Oversight of implementation of new regulatory requirements, oversight and management of compliance/regulatory related audits
- Assure that all Fraud and Abuse and Program Integrity requirements are met
- Monitoring of health plan contract management and performance and
- Management of compliance reviews and internal audits

### **Grievance System Manager**

Patrice Jackson, B.S., is the designated Grievance System Manager for Aetna Better Health in Louisiana. Ms. Jackson possesses nearly eight years of professional experience in the healthcare arena in both the public and private sectors, with responsibilities that have encompassed business development, finance, human resources, and operations. Having successfully fulfilled complex and varied responsibilities in her prior positions as an executive leader, she has a strong history of implementing processes that have demonstrably increased revenue and improved operational metrics and efficiency.

The Grievance System Manager's responsibilities include, but are not limited to:

- Managing and adjudicating member and provider disputes arising under the grievance system including member grievances, appeals and requests for hearing and provider claim and disputes
- Overseeing member and Provider Call Centers, Claims, Encounters, Provider Services, Appeals and Grievances, Prior Authorizations, Enrollment, Outreach, Data Analytics, Marketing and Application Support
- Developing and implementing operational policies and procedures that can streamline the unit when necessary and yield improved operational metrics
- Working with the data analysis and application development groups when appropriate to design, develop and deploy systems that contribute to and enhance corporate knowledge and efficiency

### **Business Continuity Planning and Emergency Coordinator**

Terry L. Newman is the designated Business Continuity Planning and Emergency Coordinator for Aetna Better Health in Louisiana. Mr. Newman possesses 18 years of supervisory and management responsibility in data centers. His expertise encompasses numerous areas, including networking security, Internet connectivity, email, web portals and ecommerce transactions, system monitoring and management, desktop support, telecommunications, operations of UNIX and Windows-based administrative systems, and data warehousing technology, and audits, which included SOX, SAS70 and internal. Mr. Newman is also experienced in HIPAA rule sets, EDI, disaster recovery and capacity planning.

The Business Continuity Planning and Emergency Coordinator's primary responsibilities will include, but not be limited to, the following:

- Management and oversight of Aetna Better Health's CCN Program emergency management plan during disasters
- Striving for continuity of core benefits and services for members who may need to be evacuated to other areas of the state or out-of-state during disasters
- Development and maintenance of infrastructure and application disaster recovery plans and business continuity plans
- Management of operating budget, also infrastructure and engineering teams
- Performs SOX audits on infrastructure and IT operations
- Management of code asset conversion when necessary
- Assist IT process owners in the development and maintenance of infrastructure and application disaster recovery plans and business continuity plans
- Plan and conduct DBAR exercises that validate recoverability in a disaster event
- Consult with technical and business areas on disaster recovery methodologies
- Interface with internal and external audit on disaster recovery readiness
- Responded to business request for proposals
- Assist with the mergers and acquisitions team, when applicable, to verify that acquired companies comply with organizational infrastructure and DBAR guidelines

### **Contract Compliance Officer**

Lisa Baird, CPC-I, CPC-H, is the designated Contract Compliance Officer for Aetna Better Health in Louisiana. Ms. Baird has formidable experience as the current Director of Implementation at Schaller Anderson, and has an extensive medical management background that encompasses a wide array of accomplishments, including project management, compliance oversight for state and federal mandates, chairing multiple intra-department committees, RFP response coordination, and company-wide personnel supervision and training. She was instrumental in the development of the Aetna Better Health's current standard contract template, displaying remarkable ability to translate administrative concepts of the contract to an operational level. A certified professional coder, she has served as a presenter of Medicaid specific billing concepts at chapter meetings of the American Academy of Professional Coders. Ms. Baird is also an active member of numerous medical community committees and boards.

The Contract Compliance Officer's primary responsibilities will include, but not be limited to, the following:

- Serving as the primary point-of-contact for all CNN operational issues
- Coordination of the tracking and submission of all contract deliverables
- Fielding and coordinating responses to DHH inquires
- Coordinating the preparation and execution of contract requirements, random and periodic audits and ad hoc visits
- Oversight of timely coordination and submission of all department responses addressing State specific contract requirements
- Drafting and obtaining approval of the company's compliance program and development of the compliance education campaign for all health plan personnel on issues related to state and federal compliance guidelines
- Collaboration with senior executive personnel as well as front line managers and personnel to develop policies, procedures and system capabilities to demonstrate compliance to state and federal mandates
- Development of coding certification training program to prepare internal personnel for coding certification testing

### **Quality Management Coordinator**

Arda Curtis, R.N., B.S., C.P.H.Q., is the designated Quality Management Coordinator for the CCN Program. She will direct the activities of the Quality Management Department personnel and is responsible for activities related to clinical quality performance measures and performance improvement projects, including the development of intervention strategies. She monitors our health care delivery system to meet the goal of providing health care services that improve the health status and health outcomes of members.

As Quality Improvement Manager for the CCN Program, her primary responsibilities include, but will not be limited to, the following:

- Confirming individual and systemic quality of care
- Integrating quality through the organization
- Implementation of process improvement
- Resolving, tracking and trending quality of care grievances
- Verifying a credentialed provider network
- Managing Quality Management department personnel and functional department, including development and oversight of performance metrics and application of quality improvement/management policies and procedures
- Creating, coordinating and implementing contractual quality initiative activities through interdepartmental workgroups and committees
- Develops and implements the infrastructure of the quality improvement/Quality Management program and patient safety strategies
- Identifying and addressing quality and performance indicator related improvement opportunities
- Developing and implementing quality improvement and performance improvement initiatives
- Utilizing data to develop intervention strategies to improve outcomes
- Evaluates and prioritizes recommendations for quality improvement to senior management
- Making Quality Management decisions based on the results of research and data analysis
- Serving as a resource and subject matter expert on aspects of the Quality Management program
- Serving as a liaison with external clients to achieve program and departmental goals

### **Performance/Quality Improvement Coordinator**

Arda Curtis, R.N., B.S., C.P.H.Q., is the designated Performance/Quality Improvement Coordinator for Aetna Better Health in Louisiana. Ms. Curtis has significant prior experience as the national director of quality, NCQA and regulatory compliance for Comprehensive Behavioral Care. She has been successful in the oversight of activities related to NCQA accreditation, QI audits and fraud investigation.

The Performance/Quality Improvement Coordinator's duties will include, but not be limited to, the following:

- Focusing organizational efforts on improving clinical quality performance measures
- Developing and implementing performance improvement projects
- Utilizing data to develop intervention strategies to improve outcome
- Reporting quality improvement/performance outcomes
- Preparation of monitoring and data trend reports that are reviewed by Quality Improvement Committee and QM/UM Committee
- Participation on the Quality Improvement Committee
- Supervision of personnel of Quality Management outreach specialists and quality consultants adequate in number to meet quality and performance measure goals

### **Maternal Child Health/EPSDT Coordinator**

Daniel P. Jansen, M.S.A., M.S.W., C.P.H.Q., is the designated Maternal Child Health/EPSDT Coordinator (MCH/EPSDT) for Aetna Better Health in Louisiana. Mr. Jansen has significant prior experience as the director of Quality Management for MCH/EPSDT services provided by Mercy Care Plan in Arizona. He has been successful in the oversight of the prevention and wellness unit, and has developed, implemented and evaluated maternal and postpartum care, family planning services, preventive health strategies as well as processes that outreach to both members and providers.

The MCH/EPSDT Coordinator's primary responsibilities will include, but not be limited to, the following:

- Verifying receipt of EPSDT services
- Verifying receipt of maternal and postpartum care
- Promoting family planning services
- Promoting preventive health strategies
- Identifying and coordinating assistance for identified member needs specific to MCH/EPSDT
- Interfacing with community partners
- Directs MCH/EPSDT processes such as outreach to members and providers regarding review of EPSDT forms, health promotion regarding MCH/EPSDT, prenatal care and family planning services, EPSDT monitoring of performance measures and implementation of interventions to address opportunities for improvement in EPSDT program
- Oversees preparation of monitoring and data trend reports that are reviewed by Quality Improvement Committee and QM/UM Committee
- Participates on Quality Improvement Committee
- Supervises a staff of Quality Management outreach specialists and quality consultants adequate in number to meet quality and performance measure goals

### **Medical Management Coordinator**

Mark Douglas, J.D., M.S.N., F.N.P., R.N., is the designated Medical Management Coordinator for Aetna Better Health in Louisiana. Mr. Douglas is a licensed professional with more than fifteen years of comprehensive experience in working with providers, practitioners, managed care organizations and consumers on care coordination for complex populations including disease management services. He wields expertise in quality improvement, utilization management, claims management, compliance, and accreditation, and in advising organizational leadership in the timely and accurate resolution of Medicaid and Medicare reimbursement and appeal issues.

The Medical Management Coordinator's primary responsibilities will include, but not be limited to, the following:

- Confirming adoption and consistent application of appropriate inpatient and outpatient medical necessity criteria
- Verifying that appropriate concurrent review and discharge planning of inpatient stays is conducted
- Developing, implementing and monitoring the provision of care coordination, disease management and case management functions
- Monitoring, analyzing and implementing appropriate interventions based on utilization data, including identifying and correcting over or under utilization of services
- Monitoring prior authorization functions and confirming that decisions are made in a consistent manner based on clinical criteria and meet timeliness standards
- Implementation of process improvements
- Oversight of case management functions
- Directs the adoption and consistent application of appropriate inpatient and outpatient medically necessary criteria
- Reporting directly to CMO and work collaboratively with all levels of the organization to measure, monitor, and improve performance including key aspects of clinical medical management, behavioral health and customer service and in key aspects of quality and safety of clinical care, including behavioral health, and quality of service for our members and participating providers/practitioners
- Serving as SME in state and federal health reform, Medicaid clinical program, policy coordination and development, homeless issues and healthcare innovation strategies
- Coordinating care across many disciplines and organizations including internal personnel, providers, facilities and home-based and community services to verify continuity of care for health plan enrollees
- Providing daily management and oversight to department performance and operations
- Collaborating with organizational leadership to meet and manage corporate initiatives and State Medicaid contractual obligations
- Developing and implementing departmental policy and procedures

### **Provider Services Manager**

Jason Rottman, B.S., is the designated Provider Services Manager for Aetna Better Health in Louisiana. Mr. Rottman possesses nearly two decades of professional experience in the healthcare arena in both the public and private sectors, with responsibilities that have encompassed business development, finance, human resources, and operations. Having successfully fulfilled complex and varied responsibilities in his prior positions as an executive leader, he has a strong history of implementing processes that have demonstrably increased revenue and improved operational metrics and efficiency.

The Provider Services Manager's responsibilities include, but are not limited to:

- Coordination of communications between Aetna Better Health and our subcontracted providers
- Management and adjudication of member and provider disputes arising under the grievance system including member grievances, appeals and requests for hearing and provider claim and disputes
- Oversight of member and Provider Call Centers, Claims, Encounters, Provider Services, Appeals and Grievances, Prior Authorizations, Enrollment, Outreach, Data Analytics, Marketing and Application Support
- Development and implementation of operational policies and procedures that can streamline the unit when necessary and yield improved operational metrics
- Working with the data analysis and application development groups when appropriate to design, develop and deploy systems that contribute to and enhance corporate knowledge and efficiency

### **Member Services Manager**

Taira Green-Kelley, B.A., is the designated Member Services Manager for Aetna Better Health in Louisiana. Ms. Green-Kelley possesses demonstrable expertise in government relations, communications and strategy; outstanding interpersonal, leadership and management skills, especially in the areas of communications management and relationship building; extensive training and experience in the health care industry; and an ability to analyze existing and emerging trends and develop strategies to best respond to market opportunities.

The Member Services Manager's primary responsibilities will include, but not be limited to, the following:

- Coordination of communications between Aetna Better Health and its subcontracted providers, verifying that there is sufficient personnel to achieve prompt resolution of inquiries/issues and appropriate education about network participation
- Overseeing the recruitment, development, training, evaluation and coaching of high caliber personnel responsible for the provision of superior member services while adhering to established quality standards
- Serving as a liaison between Aetna Better Health, the DHH, material subcontractors, and other entities to resolve member and provider issues, complaints or concerns regarding the CCN Program
- Verifying that community outreach activities promote members' understanding of benefits, services, membership opportunities and application procedures
- Providing oversight to the ongoing monitoring of Medicaid and dual eligible program materials, including member handbooks, to support the provision of current and accurate membership information
- Development of member notification materials, as needed, and the receipt of approval from DHH for all materials
- Identifies, evaluates and cultivates new business growth and opportunities by working with state officials, providers, community stakeholders and internal teams
- Provides leadership and management of all aspects of new business opportunities including planning, coordination, development, proposal response development, market positioning, strategy, implementation and financial analysis
- Evaluates, researches and acts on legislative and regulatory issues that may affect the Medicaid managed care industry with a priority focus on Medicaid appropriations
- Reports legislative activity and impact analysis to administration
- Represents the organization in professional associations, industry groups and with state agencies

### **Claims Administrator**

Von Young, B.A., is the designated Claims Administrator for Aetna Better Health in Louisiana. Mr. Young has overseen the development and implementation of numerous process improvement projects, has implemented full call center reorganization, and has authored several white papers on the subject of process improvement and performance managements. He has controlled multi-million dollar budgets and wields demonstrable results in eliminating troublesome backlogs in claims and appeals.

The Claims Administrator's primary responsibilities will include, but not be limited to, the following:

- Development and implementation of a claims processing system capable of paying claims in accordance with state and federal requirements and the terms of the contract
- Development of processes for cost avoidance
- Confirming minimization of claims recoupments
- Meeting claims processing timelines
- Meeting DHH encounter reporting requirements
- Supervising and supporting the adjudication of claims to support provider satisfaction, retention and growth
- Managing the coordination of third party resources, coordination of benefits, and payment recoupment
- Developing, training, evaluating, and coaching personnel to provide cost effective claim review/processing and claim service while verifying that quality standards are met
- Assessing individual and team performance on a regular basis, providing candid and timely developmental feedback, developing training plans and confirming training needs are met
- Managing and monitoring daily workflow and reporting to help confirm that business objectives are met and accurately reported
- Confirming regulatory compliance with policies and procedures, such as timely processing of clean claims within 30 days of receipt
- Auditing and adjudicating high dollar claims that exceed processor draft authority limits
- Allocating resources to meet volume and performance standard
- Manages the development and implementation of process improvement projects for the enterprise

### **Provider Claims Educator**

Jason Rottman, B.S., is the designated Provider Claims Educator for Aetna Better Health in Louisiana. Mr. Rottman possesses nearly two decades of professional experience in the healthcare arena in both the public and private sectors, with responsibilities that have encompassed business development, finance, human resources, and operations. Having successfully fulfilled complex and varied responsibilities in his prior positions as an executive leader, he has a strong history of implementing processes that have demonstrably increased revenue and improved operational metrics and efficiency.

The Provider Claims Educator's primary responsibilities will include, but not be limited to, the following:

- Educating in-network and out-of-network providers regarding appropriate claims submission requirements, coding updates, electronic claims transactions and electronic fund transfer, and available CCN Program resources such as provider manuals, websites, fee schedules, etc.
- Interfacing with the CCN Program's call center to compile, analyze and disseminate information from provider calls
- Identifying trends and guiding the development and implementation of strategies to improve provider satisfaction
- Regularly communicating with providers, via telephone and on-site, to confirm the effective exchange of information and to gain feedback regarding the extent to which providers are informed about appropriate claims submission practices
- Management and adjudication of member and provider disputes arising under the grievance system including member grievances, appeals and requests for hearing and provider claim and disputes
- Oversight of member and Provider Call Centers, Claims, Encounters, Provider Services, Appeals and Grievances, Prior Authorizations, Enrollment, Outreach, Data Analytics, Marketing and Application Support
- Development and implementation of operational policies and procedures that can streamline the unit when necessary and yield improved operational metrics
- Working with the data analysis and application development groups when appropriate to design, develop and deploy systems that contribute to and enhance corporate knowledge and efficiency

### **Case Management Administrator/Manager**

Melody Dowling, M.S.W., L.C.S.W. is the designated Case Management Administrator/Manager for Aetna Better Health in Louisiana. Ms. Dowling is a licensed professional with more than 17 years of comprehensive experience in working with providers, practitioners, managed care organizations and consumers on care coordination for complex populations as a social worker. She wields expertise in quality improvement, utilization management, claims management, compliance, and accreditation, and in advising organizational leadership in the timely and accurate resolution of Medicaid and Medicare reimbursement and appeal issues.

The Case Management Administrator/Manager's primary responsibilities will include, but not be limited to, the following:

- Oversight of case management functions
- Reporting directly to CMO and work collaboratively with all levels of the organization to measure, monitor, and improve performance including key aspects of clinical medical management, behavioral health and customer service
- Serving as subject matter expert in state and federal health reform, Medicaid clinical program and policy coordination and development, homeless issues and healthcare innovation strategies
- Working collaboratively with all levels of the organization to measure, monitor, and improve performance in key aspects of quality and safety of clinical care, including behavioral health, and quality of service for our members and participating providers/practitioners
- Coordinating care across many disciplines and organizations including internal personnel, providers, facilities and home-based and community services to confirm continuity of care for health plan members
- Providing daily management and oversight to department performance and operations
- Collaborating with organizational leadership to meet and manage corporate initiatives and State Medicaid contractual obligations
- Developing and implementing departmental policy and procedures

### **Information Management and Systems Director**

Gregory Krause, M.B.A., is the designated Information Management and Systems Director for Aetna Better Health in Louisiana. He will be responsible for oversight of the information technology system (IT) capabilities for the CCN Program.

Mr. Krause possesses more than 13 years of developing and managing personnel responsible for the all aspects of managed care EDI processes including claims, eligibility, encounters, and the implementation of all HIPAA-related transaction code sets. The MIS manager is responsible for monitoring IT performance of outside entities that provide information related services to Aetna Better Health, including DHH, contractors, material subcontractors and providers. He will be responsible for the development of new and/or expansion of existing IT reporting systems that will provide a sufficient platform for the effective transfer of information.

The Information Management and Systems Director's primary responsibilities will include, but not be limited to, the following:

- Oversight of all CCN information systems functions, including, but not limited to, establishing and maintaining connectivity with the DHH information systems and providing necessary and timely reports to the DHH
- Directing and coordinating personnel in the design, development and implementation of an information system which will provide the data needed for research and development of strategic plans that assist executive management in the successful direction and achievement of organizational goals
- Developing and maintaining a managed care reporting system which incorporates information from multiple entities including the DHH, contractors, material subcontractors and providers
- Determining reporting requirements and establishing and implementing procedures for data collection storage, retrieval and analysis to satisfy management, government, and contract requirements
- Serving as HIPAA privacy official to promote HIPAA compliant transactions, privacy and security standards
- Directing research, collection and analysis of financial, Medical Management, Utilization Management, Quality Management, and other data and statistical information to verify that all management reports for internal and external agents are produced and submitted in an accurate and timely manner
- Analyzing reports, identifying areas of study, developing research protocol, using statistical procedures, and developing recommendations to reduce costs while improving quality of service
- Providing strategic council to Aetna management, providers and program personnel in decision support activities
- Oversight of the development and implementation of corporate web self service delivery, including integration with internal systems to allow online submission and verification of member eligibility, claim, referral, benefits, and provider directory information

- Management of personnel responsible for building, maintaining, implementing, and delivering corporate standard and custom reports
- Supervision of personnel of application developers, responsible for all aspects of the application development lifecycle for in-house developed, custom applications
- Writes and implements policies and procedures to address departmental requirements
- Participation in the development and monitoring of departmental budget and strategic plan

### **Implementation Manager**

Lisa Baird, CPC-I, CPC-H, is the designated Implementation Manager for Aetna Better Health in Louisiana. Ms. Baird has formidable experience as the current Director of Implementation at Schaller Anderson, and has an extensive medical management background that encompasses a wide array of accomplishments, including project management, compliance oversight for state and federal mandates, chairing multiple intra-department committees, RFP response coordination, and company-wide personnel supervision and training. She was instrumental in the development of Aetna Better Health's current standard contract template, displaying remarkable ability to translate administrative concepts of the contract to an operational level. A certified professional coder, she has served as a presenter of Medicaid specific billing concepts at chapter meetings of the American Academy of Professional Coders. Ms. Baird is also an active member of numerous medical community committees and boards.

The Implementation Manager's primary responsibilities will include, but not be limited to, the following:

- Developing a pipeline from project initiation through post-transition evaluation for new and expanding business
- Providing support and guidance for all aspects of the work plan and identifying policy decisions that must be addressed
- Creating and defining the project framework, while providing clarity and vision to the Implementation Team and Functional Area Leads/SMEs as well as coordinating Implementation Team activities
- Executing resolution to implementation issues and questions, overseeing the requests for resources to complete the implementation, and managing the implementation budget
- Communicating progress and problems with the Board of Directors as well as meeting the scope of work in a timely manner and within budget constraints

### **Additional Required Staff**

Aetna Better Health's project team will include the following required staff, as well as other staff we deem necessary to serve our CCN Program members.

- **Prior Authorization Staff** to authorize health care 24-hours-a-day, 7-days-a-week. This staff shall include a Louisiana licensed registered nurse, physician or physician's assistant. The staff will work under the direction of a Louisiana-licensed registered nurse, physician or physician's assistant.
- **Concurrent Review Staff** to conduct inpatient concurrent review. This staff shall include of a Louisiana licensed nurse, physician, or physician's assistant. The staff will work under the direction of a Louisiana licensed registered nurse, physician or physician's assistant.
- **Clerical and Support Staff** to verify proper functioning of the CCN Program's operation.
- **Provider Services Staff** to enable providers to receive prompt responses and assistance and handle provider grievances and disputes. There shall be sufficient Provider Services staff to enable providers to receive prompt resolution of their problems and inquiries and appropriate education about participation in the CCN Program and to maintain a sufficient provider network.
- **Member Services Staff** to enable members to receive prompt responses and assistance. There shall be sufficient Member Services staff to enable members and potential members to receive prompt resolution of their problems or inquiries.
- **Claims Processing Staff** to verify the timely and accurate processing of original claims, resubmissions and overall adjudication of claims.
- **Encounter Processing Staff** to verify the timely and accurate processing and submission to DHH of encounter data and reports.
- **Case Management Staff** to assess, plan, facilitate and advocate options and services to meet members' health needs through community resources.

### **Workforce Development Assists TANF Members**

As part of our staffing plan, Aetna Better Health proposes a workforce development program called Aetna Building Louisiana Employment (ABLE). The program strives to reduce the number of individuals on case assistance while providing long-term stability in the workforce through training and experience.

Aetna Better Health has implemented a successful workforce development program in our Pennsylvania plan called the Contractor Partnership Program (CPP). We work collaboratively with the Pennsylvania Department of Public Welfare to create jobs for Temporary Assistance for Needy Families (TANF) recipients receiving cash assistance. Aetna Better Health used a contractor as the third party vendor to recruit, train and manage the CPP personnel. We made a \$5.6 million dollar commitment over five years to include salaries, benefits, merits and bonuses, as well as dollars for community outreach. Typical positions filled include Member Service Representatives, Prior Authorization Representatives, Care Coordinators, Credentialing Coordinator and Receptionist.

The CPP program has been highly successful with many advantages, such as creating a loyal work force that brings value to the state by reducing the number of individuals on cash assistance and providing long-term stability in the workforce.

***Aetna Building Louisiana Employment (ABLE)***

ABLE is a workforce development program, which will be created by Aetna Better Health to add 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.

Aetna Better Health will leverage our CCN Program start-up and ongoing job creation opportunities to create jobs for 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 including:

- Parish assistance offices and work development programs
- Louisiana Workforce Commission
- Community Action and Support Agencies
- Department of Labor
- Department of Health and Hospitals
- Community and/or Technical College Systems

Aetna Better Health gear ABLE outreach efforts toward all TANF members receiving State assistance. We will interview, assess and hire TANF recipients receiving cash assistance who apply for the following positions with the following hiring goals:

- Member Services Representatives (one ABLE for every three department positions)
- Receptionist
- Prior Authorization Representative (one ABLE for every four department positions)

Aetna Better Health will provide workforce and job specific training throughout their first 60 to 90 days and ongoing as needed to include:

- 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)

Aetna Better Health will pay ABLE personnel a minimum of \$30,000 in addition to an annual bonus and the opportunity to earn merit pay increases if performance expectations are met.

Aetna Better Health's ABLE commitment:

- We will strive to create a diverse work force and inclusive team environment
- Hire, train, educate and work to retain ABLE personnel
- 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

- Providing financial counseling education

***Member/Provider Notification***

Aetna Better Health will educate potential workforce development candidates through the Louisiana Department of Workforce Development and the Department of Health and Hospitals upon receipt of each agency's respective approval.

We will work with a third party vendor to assist us in recruiting eligible individuals for ABLE. Our vendor will work with and communicate with various workforce development agencies including:

- Parish assistance offices and work development programs
- Louisiana Workforce Commission
- Community Action and Support Agencies
- Department of Labor
- Department of Health and Hospitals
- Community and/or Technical College Systems

**Ongoing Staffing Plan**

Aetna Better Health understands the importance of developing accurate job descriptions to properly communicate job expectations as well as to assist in better targeted selection of qualified candidates. Aetna Better Health develops and maintains written policies, procedures and job descriptions for each functional area, consistent in format and style.

We maintain written guidelines for developing, reviewing and approving all policies, procedures and job descriptions. We consistently maintain clear and specific job descriptions that are reviewed and updated by leadership and with personnel to meet job requirements. All CCN Program policies and procedures are reviewed at least annually to verify that our written policies reflect current practices. The appropriate manager, coordinator, director or administrator reviews, signs and dates policies for each functional area. Our Medical Director reviews, approves and signs all Medical and Quality Management policies. We review job descriptions annually, at a minimum, to verify that the current duties performed by our personnel reflect written requirements.

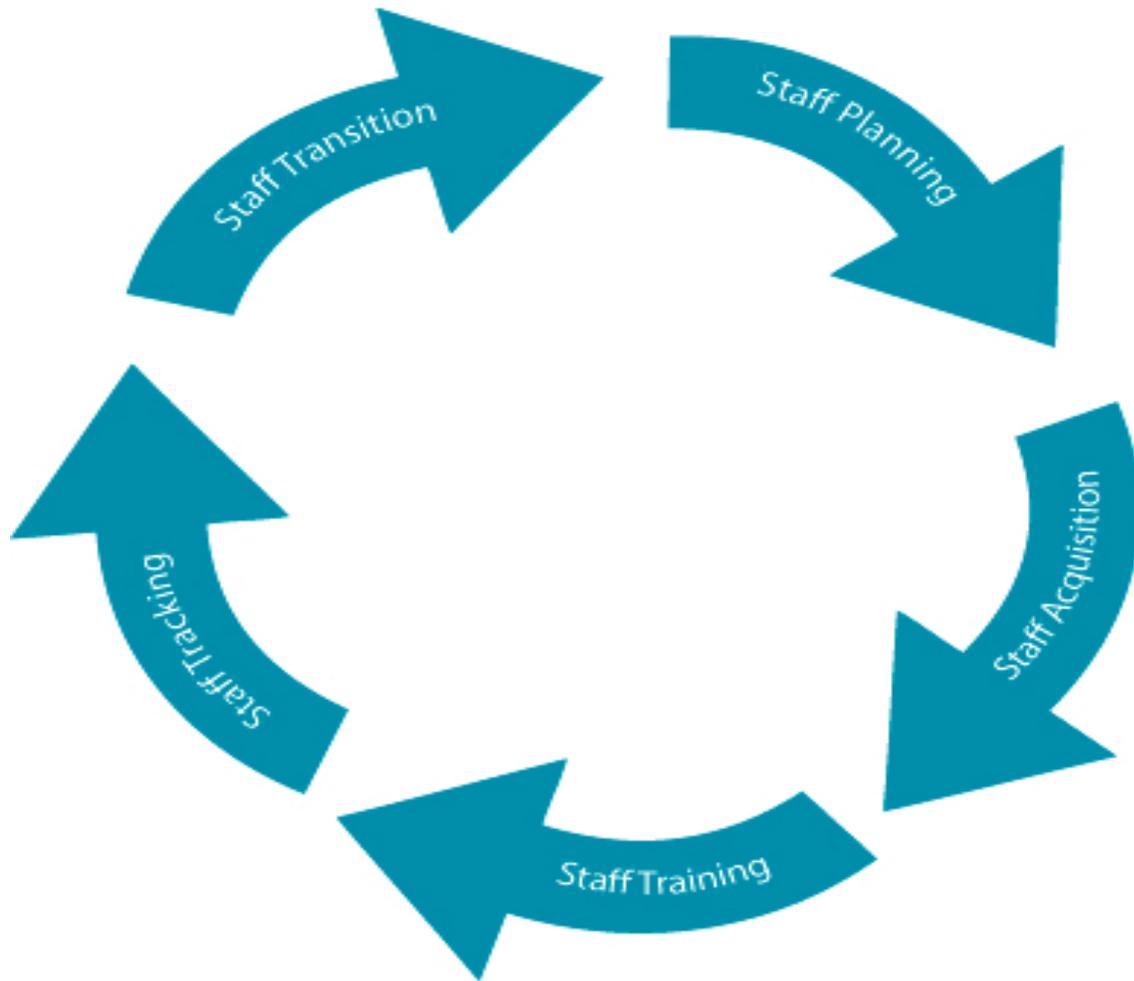
Aetna Better Health recognizes that the first step in establishing high quality, cost effective and outcomes-oriented health care service delivery is the accurate identification, maintenance and adjustment of staffing ratios. The determination of appropriate staffing levels for the CCN Program is dependent upon several factors including, but not limited to, number of projected members and consideration of the special needs of the populations being served. Should we be the successful bidder for GSA A, B and C, we anticipate staffing levels of approximately 180 full-time employees, with staffing levels contingent on membership growth.

***Ongoing Staffing Plan Phases***

Aetna Better Health understands that maintaining appropriate levels of personnel requires consistent monitoring and quick response times to make certain that there are no interruptions in meeting the needs of our members. Our staffing plan is a continuous, integrated process that is

managed by our Human Resources Department. The following diagram depicts how each phase of our staffing plan is interconnected with the others and continually in motion:

**Aetna Better Health's Staffing Plan Phases**



Aetna Better Health's continuous evaluation of our staffing ratios is woven into the following five phases of our staffing plan to verify that ongoing functions meet or exceed contract requirements.

**1) Personnel Planning**

Aetna Better Health is committed to developing a staffing infrastructure that includes highly skilled individuals and can meet the many diverse needs of the CCN Program. The identification of personnel planning strategies is the first step in this process and is crucial prior to initiating the

remaining phases in the process. Staffing strategy activities include, but are not limited to, the following:

- Developing internal and external talent pools from which we will identify and recruit qualified individuals upon contract award.
- Defining appropriate staffing levels based on our expertise in best practice staff to member ratios, including ratios for services to members with special health care needs (MSHCNs) and children with special health care needs (CSHCNs).
- Developing and executing a “critical control” plan to confirm that the staffing plan is executed efficiently and consistently.

## **2) Personnel Acquisition**

Aetna Better Health’s personnel acquisition process for the CCN Program will begin with the identification of potential candidates for all key positions required by the DHH, as well as additional positions that Aetna Better Health deems essential to establishing a well-rounded program. We believe this strategy is critical to assuring that our team is highly qualified and prepared to meet the day-to-day operations of the program. Aetna Better Health is committed to identifying and actively recruiting candidates with bi-lingual skills and cultural diversity experience. We will deploy an array of recruiting and personnel acquisition activities including, but not limited to, the following:

- Utilizing local referral opportunities, employment agencies, job fairs, and Internet tools to identify diverse, high-caliber Louisiana talent
- Searching internal talent pool of potential employees generated by our recruiting efforts
- Allowing for promotional opportunities from within our organization to attract candidates with excellent transferrable skills

### ***Initial Screening***

An important part of our personnel acquisition phase is our background screening process. Aetna Better Health will screen candidates for all positions according to DHH requirements, as well as our own internal requirements for each staff position. Our Human Resources Department will thoroughly examine each candidate’s job qualifications, including education, experience and references. Candidates will be further examined by the supervisors and managers in their individual departments to determine if they have the appropriate qualifications and understanding of Medicaid managed care to become members of the CCN Program project team.

Aetna Better Health is committed to the safety of our members and conducts background screening and criminal background checks for personnel that have one-on-one, in-person contact with our members (e.g., Care Management Associates, Case Managers). Our background screening process includes validation that the potential employee is not on the Medicare/Medicaid exclusion list nor was found liable in the last 10 years or currently facing criminal or civil action for:

- False claim act violations
- Medicare fraud

- Medicaid fraud
- Consumer fraud
- Health care fraud
- Similar actions in any jurisdiction

Aetna Better Health will not employ or contract with any individual who has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities. We will screen all employees and subcontractors to determine whether any of them have been excluded from participation in federal health care programs.

Aetna Better Health will comply with DHH Policy 8133-98, “Criminal History Records Check of Applicants and Employees,” which requires criminal background checks to be performed on all employees of DHH contractors who have access to electronic protected health information on Medicaid applicants and recipients. We will, upon request, provide DHH with a satisfactory criminal background check or an attestation that a satisfactory criminal background check has been completed for any of its personnel or subcontractor’s personnel assigned to or proposed to be assigned to any aspect of the performance of this contract. Aetna Better Health will also remove or reassign, upon written request from DHH, any CCN employee or subcontractor employee that DHH deems to be unacceptable.

### **3) Personnel Training**

Aetna Better Health will provide a comprehensive orientation and training program designed to “on-board” new personnel. This process includes specific training to reinforce our mission, values, and commitment to high quality and efficient health care for older adults and adults with disabilities. Essential components of our training plan include, but are not limited to, the following:

- Providing a comprehensive overview of our culture, including our values and ethics, and dedication to providing an environment that is focused on our members and providers
- Providing cultural competency initiatives and training to personnel to address members’ specific cultural and language needs that might challenge their ability to access care or understand healthy practices. This includes an effective health literacy and cultural competency training program as a component of our employee orientation.
- Providing training to dispel the myths and stigmas related to disabilities and the negative attitudes often associated with mental illness, HIV/AIDS, and physical/sensorial disabilities
- Making sure that personnel are trained and tested and pass our mandatory compliance and ethics training, including but not limited to topics such as Health Insurance Portability and Accountability Act (HIPAA), Ethical Code of Conduct, preventing fraud, waste and abuse and diversity
- Completing job specific training to include education from experienced personnel in a hands-on, laboratory environment, access to job specific policies, procedures and helpful resources, as well as job shadowing

- Providing extensive training on technology and systems tools that will support employees in performing their duties and enhance their ability to work efficiently

#### **4) Personnel Development**

Personnel development refers to the important process of providing regular and ongoing performance feedback to employees as well as affording personnel the opportunity to provide feedback to program leadership. Aetna Better Health understands how critical personnel development is in the successful administration of the CCN Program and will verify that we, as well as our subcontractors, adhere to documented performance monitoring and feedback processes. Personnel development activities include, but are not limited to:

- Maintaining clear and specific job descriptions that are regularly reviewed with personnel and updated to meet current job requirements
- Establishing, at a minimum, annual performance expectations with clearly defined performance metrics and documented steps necessary to achieving the expectations
- Setting aside time at regular intervals to review performance to-date and achieve appropriate course-correction for employees who appear to not be on track, and discussing consequences of non-performance
- Performing, at a minimum, an annual review process that analyzes performance achieved, creates plans for ongoing professional development and addresses consequences of nonperformance
- Providing ongoing opportunities for personnel to gain additional job training and continual education necessary to enable employees to be successful in current and future job goals

#### **5) Personnel Transition**

Aetna Better Health understands that a key element in any successful staffing plan is the establishment of succession planning processes and procedures for efficiently addressing retention and transfer of knowledge during personnel transition. Key elements of our transition phase activities include, but are not limited to, the following:

- Maintaining appropriate levels of program administration documentation, including established policies and procedures, in current and accessible formats so that they can be easily obtained and referenced by new personnel
- Providing timely and detailed information to the DHH in the event of a key staff transition, including the submission of a comprehensive transition plan
- Identifying interim replacements, when applicable, to maintain continuity of program administration and personnel management
- Executing plans for work re-allocation, cross training and issue delegation in the event of personnel turnover
- Establishing regular opportunities for personnel to learn about promotional opportunities

An important part of our personnel transition phase is our continual monitoring of potential recruitment and/or position vacancy issues. Aetna Better Health utilizes the following activities to identify quality candidates to fill expected or unexpected vacancies due to promotions, departmental transfers and discharges:

- Current/accurate job descriptions and job profiles to properly communicate both what the position is expected to do as well as to assist in better targeted selection of qualified candidates
- Advertising (e.g., newspaper classifieds, job search websites, corporate website)
- Career fairs, open houses
- Search firm assistance
- Proven hiring procedures (e.g., candidate qualifications check, intensive interviews, comprehensive background check)
- Recruitment incentives (e.g., sign-on bonuses, flexible scheduling)

### **Ongoing Personnel Training**

Aetna Better Health understands the importance of a high quality employee training program in developing and maintaining a high performing organization. As a result, we provide a comprehensive ongoing training program designed to meet the training needs of employees across all levels of the organization. Our employee training program will provide the appropriate orientation, training, and education necessary for our employees to successfully fulfill the requirements of individual positions while adhering to Aetna Better Health policies and procedures and DHH, State and federal guidelines, laws and regulations.

Aetna Better Health's Training Department personnel will work closely with our leadership, managers, supervisors, and team leads to make certain that employee training needs and requirements are consistently met. Our Training Department personnel will be responsible for assisting in the training process through the following activities:

- Employee Needs Assessments
- Training Curriculum Development
- Attendee Tracking and Record Keeping
- Development and Maintenance of Course Catalog
- Development of Delivery Methodologies and Modalities
- Individual Coaching and Development
- Customized Business Solutions
- Performance Tracking

Our Training Department will communicate operational updates and process changes to Aetna Better Health personnel via permanently recorded memorandums sent to the affected personnel. These memorandums are used to revise curriculums biannually. Training documentation will be updated and maintained by the Aetna Better Health Training Department. Training materials will be republished biannually and are available within the online Resource Library.

### ***Training Curriculum***

Aetna Better Health believes that an effective employee training program results in improved member satisfaction as well as greater employee satisfaction and retention. Our Training Department will develop a comprehensive initial and ongoing training program that includes

Aetna Better Health, DHH, State and federal requirements, as well as additional courses that will enhance the ability of our employees to meet the diverse needs of our members.

All newly hired Aetna Better Health employees will be required to attend and participate in an orientation and mandatory training classes within three days of hire, which will include, but not be limited to, the following topics:

- Department of Health and Hospitals and the Louisiana Medicaid CCN Program
- Centers for Medicare and Medicaid Services (CMS) including the Patient Protection and Affordable Care Act and Health Care Education and Reconciliation Act
- CCN Program Policy and Procedure Manuals
- Contract Requirements
- Compliance and Fraud and Abuse (including HIPAA and False Claims Act Provisions)
- Business Continuity and Recovery Plan (BCP)/Disaster Recovery Plan (DRP)
- Business Conduct and Integrity
- Medicaid Complaints/Grievance System
- Cultural Competency/Health Literacy and Diversity
- Quality of Care – Identification of Issues and Service Concerns
- Introduction and Overview of Integrated Case Management (ICM)
- Electronic Systems Navigation
- Risk Management

All Aetna Better Health employees will participate in ongoing training at a minimum of twice annually. Ongoing training needs are determined by trends in business operations, frequent questions from staff members, feedback from managers, and new requirements/procedures/policies. Ongoing training is delivered using a variety of methods to include instructor led training sessions, online memo reviews, in-services, e-learning courses and presentations. Ongoing training is mandatory for compliance, business continuity planning, quality of care issues and service concerns, cultural competencies/health literacy, reporting member/provider complaints and DHH program changes resulting in regulatory updates to our training curriculum. Ongoing instructor led training includes operational regulatory updates, medical terminology, grievance and coverage determination and claims payment.

### **Position Specific Training**

Department and position specific training is conducted at the time of hire and is refreshed based upon the needs of the employee and the department as well as for DHH and CMS updates, and Aetna Better Health process improvement changes.

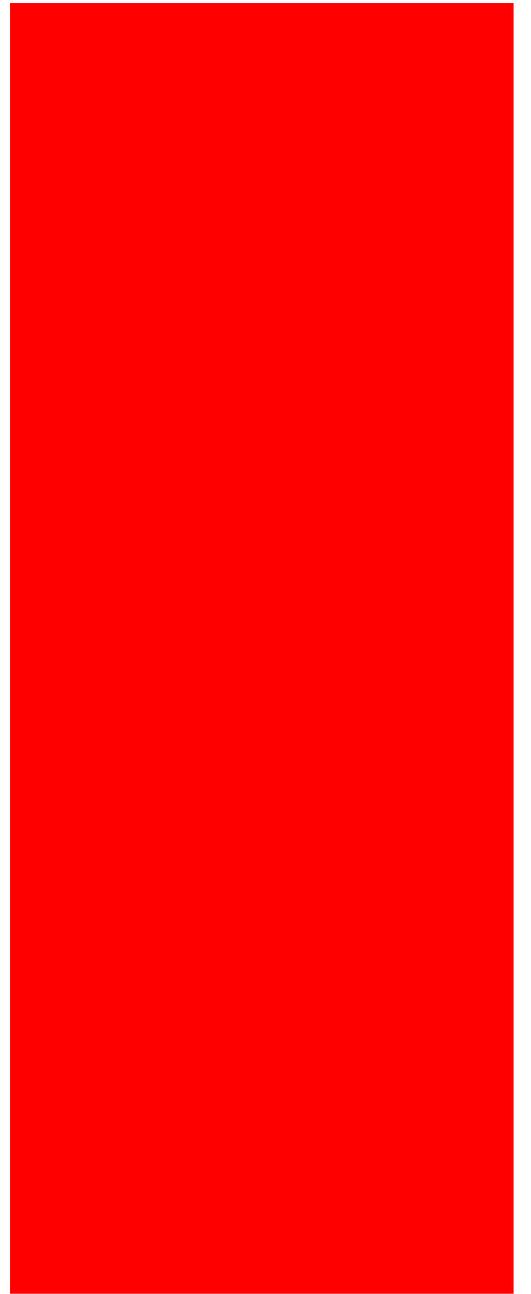
Training specific to employee positions in Utilization Management, Quality Management, Member Services, Provider Services, Network Development and other areas is conducted through instructor led classroom instruction and on the job training. Courses range from one to six weeks. These learners complete online assessments while in the classroom and are evaluated daily using a checklist of criteria constructed to demonstrate knowledge transfer. The checklist is sent the hiring manager detailing the learners' performance at the completion of class. The



trainer consults with the manager of the department and provides suggested additional training based upon the learner's performance.

Aetna Better Health will continually work with our project team to develop each individual's full potential and to meet the evolving needs of our membership. Ongoing employee training and education are key components in achieving increased member and provider satisfaction with services.

12 B.10



**B.10 Attach a personnel roster and resumes of key people who shall be assigned to perform duties or services under the Contract, highlighting the key people who shall be assigned to accomplish the work required by this RFP and illustrate the lines of authority. Submit current resumes of key personnel documenting their educational and career history up to the current time. Include information on how long the personnel have been in these positions and whether the position included Medicaid managed care experience.**

**If any of your personnel named is a current or former Louisiana state employee, indicate the Agency where employed, position, title, termination date, and last four digits of the Social Security Number.**

**If personnel are not in place, submit job descriptions outlining the minimum qualifications of the position(s). Each resume or job description should be limited to 2 pages.**

**For key positions/employees which are not full time provide justification as to why the position is not full time. Include a description of their other duties and the amount of time allocated to each.**

## **Key Personnel**

Aetna Better Health, Inc.'s, a Louisiana corporation, d/b/a Aetna Better Health's<sup>®</sup> ("Aetna Better Health's") staffing infrastructure is designed to provide the Louisiana Medicaid Coordinated Care Network (CCN) Program with high levels of expertise for each functional area at every stage of the program's development and ongoing operations. Aetna Better Health is committed to hiring qualified, experienced individuals who meet all Request for Proposal (RFP) requirements. We will make sure that all personnel are well trained on the specifics of their CCN Program job responsibilities. Our experienced personnel will support the Department of Health and Hospital's (DHH) mission to protect and promote good health and access to medical, preventive and rehabilitative services for citizens of the State of Louisiana. We will provide timely, quality services and utilize all available resources to serve our members in the most effective manner.

### ***Current/Former Louisiana State Employees***

Our personnel do not include any current or former Louisiana State employees.

### ***Full-Time Employees***

All key personnel are in place and all are full-time, experienced personnel dedicated to serving our members. Aetna Better Health's most experienced team of Medicaid managed care experts will manage the seamless transition of members to an effective and efficient Medicaid managed care model during Phase I: the implementation period and initial start-up operations. This team will remain in place for a period of nine months or more, as required to manage members' successful transition to the CCN Program and initial operations. During this period, our Chief Executive Officer and his personnel will be recruiting from among the local Louisiana talent pool, as well as a national talent pool of experienced Medicaid managed care executives, to smoothly transition certain key positions to Louisiana-based personnel. Accordingly, during Phase I, some of our full-time personnel will have responsibilities related to other Aetna Better Health affiliated plan duties. The following chart delineates the approximate division of time during Phase I implementation and transition activities. The chart also indicates personnel that will be 100 percent devoted to the CCN Program during Phase II: Ongoing Operations.

Aetna Better Health will inform the Department of Health and Hospitals (DHH) in writing within five business days when a key staff member in one of the positions listed below transitions out of the CCN Program, leaving a fully trained key staff member in place. This notification will provide the name and contact information for the new key staff member. Aetna Better Health will replace any of the key staff with a person of equivalent experience, knowledge and talent. The name and resume of the new employee will be submitted as soon as the new hire has taken place, along with a revised organization chart complete with key staff time allocation. The replacement of the Administrator/CEO/COO or Medical Director/CMO will be submitted to the DHH for prior written approval.

This phased-in transition/operations model has been extremely successful in implementations we have achieved in other states. Our top team manages the transition, trains ongoing staff and remains available for consultation and assistance throughout the life of the contract. Our ongoing local team of Louisiana key personnel will be supported by a national organization and have access to the resources available to Aetna Better Health and our affiliates. This depth and breadth of diversified support will enable our core Louisiana CCN Program ongoing operations team to draw upon over 25 years of Medicaid managed care experience in making decisions and developing processes to serve our member in Louisiana. Should we be the successful bidder for GSA A, B and C, we anticipate staffing levels of approximately 180 full-time employees, with staffing levels contingent on membership growth. We anticipate that our Administrator, Janet Stallmeyer, and our Chief Executive Officer, Patrick Powers, will remain in place throughout Phase I and Phase II: implementation and ongoing operations. They will continue to be supported by the resources of Aetna Better Health's affiliates throughout the contract.

***Key Personnel Roster***

The following roster highlights personnel in each key position including:

- Lines of authority
- Reporting relationships
- Years of Medicaid experience
- Years of health care experience
- Percentage of time devoted to the CCN Program
- Percentage of time devoted to other responsibilities



Part Two: Technical Proposal  
Section B: Qualifications and Experience

Names and Title	Functional Area	Reports To	Medicaid Experience	Health Care Experience	CCN %	Other Responsibilities
Janet Stallmeyer, M.B.A. Administrator	Administration	Tom Kelly, Head of Aetna Medicaid	8 years 6 months	19 years 3 months	25%	Responsible for oversight and management of all healthplan operations in the Central Region: 75%
Patrick C. Powers, B.A., C.P.A. Chief Executive Officer <sup>3</sup>	Administration/all functional areas	Janet Stallmeyer	1 month	25 years 8 months	100%	N/A
Ruth Sirotnik Chief Operating Officer	Operations/all functional areas	Patrick C. Powers	10 years	23 years 2 months	100%	N/A
John Esslinger, M.D., M.M.M. Medical Director/Chief Medical Officer	All Utilization Management/Quality Management/Medical Management activities including: Case Management Concurrent Review Prior Authorization	Patrick C. Powers	6 years	22 years 1 month	75%; ongoing operations personnel will be 100%	Chief Medical Officer of Missouri Care, an Aetna Medicaid managed care plan: 25%

<sup>3</sup> The filings required by the Department of Insurance for Mr. Powers to serve as the CEO of Aetna Better Health have been submitted to DOI and are pending. Per DOI Regulation 66, approval is anticipated within 30 days, and certainly well in advance of the CCN go-live date of January 1, 2012. In the interim, Mr. Tom Kelly, who has been approved by the DOI to serve as the interim CEO of Aetna Better Health, will execute any documents required to be signed by the CEO.



Part Two: Technical Proposal  
Section B: Qualifications and Experience

Names and Title	Functional Area	Reports To	Medicaid Experience	Health Care Experience	CCN %	Other Responsibilities
Lauren Edgington, M.S. Chief Financial Officer	Finance and Reporting	Patrick C. Powers	8 years 5 months	8 years 5 months	40%; ongoing operations personnel will be 100%	Regional CFO with oversight of finances of Aetna Better Health affiliated plans in the region: 60%
Patricia Simpson, M.B.A. Compliance Officer	Compliance	Patrick C. Powers	10 years 10 months	18 years 2 months	40%; ongoing operations personnel will be 100%	Compliance Officer with oversight of compliance at Aetna Better Health affiliated plans: 60%
Patrice Jackson, B.S. Grievance System Manager	Grievances and Appeals	Ruth Sirotnik	4 years 9 months	7 years 8 months	20% ongoing operations personnel will be 100%	Director, Medicaid Policy and Program Administration, oversees fraud and abuse programs for Aetna Better Health affiliated plans: 80%
Terry L. Newman Business Continuity Planning and Emergency Coordinator	Business Continuity	Patrick C. Powers	22 years 3 months	22 years 3 months	25%	Director, Systems and Technology/Head of Disaster Recovery Planning Services for Aetna Better Health affiliated plans: 75%
Lisa Baird, CPC-I, CPC-H Contract Compliance Officer	Contracts Compliance & Implementation Lead	Patrick C. Powers	13 years 8 months	22 years 7 months	Total: 100% (20% Contract Compliance; 80% Implementation)	N/A



Part Two: Technical Proposal  
Section B: Qualifications and Experience

Names and Title	Functional Area	Reports To	Medicaid Experience	Health Care Experience	CCN %	Other Responsibilities
Arda Curtis, R.N., B.S., C.P.H.Q. Quality Management Coordinator	Quality Management	John Esslinger, M.D., M.M.M.	16 years 9 months	41 years	20% Quality Management Coordinator; 20% Performance/Quality Improvement Coordinator; ongoing operations personnel will be 100%	Manager of Quality Management for Aetna Better Health affiliated plan: 60%
Arda Curtis, R.N., B.S., C.P.H.Q. Performance/Quality Improvement Coordinator	Quality Management	John Esslinger, M.D., M.M.M.	16 years 9 months	41 years	20% Quality Management Coordinator; 20% Performance/Quality Improvement Coordinator; ongoing operations personnel will be 100%	Manager of Quality Improvement for Aetna Better Health affiliated plan: 60%
Daniel P. Jansen, M.S.A., M.S.W., C.P.H.Q. Maternal Child Health/EPSTD Coordinator	Maternal Child Health/EPSTD	Melody Dowling, M.S.W., L.C.S.W.	10 years 8 months	29 years	40%; ongoing operations personnel will be 100%	Director, Quality Management at Aetna Better Health affiliated plan: 60%
Mark Douglas, J.D., M.S.N., F.N.P., R.N. Medical Management Coordinator	Utilization Management/Medical Management	John Esslinger, M.D., M.M.M.	19 years 1 month	19 years 1 month	50%; ongoing operations personnel will be 100%	Aetna Medicaid Unit Medical Management Coordinator: 50%
Jason Rottman, B.S. Provider Services Manager	Provider Services and Provider Claims Education	Ruth Sirotnik	13 years 11 months	16 years 7 months	20% Provider Services Manager; 20% Provider Claims Educator, ongoing operations personnel will be 100%	COO Aetna's Maryland Medicaid plan: 60%



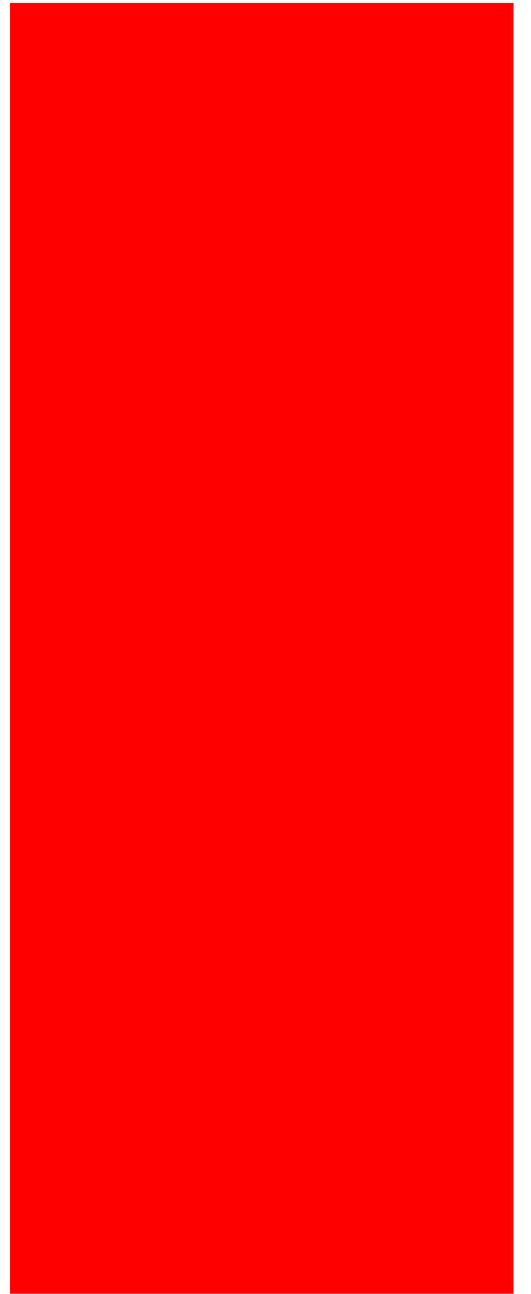
Part Two: Technical Proposal  
Section B: Qualifications and Experience

Names and Title	Functional Area	Reports To	Medicaid Experience	Health Care Experience	CCN %	Other Responsibilities
Taira Green-Kelley, B.A. Member Services Manager	Member Services	Ruth Sirotnik	11 years, 7 months	15 years	40%; ongoing operations personnel will be 100%	Medicaid unit regional business development: 60%
Von Young, B.A. Claims Administrator	Claims	Ruth Sirotnik	6 years 7 months	19 years 2 months	40%, ongoing operations personnel will be 100%	Medicaid unit claims supervisor: 60%
Jason Rottman, B.S. Provider Claims Educator	Provider Services and Provider Claims Education	Ruth Sirotnik	13 years 11 months	16 years 7 months	20% Provider Services Manager, 20% Provider Claims Educator, ongoing operations personnel will be 100%	COO Aetna's Maryland Medicaid plan: 60%
Melody Dowling, M.S.W., L.C.S.W. Case Management Administrator/Manager	Utilization Management (including Case Management Concurrent Review Prior Authorization)	Mark Douglas, J.D., M.S.N., F.N.P., R.N.	9 years 5 months	15 years 11 months	50%, ongoing operations personnel will be 100%	Aetna Medicaid Unit Medical Management Coordinator: 50%
Gregory Krause, M.B.A. Management Information Systems Manager	Information Management and Systems Director	Patrick C. Powers	12 years 10 months	12 years 10 months	25%, ongoing operations personnel will be 100%	Aetna Medicaid Unit Information Management Systems Head: 75%
Lisa Baird, CPC-I, CPC-H Implementation Manager	Implementation Manager	Patrick C. Powers	13 years 8 months	22 years 7 months	Total 100% (20% Contract Compliance, 80% Implementation)	N/A

**Key Personnel Resumes**

Please see Appendix E for resumes of our key personnel.

13 B.11



**B.11 Provide a statement of whether you intend to use major subcontractors (as defined in the RFP Glossary), and if so, the names and mailing addresses of the subcontractors and a description of the scope and portions of the work for each subcontractor with more than \$100,000 annually. Describe how you intend to monitor and evaluate subcontractor performance. Also specify whether the subcontractor is currently providing services for you in other states and where the subcontractor is located.**

**In addition, as part of the response to this item, for each major subcontractor that is not your organization's parent organization, affiliate, or subsidiary, restate and respond to items B.1 through B.7, B.10 and, B.16 through B.27**

**If the major subcontractor is your organization's parent organization, affiliate, or subsidiary, respond to items B.1, B.8 and B.9. You do not need to respond to the other items as part of the response to B.11; note, however, responses to various other items in Section B must include information on your organization's parent organization, affiliates, and subsidiaries, which would include any major subcontractors that are your organization's parent organization, affiliate, or subsidiary.**

In this section we have included the requested information about the major subcontractors that Aetna Better Health, Inc., a Louisiana corporation, d/b/a Aetna Better Health ("Aetna Better Health") will contract with for the Louisiana Medicaid Coordinated Care Network (CCN) program. As stated in the RFP, a major subcontractor is any entity retained by Aetna Better Health to provide a key type of service or function where the value of the subcontracted services exceeds 100,000.

Aetna Better Health actively reviews all subcontractors' programs for adherence to health plan standards and NCQA standards, as well as compliance with applicable federal and state laws and regulations. Through our Quality Management Program we routinely monitor the quality of care and services, as well as the quality of reporting data, provided under any subcontract/delegation agreement.

As part of our Quality Management Program, Aetna Better Health maintains a comprehensive set of policies and procedures to monitor subcontractor performance. Our policies require all subcontract arrangements to be supported by a written, signed agreement that delineates the responsibilities of the parties, defines their relationship, specifies how the subcontractor's performance will be monitored and sets forth remedies if the party is not meeting contractual obligations. The written agreement also outlines on-going monitoring activities, including the provision of quarterly reports that include information appropriate to the scope of the subcontracted function. Material subcontractors submit regular reports to Aetna Better Health for review and approval. If any deficiencies in performance are identified, a corrective action plan will be required.

Aetna Better Health regularly monitors and reviews performance measure outcomes and subcontractor reports, and makes recommendations on cross-departmental strategies to improve quality of care and/or to determine if additional quality indicator measures are necessary to

measure program performance. The Quality Management Oversight Committee (QMOC) is responsible for the oversight of subcontracted/delegated functions through the following activities:

- Monitoring subcontractor’s adherence to performance standards through routine administrative reports
- Reviewing subcontractor reports for compliance with contractual requirements
- Conducting readiness reviews to verify subcontractor’s ability to perform subcontracted functions
- Reviewing member and provider feedback on subcontractor performance
- Recommending remedial actions to address subcontractor performance issues such as training or more frequent monitoring
- Tracking corrective action plans to satisfactory completion

Aetna Better Health will be using the following highly qualified major subcontractors:

- Schaller Anderson, LLC (affiliated subcontractor)
- Aetna Life Insurance Company (ALIC) (affiliated subcontractor)
- Aetna Health Management, LLC (AHM) (affiliated subcontractor)
- Medical Transportation Management, Inc. (transportation subcontractor)
- Avesis (vision subcontractor)

**Major Subcontractors’ Functional Responsibilities:**

Subcontractor	Type	Functional Responsibilities
Schaller Anderson, LLC	Affiliated	Licensed as a third party administrator in Louisiana, Schaller Anderson will provide accounting, actuarial and reporting functions; procurement services; quality assessment; disease management; and data processing.
Aetna Life Insurance Company	Affiliated	Pursuant to intercompany arrangements with Aetna Better Health's affiliates, ALIC will provide administrative services which may include management of Aetna's contracts with subcontractors.
Aetna Health Management, LLC	Affiliated	Provides administrative services related to credentialing.
Medical Transportation Management	Non-Affiliated	Provides transportation services.
Avesis	Non-Affiliated	Provides vision network; vision services.

**Affiliated Major Subcontractors:**

- Schaller Anderson, LLC
- Aetna Life Insurance Company (ALIC)
- Aetna Health Management, LLC (AHM)

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**SCHALLER ANDERSON, LLC**

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Aetna Better Health’s affiliate, Schaller Anderson, LLC (Schaller Anderson), will provide a subset of services for the administration of the Louisiana Medicaid CCN Program through an administrative services agreement with Aetna Better Health. Licensed as a third party administrator in Louisiana, Schaller Anderson will provide accounting, actuarial and reporting functions; procurement services; quality assessment; disease management; and data processing.

**B.11 Major Subcontractor**

**B.1 Indicate your organization’s legal name, trade name, dba, acronym, and any other name under which you do business; the physical address, mailing address, and telephone number of your headquarters office. Provide the legal name for your organization’s ultimate parent (e.g. publicly traded corporation).**

**Describe your organization’s form of business (i.e., individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and detail the names, mailing address, and telephone numbers of its officers and directors and any partners (if applicable). Provide the name and address of any health professional that has at least a five percent (5%) financial interest in your organization, and the type of financial interest.**

**Provide your federal taxpayer identification number and Louisiana taxpayer identification number.**

**Provide the name of the state in which you are incorporated and the state in which you are commercially domiciled. If out-of-state, provide the name and address of the local representative; if none, so state.**

**If you have been engaged by DHH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; if not, so state.**

**Legal Name and Ownership**

Schaller Anderson, LLC (Schaller Anderson), an Arizona limited liability corporation, is a wholly-owned subsidiary of a publicly-traded corporation, Aetna Inc. (Aetna). Schaller Anderson is wholly owned by Aetna Health Holdings, LLC, which is wholly owned by Aetna Inc. Schaller Anderson is a for-profit corporation and our ultimate parent, Aetna, Inc., is also a for-profit corporation.

Through an administrative services agreement, Schaller Anderson will serve as the third party administrator for its affiliate, Aetna Better Health, Inc., in administering the Louisiana Medicaid Coordinated Care Network (CCN) Program. The two companies are affiliates. Schaller Anderson is a wholly owned subsidiary of Aetna Health Holdings, LLC, which is a wholly



owned subsidiary of Aetna Inc., a Fortune 500 company. Aetna Better Health is also a wholly owned subsidiary of Aetna Health Holdings, LLC.

Aetna has been serving the health and insurance needs of Americans since 1853 and has established a solid financial foundation for its operations. Total revenues for 2010 exceeded \$34 billion dollars; A.M. Best continued to rate Aetna’s financial strength as A (Excellent) and affirmed an A+ (Excellent) long-term credit rating for Aetna, Inc.

To review Aetna Inc.’s corporate structure and the lines of responsibility and authority in the administration of Aetna Better Health’s business as a health plan, please refer to Appendix C for a copy of our organizational charts:

**Headquarters Address**

The physical address, mailing address and phone number for Schaller Anderson, LLC are as follows:

Schaller Anderson, LLC  
 4645 E. Cotton Center Blvd, Building 1  
 Phoenix, Arizona 85040  
 602-659-1100

**Officers**

Following are the names, addresses and phone numbers of our officers:

Name	Title	Address	Phone Number
Thomas L. Kelly	President	4645 E. Cotton Center Blvd., Bldg. #1 Phoenix, AZ 85040	602-659-1631
Brian K. Fischer	Chief Financial Officer	4645 E. Cotton Center Blvd., Bldg. #1 Phoenix, AZ 85040	602-659-2048
Brian K. Fischer	Treasurer	4645 E. Cotton Center Blvd., Bldg. #1 Phoenix, AZ 85040	602-659-2048
Michelle M. Matiski	Secretary	4645 E. Cotton Center Blvd., Bldg. #1 Phoenix, AZ 85040	860-273-8597
Peter R. Oades	Senior Investment Officer	151 Farmington Avenue, Hartford, CT 06156	860-273-8803
Elaine R. Cofrancesco	Vice President and Assistant Treasurer	151 Farmington Avenue, Hartford, CT 06156	860-273-5784
Jerry J. Bellizzi	Vice President and Assistant Secretary	151 Farmington Avenue, Hartford, CT 06156	860-273-0590

Name	Title	Address	Phone Number
Edward C. Lee	Vice President and Assistant Secretary	151 Farmington Avenue, Hartford, CT 06156	860-273-8329
Frederick R. Hatfield	Vice President	4645 E. Cotton Center Blvd., Bldg. #1 Phoenix, AZ 85040	602-659-1603
Nancy Schermerhorn Haase	Assistant Treasurer	151 Farmington Avenue, Hartford, CT 06156	860-273-5860
Michael M. Sinisgalli	Assistant Treasurer	151 Farmington Avenue, Hartford, CT 06156	860-273-3784
Eric Sidney Trafton	Assistant Treasurer	151 Farmington Avenue, Hartford, CT 06156	860-273-4137
Tonya M. Affricano	Assistant Secretary	151 Farmington Avenue, Hartford, CT 06156	860-273-0256
Thorne W. Clark	Assistant Secretary	4645 E. Cotton Center Blvd., Bldg. #1 Phoenix, AZ 85040	212-457-0706
Robert Kessler	Assistant Secretary	4645 E. Cotton Center Blvd., Bldg. #1 Phoenix, AZ 85040	860-273-1051
Melissa Bush Pavlovich	Assistant Secretary	151 Farmington Avenue, Hartford, CT 06156	860-273-5244
Stephen A. Stites	Assistant Secretary	151 Farmington Avenue, Hartford, CT 06156	860-273-1056
Melinda Westbrook	Assistant Secretary	151 Farmington Avenue, Hartford, CT 06156	860-273-3386

**Directors**

Schaller Anderson, LLC (Schaller Anderson) does not have any directors; it has members. The sole member of Schaller Anderson is Aetna Health Holdings, LLC.

**No Health Professionals with a Five Percent Financial Interest**

No health professional has a financial interest of five percent or more in Schaller Anderson, LLC.

**Taxpayer Identification Numbers**

The federal taxpayer identification number for Schaller Anderson, LLC is: 86-0842559.

***State of Incorporation and Domicile***

Schaller Anderson, LLC is commercially domiciled and incorporated in Arizona and is licensed to do business in eleven states; California, Connecticut, Delaware, Florida, Illinois, Louisiana, Maryland, Missouri, Pennsylvania, Texas and Virginia.

***Not Engaged by DHH in the Past 24 Months***

Schaller Anderson has not been engaged by the Department of Health and Hospitals in the past 24 months.

**B.8 Describe your organization's number of employees, client base, and location of offices. Submit an organizational chart (marked as Chart A of your response) showing the structure and lines of responsibility and authority in your company. Include your organization's parent organization, affiliates, and subsidiaries.**

Please refer to Appendix C for a copy of organizational chart (Chart A), which illustrates the structure and lines of responsibility and authority for Schaller Anderson, LLC (Schaller Anderson), its parent company, affiliates and subsidiaries.

***Employees***

Schaller Anderson currently employs 2,120.

***Client Base***

The following table provides information for each State Medicaid or CHIP Program for which we are contracted, either directly with a State client or indirectly through a sponsoring organization, to coordinate managed health care services. Our integrated medical management capabilities, provider network and strong administrative services are fully embedded in a variety of delivery systems, including fully capitated health plans, complex care management and administrative services organizations.



Part Two: Technical Proposal  
Section B: Qualifications and Experience

Client Name & Address	Prime or Subcontractor	Contract Size		Contract Details	
		Average Monthly Covered Lives*	Capitated	Duration	
<b>Arizona (Mercy Care)</b>					
Department of Economic Security Div. of Developmental Disability 2200 N. Central, Suite 207 Phoenix, AZ 85004	Subcontractor	ABD: 8,850 Total: 8,850	Yes	6 years Contract expires October 2011	1985 Original Contract Start Date
<b>Contact Information</b> <b>Name:</b> Louetta Coulson, Administrator of Health Services <b>Telephone:</b> 602-238-0928, ext 6012 <b>E-mail:</b> <a href="mailto:lcoulson@azdes.gov">lcoulson@azdes.gov</a>					
<b>Scope of Services:</b> Manage and coordinate medical services including inpatient, outpatient and ancillary services; Medicare wraparound for dual eligibles. Behavioral health services are carved out we coordinate care with the vendor.					
<b>*Covered Population:</b> Individuals enrolled with the Division of Developmental Disabilities who are diagnosed with severe chronic disability appearing before age of 18, who are diagnosed with cognitive difficulties, cerebral palsy, epilepsy, autism, or for children 0-5 who are mentally delayed.					



Part Two: Technical Proposal  
Section B: Qualifications and Experience

Client Name & Address	Prime or Subcontractor	Contract Size		Contract Details
		Average Monthly Covered Lives*	Capitated	
<b>Arizona (Mercy Care Plan AZ)</b>				
State of Arizona AHCCCS Administration 701 E. Jefferson Phoenix, AZ 85034 <b>Contact Information</b> <b>Name:</b> Elizabeth Stackfleth <b>Telephone:</b> 602-417-4796 <b>E-mail:</b> <a href="mailto:elizabeth.stackfleth@azahcccs.gov">elizabeth.stackfleth@azahcccs.gov</a>	Subcontractor	TANF: 292,189 *** ABD: 41,534 Total: 333,723 *** The TANF number includes dual eligible members, 15,716, already reflected on the Mercy Care Advantage Page	Yes	5 years Contract expires October 2013 May 2002 Original Contract Start Date
<b>Scope of Services:</b> Manage and coordinate medical services including inpatient, outpatient and ancillary services; Medicare wraparound for dual eligibles. Behavioral health services are carved out we coordinate care with the vendor.				
<b>*Covered Population:</b> TANF, Aged, Blind and Disabled (ABD)				



Part Two: Technical Proposal  
Section B: Qualifications and Experience

Client Name & Address	Prime or Subcontractor	Contract Size		Contract Details	
		Average Monthly Covered Lives*	Capitated	Duration	
<b>Arizona (Mercy Care Advantage AZ)</b>					
CMS Div of Medicare Health Plans 90 7th Street Suite 5-300 (5W) San Francisco, CA 94103	Subcontractor	SNP/Duals: 15,716  Total: 15,716	Yes	Annual Renewal January 2006 Original Contract Start Date	
<b>Contact Information</b>					
<b>Name:</b> Virginia (Ginnie) Brooks <b>Telephone:</b> 415-744-3696 <b>E-mail:</b> <a href="mailto:vbrooks@cms.hhs.gov">vbrooks@cms.hhs.gov</a>					
<b>Scope of Services:</b> Medicare Advantage, Special Needs Program (SNP) contractor with CMS. Provide and coordinate all Medicare covered services and benefits					
<b>*Covered Population:</b> Individuals eligible for both Medicare and Medicaid (aka dual eligibles).					



Part Two: Technical Proposal  
Section B: Qualifications and Experience

Client Name & Address	Prime or Subcontractor	Contract Size		Contract Details	
		Average Monthly Covered Lives*	Capitated	Duration	
<b>Arizona (Mercy Care Plan AZ)</b>					
State of Arizona AHCCCS Administration Arizona Long Term Care System(ALTCS) 701 E. Jefferson Phoenix, AZ 85034	Subcontractor	LTC: 8,867 Total: 8,867	Yes	5 years Contract expires October 2011	May 2002 Original Contract Start Date
<b>Contact Information</b> Name: John Black Telephone: 602-417-4055 E-mail: <a href="mailto:john.black@azahcccs.gov">john.black@azahcccs.gov</a>					
<b>Scope of Services:</b> Manage and coordinate services for members residing in skilled nursing facilities, assisted living facilities and home and community-based settings with acute care and behavioral health services, including case management.					
<b>*Covered Population:</b> Aged Blind and Disabled (ABD), and Supplemental Security Income (SSI) who meet criteria for institutional placement.					



Part Two: Technical Proposal  
Section B: Qualifications and Experience

Client Name & Address	Prime or Subcontractor	Contract Size		Contract Details	
		Average Monthly Covered Lives*	Capitated	Duration	
<b>Arizona (Mercy Healthcare Group)</b>					
Healthcare Group of Arizona Healthcare Group Administration 701 E. Jefferson Phoenix, AZ 85034	Subcontractor	HCG: 3,813 Total: 3,813	Yes	9 years (Annual renewal increments) Contract expires August 2011	May 2002 Original Contract Start Date
<b>Contact Information</b> Name: Carla Kot Telephone: 602-417-6743 E-mail: <a href="mailto:carla.kot@azahcccs.gov">carla.kot@azahcccs.gov</a>					
<b>Scope of Services:</b> Manage and coordinate medical services including inpatient, outpatient and ancillary services; Medicare wraparound for dual eligibles. Behavioral health services are carved out we coordinate care with the vendor.					
<b>*Covered Population:</b> Healthcare coverage for working uninsured.					



Part Two: Technical Proposal  
Section B: Qualifications and Experience

Client Name & Address	Prime or Subcontractor	Contract Size		Contract Details	
		Average Monthly Covered Lives	Capitated	Duration	
<b>California</b>					
CalOptima 1120 West La Veta Avenue Orange, CA 92868 <b>Contact Information</b> Children's Hospital Orange County (CHOC) Health Alliance <b>Name:</b> Kerri Ruppert Schiller <b>Telephone:</b> 714-532-8451 <b>E-mail:</b> <a href="mailto:kschiller@choc.org">kschiller@choc.org</a>	Subcontractor	TANF: 86,826 CHIP: 18,156 ABD: 4,053 Other: 729 Total: 109,764	Yes	15 years  Current contract expires August 2012  October 1995 Original Contract Start Date	
<b>Scope of Services:</b> Manage and coordinate acute care services including inpatient, outpatient and ancillary services. Behavioral health services are carved out; we coordinate care with the vendor  <b>Covered Population:</b> TANF, CHIP and ABD					



Part Two: Technical Proposal  
Section B: Qualifications and Experience

Client Name & Address	Prime or Subcontractor	Contract Size		Contract Details	
		Average Monthly Covered Lives	Capitated	Duration	
<b>Connecticut</b>					
State of Connecticut, Department of Social Services 25 Sigourney Street Hartford, CT 06106	Prime	TANF: 95,565 CHIP: 4,825 Other(Charter Oak): 4,218 Total: 104,608	Yes	6 years	Three year contract with three, 1-year extensions. Current term ends 6/30/11
<b>Contact Information</b> <b>Name:</b> Mark Schaefer, Interim Director <b>Telephone:</b> 860-424-5067 <b>E-mail:</b> <a href="mailto:mark.schaefer@ct.gov">mark.schaefer@ct.gov</a>					
<b>Scope of Services</b> Manage and coordinate acute care services including inpatient, outpatient and ancillary services. Behavioral health services are carved out; we coordinate care with the vendor					
<b>Covered Population:</b> HUSKY A (TANF), and HUSKY B (CHIP), Charter Oak (State program covering 19 to 64-year-olds)					



Part Two: Technical Proposal  
Section B: Qualifications and Experience

Client Name & Address	Prime or Subcontractor	Contract Size		Contract Details	
		Average Monthly Covered Lives*	Capitated	Duration	
<b>Delaware (Risk)</b>					
Delaware Medicaid & Medical Assistance 1901 N. Dupont Highway Lewis Building New Castle, DE 19720	Prime	TANF: 68,463 CHIP: 3,986 ABD: 7,835 Other (Expanded): 20,655 Total: 100,939	Yes	6 years  Contract expires 6/30/11 with option to extend contract until 6/30/2012	July 2004  Original Contract Start Date
<b>Contact Information</b> <b>Name:</b> Mary Marinari, MCO Liaison <b>Telephone:</b> 302-255-9548 <b>E-mail:</b> <a href="mailto:mary.marinari@state.de.us">mary.marinari@state.de.us</a>					
<b>Scope of Services:</b> Manage and coordinate acute care and behavioral health services including inpatient, outpatient and ancillary services.					
<b>*Covered Population:</b> TANF, CHIP, and ABD					



Part Two: Technical Proposal  
Section B: Qualifications and Experience

Client Name & Address	Prime or Subcontractor	Contract Size		Contract Details	
		Average Monthly Covered Lives	Capitated	Duration	
<b>Illinois</b>					
Illinois Integrated Care Program Illinois Department of HealthCare and Family Services 201 South Grand Springfield, Illinois 62763 <b>Contact Information</b> Michelle Maher Bureau Chief Bureau of Managed Care 217-524-7478	Prime	Membership unavailable due to new contract starting May 2011.	Yes	3/1/2011	5 year contract with option to renew for a total of 10 years  March 2011 <i>Original Contract Start Date</i>
<b>Scope of Services:</b> Manage and coordinate services for members residing in skilled nursing facilities, assisted living facilities and home and community-based settings with acute care and behavioral health services, including case management.					
<b>Covered Population:</b> ABD (adults and older adults with disabilities) Older Adults and Adults with Disabilities who are eligible for Medicaid but are not eligible for Medicare.					



Part Two: Technical Proposal  
Section B: Qualifications and Experience

Client Name & Address	Prime or Subcontractor	Contract Size		Contract Details	
		Average Monthly Covered Lives	Capitated	Duration	
<b>Florida</b>					
Integral Health Plan, Inc .D/B/A Integral Quality Care 4630 Woodland Corporate Blvd Tampa, FL 33614	Subcontractor	TANF: 11,262 ABD: 1,075 Total: 12,337	No	1 year  Current contract expires August 2012	March 2010  Original Contract Start Date
<p><b>Contact Information</b> Name: Richard Akin Telephone: 239-658-3138 E-mail: <a href="mailto:rbakin@aol.com">rbakin@aol.com</a></p>					
<p><b>Scope of Services</b> Manage and coordinate acute care services including inpatient, outpatient and ancillary services. Behavioral health services are carved out; we coordinate care with the vendor.</p>					
<p><b>Covered Population:</b> TANF and ABD</p>					



Part Two: Technical Proposal  
Section B: Qualifications and Experience

Client Name & Address	Prime or Subcontractor	Contract Size		Contract Details	
		Average Monthly Covered Lives	Capitated	Duration	
<b>Maryland</b>					
Maryland Physicians Care 509 Progress Drive Linthicum, MD 21090	Subcontractor	TANF: 112,820 CHIP: 11,560 ABD: 16,909 Other (PAC): 18,302 Total: 159,591	Yes	13 years	State automatically renews contract every year. July 1997 Original Contract Start Date
<b>Contact Information</b> Name: Raymond Grahe, Chairman Telephone: 301-790-8102 E-mail: <a href="mailto:ragrahe@meritushealth.com">ragrahe@meritushealth.com</a>					
<b>Scope of Services</b> Manage and coordinate acute care services including inpatient, outpatient and ancillary services. Behavioral health services are carved out; we coordinate care with the vendor					
<b>Covered Population:</b> TANF, CHIP, ABD and Primary Adult Care (PAC) – PAC is for low income adults age 19 and over who meet the minimum income requirements. PAC benefits cover cost of prescriptions, primary care, mental health care and other limited services.					



Part Two: Technical Proposal  
Section B: Qualifications and Experience

Client Name & Address	Prime or Subcontractor	Contract Size		Contract Details	
		Average Monthly Covered Lives*	Capitated	Duration	
<b>Missouri (Risk)</b>					
MO HealthNet (Missouri Medicaid) 615 Howerton Court P.O. Box 6500 Jefferson City, MO 65102	Prime	TANF: 45,203 CHIP: 5,381  Total: 50,584	Yes	13 years  Current contract expires June 2012	March 1998  Original Contract Start Date
<b>Contact Information</b> <b>Name:</b> Susan Eggen, Assistant to Deputy Director <b>Telephone:</b> 573-526-2886 <b>E-mail:</b> <a href="mailto:Susan.M.Eggen@dss.mo.gov">Susan.M.Eggen@dss.mo.gov</a>					
<b>Scope of Services</b> Manage and coordinate acute care and behavioral health services including inpatient, outpatient and ancillary services.					
<b>Covered Population:</b> TANF, CHIP and foster children					



Part Two: Technical Proposal  
Section B: Qualifications and Experience

Client Name & Address	Prime or Subcontractor	Contract Size		Contract Details	
		Average Monthly Covered Lives	Capitated	Duration	
<b>New Hampshire</b>					
New Hampshire Medicaid Care Coordination Pilot 53 Regional Drive, Suite 201 Concord, NH 03301 <b>Contact Information</b> <b>Name:</b> Katie Dunn, Director <b>Telephone:</b> 603-271-5254 <b>E-mail:</b> <a href="mailto:Kdunn@dhhs.state.nh.us">Kdunn@dhhs.state.nh.us</a>		Prime	TANF: 104,209 ABD: 18,375 Total: 122,584	No	3 years  <i>Current contract expires June 2012</i>  January 2007 <i>Original Contract Start Date</i>
<b>Scope of Services</b> Provide enhanced care coordination (ECC) and administrative services for Medicaid recipients. The ECC pilot program was established to provide efficient and effective primary and secondary medical/behavioral health care, focused on prevention and the establishment of a medical home, was delivered to Medicaid recipients. The programs' two areas of focus are enhanced care coordination and medical administrative services/ utilization management.					
<b>Covered Population:</b> TANF and ABD					



Part Two: Technical Proposal  
Section B: Qualifications and Experience

Client Name & Address	Prime or Subcontractor	Contract Size		Contract Details	
		Average Monthly Covered Lives	Capitated	Duration	
<b>Pennsylvania</b>					
State of Pennsylvania Department of Public Wealth (DPW) of the Commonwealth of Pennsylvania	Prime	TANF 35,817 ABD: 6,858 Total: 42,675	Yes	1 year  Current contract expires December 2015  April 2010 Original Contract Start Date	
<b>Contact Information</b> <b>Name:</b> Vivienne Elby-Bowers, Aetna Core Team Manager <b>Telephone:</b> 717-772-6289 <b>E-mail:</b> <a href="mailto:VELBYBOWER@state.pa.us">VELBYBOWER@state.pa.us</a>					
<b>Scope of Services</b> Manage and coordinate acute care services including inpatient, outpatient, pharmacy and ancillary services. Behavioral health services are carved out; we coordinate care with the vendor.					
<b>Covered Population:</b> TANF, SSI and dual eligibles under 21					



Part Two: Technical Proposal  
Section B: Qualifications and Experience

Client Name & Address	Prime or Subcontractor	Contract Size		Contract Details	
		Average Monthly Covered Lives	Capitated	Duration	
<b>Pennsylvania (Risk)</b>					
Commonwealth of Pennsylvania Department of Insurance Office of CHIP and Adult Basic 1142 Strawberry Square Harrisburg, PA 17120	Prime	CHIP: 29,800 Total: 29,800	Yes	17 years <i>Currently in negotiations with state for another three year contract</i>	1993 <i>Original Contract Start Date</i>
<b>Contact Information</b> Name: Lowware Holliman, Division Chief Telephone: 717-783-1437 E-mail: <a href="mailto:lholliman@state.pa.us">lholliman@state.pa.us</a>					
<b>Scope of Services</b> Provide all managed care medical services including inpatient, outpatient and ancillary services; Coordinate behavioral health services					
<b>Covered Population:</b> CHIP					



Part Two: Technical Proposal  
Section B: Qualifications and Experience

Client Name & Address	Prime or Subcontractor	Contract Size		Contract Details
		Average Monthly Covered Lives*	Capitated	
<b>Texas (Risk)</b>				
Texas Health and Human Services Commission Health Plan Operations, H-320 11209 Metric Blvd., Bldg H Austin, Texas 78758	Prime	TANF: 50,232 CHIP: 12,708	Yes	4 years  Contract expires August 2013  September 2006 Original Contract Start Date
<b>Contact Information</b> <b>Name:</b> Rudy Villarreal, Health Plan Manager <b>Telephone:</b> 512-491-1466 <b>E-mail:</b> <a href="mailto:Rudy.Villarreal@hpsc.state.tx.us">Rudy.Villarreal@hpsc.state.tx.us</a>		Total: 62,940		
<b>Scope of Services:</b> Manage and coordinate all acute care and behavioral health services including inpatient, outpatient and ancillary services				
<b>*Covered Population:</b> TANF and CHIP				



Part Two: Technical Proposal  
Section B: Qualifications and Experience

Client Name & Address	Prime or Subcontractor	Contract Size		Contract Details
		Average Monthly Covered Lives*	Capitated	
<b>Texas – Parkland (ASO)</b>				
Texas Health and Human Services Commission Health Plan Operations, H-320 11209 Metric Blvd., Bldg H Austin, Texas 78758 <b>Contact Information</b> <b>Name:</b> Rudy Villarreal, Health Plan Manager <b>Telephone:</b> 512-491-1466 <b>E-mail:</b> <a href="mailto:Rudy.Villarreal@hsc.state.tx.us">Rudy.Villarreal@hsc.state.tx.us</a>	Subcontractor	TANF: 155,355 CHIP: 42,350 Total: 197,705	No	12 years Contract expires August 2013 December 1998 Original Contract Start Date
<b>Scope of Services:</b> Manage and coordinate acute care services including inpatient, outpatient and ancillary services. Behavioral health services are carved out; we coordinate care with the vendor <b>*Covered Population:</b> TANF and CHIP				

***Location of Offices***

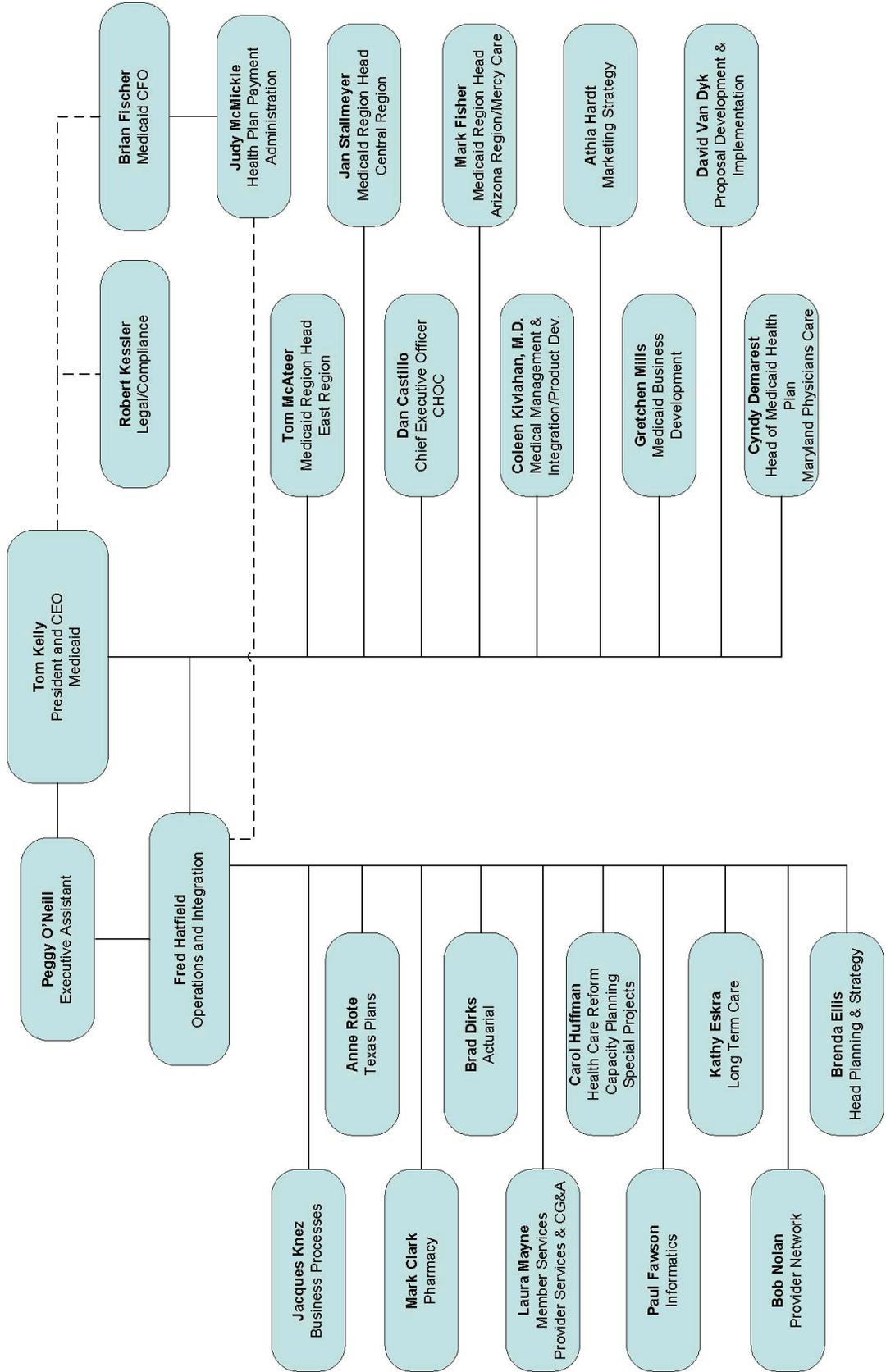
Following is the address and phone number for Schaller Anderson, LLC headquarters:

Schaller Anderson, LLC  
4645 E. Cotton Center Blvd, Building 1  
Phoenix, Arizona 85040  
602-659-1100

**B.9 Provide a narrative description of your proposed Louisiana Medicaid Coordinated Care Network project team, its members, and organizational structure including an organizational chart showing the Louisiana organizational structure, including staffing and functions performed at the local level. If proposing for more than one (1) GSA, include in your description and organizational chart if: 1) the team will be responsible for all GSAs or 2) if each GSA will differ provide details outlining the differences and how it will differ.**

The graphic on the following page illustrates our affiliate, Schaller Anderson, LLC's organizational chart with the names and titles of key personnel. Schaller Anderson will provide supportive administrative services for GSAs A, B and C. Please refer to Appendix C for a copy of Aetna Better Health's® (Chart A) organizational structure for the Louisiana Coordinated Care Network program. Aetna Better Health's organizational structure shows the staffing and functions to be performed at the local level.

Schaller Anderson, LLC Organizational Structure



Total Schaller Anderson, LLC FTE's: 2,120

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## **AETNA LIFE INSURANCE COMPANY (ALIC)**

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### **B.11 Major Subcontractor**

**B.1** Indicate your organization's legal name, trade name, *dba*, acronym, and any other name under which you do business; the physical address, mailing address, and telephone number of your headquarters office. Provide the legal name for your organization's ultimate parent (e.g. publicly traded corporation).

Describe your organization's form of business (i.e., individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and detail the names, mailing address, and telephone numbers of its officers and directors and any partners (if applicable). Provide the name and address of any health professional that has at least a five percent (5%) financial interest in your organization, and the type of financial interest.

Provide your federal taxpayer identification number and Louisiana taxpayer identification number.

Provide the name of the state in which you are incorporated and the state in which you are commercially domiciled. If out-of-state, provide the name and address of the local representative; if none, so state.

If you have been engaged by DHH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; if not, so state.

#### **Legal Name**

The legal name of this subcontractor is Aetna Life Insurance Company.

#### **Type of Ownership**

Aetna Life Insurance Company is a corporation whose ultimate parent is Aetna Inc. Aetna Inc. is a publicly-traded corporation.

Aetna Life Insurance Company (ALIC) was incorporated in Connecticut in June 1853. It was a publicly held corporation until 1967 when all outstanding shares of its stock were acquired by Aetna Life and Casualty Company (AL&C) in a share exchange. In 1996, AL&C changed its name to Aetna Services, Inc. (ASI) and became a wholly owned subsidiary of Aetna, Inc., a Connecticut corporation ("Old Aetna"). On October 31, 2000, ASI merged into Old Aetna and on November 3, 2000 Aetna became a wholly owned subsidiary of Aetna U.S. Healthcare Inc., a Pennsylvania corporation ("New Aetna"), which was a wholly owned subsidiary of Old Aetna at such time. On December 13, 2000, Old Aetna sold its financial services and international businesses and simultaneously spun-off New Aetna to its shareholders. On the same date, New Aetna was renamed Aetna, Inc. Aetna Life Insurance Company is a wholly owned subsidiary of Aetna, Inc., a Pennsylvania corporation. The company's main product lines are health care, group insurance and large case pensions.

ALIC is licensed as a life, accident and health insurer in all 50 states and the District of Columbia. It also is licensed in Guam, Puerto Rico and the U.S. Virgin Islands.



**Headquarters Address**

The physical and mailing address is:  
 Aetna Life Insurance Company  
 151 Farmington Avenue  
 Hartford, CT 06156  
 860-273-0123

**Name and Address of Any Health Professional That Has at Least a Five Percent (5%) Financial Interest**

No health professional has a five percent or greater financial interest in Aetna Life Insurance Company. Aetna Life Insurance Company is a wholly owned subsidiary of Aetna, Inc.

**Federal Taxpayer Identification Number**

Aetna Life Insurance Company’s federal taxpayer identification number is 06-6033492.

**State of Incorporation**

Aetna Life Insurance Company is incorporated in Connecticut and is licensed as a life, accident and health insurer in all fifty states and the District of Columbia. They are also licensed in Guam, Puerto Rico and the U.S. Virgin Islands.

**Officers**

Following are the names, addresses and phone numbers of Aetna Life Insurance Company’s officers:

Name	Corporate Title	Address	Phone Number
Mark T. Bertolini	Chairman, Chief Executive Officer and President, Director	151 Farmington Ave. Hartford, CT 06156	860-273-1188
Joseph M. Zubretsky	Senior Executive Vice President and Chief Financial Officer, Director	151 Farmington Ave. Hartford, CT 06156	860-273-0615
William J. Casazza	Senior Vice President and General Counsel	151 Farmington Ave. Hartford, CT 06156	860-273-1773
Judith H. Jones	Vice President and Corporate Secretary	151 Farmington Ave. Hartford, CT 06156	860-273-0810
Jean C. LaTorre	Vice President, Chief Investment Officer and Director	151 Farmington Ave. Hartford, CT 06156	860-273-8610
Lonny Reisman, M.D.	Senior Vice President and Chief Medical Officer	151 Farmington Ave. Hartford, CT 06156	212-651-8201
Rajan Parmeswar	Vice President, Controller and Chief Controlling Officer	151 Farmington Ave. Hartford, CT 06156	860-273-7210
Alfred P. Quirk, Jr.	Vice President and Treasurer	151 Farmington Ave. Hartford, CT 06156	860-273-1322



**Not Engaged by DHH in the Past 24 Months**

Aetna Life Insurance Company has not been engaged by the Department of Health and Hospitals in the past 24 months.

**B.8 Describe your organization’s number of employees, client base, and location of offices. Submit an organizational chart (marked as Chart A of your response) showing the structure and lines of responsibility and authority in your company. Include your organization’s parent organization, affiliates, and subsidiaries.**

**Subcontractor’s Number of Employees**

Aetna Life Insurance Company has over 27,000 employees.

**Subcontractor’s Client Base**

Aetna Life Insurance Company’s client base and main product lines are health care, commercial group and self-insured insurance and large case pensions. Aetna Life Insurance Company’s client base changes frequently as new clients are added due to growth, a full list of clients would be rather large in scale, therefore we have provided the names of three major clients of Aetna Life Insurance Company’s; Texas Retirement System, Harris County, and Houston Independent School District. Aetna Life Insurance Company is not license to sell insurance in the State of Louisiana.

**Subcontractor’s Locations**

Please refer to the table on the next page for Aetna Life Insurance Company’s list of locations:

Address 1	Address 2	State / City	Main Phone
		<b>Arizona</b>	
1830 North 95th Avenue, Phoenix, AZ 85037	Suite 100	Phoenix	
4645 E. Cotton Center Blvd., Phoenix, AZ 85040-8884	Bldg 1	Phoenix	602-659-1100
4675 E. Cotton Center Blvd., Phoenix, AZ 85040	Bldg 2	Phoenix	
4625 E. Cotton Center Blvd., Phoenix, AZ 85040	Bldg 3	Phoenix	
4350 E. Cotton Center Blvd., Phoenix, AZ 85040	Bldg 4	Phoenix	602-263-3000
1475 N. Scottsdale Road, Scottsdale, AZ 85257		Scottsdale	
		<b>California</b>	
1120 W. LaVeta Ave., Orange, CA 92868	Suite 450	Orange	
1333 / 1385 East Shaw Avenue, Fresno, CA 93710		Fresno	559-241-1000
10370 Commerce Center Drive, Rancho Cucamonga, CA 91730	Suite 210	Rancho Cucamonga	909-476-5200
515 South Flower St., Los Angeles, CA 90071	Suite 505	Los Angeles	213-988-4000 / 800-362-0442
3100 Zinfandel, Rancho Cordova, CA 95670	Suite 125	Rancho Cordova	916-403-4143



Address 1	Address 2	State / City	Main Phone
2677 N Main St, Santa Ana, CA 92705	Suite 500	Santa Ana	714-972-3200
2625 Shadelands Dr., Walnut Creek, CA 94598-2512		Walnut Creek	925-948-4700
7676 Hazard Ctr Dr, San Diego, CA 92108		San Diego	619-718-6200
One Front Street, San Francisco, CA 94111	Suite 600	San Francisco	415-645-8200
6303 Owensmouth, Woodland Hills, CA 91367	Suite 900	Woodland Hills	805-376-5351
<b>China</b>			
88 Century Blvd., Pudong New District, Shanghai, China		Shanghai	
DCH Commercial Centre, No. 25 Westlands Road, Hong Kong, China	4th Flr, Units 401-403	Hong Kong	
18 Middle Xi Zang Road, Harbour Ring Plaza, Shanghai, China	Unit No. 06B-7	Shanghai	
<b>Colorado</b>			
6501 South Fiddler's Green Cir, Greenwood Village, CO 80111	Suite 320	Greenwood Village	303-824-7200
<b>Connecticut</b>			
151 Farmington Ave., Hartford, CT 06156		Hartford	
930 Middle St., Middletown, CT 06457		Middletown	
151 Farmington Ave., Hartford, CT 06156		Hartford	
570 Pigeon Hill Rd., Windsor, CT 06095		Windsor	
20 Glover Avenue, Norwalk, CT 06850	4th Floor	Norwalk	203-846-7800
29 South Main St., West Hartford, CT 06107	Suite 309	West Hartford	
<b>District of Columbia</b>			
20 F Street NW , Washington, DC 20001-6700	Suite 350	Washington	202-223-2821
<b>Delaware</b>			
252 Chapman Rd., Newark, DE 19702-5406	Suite 250	Newark	302-894-6700
<b>Florida</b>			
1060 Maitland Center Commons Blvd., Maitland, FL 32751	Suite 405	Maitland	
5237 Summerlin Commons Blvd, Ft. Myers, FL 33907-2158		Fort Myers	
2528 NW 19th St., Pompano Beach, FL 33069-5229		Pompano Beach	954-876-5000
841 Prudential Dr., Jacksonville, FL 32207-8349	2nd Floor	Jacksonville	904-351-3000
503 Sunport Lane, Orlando, FL 32809	Suite 500	Orlando	407-513-6400



Address 1	Address 2	State / City	Main Phone
502 Sunport Lane, Orlando, FL 32809		Orlando	407-513-6400
4630 Woodland Corporate Blvd., Tampa, FL 33614-2415		Tampa	813-775-0000
1600 SW 80th Terrace, Plantation, FL 33324		Plantation	954-452-4000
35 Alhambra Plaza, Coral Gables, FL 33134		Coral Gables	
<b>Georgia</b>			
11675 Great Oaks Way, Alpharetta, GA 30022		Alpharetta	770-346-4300
3600 Mansell Road, Alpharetta, GA 30022		Alpharetta	
<b>Illinois</b>			
123 North Wacker Drive, Chicago, IL 60606	Suite 650	Chicago	
One South Wacker Drive, Chicago, IL 60606		Chicago	
3800 Golf Road, Rolling Meadows, IL 60008		Rolling Meadows	847-258-0700
<b>Indiana</b>			
3500 Coliseum Blvd. E., Fort Wayne, IN 46805		Fort Wayne	219-496-5459
9045 River Road, Indianapolis, IN 46240		Indianapolis	317-810-4455
<b>Indonesia</b>			
Jl. M.H. Thamrin No. 1, Jakarta, Indonesia 10310		Jakarta	
<b>Ireland</b>			
Tralee Rd., Castleisland, County Kerry, Ireland		County Kerry	860-636-8519
Alexandra House - The Sweepstakes, Dublin, Ireland	Suite 140 SF	Dublin	
<b>Kansas</b>			
11300 Tomahawk Creek Parkway, Leawood, KS 66211	Suite 300	Leawood	913-234-3100 or 800-708-3566
<b>Massachusetts</b>			
1 Charles Park, Cambridge, MA 02142		Cambridge	617-582-5000
<b>Maryland</b>			
509 Progress Drive, Linthicum, MD 21090	Suite 117	Linthicum Hgts.	410-401-9400
13700 McMullen Hwy. SW, Cumberland, MD 21502	Suite 1	Cumberland	
<b>Maine</b>			
175 Running Hill Road, South Portland, ME 04106	3rd Floor	South Portland	
<b>Michigan</b>			



Address 1	Address 2	State / City	Main Phone
28588 Northwestern Highway, Southfield, MI 48034	Suite 290	Southfield	616-254-3000
801 Broadway Avenue NW, Grand Rapids, MI 49504	2nd Floor	Grand Rapids	616-284-0358
<b>Minnesota</b>			
300 Highway 169 So., Minneapolis, MN 55426	Suite 600	Minneapolis	952-594-6250
<b>Missouri</b>			
2404 Forum Blvd., Columbia, MO 65203-5427		Columbia	573-441-2100 / Fax 573-441-2199
11500 NW Ambassador Drive, Kansas City, MO 64153		Kansas City	816-849-3070
1350 Elbridge Payne Road, Chesterfield, MO 63017	Suite 201	Chesterfield	636-534-2100 or 800-447-3999
10991 NW Airworld Drive, Kansas City, MO 64153		Kansas City	816-410-6400
<b>Nevada</b>			
4040 South Eastern Ave, Las Vegas, NV 89119	Suite 240	Las Vegas	702-650-8200 or 800-410-3015
<b>New Hampshire</b>			
8 Commerce Drive, Bedford, NH 03110		Bedford	603-263-0500
<b>New Jersey</b>			
8000 Midlantic Dr., Mt. Laurel, NJ 08054	Suite 100N	Mt. Laurel	856-439-4500
3 Independence Way, Princeton, NJ 08540		Princeton	609-524-7300
55 Lane Rd., Fairfield, NJ 07004-1015	Suite 200	Fairfield	
<b>New York</b>			
15 Columbia Circle, Albany, NY 12203-5156		Albany	518-451-3652
333 Earle Ovington Blvd., Uniondale, NY 11553	Suite 104	Uniondale	516-794-6565
100 Park Ave., New York, NY 10017-5516	12th Floor	New York	212-457-0700
<b>North Carolina</b>			
13860 Ballantyne Corporate Place, Charlotte, NC 28277	Suite 330	Charlotte	919-677-8464



Address 1	Address 2	State / City	Main Phone
4050 Piedmont Pkwy., Highpoint, NC 27265		High Point	336-801-7000
		<b>North Dakota</b>	
1800 East Interstate Ave, Bismarck ND 58501		Bismarck	701-221-1000
		<b>Ohio</b>	
7400 W. Campus Rd., New Albany, OH 43054		New Albany	614-933-7400 or 800-533-2830
4059 Kinross Lakes Pky., Richfield, OH 44286		Richfield	330-659-8070
3201 Enterprise Parkway, Beachwood, OH 44122	Suite 100	Beachwood	216-595-1911
1800 Indianwood Cir., Maumee, OH 43537	Suite 100	Maumee	419-891-2370
		<b>Oklahoma</b>	
3030 Northwest Expressway, Oklahoma City, OK 73112	Suite 875	Oklahoma City	405-917-2880
6120 South Yale Ave, Tulsa, OK 74136	Suite 1225	Tulsa	918-624-4700
		<b>Oregon</b>	
222 SW Columbia St, Koin Center, Portland, OR 97201	Suite 500	Portland	
		<b>Pennsylvania</b>	
1425 Union Meeting Rd., Blue Bell, PA 19422-1919		Blue Bell	800-872-3862
980 Jolly Rd., Blue Bell, PA 19422-1904		Blue Bell	
930 Harvest Dr., Blue Bell, PA 19422-1919		Blue Bell	800-872-3862
3541 Winchester Rd., (a.k.a. 1550 Pond Road) Allentown, PA 18104		Allentown	610-336-1000
730 Holiday Dr., Pittsburgh, PA 15220	Building 8	Pittsburgh	412-875-7000
2000 Market St. Philadelphia, Pa. 19103	Suite 850	Philadelphia	
		<b>Singapore</b>	
Singapore Samsung Hub, 3 Church Street, Singapore, 049483	Level 8	Singapore	
		<b>South Carolina</b>	
221 Dawson Rd, Columbia, SC 29223		Columbia	803-333-1000
		<b>Tennessee</b>	
3150 Lenox Park Blvd., Memphis TN 38115	Suite 110	Memphis	901-541-9400
1801 West End Ave., Nashville, TN 37203	Suite 500	Nashville	615-322-



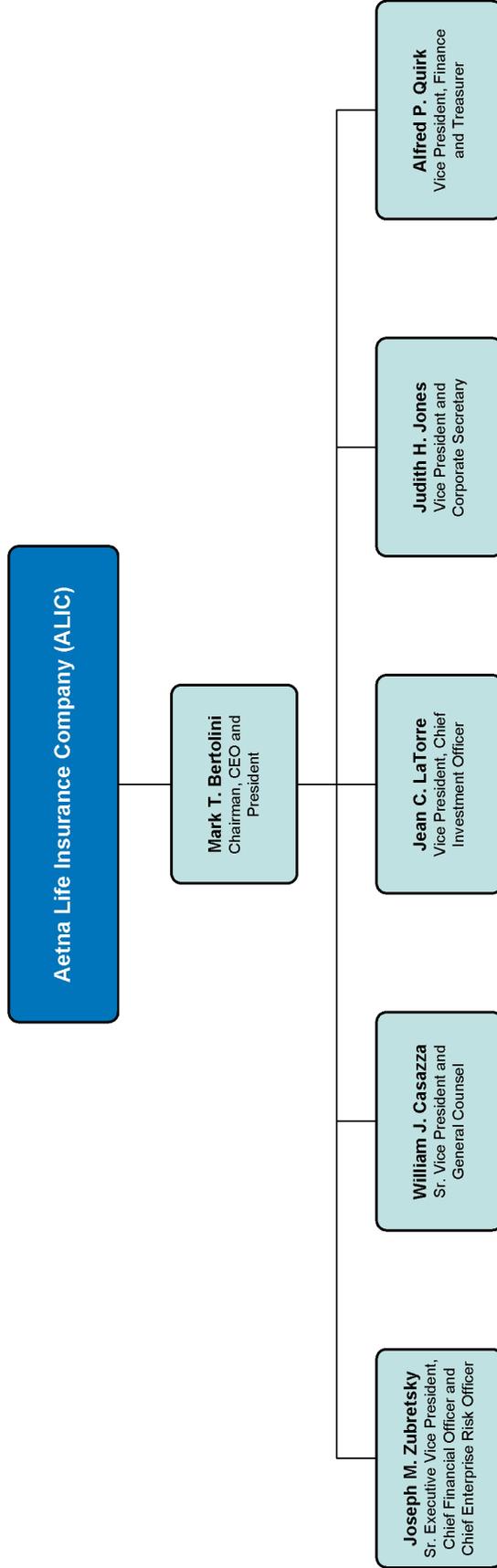
Address 1	Address 2	State / City	Main Phone
			1600
		<b>Texas</b>	
2777 Stemmons Fwy., Dallas, TX 75207	Suite 300	Dallas	214-200-8000
Three Sugar Creek Center, Sugar Land, TX 77478		Sugar Land	
4400 NW Loop 410, San Antonio, TX 78229-5123	Suite 500	San Antonio	210-515-2858
4407 Monterey Oaks Blvd., Austin, TX 78749	Suite 150	Austin	
9050 Capital of Texas Highway North, Great Hills Corporate Ctr., Austin, TX 78759	Building 3	Austin	N/A
4300 Centreway, Arlington, TX 76018		Arlington	817-417-2000
		<b>United Arab Emirates</b>	
The Gate Village 7 DIFC, Unit 1, Dubai, United Arab Emirates		Dubai	
BLDG 7-DOZ-Accademic City Road, Dubai, United Arab Emirates		Dubai	
Oud Metha Building, PO Box 416, Dubai, United Arab Emirates	Suite 416	Dubai	
		<b>United Kingdom</b>	
8 Eastcheap, London, EC3M 1AE		London	
3 Brindley Place, Birmingham, B1 2JB GBR	Suite 301	Birmingham	
		<b>Utah</b>	
10150 South Centennial Pkwy, Sandy, UT 84070	Suite 450	Sandy	801-256-7300
56 East Broadway, Salt Lake City, UT 84111		Salt Lake City	
		<b>Virginia</b>	
2010 Corporate Ridge Road, McLean, VA 22102	Suite 300	McLean	703-903-7100
14155 Newbrook Drive, Chantilly, VA 20151		Chantilly	
		<b>Washington</b>	
601 Union St, Seattle, WA 98101	Suite 810	Seattle	206-701-8000 or 888-207-2048

Please refer to Appendix C for Aetna Life Insurance Company’s Chart A organizational chart, showing the lines of authority.

**B.9 Provide a narrative description of your proposed Louisiana Medicaid Coordinated Care Network project team, its members, and organizational structure including an organizational chart showing the Louisiana organizational structure, including staffing and functions performed at the local level. If proposing for more than one (1) GSA, include in your description and organizational chart if: 1) the team will be responsible for all GSAs or 2) if each GSA will differ provide details outlining the differences and how it will differ.**

The graphic on the following page illustrates our affiliate, Aetna Life Insurance Company's organizational chart with the names and titles of key personnel. Aetna Life Insurance Company will provide supportive administrative services by managing subcontractor services for GSAs A, B and C. Please refer to Appendix C for a copy of Aetna Better Health's (Chart A) organizational structure for the Louisiana Coordinated Care Network program. Aetna Better Health's organizational structure shows the staffing and functions to be performed at the local level.

**Aetna Life Insurance Company (ALIC) Organizational Structure**



**ALIC FTE count: 27,648**

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## **AETNA HEALTH MANAGEMENT, LLC (AHM)**

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### **B.11 Major Subcontractor**

**B.1** Indicate your organization's legal name, trade name, *dba*, acronym, and any other name under which you do business; the physical address, mailing address, and telephone number of your headquarters office. Provide the legal name for your organization's ultimate parent (e.g. publicly traded corporation).

Describe your organization's form of business (i.e., individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and detail the names, mailing address, and telephone numbers of its officers and directors and any partners (if applicable). Provide the name and address of any health professional that has at least a five percent (5%) financial interest in your organization, and the type of financial interest.

Provide your federal taxpayer identification number and Louisiana taxpayer identification number.

Provide the name of the state in which you are incorporated and the state in which you are commercially domiciled. If out-of-state, provide the name and address of the local representative; if none, so state.

If you have been engaged by DHH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; if not, so state.

#### **Legal Name**

The legal name of this subcontractor is Aetna Health Management, LLC (AHM).

#### **Type of Ownership**

Aetna Health Management, LLC (AHM) is wholly-owned by Aetna Health Holdings, LLC whose ultimate parent is Aetna Inc. Aetna Inc. is a publicly-traded corporation.

#### **Headquarters Address**

The physical and mailing address is:  
Aetna Health Management  
151 Farmington Avenue  
Hartford, CT 06156  
860-273-0123

#### **Name and Address of Any Health Professional That Has at Least a Five Percent (5%) Financial Interest**

No health professional has a five percent or greater financial interest in Aetna Health Management, LLC. Aetna Health Management, LLC is a wholly owned subsidiary of Aetna, Inc.

#### **Federal Taxpayer Identification Number**

Aetna Health Management, LLC's federal taxpayer identification number is 13-3670795.



**State of Incorporation**

Aetna Health Management, LLC is incorporated in Delaware and listed to do business in the states mentioned below:

Jurisdiction	Qualified Date	Status
Arizona - UR License	07/06/1998	Active
Arkansas Sec. of State	05/04/2004	Active
California Sec. of State	12/06/2002	Active
Colorado Sec. of State	12/17/2002	Active
Connecticut Sec. of State	12/17/2002	Active
Connecticut - UR License	12/23/2003	Active
Florida Sec. of State	12/06/2002	Active
Georgia Sec. of State	12/06/2002	Active
Georgia - PPO	08/31/2005	Active
Georgia - UR License	02/03/2004	Active
Idaho Sec of State	04/29/2004	Active
Illinois Sec. of State	04/30/2003	Active
Illinois - PPO License	05/15/1996	Active
Illinois - TPA License	02/22/1996	Active
Illinois - UR License	02/03/2004	Active
Indiana Sec. of State	12/30/2002	Active
Indiana - UR License	01/08/2003	Active
Kansas Sec. of State	04/29/2004	Active
Kansas - UR License	02/13/2003	Active
Kentucky Sec. of State	12/17/2002	Active
Kentucky - TPA License	06/05/2003	Active
Kentucky - UR License	08/01/2003	Active
Louisiana Sec. of State	12/31/2002	Active
Louisiana - TPA License	05/09/1996	Active
Maine Sec. of State	12/17/2002	Active
Maine - PPO License	12/05/2002	Active
Maine - TPA License	11/09/2001	Active
Maine - UR License	11/26/2001	Active
Maryland Sec. of State	12/06/2004	Active
Maryland -UR License	12/29/2002	Active
Michigan - TPA License	03/13/2003	Active
Minnesota Sec. of State	12/17/2002	Active
Missouri Sec. of State	12/16/2002	Active
Missouri - TPA License	03/14/2003	Active
Missouri-UR License	01/10/2003	Active
Nevada Sec. of State	12/10/2002	Active



Jurisdiction	Qualified Date	Status
Nevada - UR License	03/14/1995	Active
New Jersey Sec. of State	12/19/2002	Active
New York Sec. of State	12/10/2002	Active
New York - UR License	08/26/2005	Active
North Carolina Sec. of State	01/15/2003	Active
Ohio Sec. of State	03/27/2003	Active
Ohio - TPA License	07/01/2002	Active
Oklahoma - UR License	01/09/2003	Active
Oregon Sec. of State	04/29/2004	Active
Pennsylvania Sec. of State	12/10/2002	Active
Pennsylvania - UR License	03/07/2005	Active
S. Carolina Sec. of State	04/29/2004	Active
Tennessee Sec. of State	02/05/2003	Active
Tennessee - UR License	06/16/2003	Active
Texas Sec. of State	12/30/2002	Active
Texas - TPA License	05/16/2003	Active
Texas - UR License	05/13/2003	Active
Utah Sec. of State	12/07/2004	Active
Virginia Sec. of State	12/06/2002	Active
Virginia - UR License	06/30/2003	Active

**Officers**

Following are the names, addresses, and phone numbers of Aetna Life Insurance Company’s officers:

Name	Title	Address	Phone
Zubretsky, Joseph M.	President	151 Farmington Avenue, Hartford, CT 06156	860-273-0615
Reisman, Lonny	Medical Director	151 Farmington Avenue, Hartford, CT 06156	860-273-1800
Sullivan, John Francis	Vice President and Controller	151 Farmington Avenue, Hartford, CT 06156	860-273-8870
Cofrancesco, Elaine Rose	Vice President and Treasurer	151 Farmington Avenue, Hartford, CT 06156	860-273-5784
Lee, Edward C.	Vice President and Secretary	151 Farmington Avenue, Hartford, CT 06156	860-273-8329
Kramer, William Ira	Vice President and Assistant Secretary	980 Jolly Road, Blue Bell, PA 19422	215-775-5659

### **Not Engaged by DHH in the Past 24 Months**

Aetna Health Management, LLC has not been engaged by the Department of Health and Hospitals in the past 24 months.

**B.8 Describe your organization's number of employees, client base, and location of offices. Submit an organizational chart (marked as Chart A of your response) showing the structure and lines of responsibility and authority in your company. Include your organization's parent organization, affiliates, and subsidiaries.**

Aetna Health Management, LLC does not have any employees. Employees who perform work on behalf of AHM are employed by Aetna Life Insurance Company.

**B.9 Provide a narrative description of your proposed Louisiana Medicaid Coordinated Care Network project team, its members, and organizational structure including an organizational chart showing the Louisiana organizational structure, including staffing and functions performed at the local level. If proposing for more than one (1) GSA, include in your description and organizational chart if: 1) the team will be responsible for all GSAs or 2) if each GSA will differ provide details outlining the differences and how it will differ.**

Aetna Health Management, LLC does not have employees, therefore an organization chart is not available. AHM will provide administrative services by credentialing providers for GSAs A, B, and C. Please refer to Appendix C for a copy of Aetna Better Health's (Chart A) organizational structure for the Louisiana Coordinated Care Network program. Aetna Better Health's organizational structure shows the staffing and functions to be performed at the local level. For a of the project team, please refer to Aetna Better Health's response to question B.9 above.

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## **MEDICAL TRANSPORTATION MANAGEMENT, INC.**

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### **B.11 Major Subcontractor**

**B.1** Indicate your organization's legal name, trade name, *dba*, acronym, and any other name under which you do business; the physical address, mailing address, and telephone number of your headquarters office. Provide the legal name for your organization's ultimate parent (e.g. publicly traded corporation).

Describe your organization's form of business (i.e., individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and detail the names, mailing address, and telephone numbers of its officers and directors and any partners (if applicable). Provide the name and address of any health professional that has at least a five percent (5%) financial interest in your organization, and the type of financial interest.

Provide your federal taxpayer identification number and Louisiana taxpayer identification number.

Provide the name of the state in which you are incorporated and the state in which you are commercially domiciled. If out-of-state, provide the name and address of the local representative; if none, so state.

If you have been engaged by DHH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; if not, so state.

#### **Legal Name/Acronym**

Medical Transportation Management, Inc. (MTM)

#### **Physical/Mailing Address of Headquarters**

16 Hawk Ridge Drive, Lake St. Louis, MO 63367

#### **Telephone Number of Headquarters**

(636) 695-5686

#### **Form of Business**

Privately held "S" corporation and MTM is not owned or operated by a publicly traded parent company.

The names, mailing addresses, and telephone numbers of our officers and directors are as follows:



Board of Directors	
Peggy A. Griswold, Chairperson of the Board 2608 Arrowhead Estates Rd. Lake Ozark, MO 65049 888-561-8747, Ext. 5578	Lynn C. Griswold, Executive Vice President 2608 Arrowhead Estates Rd. Lake Ozark, MO 65049 888-561-8747, Ext.5568
Alaina Macia, President and CEO 6 Windsor Lane Kirkwood, MO 63122 888-561-8747, Ext.5503	J B Bowers, Board Member 10222 East Southwind Lane #1006 Scottsdale, AZ 85262 480-585-9552

Other Officers	
Gary Richardson, CFO, Treasurer 642 Woodchuck Lane Lake St. Louis, MO 63367 888-561-8747, Ext.5549	Elaine Sneed, Vice President 10 Forest Knoll Circle Lake St. Louis, MO 63367 888-561-8747, Ext. 5017
Donald C. Tiemeyer, Executive Vice President and General Counsel, Secretary 2012 Willow Trail St. Charles, MO 63303 888-561-8747, Ext. 5550	Kimberly Matreci, Vice President 319 Crystal Brook Ct. Lake St. Louis, MO 63367 888-561-8747, Ext. 5563
Thomas L. Sweeney, Vice President 3638 Flora Place St. Louis, MO 63110 888-561-8747, Ext. 5524	Patrick McNiff, Vice President 19 Ravens Pointe Lake St. Louis, MO 63367 888-561-8747, Ext. 5038
Aaron Crowell, Vice President 4011 Austin Drive Saint Charles, MO 63304 888-561-8747, Ext. 5123	Alison Whitelaw, Vice President 116 Antoinette Terrace Lake St. Louis, MO 63367 888-561-8747, Ext. 5529

No health professionals have a financial interest in our organization.

**Federal Taxpayer Identification Number**

43-1719762

### **MTM Corporate Identification Number in Louisiana**

36564296F

### **Louisiana Tax Account Identification Number**

1516723001200

MTM was incorporated in Missouri and is domiciled in Missouri.

MTM's local representative is CT Corporation System, 8550 United Plaza Blvd., Baton Rouge, LA 70809.

MTM has not been engaged by DHH within the past 24 months.

**B.2 Provide a statement of whether there have been any mergers, acquisitions, or sales of your organization within the last ten years, and if so, an explanation providing relevant details. If any change of ownership is anticipated during the 12 months following the Proposal Due Date, describe the circumstances of such change and indicate when the change is likely to occur. Include your organization's parent organization, affiliates, and subsidiaries.**

Neither MTM nor its affiliates have had any mergers, acquisitions, or sales of the organization within the last 10 years, nor do we anticipate any change in ownership during the 12 months following the Proposal Due Date.

**B.3 Provide a statement of whether you or any of your employees, agents, independent contractors, or subcontractors have ever been convicted of, pled guilty to, or pled *nolo contendere* to any felony and/or any Medicaid or health care related offense or have ever been debarred or suspended by any federal or state governmental body. Include an explanation providing relevant details and the corrective action plan implemented to prevent such future offenses. Include your organization's parent organization, affiliates, and subsidiaries.**

Neither MTM nor its affiliates, employees, agents, independent contractors, or subcontractors have ever been convicted of, pled guilty to, or pled *nolo contendere* to any felony and/or any Medicaid or health care related offense, or have ever been debarred or suspended by any federal or state governmental body.

**B.4 Provide a statement of whether there is any pending or recent (within the past five years) litigation against your organization. This shall include but not be limited to litigation involving failure to provide timely, adequate or quality physical or behavioral health services. You do not need to report workers' compensation cases. If there is pending or recent litigation against you, describe the damages being sought or awarded and the extent to which adverse judgment is/would be covered by insurance or reserves set aside for this purpose. Include a name and contact number of legal counsel to discuss pending litigation or recent litigation. Also include any SEC filings discussing any pending or recent litigation. Include your organization's parent organization, affiliates, and subsidiaries.**

As is typical for any large transportation management firm, and its affiliates, with numerous ongoing contracts, MTM occasionally has accident damage and workers compensation claims in process. All of these matters are of a size or scope that would not impact this contract, and we work diligently to resolve all legal matters quickly and in a fair manner. MTM has, at all times, sufficient liability insurance to cover all vehicle accident claims and workers compensation claims. MTM is not under investigation by any government or agency.

MTM is, from time to time, involved in litigation with transportation providers. Examples of what this might pertain to include a provider not meeting MTM contract requirements, such as not providing verification of trips, via passenger signatures, assessment of liquidated damages for contract noncompliance, etc. The financial stability of MTM or the ability of MTM to perform any of its contractual obligations is not threatened, in anyway, by any current litigation should an adverse judgment be entered against MTM.

The providing by MTM, and the subsequent reviewing of all details of litigation for a large company such as MTM, with a national scope and numerous large contracts, is impractical since much of this information is subject to attorney-client privilege or privacy/confidentiality considerations. MTM is hopeful that the submittal of the summary statement above will suffice. Should you require, for the purposes of evaluating MTM, information on any specific litigation or claim, MTM will supply that information which can be released without jeopardizing attorney-client privilege or privacy/confidentiality considerations incident to litigation.

**B.5 Provide a statement of whether, in the last ten years, you or a predecessor company has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. If so, provide an explanation providing relevant details including the date in which the Proposer emerged from bankruptcy or expects to emerge. If still in bankruptcy, provide a summary of the court-approved reorganization plan. Include your organization's parent organization, affiliates, and subsidiaries.**

Neither MTM nor its affiliates has ever filed any bankruptcy or insolvency proceedings or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors.

**B.6 If your organization is a publicly-traded (stock-exchange-listed) corporation, submit the most recent United States Securities and Exchange Commission (SEC) Form 10K Annual Report, and the most-recent 10-Q Quarterly report.**

**Provide a statement whether there have been any Securities Exchange Commission (SEC) investigations, civil or criminal, involving your organization in the last ten (10) years. If there have been any such investigations, provide an explanation with relevant details and outcome. If the outcome is against the Proposer, provide the corrective action plan implemented to prevent such future offenses. Also provide a statement of whether there are any current or pending Securities Exchange Commission investigations, civil or criminal, involving the Proposer, and, if such investigations are pending or in progress, provide an explanation providing relevant details and provide an opinion of counsel as to whether the pending investigation(s) will impair the Proposer's performance in a contract/Agreement under this RFP. Include your organization's parent organization, affiliates, and subsidiaries.**

MTM is not a publicly traded corporation.

**B.7 If another corporation or entity either substantially or wholly owns your organization, submit the most recent detailed financial reports for the parent organization. If there are one (1) or more intermediate owners between your organization and the ultimate owner, this additional requirement is applicable only to the ultimate owner.**

**Include a statement signed by the authorized representative of the parent organization that the parent organization will unconditionally guarantee performance by the proposing organization of each and every obligation, warranty, covenant, term and condition of the Contract.**

MTM is neither substantially nor wholly owned by another organization. Please see Appendix F for a copy of our most recent financial reports.

**B.10 Attach a personnel roster and resumes of key people who shall be assigned to perform duties or services under the Contract, highlighting the key people who shall be assigned to accomplish the work required by this RFP and illustrate the lines of authority. Submit current resumes of key personnel documenting their educational and career history up to the current time. Include information on how long the personnel have been in these positions and whether the position included Medicaid managed care experience.**

**If any of your personnel named is a current or former Louisiana state employee, indicate the Agency where employed, position, title, termination date, and last four digits of the Social Security Number.**

**If personnel are not in place, submit job descriptions outlining the minimum qualifications of the position(s). Each resume or job description should be limited to 2 pages.**

**For key positions/employees which are not full time provide justification as to why the position is not full time. Include a description of their other duties and the amount of time allocated to each.**

The following MTM key personnel will perform duties and services pertaining to this contract:

Key Personnel Title	Name	Reports To	Full Time
<b>Account Manager</b>	Duane Williams	V.P. Client Services	No
<b>Call Center Manager</b>	Kevin Cales	Director, Customer Service Center	Yes
<b>Care Manager Coordinator</b>	Jeanie Butler	Manager, Care Management	Yes
<b>Quality Service Coordinator</b>	Will be filled upon notice of contract award with a qualified QM Team Lead	Quality Management Team Lead	Yes
<b>Network Representative</b>	Damion Frederick	Manager, Network Operations	No
<b>Area Liaison</b>	Eric Kuntz	Manager, Network Recruiting	No

Duane Williams, as Account Manager, has dotted line authority over all other listed key personnel for this contract. Resumes for all key personnel are located in Appendix F. A job description for the Quality Service Coordinator is also included in Appendix F.

None of the personnel listed are current or former Louisiana state employees.

Duane Williams manages other managed care clients throughout the nation. He will dedicate approximately 25% of his time to this account, but can increase that amount dependent on client requirements. His other time is spent overseeing the NEMT programs for other managed care clients.

Similarly, Damion Frederick and Eric Kuntz have network responsibilities in states other than Louisiana. They will each dedicate 50% of their time to building and strengthening our network of transportation providers in Louisiana. The other portion of their time will be spent performing similar duties in other states.

**B.16 Identify, in Excel format, all of your organization’s publicly-funded managed care contracts for Medicaid/CHIP and/or other low-income individuals within the last five (5) years. In addition, identify, in Excel format your organization’s ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP and/or other low-income individuals within the last five (5) years. For each prior experience identified, provide the trade name, a brief description of the scope of work, the duration of the contract, the contact name and phone number, the number of members and the population types (e.g., TANF, ABD, duals, CHIP), the annual contract payments, whether payment was capitated or other, and the role of subcontractors, if any. If your organization has not had any publicly-funded managed care contracts for Medicaid/SCHIP individuals within the last five (5) years, identify the Proposer’s ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP individuals within the last five (5) years and provide the information requested in the previous sentence. Include your organization’s parent organization, affiliates, and subsidiaries.**

Information about our Medicaid and Medicare managed care clients that fit the criteria listed above are included below. Please note, MTM’s client base is confidential information.

MTM MCO Clients

Organization Name	Medicaid/Medicare	Geographic Specs	Effective Date	Scope of Service	Members	Annual Value of Contract	Capitated	Contact Title	Address	Contact Phone #	Role of Subcontractor
Healthplan of Michigan/Meridian	Medicaid	MI; All MI will be serviced	11/1/2010	Non-emergency Transportation services	283562	\$3,950,376*	Yes	Kelly Kramer, Director, Member Services	777 Woodward Avenue Suite 600 Detroit, MI 48226	313-324-3726	Vehicles and transportation
MDWise	Medicaid	IN; Statewide MCO	12/01/2010	Non-emergency Transportation services	246183	\$4,056,456*	Yes	Julie Ulrich, Operations	1200 S. Madison Ave Indianapolis, IN (don't know the zip)	317-822-7109	Vehicles and transportation
HealthCare USA	Medicaid	East: Franklin, Jefferson, Lincoln, Pike, St. Charles, St. Francois, Ste. Genevieve, St. Louis City, St. Louis County, Warren, Washington Central: Audrain, Benton, Boone, Callaway, Camden, Chariton, Cole, Cooper, Gasconade, Howard, Laclede, Linn, Macon, Maries, Marion, Miller, Moniteau, Monroe, Montgomery, Morgan, Osage, Pettis, Phelps, Pulaski, Ralls, Randolph, Saline, Shelby West: Bates, Cass, Cedar, Clay, Henry, Jackson, Johnson, Lafayette, Polk, Platte, Ray, St. Clair, Vernon	9/1/1995	Non-emergency Transportation services	190198	\$ 3,427,108	Yes	Kathy Whaley, Vice President of Operations	10 South Broadway, Ste. 1200 St. Louis, MO 63102	314-444-7914 614-410-7927	Vehicles and transportation
Unison Health Plan of Ohio	Medicaid	Ashland, Athens, Belmont, Carroll, Columbiana, Coshocton, Gallia, Guernsey, Harrison, Holmes, Jackson, Jefferson, Lawrence, Mahoning, Meigs, Monroe, Morgan, Muskingum, Noble, Portage, Richland, Stark, Summit, Trumbull, Tuscarawas, Vinton, Washington & Wayne	11/1/2005	Non-emergency Transportation services	119037	\$ 2,247,913	Yes	Tim Binkley, CFO	9200 Worthington Rd. 3rd Floor Westerville, OH 43082		Vehicles and transportation
Molina Healthcare of Missouri (formerly Mercy Care Plus)	Medicaid	Eastern: Franklin, Jefferson, Lincoln, Madison, Perry, Pike, St. Charles, St. Francois, Ste. Genevieve, St. Louis, Warren, Washington, St. Louis City Central: Audrain, Benton, Boone, Callaway, Camden, Chariton, Cole, Cooper, Gasconade, Howard, Laclede, Linn, Macon, Maries, Marion, Miller, Moniteau, Monroe, Montgomery, Morgan, Osage, Pettis, Phelps, Pulaski, Ralls, Randolph, Saline, Shelby Western: Bates, Cass, Cedar, Clay, Henry, Jackson, Johnson, Lafayette, Platte, Polk, Ray, St. Clair, Vernon	2/9/1997	Non-emergency Transportation services	56332	\$ 1,344,701	Yes	Christine Cybulski, Manager Delegation Oversight	12400 Olive Blvd, Ste. 100 St. Louis, MO 63141	314-819-5162	Vehicles and transportation

MTM MCO Clients

Organization Name	Medicaid/Medicare	Geographic Specs	Effective Date	Scope of Service	Members	Annual Value of Contract	Capitated	Contact Title	Address	Contact Phone #	Role of Subcontractor
Children's Mercy Family Health Partners	Medicaid	MO: Bates, Cass, Cedar, Clay, Henry, Jackson, Johnson, Lafayette, Platte, Polk, Ray, St. Clair, Vernon KS: Allen, Anderson, Atchison, Barber, Barton, Bourbon, Brown, Butler, Chase, Chautauqua, Cherokee, Clay, Cloud, Coffey, Comanche, Cowley, Crawford, Dickinson, Doniphan, Douglas, Edwards, Elk, Ellis, Ellsworth, Franklin, Geary, Greenwood, Harper, Harvey, Jackson, Jefferson, Jewell, Johnson, Kingman, Kiowa, Labette, Leavenworth, Lincoln, Linn, Lyon, Marion, Marshall, McPherson, Miami, Mitchell, Montgomery, Morris, Nemaha, Neosho, Osage, Osborne, Ottawa, Pawnee, Phillips, Pottawatomie, Pratt, Reno, Republic, Rice, Riley, Rooks, Rush, Russell, Saline, Sedgwick, Shawnee, Smith, Stafford, Sumner, Wabaunsee, Washington, Wilson, Woodson, Wyandotte	1/1/1996	Non-emergency Transportation services	56091	\$ 2,441,871	Yes	Cindy Mense, Customer Service Director	2420 Pershing Rd, Suite G-10 Kansas City, MO 64116	816-559-9472	Vehicles and transportation
OmniCare Health Plan	Medicaid	Wayne, Oakland and Macomb counties in MI Central Region: Audrain, Benton, Boone, Callaway, Camden, Chariton, Cole, Cooper, Gasconade, Howard, Laclede, Linn, Macon, Maries, Marion, Miller, Moniteau, Monroe, Montgomery, Morgan, Osage, Pettis, Phelps, Pulaski, Ralls, Randolph, Saline, Shelby Eastern Region: Franklin, Jefferson, Lincoln, Madison, Perry, Pike, St. Charles, St. Francois, Ste. Genevieve, St. Louis, Warren, Washington, and St. Louis City	10/1/2004	Non-emergency Transportation services	50258	\$ 1,892,114	Yes	Sandra McGriff, Vice President Operations	1333 Gratiot, Suite 400 Detroit, Michigan 48207	313-465-1552 573-355-4168	Vehicles and transportation
Missouri Care Health Plan	Medicaid	Western Region: Bates, Cass, Cedar, Clay, Henry, Jackson, Johnson, Lafayette, Platte, Polk, Ray, St. Clair, Vernon Nebraska: Counties of Cass, Dodge, Douglas, Gage, Lancaster, Otoe, Seward, Sarpy, Saunders, and Washington may travel in the bordering Iowa counties: of Fremont, Harrison, Mills and Pottawattamie were services may be provided as long as the distance does not exceed 50 miles.	9/1/1998	Non-emergency Transportation services	49928	\$ 723,132	Yes	Ed Williams, Member Advocacy and Customer Service Manager	2404 Forum Blvd. Columbia, MO 65203		Vehicles and transportation
Coventry Nebraska	Medicaid	MO counties of Cass, Clay, Henry, Jackson, Johnson, Lafayette, Platte, Ray, St. Clair Trips going to Wyandotte or Johnson County KS do not need prior auth	8/1/2010	Non-emergency Transportation services	47119	\$771,484*	Yes	Cassandra Price, Manager of Medicaid Program	15950 W. Dodge Road Omaha, NE 68118	402-995-7177	Vehicles and transportation
Blue Advantage Plus	Medicaid	Trips going to Wyandotte or Johnson County KS do not need prior auth	1/1/1996	Non-emergency Transportation services	30899	\$ 406,962	Yes	Judy Brennan, Director of State Programs	2301 Main Street PO Box 419169 Kansas City, MO 64141	816-395-2421 407-637-1579	Vehicles and transportation
Molina Healthcare of Florida	Medicaid	Broward, Dade and Palm Beach counties	5/1/2009	Non-emergency Transportation services	24237	\$ 679,962	Yes	Steve Bennett, Manager Provider	8300 NW 33rd Street, Ste. 400 Doral, FL 33122		Vehicles and transportation

Confidential

MTM MCO Clients

Organization Name	Medicaid/Medicare	Geographic Specs	Effective Date	Scope of Service	Members	Annual Value of Contract	Capitated	Contact Title	Address	Contact Phone #	Role of Subcontractor
Harmony Health Plan of Missouri	Medicaid	IL: Jackson, Madison, Perry, Randolph, St. Clair, Washington, Williamson MO: St. Louis City, St. Louis County, St. Charles, Franklin, Jefferson, Lincoln, St. Francois, Ste. Genevieve, Warren, Washington, Crawford, Iron, Madison, Perry, Pike	7/1/2006	Non-emergency Transportation services	16936	\$ 293,567	Yes	Gretchen Stephenson, Sr. Provider Relations Representative	13 Wolf Creek Drive, Ste. 4 Swanssea, IL 62226	618-236-9055	Vehicles and transportation
Harmony Health Plan of Illinois	Medicaid	IL: Jackson, Madison, Perry, Randolph, St. Clair, Washington, Williamson MO: St. Louis City, St. Louis County, St. Charles, Franklin, Jefferson, Lincoln, St. Francois, Ste. Genevieve, Warren, Washington, Crawford, Iron, Madison, Perry, Pike WI: Milwaukee, Washington, Kenosha, Waukesha, Racine, and IL: Lake and McHenry	2/1/2002	Non-emergency Transportation services	12879	\$ 271,289	Yes	Gretchen Stephenson, Sr. Provider Relations Representative	13 Wolf Creek Drive, Ste. 4 Swanssea, IL 62226	618-236-8055	Vehicles and transportation
Wellpoint Wisconsin (Community Connect Healthplan)	Medicaid	IL: Lake and McHenry	09/01/2010	Non-emergency Transportation services	7307	\$115,059*	Yes	Terri Maccanti, Manager, Vendor Compliance	5151-A Camina Ruiz, CACC01-043C Camanilla, CA 93012	805-910-6238	Vehicles and transportation
Children's Special Health Care Services	Medicaid	State of Michigan, including Upper Peninsula	10/4/2004	Non-emergency Transportation services	828	\$ 56,528	No - per trip	Karla McCandless, Manager, Policy and Program Development	4707 St. Antoine, Suite 620 Detroit, Michigan 48201	313-966-7038	Vehicles and transportation
Advantage Care Select (Schaller Anderson Medical Admin - Advantage Health Solutions)	Medicaid	IL: Cook, Vermillion, Iroquois KY: Jefferson, Davies MI: St. Joseph	3/12/2008	Non-emergency Transportation services	133	\$ 136,433	No - per trip	Karen Grays, Member Services Supervisor	9045 River Road Suite 150 Indianapolis, IN 46240	317-810-4468	Vehicles and transportation
Essence Healthcare	Medicare	Missouri: Boone, Jefferson, St. Charles, St. Louis City & County Illinois: Madison, Monroe, St. Clair, Washington, King Whatcom, Skagit, Spokane New York: Monroe, Wayne	1/1/11	Non-emergency Transportation services	30540	TBR	Yes	Susan Wilson, Manager of Implementation	13900 Riverport Drive Maryland Heights, MO 63043	314-209-2845	Vehicles and transportation
Care Improvement Plus	Medicare	Entire states of AR, GA, MO, SC, TX and the MD counties of Anne Arundel, Baltimore, Baltimore City, Carroll, Harford, Howard, Montgomery, Prince George's, Calvert, St. Mary's, Charles	1/1/2007	Non-emergency Transportation services	93377	\$ 3,192,938	Yes	Karl J. Broussard, V.P. of Contracting and Provider Relations	351 West Camden St., Ste. 100 Baltimore, MD 21201	954-778-0224	Vehicles and transportation
Molina National	Medicare	Select counties in CA, FL, MI, NM, OH, TX, UT, WA	01/01/2009	Non-emergency Transportation services	20725	\$ 1,049,258	Yes	John Stites, Director of Strategic Contracting	200 Oceangate, Suite 100 Long Beach, CA 90802	562-901-1082	Vehicles and transportation
Gateway Health Plan	Medicare	PA: Adams, Allegheny, Armstrong, Beaver, Berks, Blair, Butler, Cambria, Cumberland, Dauphin, Erie, Fayette, Indiana, Lackawanna, Lancaster, Lawrence, Lebanon, Lehigh, Mercer, Northampton, Northumberland, Perry, Schuylkill, Somerset, Washington, Westmoreland, and York	1/1/2009	Non-emergency Transportation services	26858	\$ 585,619	Yes	Angela Jackson, Director Medicare Administration	600 Grant Street, Floor 41 Pittsburgh, PA 15219	412-255-4296	Vehicles and transportation
Acadian Health Plan	Medicare	Select counties in AR, CA, GA, LA, ME, MO, NH, NC, OK, SC, TX, VA, NY and WA	1/1/2009	Non-emergency Transportation services	27229	\$ 298,717	Yes	Chase Milbrandt, V.P. of Marketing and National Contracting	3767 Karico Lane Suite D Prescott, AZ 86303	928-777-9226	Vehicles and transportation
Colorado Access	Medicare	Colorado, Denver and San Luis Areas	1/1/2010	Non-emergency Transportation services	3176	\$ 200,806	Yes	Bettina Kline, Director of Operations	10065 E. Harvard Avenue, Ste 600 Denver, CO 80231	800-511-5010	Vehicles and transportation

Confidential

MTM MCO Clients

Organization Name	Medicaid/Medicare	Geographic Specs	Effective Date	Scope of Service	Members	Annual Value of Contract	Capitated	Contact Title	Address	Contact Phone #	Role of Subcontractor
Humana Health Plan of Louisiana	Medicare	New Orleans; Jefferson, Lafourche, Orleans, Plaquemines, St. Bernard, St. Charles, St. Tammany, St. John the Baptist, Tangipahoa, Terrebonne and Washington Counties; Baton Rouge; Parishes of Ascension, East Baton Rouge, East Feliciana, Iberville, Livingston, Pointe Coupee, St. Helena, West Baton Rouge and West Feliciana	1/1/2008	Non-emergency Transportation services	3043	\$ 157,341	Yes	Cheryl Haas, Director, Finance	1 Galleria Blvd, Suite 1122 Metairie, LA 70001	504-219-8635	Vehicles and transportation
Humana Health Plan of Texas	Medicare	Bexar, Dallas and Nueces counties - not covered beyond 10 miles of bordering counties or zip codes. Per Amendment 7 Effective 01/01/2010 the service area in the corpus christy and San Antonio area shall be expanded by adding the following counties Aransas, Atascosa, Bander, Bee, Comal, Guadalupe, Jim Wells, Kendall, Kieberg, Medina, San Patricio, and Wilson, Also, El Paso County	1/1/2007	Non-emergency Transportation services	1591	\$ 82,486	Yes	Charles Majdalani, Finance Director	8431 Fredericksburg Rd, Ste. 580 San Antonio, TX 78229	210-617-1748	Vehicles and transportation
Kaiser Foundation Health Plan of Colorado, Inc.	Medicare	Senior Advantage Gold Plan service area: Adams, Arapahoe, Clear Creek, Douglas, Elbert, Jefferson, Larimer, Park, Weld, Boulder, Broomfield, Denver, Gilpin. The service area for Senior Advantage Silver Plan is Teller, Fremont, Pueblo and El Paso.	1/1/2009	Non-emergency Transportation services	5040	\$ 78,467	Yes	Deborah Gordon, Medicare Project Manager	2500 South Havana St. Aurora, CO 80014	303-358-3520	Vehicles and transportation
Premier Plus by Mercy Health Plan	Medicare	IL: Madison, Monroe, Randolph, St. Clair MO: Franklin, Jefferson, Lincoln, St. Charles, St. Louis, St. Louis City, Warren	1/1/1999	Non-emergency Transportation services	6623	\$ 76,589	Yes	Debbie Todd, Manager Member Services	14528 South Outer 40, Ste. 300 Chesterfield, MO 63017	314-214-8245	Vehicles and transportation

\*Estimated

**B.17 Identify whether your organization has had any contract terminated or not renewed within the past five (5) years. If so, describe the reason(s) for the termination/nonrenewal, the parties involved, and provide the address and telephone number of the client. Include your organization's parent organization, affiliates, and subsidiaries.**

The requested information for MTM contracts no longer held is included on the following page.

**MTM Contracts No Longer Held**

Plan	Contact	Address	Contact Phone #	Termination Date
Arkansas Department of Human Services	Floyd Sparks	P.O. Box 1439, Slot 414 Little Rock, AR 72203	501-375-1200	01/31/2007
CAPE Health Plan	Rodger Prong	26711 Northwestern Highway, Suite 300 Southfield, Michigan 48034	888-354-2273	12/31/2006
CareSource Indiana	Steve Smitherman	8001 Broadway, Suite 400 Merrville, IN 46410	937-531-3804	12/31/2006
Colorado Access	Christine Pazell	10065 E. Harvard Ave., Ste. 600 Denver, CO 80231	800-511-5010	02/29/2008
Community Choice Michigan	Lorna Hoilette	2369 Woodlake Drive, STE 200 Okemos, MI 48864	937-531-3700	12/31/2006
Evercare Choice of Texas	Carl Kidd	9700 Bissonnet, Ste 2225 Houston, TX 77036	713-778-8664	09/01/2007
Great Lakes Health Plan	Meredith Taylor	171117 West Nine Mile Rd. Ste. 1600 Southfield, MI 48075	800-903-5253	06/30/2006
Group Health Plan	Kay Lombardo	111 Corporate Office Dr., Ste. 400 Earth City, MO 63045	314-506-1592	12/31/2007
Harmony Health Plan of Indiana	Donica Brown	504 Broadway, Suite 200 Gary, IN 46402	219-880-4402	12/31/2006
Health Plan of Michigan	Ray Pitera	777 Woodward Ave., Ste. 600 Detroit, MI 48226	248-204-6006	02/01/2007
Managed Health Services	Yolanda Moton	1099 Meridian Street, Ste. 400 Indianapolis, IN 46204	314-684-9478	01/31/2008
Molina Healthcare of Indiana	Francine Woodson-Porter	8001 Broadway, Suite 400 Merrville, IN 46410	219-739-9140	12/31/2006
Molina Healthcare of Michigan	Camille Adams	100 W Big Beaver Road, Ste 600 Troy, Michigan 48064	248-925-1813	05/31/2008
Molina Healthcare of Nevada	John Sities, Director of Strategic Contracting	200 Oceangate, Suite 100 Long Beach, CA 90802	562-901-1082	01/01/2010
Optima Health Management	Jennifer Varbero	4417 Corporation Lane, Ste 200 Virginia Beach, VA 23462	757-687-6439	01/16/2007
Philadelphia County MATP	Patricia Jacobs	P.O. Box 2675 Harrisburg, PA 17105-2675	717-783-3767	11/30/2006
Physicians United Plan (PUP)	Dawn Kinkead	84 NE Loop 410, Ste 200 San Antonio, TX, 78216	727-459-8435	05/10/2010
South Carolina TANF	Goya Spry	1535 Confederate Avenue Extension Columbia, South Carolina 29202	803-898-7802	01/31/2010
St. Catherine's Hospital	Sarah Woelfl	4321 Fir Street East Chicago, IN 46312	219-392-7039	12/31/2006
Star Plus Medicaid Managed Care Plan	Darla McGahee	9702 Bissonnet, Suite 2225 Houston, TX 77036	713-596-2682	03/31/2007
Bravo Health	Joe Farver	3601 O'Donnell St. Baltimore, MD 21224	410-864-4431	05/10/2010
United HealthCare Insurance Company	Joe Hafermann, CFO	990 Bren Road East, Minnetonka, MN 55343	952-936-4943	12/31/2007

**B.18 If the contract was terminated/non-renewed in B.17 above, based on your organization's performance, describe any corrective action taken to prevent any future occurrence of the problem leading to the termination/non-renewal. Include your organization's parent organization, affiliates, and subsidiaries.**

In each of the contracts no longer held identified above, the termination/non-renewal was not based on performance issues from our company.

**B.19 As applicable, provide (in table format) the Proposer's current ratings as well as ratings for each of the past three years from each of the following:  
AM Best Company (financial strengths ratings);  
TheStreet.com, Inc. (safety ratings); and  
Standard & Poor's (long-term insurer financial strength.**

MTM is not rated by Standard & Poor or The Street because we are not publicly traded, and we do not operate in a regulated industry that would require an AM Best rating.

**B.20 For any of your organization's contracts to provide physical health services within the past five years, has the other contracting party notified the Proposer that it has found your organization to be in breach of the contract? If yes: (1) provide a description of the events concerning the breach, specifically addressing the issue of whether or not the breach was due to factors beyond the Proposer's control. (2) Was a corrective action plan (CAP) imposed? If so, describe the steps and timeframes in the CAP and whether the CAP was completed. (3) Was a sanction imposed? If so, describe the sanction, including the amount of any monetary sanction (e.g., penalty or liquidated damage) (4) Was the breach the subject of an administrative proceeding or litigation? If so, what was the result of the proceeding/litigation? Include your organization's parent organization, affiliates, and subsidiaries.**

MTM does not provide physical health services.

**B.21 Indicate whether your organization has ever sought, or is currently seeking, National Committee for Quality Assurance (NCQA) or American Accreditation HealthCare Commission (URAC) accreditation status. If it has or is, indicate current NCQA or URAC accreditation status and accreditation term effective dates if applicable.**

MTM sought and received URAC Core accreditation in March 2010. This accreditation is effective April 1, 2010 through April 1, 2013.

**B.22 Have you ever had your accreditation status (e.g., NCQA, URAC,) in any state for any product line adjusted down, suspended, or revoked? If so, identify the state and product line and provide an explanation. Include your organization's parent organization, affiliates, and subsidiaries.**

Neither MTM nor our affiliates have ever had an accreditation status in any state for any product line adjusted down, suspended, or revoked.

**B.23 If you are NCQA accredited in any state for any product line, include a copy of the applicable NCQA health plan report cards for your organization. Include your organization's parent organization, affiliates, and subsidiaries.**

We are not NCQA accredited, but we have established and hold our Customer Service Center operations to high performance standards. Across our book of business, we strive to maintain and meet NCQA standards for Customer Service Center operations.

**B.24 Provide (as an attachment) a copy of the most recent external quality review report (pursuant to Section 1932(c)(2) of the Social Security Act) for the Medicaid contract identified in response to item B.16 that had the largest number of enrollees as of January 1, 2011. Provide the entire report. In addition, provide a copy of any corrective action plan(s) requested of your organization (including your organization's parent organization, affiliates, and subsidiaries) in response to the report.**

We do not receive copies of the external quality review reports that our managed care clients are required to participate in. From time to time, we are asked to provide information on our processes and copies of our policies that our clients use for the quality review. We participate on behalf of our clients, but do not have access to the reports.

**B.25 Identify and describe any regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against your organization within the last five (5) years. In addition, identify and describe any letter of deficiency issued by as well as any corrective actions requested or required by any federal or state regulatory entity within the last five (5) years that relate to Medicaid or CHIP contracts. Include your organization's parent organization, affiliates, and subsidiaries.**

MTM has had no regulatory action or sanction imposed by any federal or state regulatory entity against our organization within the last five (5) years.

**B.26 Provide a statement of whether your organization is currently the subject or has recently (within the past five (5) years) been the subject of a criminal or civil investigation by a state or federal agency other than investigations described in response to item B.6. If your organization has recently been the subject of such an investigation, provide an explanation with relevant details and the outcome. If the outcome is against your organization, provide the corrective action plan implemented to prevent such future offenses. Include your organization's parent company, affiliates and subsidiaries.**

In 2009, the Federal government conducted an audit of the Minnesota Department of Human Services Medicaid NET services program and had questions concerning MTM's billing processes. MTM conducted its claims billings processes in accordance with a contract amendment executed by the Department of Human Services. When a copy of the contract amendment was provided to the Federal agency, the matter was closed and no action was taken.

**B.27 Submit client references (minimum of three, maximum of five) for your organization for major contracts; with at least one reference for a major contract you have had with a state Medicaid agency or other large similar government or large private industry contract. Each reference must be from contracts within the last five (5) years. References for your organization shall be submitted to the State using the questionnaire contained in RFP Appendix PP. You are solely responsible for obtaining the fully completed reference check questionnaires, and for submitting them sealed by the client providing the reference, with your Proposal, as described herein. You should complete the following steps:**

- a. Make a duplicate (hard copy or electronic document) of the appropriate form, as it appears in RFP Appendix PP (for your organization or for subcontractors, adding the following customized information:  
Your/Subcontractor's name;  
Geographic Service Area(s) for which the reference is being submitted;  
Reference organization's name; and  
Reference contact's name, title, telephone number, and email address.**
- b. Send the form to each reference contact along with a new, sealable standard #10 envelope;**
- c. Give the contact a deadline that allows for collection of all completed questionnaires in time to submit them with your sealed Proposal;**
- d. Instruct the reference contact to:**

**Complete the form in its entirety, in either hard copy or electronic format (if completed electronically, an original should be printed for submission);**

- Sign and date it;**
- Seal it in the provided envelope;**
- Sign the back of the envelope across the seal; and**
- Return it directly to you.**
- e. Enclose the unopened envelopes in easily identifiable and labeled larger envelopes and include these envelopes as a part of the Proposal. When DHH the opens your Proposal, it should find clearly labeled envelope(s) containing the sealed references.**

**B.27 THE STATE WILL NOT ACCEPT LATE REFERENCES OR REFERENCES SUBMITTED THROUGH ANY OTHER CHANNEL OF SUBMISSION OR MEDIUM, WHETHER WRITTEN, ELECTRONIC, VERBAL, OR OTHERWISE.**

**Each completed questionnaire should include:**

- **Proposing Organization/Subcontractor's name;**
- **GSA (s) for which the reference is being submitted;**
- **Reference Organization's name;**
- **Name, title, telephone number, and email address of the organization contact knowledgeable about the scope of work;**
- **Date reference form was completed; and**
- **Responses to numbered items in RFP Attachment # (as applicable).**

**DHH reserves the authority to clarify information presented in questionnaires and may consider clarifications in the evaluation of references. However DHH is under no obligation to clarify any reference check information.**

Please see Appendix L for MTM's client references.

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## AVESIS

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### B.11 Major Subcontractor

**B.1** Indicate your organization's legal name, trade name, *dba*, acronym, and any other name under which you do business; the physical address, mailing address, and telephone number of your headquarters office. Provide the legal name for your organization's ultimate parent (e.g. publicly traded corporation).

Describe your organization's form of business (i.e., individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and detail the names, mailing address, and telephone numbers of its officers and directors and any partners (if applicable). Provide the name and address of any health professional that has at least a five percent (5%) financial interest in your organization, and the type of financial interest.

Provide your federal taxpayer identification number and Louisiana taxpayer identification number.

Provide the name of the state in which you are incorporated and the state in which you are commercially domiciled. If out-of-state, provide the name and address of the local representative; if none, so state.

If you have been engaged by DHH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; if not, so state.

### Legal Name and Ownership

The organization's legal name is Avesis Third Party Administrators, Inc. We do not do business under any other name. The physical address is 3030 North Central Avenue, Suite 300, Phoenix, Arizona 85012 and the mailing address is 10324 South Dolfield Road, Owings Mills, Maryland 21117. The telephone number for the Corporate headquarters is (800) 643-1132. The parent company is Avesis Incorporated.

Avesis Third Party Administrators, Inc. is an Arizona domestic corporation. The officers and directors are Joel H. Alperstein, President, Treasurer and Director and Michael P. Reamer, Secretary and Director. The mailing address for Mr. Alperstein and Mr. Reamer is 10324 South Dolfield Road, Owings Mills, Maryland 21117 and the phone number is (800) 643-1132, extensions 404 and 304 respectively. There is no health professional with an ownership interest in Avesis

### Federal Tax Identification

The federal tax identification number is 86-0986927. Avesis does not have a Louisiana taxpayer identification number.

### State Domiciled

Avesis Third Party Administrators, Inc. is domiciled in the state of Arizona. CT Corporation System is our registered agent. Their address is: 5615 Corporate Boulevard, Suite 400B, Baton Rouge, Louisiana 70808.

**Engaged by DHH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; if not, so state.**

Not applicable.

**B.2 Provide a statement of whether there have been any mergers, acquisitions, or sales of your organization within the last ten years, and if so, an explanation providing relevant details. If any change of ownership is anticipated during the 12 months following the Proposal Due Date, describe the circumstances of such change and indicate when the change is likely to occur. Include your organization's parent organization, affiliates, and subsidiaries.**

There have been no mergers, acquisitions or sales of our organization in the past ten years. There is no change of ownership anticipated during the twelve months following the proposal due date.

**B.3 Provide a statement of whether you or any of your employees, agents, independent contractors, or subcontractors have ever been convicted of, pled guilty to, or pled *nolo contendere* to any felony and/or any Medicaid or health care related offense or have ever been debarred or suspended by any federal or state governmental body. Include an explanation providing relevant details and the corrective action plan implemented to prevent such future offenses. Include your organization's parent organization, affiliates, and subsidiaries.**

Since 1992, when the current majority ownership/ management of Avesis Incorporated assumed control, none of its affiliates, subsidiaries, employees, agents, independent contractors, or subcontractors have been convicted of, pled guilty to, or pled *nolo contendere* to any felony and/or any Medicaid or healthcare related offense, or have been debarred or suspended by any federal or state governmental body.

**B.4 Provide a statement of whether there is any pending or recent (within the past five years) litigation against your organization. This shall include but not be limited to litigation involving failure to provide timely, adequate or quality physical or behavioral health services. You do not need to report workers' compensation cases. If there is pending or recent litigation against you, describe the damages being sought or awarded and the extent to which adverse judgment is/would be covered by insurance or reserves set aside for this purpose. Include a name and contact number of legal counsel to discuss pending litigation or recent litigation. Also include any SEC filings discussing any pending or recent litigation. Include your organization's parent organization, affiliates, and subsidiaries.**

Within the past five years there has been one lawsuit in which the Company has been a party which may be considered to involve the failure to provide timely, adequate or quality health services. The Company was named a co-defendant along with the Georgia Department of Community Health, WellCare of Georgia, Peach State Health Plan, Inc. and Doral Dental Services of Georgia, LLC in a Class Action filing related to the termination of two dental provider groups from the codefendants' Medicaid dental networks on August 22, 2007. The suit was dismissed without prejudice on September 28, 2007.

Avesis Third Party Administrators, Inc. was named in the class action suit, Eagle Vision Optometry, Inc. v. Avesis in the Circuit Court of Jefferson County, Alabama during May 2011. Avesis is being represented by Balch & Bingham, LLP in Birmingham, AL. Lead counsel is R. Bruce Barze, Jr. (205-251-8100). Projected damages have not been estimated as of yet as the issue being litigated was worth less than \$16.00 to the lead plaintiff and less than \$9,000 to the entire class.

**B.5 Provide a statement of whether, in the last ten years, you or a predecessor company has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. If so, provide an explanation providing relevant details including the date in which the Proposer emerged from bankruptcy or expects to emerge. If still in bankruptcy, provide a summary of the court-approved reorganization plan. Include your organization's parent organization, affiliates, and subsidiaries.**

In the last ten years neither Avesis Third Party Administrators, Inc. nor its parent company, Avesis Incorporated have filed or had filed against it any bankruptcy or insolvency proceeding.

**B.6 If your organization is a publicly-traded (stock-exchange-listed) corporation, submit the most recent United States Securities and Exchange Commission (SEC) Form 10K Annual Report, and the most-recent 10-Q Quarterly report.**

**Provide a statement whether there have been any Securities Exchange Commission (SEC) investigations, civil or criminal, involving your organization in the last ten (10) years. If there have been any such investigations, provide an explanation with relevant details and outcome. If the outcome is against the Proposer, provide the corrective action plan implemented to prevent such future offenses. Also provide a statement of whether there are any current or pending Securities Exchange Commission investigations, civil or criminal, involving the Proposer, and, if such investigations are pending or in progress, provide an explanation providing relevant details and provide an opinion of counsel as to whether the pending investigation(s) will impair the Proposer's performance in a contract/Agreement under this RFP. Include your organization's parent organization, affiliates, and subsidiaries.**

Not applicable.

**B.7 If another corporation or entity either substantially or wholly owns your organization, submit the most recent detailed financial reports for the parent organization. If there are one (1) or more intermediate owners between your organization and the ultimate owner, this additional requirement is applicable only to the ultimate owner.**

**Include a statement signed by the authorized representative of the parent organization that the parent organization will unconditionally guarantee performance by the proposing organization of each and every obligation, warranty, covenant, term and condition of the Contract.**

The year ended 2010 audited financial statements for Avesis Incorporated, the parent company of Avesis Third Party Administrators, Inc. along with the signed statement by an authorized representative of the parent organization is included in Appendix F.

**B.10 Attach a personnel roster and resumes of key people who shall be assigned to perform duties or services under the Contract, highlighting the key people who shall be assigned to accomplish the work required by this RFP and illustrate the lines of authority. Submit current resumes of key personnel documenting their educational and career history up to the current time. Include information on how long the personnel have been in these positions and whether the position included Medicaid managed care experience.**

**If any of your personnel named is a current or former Louisiana state employee, indicate the Agency where employed, position, title, termination date, and last four digits of the Social Security Number.**

**If personnel are not in place, submit job descriptions outlining the minimum qualifications of the position(s). Each resume or job description should be limited to 2 pages.**

**For key positions/employees which are not full time provide justification as to why the position is not full time. Include a description of their other duties and the amount of time allocated to each.**

Following is a roster of key personnel who will be assigned to perform duties and services under the contract, followed by organization charts that illustrate lines of authority and reporting relationships.

Name	Title	Reports To	Full Time
Alan S. Cohn, J.D.	President and Chief Executive Officer	Board of Directors	Full Time
Peter D. Liane, O.D.	Chief Optometric Officer	Alan Cohn, CEO	Full Time Consultant
Paul C. Ajamian, O.D., F.A.A.O	Chief Eye Care Officer	Alan Cohn, CEO	Part Time Consultant
Ahmed Nassar, M.D., M.S.	Chief Eye Medical Officer	Alan Cohn, CEO	Part Time Consultant
Fred L. Sharpe, D.D.S., J.D.	Chief Dental Officer	Alan Cohn, CEO	Full Time
Joel H. Alperstein, C.P.A., M.B.A.	Chief Financial Officer	Alan Cohn, CEO	Full Time
Michael Reamer, M.B.A.	Chief Marketing Officer	Alan Cohn, CEO	Full Time
Linda Chirichella	Chief Operating Officer	Alan Cohn, CEO	Full Time
Laura Gill	Chief Information Officer	Alan Cohn, CEO	Full Time
Nichole Mitchell	Director of Government Services	Linda Chirichella, COO	Full Time

With the current distribution of Avesis' lines of business and Avesis' experience, Avesis has hired consultants for the positions of Chief Optometric Officer, Chief Eye Care Officer and Chief Eye Medical Officer. The providers in these roles are active in their respective fields and continue to practice Optometry or Ophthalmology on a part time or full time basis.

Avesis' Chief Optometric Officer practices a ½ day per week and does provide some minor consulting services outside of his Full Time commitment to Avesis. He is a nationally renowned expert in the routine and eye medical surgical managed vision care industry.

Avesis' Chief Eye Care Officer continues to practice Full Time and is Part Time in his role with Avesis. This role was created as Avesis began to contract with Medicaid Managed Care Organizations as the administrator of their routine managed vision care programs.

Avesis' Chief Eye Medical Officer continues to practice Full Time and is Part Time in his role with Avesis. This role was created as Avesis began to contract with Medicaid Managed Care Organizations as the administrator of their managed eye medical surgical vision care programs.

It has proven to be beneficial for Avesis to have actively practicing providers in these lead roles that represent Avesis throughout the provider community. In addition to these positions, Avesis contracts with sub-specialty consultants to advise on protocol and criteria, participate on several Avesis Committees and to serve as peer reviewers for Avesis.

As Avesis continues to grow, we constantly monitor and evaluate the necessity for additional provider consultants, on a Full Time or Part Time basis.

***If any of your personnel named is a current or former Louisiana state employee, indicate the Agency where employed, position, title, termination date, and last four digits of the Social Security Number.***

No personnel are current or former Louisiana state employees.

***If personnel are not in place, submit job descriptions outlining the minimum qualifications of the position(s). Each resume or job description should be limited to 2 pages.***

Not applicable.

***For key positions/employees which are not full time provide justification as to why the position is not full time. Include a description of their other duties and the amount of time allocated to each.***

Not applicable.

**B.16 Identify, in Excel format, all of your organization's publicly-funded managed care contracts for Medicaid/CHIP and/or other low-income individuals within the last five (5) years. In addition, identify, in Excel format your organization's ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP and/or other low-income individuals within the last five (5) years. For each prior experience identified, provide the trade name, a brief description of the scope of work, the duration of the contract, the contact name and phone number, the number of members and the population types (e.g., TANF, ABD, duals, CHIP), the annual contract payments, whether payment was capitated or other, and the role of subcontractors, if any. If your organization has not had any publicly-funded managed care contracts for Medicaid/SCHIP individuals within the last five (5) years, identify the Proposer's ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP individuals within the last five (5) years and provide the information requested in the previous sentence. Include your organization's parent organization, affiliates, and subsidiaries.**

Not applicable.

**B.17 Identify whether your organization has had any contract terminated or not renewed within the past five (5) years. If so, describe the reason(s) for the termination/nonrenewal, the parties involved, and provide the address and telephone number of the client. Include your organization's parent organization, affiliates, and subsidiaries.**

Avesis' contract with PeachState Health Plan, a Medicaid routine eye care program in Georgia was terminated when PeachState purchased their own eye care company.

Avesis' contract with PeachState Health Plan, a Medicaid dental program in Georgia was terminated within the first twenty days of the tenure of the Plan's fourth CEO in three years.

Avesis' contract with Molina Healthcare of Texas, a Medicaid dental program in Texas was not renewed as the parties could not agree on an appropriate Administrative Services Only rate.

**B.18 If the contract was terminated/non-renewed in B.17 above, based on your organization's performance, describe any corrective action taken to prevent any future occurrence of the problem leading to the termination/non-renewal. Include your organization's parent organization, affiliates, and subsidiaries.**

The above contracts were not terminated or renewed due to any performance issues or corrective actions taken.

**B.19 As applicable, provide (in table format) the Proposer’s current ratings as well as ratings for each of the past three years from each of the following:**

**AM Best Company (financial strengths ratings);**

**TheStreet.com, Inc. (safety ratings); and**

**Standard & Poor’s (long-term insurer financial strength.**

Not applicable.

**B.20 For any of your organization’s contracts to provide physical health services within the past five years, has the other contracting party notified the Proposer that it has found your organization to be in breach of the contract? If yes: (1) provide a description of the events concerning the breach, specifically addressing the issue of whether or not the breach was due to factors beyond the Proposer’s control. (2) Was a corrective action plan (CAP) imposed? If so, describe the steps and timeframes in the CAP and whether the CAP was completed. (3) Was a sanction imposed? If so, describe the sanction, including the amount of any monetary sanction (e.g., penalty or liquidated damage) (4) Was the breach the subject of an administrative proceeding or litigation? If so, what was the result of the proceeding/litigation? Include your organization’s parent organization, affiliates, and subsidiaries.**

Avesis has never been notified by a contracting party that we were in breach of a contract.

**B.21 Indicate whether your organization has ever sought, or is currently seeking, National Committee for Quality Assurance (NCQA) or American Accreditation HealthCare Commission (URAC) accreditation status. If it has or is, indicate current NCQA or URAC accreditation status and accreditation term effective dates if applicable.**

Avesis has never sought accreditation from the NCQA or URAC.

**B.22 Have you ever had your accreditation status (e.g., NCQA, URAC,) in any state for any product line adjusted down, suspended, or revoked? If so, identify the state and product line and provide an explanation. Include your organization’s parent organization, affiliates, and subsidiaries.**

Not applicable.

**B.23 If you are NCQA accredited in any state for any product line, include a copy of the applicable NCQA health plan report cards for your organization. Include your organization's parent organization, affiliates, and subsidiaries.**

Not applicable.

**B.24 Provide (as an attachment) a copy of the most recent external quality review report (pursuant to Section 1932(c)(2) of the Social Security Act) for the Medicaid contract identified in response to item B.16 that had the largest number of enrollees as of January 1, 2011. Provide the entire report. In addition, provide a copy of any corrective action plan(s) requested of your organization (including your organization's parent organization, affiliates, and subsidiaries) in response to the report.**

Avesis has not received any external quality review reports.

**B.25 Identify and describe any regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against your organization within the last five (5) years. In addition, identify and describe any letter of deficiency issued by as well as any corrective actions requested or required by any federal or state regulatory entity within the last five (5) years that relate to Medicaid or CHIP contracts. Include your organization's parent organization, affiliates, and subsidiaries.**

Avesis Third Party Administrators, Inc. was charged an administrative penalty by the Connecticut Department of Insurance for its inadvertent failure to disclose an administrative matter in a different state. There have been no letters of deficiency issued or corrective actions requested by any federal or state regulatory entity in the last five (5) years.

**B.26 Provide a statement of whether your organization is currently the subject or has recently (within the past five (5) years) been the subject of a criminal or civil investigation by a state or federal agency other than investigations described in response to item B.6. If your organization has recently been the subject of such an investigation, provide an explanation with relevant details and the outcome. If the outcome is against your organization, provide the corrective action plan implemented to prevent such future offenses. Include your organization's parent company, affiliates and subsidiaries.**

Neither Avesis Third Party Administrators, Inc. nor its parent company, Avesis Incorporated have been the subject of a criminal or civil investigation by a state or federal agency in the past five (5) years.

**B.27** Submit client references (minimum of three, maximum of five) for your organization for major contracts; with at least one reference for a major contract you have had with a state Medicaid agency or other large similar government or large private industry contract. Each reference must be from contracts within the last five (5) years. References for your organization shall be submitted to the State using the questionnaire contained in RFP Appendix PP. You are solely responsible for obtaining the fully completed reference check questionnaires, and for submitting them sealed by the client providing the reference, with your Proposal, as described herein. You should complete the following steps:

- a. Make a duplicate (hard copy or electronic document) of the appropriate form, as it appears in RFP Appendix PP (for your organization or for subcontractors, adding the following customized information:

Your/Subcontractor's name;  
Geographic Service Area(s) for which the reference is being submitted;  
Reference organization's name; and  
Reference contact's name, title, telephone number, and email address.

- b. Send the form to each reference contact along with a new, sealable standard #10 envelope;
- c. Give the contact a deadline that allows for collection of all completed questionnaires in time to submit them with your sealed Proposal;
- d. Instruct the reference contact to:

Complete the form in its entirety, in either hard copy or electronic format (if completed electronically, an original should be printed for submission);

Sign and date it;  
Seal it in the provided envelope;  
Sign the back of the envelope across the seal; and  
Return it directly to you.

- e. Enclose the unopened envelopes in easily identifiable and labeled larger envelopes and include these envelopes as a part of the Proposal. When DHH the opens your Proposal, it should find clearly labeled envelope(s) containing the sealed references.

**B.27 THE STATE WILL NOT ACCEPT LATE REFERENCES OR REFERENCES SUBMITTED THROUGH ANY OTHER CHANNEL OF SUBMISSION OR MEDIUM, WHETHER WRITTEN, ELECTRONIC, VERBAL, OR OTHERWISE.**

Each completed questionnaire should include:

- Proposing Organization/Subcontractor's name;
- GSA (s) for which the reference is being submitted;
- Reference Organization's name;
- Name, title, telephone number, and email address of the organization contact knowledgeable about the scope of work;
- Date reference form was completed; and
- Responses to numbered items in RFP Attachment # (as applicable).

DHH reserves the authority to clarify information presented in questionnaires and may consider clarifications in the evaluation of references. However DHH is under no obligation to clarify any reference check information.

Please see Appendix L for Avesis' client references.

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## **EMDEON INC.**

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### **B.11 Major Subcontractor**

**B.1 Indicate your organization's legal name, trade name, *dba*, acronym, and any other name under which you do business; the physical address, mailing address, and telephone number of your headquarters office. Provide the legal name for your organization's ultimate parent (e.g. publicly traded corporation).**

**Describe your organization's form of business (i.e., individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and detail the names, mailing address, and telephone numbers of its officers and directors and any partners (if applicable). Provide the name and address of any health professional that has at least a five percent (5%) financial interest in your organization, and the type of financial interest.**

**Provide your federal taxpayer identification number and Louisiana taxpayer identification number.**

**Provide the name of the state in which you are incorporated and the state in which you are commercially domiciled. If out-of-state, provide the name and address of the local representative; if none, so state.**

**If you have been engaged by DHH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; if not, so state.**

#### **Legal Name**

Envoy LLC, an Emdeon company

#### **Trade Name**

Emdeon, Emdeon Business Services

#### **DBA**

Emdeon, Emdeon Business Service

#### **Any Other Name under Which You Do Business**

For purposes of this RFP, Emdeon does not do business under any other name; however, Emdeon is comprised of various affiliates and subsidiaries.

#### **Physical/Mailing Address of Headquarters**

3055 Lebanon Pike, Suite 1000, Nashville, Tennessee, 37214

#### **Telephone Number of Headquarters**

(615) 932-3000

#### **Legal Name for Organization's Ultimate Parent Company (e.g., publicly traded corporation)**

Emdeon Inc.



**Form of Business**

Emdeon is a Corporation. Emdeon is a leading provider of revenue and payment cycle management and clinical information exchange solutions, connecting payers, providers and patients in the U.S. healthcare system. Emdeon's product and service offerings integrate and automate key business and administrative functions of its payer and provider customers throughout the patient encounter. Through the use of Emdeon's comprehensive suite of products and services, which are designed to easily integrate with existing technology infrastructures, customers are able to improve efficiency, reduce costs, increase cash flow and more efficiently manage the complex revenue and payment cycle and clinical information exchange processes.

**Officers, Directors and Any Partners**

Chief Executive Officer (CEO) and Director - George I. Lazenby IV, (801) 747-5815

Chief Financial Officer (CFO) - Bob A. Newport Jr.

Chief Information Officer (CIO) - Damien Creavin

**Name of Any Health Profession that has at Least Five Percent (5%) Financial Interest in your Organization**

No health professional has at least five percent financial interest in Emdeon.

**Federal Tax Identification**

The federal tax identification number for Envoy LLC, an Emdeon company is 20-5716594. The Louisiana taxpayer identification number is 20-5716594.

**State Incorporated**

Envoy LLC, an Emdeon company is incorporated in the state of Delaware.

**State Domiciled**

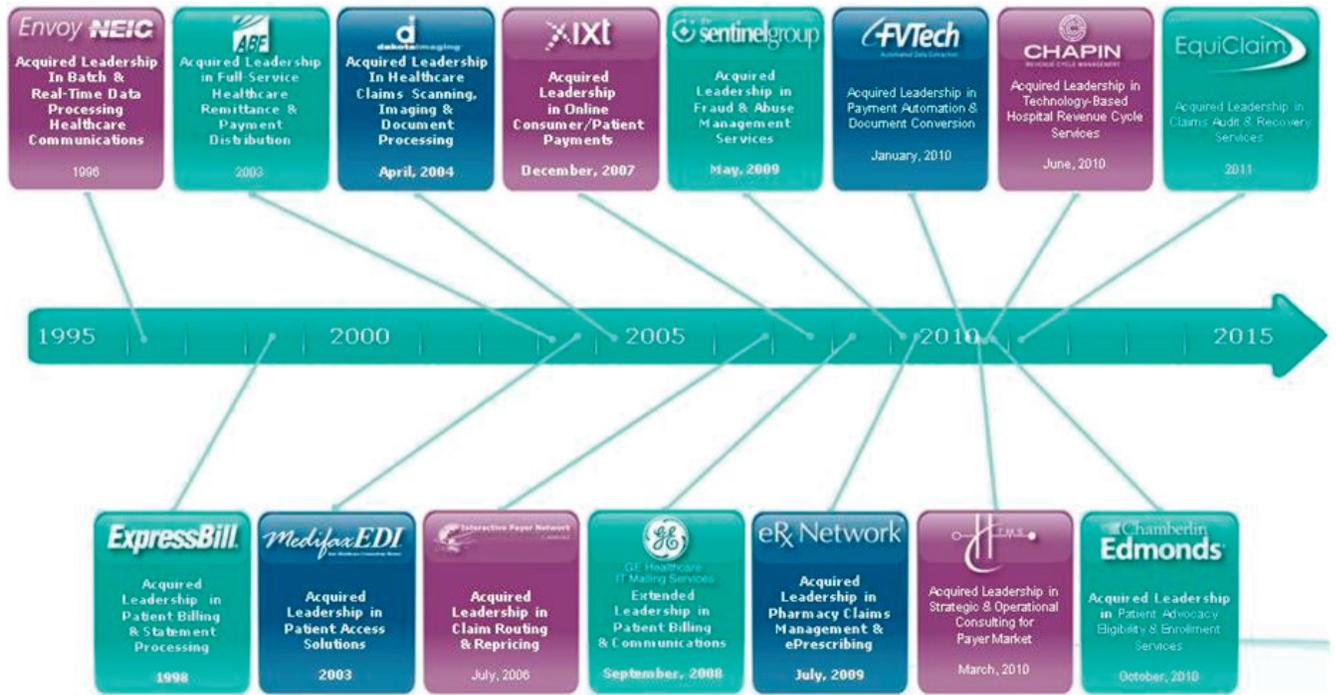
Emdeon, Inc. is domiciled in the state of Tennessee. The local representative is Gregory T. Stevens located at 3055 Lebanon Pike, Suite 1000, Nashville, Tennessee 37214

**Engaged by DHH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; if not, so state.**

Envoy, LLC has not been engaged by DHH in the past 24 months.

**B.2 Provide a statement of whether there have been any mergers, acquisitions, or sales of your organization within the last ten years, and if so, an explanation providing relevant details. If any change of ownership is anticipated during the 12 months following the Proposal Due Date, describe the circumstances of such change and indicate when the change is likely to occur. Include your organization's parent organization, affiliates, and subsidiaries.**

Through strategic acquisitions and mergers, Emdeon has created a unique business entity that focuses on the entire expanse of administrative and financial healthcare information technology.



By establishing a company that provides end-to-end services, Emdeon is not only positioned to have the capabilities to streamline the entire healthcare process for its payer and provider clients, but can also provide the ability to connect the entire marketplace at all levels, placing itself in a position to be a guiding force in implementing future innovations.

**B.3 Provide a statement of whether you or any of your employees, agents, independent contractors, or subcontractors have ever been convicted of, pled guilty to, or pled *nolo contendere* to any felony and/or any Medicaid or health care related offense or have ever been debarred or suspended by any federal or state governmental body. Include an explanation providing relevant details and the corrective action plan implemented to prevent such future offenses. Include your organization's parent organization, affiliates, and subsidiaries.**

Neither Emdeon nor its officers and directors, nor to Emdeon's knowledge of its subcontractors have ever been convicted of, pled guilty to, or pled *nolo contendere* to any felony and/or any Medicaid or health care related offense or have ever been debarred or suspended by any federal or state governmental body.

**B.4 Provide a statement of whether there is any pending or recent (within the past five years) litigation against your organization. This shall include but not be limited to litigation involving failure to provide timely, adequate or quality physical or behavioral health services. You do not need to report workers' compensation cases. If there is pending or recent litigation against you, describe the damages being sought or awarded and the extent to which adverse judgment is/would be covered by insurance or reserves set aside for this purpose. Include a name and contact number of legal counsel to discuss pending litigation or recent litigation. Also include any SEC filings discussing any pending or recent litigation. Include your organization's parent organization, affiliates, and subsidiaries.**

In the normal course of business, the Company is subject to claims, lawsuits and legal proceedings. While it is not possible to ascertain the ultimate outcome of such matters, in management's opinion, the liabilities, if any, in excess of amounts provided or covered by insurance, are not expected to have a material adverse effect on our consolidated financial position, results of operations or liquidity.

**B.5 Provide a statement of whether, in the last ten years, you or a predecessor company has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. If so, provide an explanation providing relevant details including the date in which the Proposer emerged from bankruptcy or expects to emerge. If still in bankruptcy, provide a summary of the court-approved reorganization plan. Include your organization's parent organization, affiliates, and subsidiaries.**

During the last ten years, Envoy LLC, an Emdeon company has not filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors.

**B.6 If your organization is a publicly-traded (stock-exchange-listed) corporation, submit the most recent United States Securities and Exchange Commission (SEC) Form 10K Annual Report, and the most-recent 10-Q Quarterly report.**

**Provide a statement whether there have been any Securities Exchange Commission (SEC) investigations, civil or criminal, involving your organization in the last ten (10) years. If there have been any such investigations, provide an explanation with relevant details and outcome. If the outcome is against the Proposer, provide the corrective action plan implemented to prevent such future offenses. Also provide a statement of whether there are any current or pending Securities Exchange Commission investigations, civil or criminal, involving the Proposer, and, if such investigations are pending or in progress, provide an explanation providing relevant details and provide an opinion of counsel as to whether the pending investigation(s) will impair the Proposer's performance in a contract/Agreement under this RFP. Include your organization's parent organization, affiliates, and subsidiaries.**

Please see Appendix F for Emdeon's 10-K and 10-Q reports.

There have been no Securities Exchange Commission (SEC) investigations, civil or criminal, involving Emdeon, its affiliates or subsidiaries in the last ten (10) years and to Emdeon's knowledge there are no current or pending Securities Exchange Commission investigations, civil or criminal.

**B.7 If another corporation or entity either substantially or wholly owns your organization, submit the most recent detailed financial reports for the parent organization. If there are one (1) or more intermediate owners between your organization and the ultimate owner, this additional requirement is applicable only to the ultimate owner.**

**Include a statement signed by the authorized representative of the parent organization that the parent organization will unconditionally guarantee performance by the proposing organization of each and every obligation, warranty, covenant, term and condition of the Contract.**

Envoy LLC is an indirect wholly owned subsidiary of Emdeon, Inc.

Please see Appendix F for Emdeon's 10-K and 10-Q reports.

**B.10 Attach a personnel roster and resumes of key people who shall be assigned to perform duties or services under the Contract, highlighting the key people who shall be assigned to accomplish the work required by this RFP and illustrate the lines of authority. Submit current resumes of key personnel documenting their educational and career history up to the current time. Include information on how long the personnel have been in these positions and whether the position included Medicaid managed care experience.**

**If any of your personnel named is a current or former Louisiana state employee, indicate the Agency where employed, position, title, termination date, and last four digits of the Social Security Number.**

**If personnel are not in place, submit job descriptions outlining the minimum qualifications of the position(s). Each resume or job description should be limited to 2 pages.**

**For key positions/employees which are not full time provide justification as to why the position is not full time. Include a description of their other duties and the amount of time allocated to each.**

Following is a roster of key personnel who will be assigned to perform duties and services under the contract, followed by organization charts that illustrate lines of authority and reporting relationships.

Name	Title	Full Time
Anthony Pilotto	Vice President, Payer Services	Full Time
Richard Morino	Vice President, Payer Services	Full Time
Marc Wischmeier	Vice President, Payer Sales	Full Time
Maryanne Bishop	Account Manager	Full Time
Erin Jenner	Client Services Analyst	Full Time
Linda Storey	Payer Services Manager	Full Time
Jeremy Gregersen	Payer Services Manager	Full Time

***If any of your personnel named is a current or former Louisiana state employee, indicate the Agency where employed, position, title, termination date, and last four digits of the Social Security Number.***

No personnel are current or former Louisiana state employees.

***If personnel are not in place, submit job descriptions outlining the minimum qualifications of the position(s). Each resume or job description should be limited to 2 pages.***

Not applicable.

***For key positions/employees which are not full time provide justification as to why the position is not full time. Include a description of their other duties and the amount of time allocated to each.***

Not applicable.

**B.16 Identify, in Excel format, all of your organization's publicly-funded managed care contracts for Medicaid/CHIP and/or other low-income individuals within the last five (5) years. In addition, identify, in Excel format your organization's ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP and/or other low-income individuals within the last five (5) years. For each prior experience identified, provide the trade name, a brief description of the scope of work, the duration of the contract, the contact name and phone number, the number of members and the population types (e.g., TANF, ABD, duals, CHIP), the annual contract payments, whether payment was capitated or other, and the role of subcontractors, if any. If your organization has not had any publicly-funded managed care contracts for Medicaid/SCHIP individuals within the last five (5) years, identify the Proposer's ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP individuals within the last five (5) years and provide the information requested in the previous sentence. Include your organization's parent organization, affiliates, and subsidiaries.**

Not applicable.

**B.17 Identify whether your organization has had any contract terminated or not renewed within the past five (5) years. If so, describe the reason(s) for the termination/nonrenewal, the parties involved, and provide the address and telephone number of the client. Include your organization's parent organization, affiliates, and subsidiaries.**

Due to client confidentiality, we are prohibited from disclosing information.

**B.18 If the contract was terminated/non-renewed in B.17 above, based on your organization's performance, describe any corrective action taken to prevent any future occurrence of the problem leading to the termination/non-renewal. Include your organization's parent organization, affiliates, and subsidiaries.**

Due to client confidentiality, we are prohibited from disclosing information.

**B.19 As applicable, provide (in table format) the Proposer’s current ratings as well as ratings for each of the past three years from each of the following:**

**AM Best Company (financial strengths ratings);**

**TheStreet.com, Inc. (safety ratings); and**

**Standard & Poor’s (long-term insurer financial strength).**

These questions appear to be specific to insurance entities such as Aetna. For Emdeon, as a non-financial concern, these questions would not be applicable. However, Emdeon is publicly traded on the New York Stock Exchange (NYSE) under the ticker symbol “EM.” As such, our applicable financial information has been filed with the Securities and Exchange Commission (SEC). This information is publicly available and can be found on our website at [www.emdeon.com](http://www.emdeon.com), under the “Investor” page or on the SEC’s website at [www.sec.gov](http://www.sec.gov).

**B.20 For any of your organization’s contracts to provide physical health services within the past five years, has the other contracting party notified the Proposer that it has found your organization to be in breach of the contract? If yes: (1) provide a description of the events concerning the breach, specifically addressing the issue of whether or not the breach was due to factors beyond the Proposer’s control. (2) Was a corrective action plan (CAP) imposed? If so, describe the steps and timeframes in the CAP and whether the CAP was completed. (3) Was a sanction imposed? If so, describe the sanction, including the amount of any monetary sanction (e.g., penalty or liquidated damage) (4) Was the breach the subject of an administrative proceeding or litigation? If so, what was the result of the proceeding/litigation? Include your organization’s parent organization, affiliates, and subsidiaries.**

Not applicable. Emdeon does not provide physical health services.

**B.21 Indicate whether your organization has ever sought, or is currently seeking, National Committee for Quality Assurance (NCQA) or American Accreditation HealthCare Commission (URAC) accreditation status. If it has or is, indicate current NCQA or URAC accreditation status and accreditation term effective dates if applicable.**

Envoy LLC, an Emdeon company, does not currently have NCQA or URAC accreditation or certification status, nor have they sought these accreditations. They have never been denied NCQA or URAC accreditation.

**B.22 Have you ever had your accreditation status (e.g., NCQA, URAC,) in any state for any product line adjusted down, suspended, or revoked? If so, identify the state and product line and provide an explanation. Include your organization’s parent organization, affiliates, and subsidiaries.**

Not applicable.

**B.23 If you are NCQA accredited in any state for any product line, include a copy of the applicable NCQA health plan report cards for your organization. Include your organization's parent organization, affiliates, and subsidiaries.**

Not applicable.

**B.24 Provide (as an attachment) a copy of the most recent external quality review report (pursuant to Section 1932(c)(2) of the Social Security Act) for the Medicaid contract identified in response to item B.16 that had the largest number of enrollees as of January 1, 2011. Provide the entire report. In addition, provide a copy of any corrective action plan(s) requested of your organization (including your organization's parent organization, affiliates, and subsidiaries) in response to the report.**

Not applicable. Emdeon does not provide direct medical services.

**B.25 Identify and describe any regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against your organization within the last five (5) years. In addition, identify and describe any letter of deficiency issued by as well as any corrective actions requested or required by any federal or state regulatory entity within the last five (5) years that relate to Medicaid or CHIP contracts. Include your organization's parent organization, affiliates, and subsidiaries.**

Not applicable.

**B.26 Provide a statement of whether your organization is currently the subject or has recently (within the past five (5) years) been the subject of a criminal or civil investigation by a state or federal agency other than investigations described in response to item B.6. If your organization has recently been the subject of such an investigation, provide an explanation with relevant details and the outcome. If the outcome is against your organization, provide the corrective action plan implemented to prevent such future offenses. Include your organization's parent company, affiliates and subsidiaries.**

Neither Envoy, LLC, an Emdeon company, nor its parent company, Emdeon Business Services LLC have been the subject of a criminal or civil investigation by a state or federal agency in the past five (5) years.

**B.27** Submit client references (minimum of three, maximum of five) for your organization for major contracts; with at least one reference for a major contract you have had with a state Medicaid agency or other large similar government or large private industry contract. Each reference must be from contracts within the last five (5) years. References for your organization shall be submitted to the State using the questionnaire contained in RFP Appendix PP. You are solely responsible for obtaining the fully completed reference check questionnaires, and for submitting them sealed by the client providing the reference, with your Proposal, as described herein. You should complete the following steps:

- a. Make a duplicate (hard copy or electronic document) of the appropriate form, as it appears in RFP Appendix PP (for your organization or for subcontractors, adding the following customized information:

Your/Subcontractor's name;  
Geographic Service Area(s) for which the reference is being submitted;  
Reference organization's name; and  
Reference contact's name, title, telephone number, and email address.

- b. Send the form to each reference contact along with a new, sealable standard #10 envelope;
- c. Give the contact a deadline that allows for collection of all completed questionnaires in time to submit them with your sealed Proposal;
- d. Instruct the reference contact to:

Complete the form in its entirety, in either hard copy or electronic format (if completed electronically, an original should be printed for submission);

Sign and date it;  
Seal it in the provided envelope;  
Sign the back of the envelope across the seal; and  
Return it directly to you.

- e. Enclose the unopened envelopes in easily identifiable and labeled larger envelopes and include these envelopes as a part of the Proposal. When DHH the opens your Proposal, it should find clearly labeled envelope(s) containing the sealed references.

**B.27 THE STATE WILL NOT ACCEPT LATE REFERENCES OR REFERENCES SUBMITTED THROUGH ANY OTHER CHANNEL OF SUBMISSION OR MEDIUM, WHETHER WRITTEN, ELECTRONIC, VERBAL, OR OTHERWISE.**

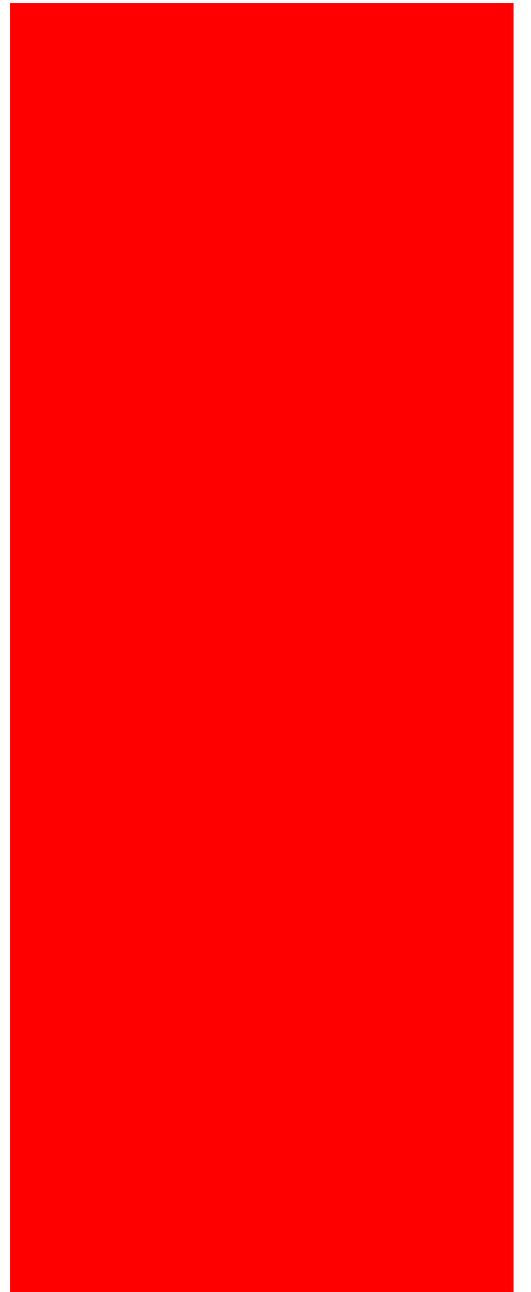
**Each completed questionnaire should include:**

- **Proposing Organization/Subcontractor's name;**
- **GSA (s) for which the reference is being submitted;**
- **Reference Organization's name;**
- **Name, title, telephone number, and email address of the organization contact knowledgeable about the scope of work;**
- **Date reference form was completed; and**
- **Responses to numbered items in RFP Attachment # (as applicable).**

**DHH reserves the authority to clarify information presented in questionnaires and may consider clarifications in the evaluation of references. However DHH is under no obligation to clarify any reference check information.**

Please see Appendix L for Envoy LLC, an Emdeon company's client references.

14 B.12



**B.12 Provide a description your Corporate Compliance Program including the Compliance Officer's levels of authority and reporting relationships. Include an organizational chart of staff (marked as Chart B in your response) involved in compliance along with staff levels of authority.**

### **Aetna Better Health Experience**

Aetna Better Health, with our affiliates, has more than 20 years experience designing, implementing, and managing comprehensive compliance programs for our Medicaid health plans across the country. We currently own, manage or administer Medicaid health plans in 10 states, including Arizona, California, Connecticut, Delaware, Florida, Illinois, Maryland, Missouri, Pennsylvania, and Texas. The Aetna Better Health Board of Directors is our governing body and has ultimate accountability for the sufficient staffing and utilization of appropriate resources to achieve contractual compliance and meet federal, state, and local laws and regulations.

### **Corporate Compliance Program**

Aetna Better Health is committed to the development and management of a comprehensive compliance program including, but not limited to, a fraud and abuse plan for the Louisiana Department of Health and Hospitals (DHH). Our compliance program is designed to provide information and guidance for complying with federal, state, and local laws and regulations that are applicable to the services provided to DHH members and to guard against fraud and abuse. Aetna Better Health's compliance program is based on comprehensive written policies, procedures, and standards of conduct that articulate our commitment to complying with DHH, the Louisiana Office of the Inspector General (OIG), and Centers for Medicare & Medicaid Services (CMS).

Aetna Better Health will submit a copy of our compliance program, including our fraud and abuse plan, to DHH for approval within 30 days from the Contract date. Any modifications, changes, or updates to our compliance program will be submitted to DHH for approval 30 days in advance of the effective date. The following components comprise our compliance program in accordance with the required provisions:

- Designation of the Compliance Officer (CO) and Compliance Committee accountable to senior management including reporting responsibilities
- Provision of written policies, procedures, and standards of conduct articulating Aetna Better Health's commitment to comply with all applicable federal and state standards
- Establishment of effective lines of communication between the CO and employees, providers, and contractors
- Provision of effective training/education of employees, members and providers
- Provision of written disciplinary guidelines for compliance violations including, but not limited to, fraud and abuse
- Utilization of internal monitoring and auditing procedures

- Establishment of procedures for responding to detected compliance offenses including, but not limited to, the following:
  - Coordinating and sharing information with DHH’s Program Integrity Unit (PIU)
  - Implementing corrective action
  - Establishing confidentiality and non-retaliation protections
  - Reporting of investigation results

***Compliance Officer***

The Aetna Better Health Board of Directors has delegated the design, maintenance, administration, monitoring, and daily functioning of the compliance program to the Aetna Better Health Compliance Officer (CO). While ultimately accountable to the Board of Directors, the CO reports dually to the Aetna Better Health Chief Executive Officer (CEO) and the head of Medicaid Compliance in Aetna Life Insurance Co (ALIC). However, for day-to-day responsibility, the CO is supervised by and answer to Aetna Better Health’ CEO. Our CO is qualified, trained and experienced to oversee our Louisiana compliance program. Aetna Better Health’s CO is located in Louisiana and has direct access to senior management and legal counsel at all times. Aetna Better Health has developed written criteria that outline the authority and responsibilities of the CO position as well as a job description that clearly defines required and essential skills and experience. The CO also serves as the Contract Compliance Officer and is the primary point of contact for compliance issues and is responsible for the following:

- Immediately responding to, investigating, and reporting, as appropriate, unusual incidents and suspected fraud and abuse issues
- Coordinating the tracking and submission of contractual compliance deliverables
- Consulting with and responding to DHH regarding compliance concerns and issues
- Educating and training employees on compliance requirements
- Fielding and coordinating responses to electronic, telephonic, and written inquiries and/or requests from the PIU and Louisiana OIG
- Coordinating the preparation and execution of operational and financial reviews, random, and periodic audits, and ad hoc reports and regulatory visits

**Reporting Relationships**

The organizational chart in Appendix G illustrates the reporting structure of the Aetna Better Health Compliance Department.

***Committee Involvement***

In collaboration with the Aetna Better Health Board of Directors, CEO and Compliance Committee, our CO will determine the need for additional personnel to meet federal, state, and contractual requirements. We will determine the positions necessary to effectively and efficiently support our compliance program and identify the skills, knowledge, and experience necessary for these positions. For example, in our compliance program in Arizona, Aetna Better Health has a claims analyst dedicated to data mining for potential fraudulent billings. This

position provides information directly to the CO for review and identification of trends and patterns.

Our CO fosters open lines of communication across all levels of the organization by attending the compliance components of new hire, annual, and ad hoc training, as well as numerous departmental routine and ad hoc meetings. Compliance is a standing agenda item for the following operational and quality meetings:

#### **Quality Management Oversight Committee**

Aetna Better Health's Quality Management Oversight Committee's (QMOCs) primary purpose is to integrate quality assurance and performance improvement (QAPI) activities throughout the health plan and the provider network. The committee is designated to provide executive oversight of the QAPI and make decisions about Aetna Better Health's Quality Management and performance improvement activities. The committee reviews and approves the annual QAPI, work plan, and evaluation and works to make sure the QAPI is integrated throughout the organization, and among departments, delegated organizations and network providers. The QMOC's responsibilities include, but are not limited to, the following:

- Making sure that quality activities are designed to improve the quality of care and services provided to members
- Advising or making recommendations to improve the health plan
- Recommending pertinent policy decisions involving quality
- Reviewing and evaluating company-wide performance and compliance monitoring activities, including care management, customer service, , credentialing, claims, grievance and appeals, prevention and wellness, provider service and quality and utilization management

#### **Compliance Committee**

The Aetna Better Health Compliance Committee reports directly to the QMOC and is responsible for reviewing, monitoring, and assessing the compliance program and advising our CO on interventions for improving program effectiveness. This committee is chaired by the CO and comprised of several Board members along with key Aetna Better Health executives. These executives include, but are not limited to, the Chief Operating Officer (COO), Chief Medical Officer (CMO) or designee, and representatives from key departments such as Quality Management, Utilization Management, Grievance and Appeals, Provider Relations, and Claims. The committee meets at least quarterly and minutes and summary reports are recorded, maintained, and provided to DHH as requested. The functions of the compliance committee include, but are not limited to, the following:

- Overseeing the development, maintenance, and revision of all compliance program policies and procedures and other related documents
- Recommending, reviewing, and monitoring internal controls such as compliance reports and corrective action plans resulting from audits
- Initiating and directing investigations related to any identified potential compliance gaps
- Reporting all compliance issues to the Board of Directors and subcommittees as appropriate

**Quality Management/Utilization Management Committee**

Aetna Better Health's Quality Management/Utilization Management (QM/UM) Committee's primary purpose is to advise and make recommendations to the CMO on matters pertaining to the quality of care and service provided to members including the oversight and maintenance of the QAPI and utilization management program. The QM/UM Committee will provide utilization review and monitoring of UM activities of both Aetna Better Health and its providers and is directed by Aetna Better Health's Medical Director. This committee convenes quarterly and submits meeting minutes to DHH within five (5) business days of each meeting. The QM/UM Committee responsibilities include, but are not limited to, the following:

- Monitoring providers' requests for rendering healthcare services to its members
- Monitoring the medical appropriateness and necessity of healthcare services provided to its members utilizing provider quality and utilization profiling
- Reviewing the effectiveness of the utilization review process and making changes to the process as needed
- Approving policies and procedures for utilization management that conform to industry standards, including methods, timelines and individuals responsible for completing each task
- Monitoring over- and under-utilization
- Reviewing member medical records to monitor Primary Care Provider (PCP) provision of high quality health care that is documented according to established standards

**Service Improvement Committee**

Aetna Better Health's Service Improvement Committee (SIC) is an interdisciplinary team that includes senior management and employees from multiple departments across the organization. The SIC is our principal forum to systematically identify, discuss and resolve issues that impact both members and providers. This committee is chaired by the Aetna Better Health COO and its functions include, but are not limited to, the following:

- Review of trended data to identify for service improvement opportunities
- Approves recommended intervention activities
- Identifies additional improvement activities
- Assigns action plans and monitors the action plans to completion.

The SIC also uses results from provider inquiries, complaints, requests for information, data analysis (trends) to develop recommendations regarding process and service improvements.

***Effective Lines of Communication***

In order to promote effective communication between the CO and all Aetna Better Health employees the CO maintains an "open door" policy. Any Aetna Better Health employee is able to have direct communication (in person or electronically) with the CO. The CO has the authority to meet with any employee, member, provider or stakeholder in the course of fraud, waste or abuse investigations. The CO serves as a resource to Aetna Better Health employees, members, providers, and other parties for issues, inquiries and requests. These requests may include providing information regarding the Aetna Better Health compliance program,

compliance code of conduct and interpretation of compliance policies. Aetna Better Health utilizes an array of communication mechanisms to promote open, two-way communication for the receipt of and dissemination of compliance information; including:

- Dedicated toll-free hotline that is accessible to any individual (e.g., our employees, providers, members) to make confidential, anonymous and non-retaliatory reports of compliance issue/inquiries verbally or in writing.
- Easy on-line access for Aetna Better Health employees to provide fraud and abuse reporting that can be confidentially, anonymously sent directly to DHH or our compliance unit.
- Written materials about the compliance program are distributed through employee or provider training sessions, direct e-mails, or in Aetna Better Health publications (e.g., network and provider newsletters, provider manual, member handbook, and employee handbook). This includes information about other toll-free telephone numbers and fraud and abuse reporting forms to report suspected fraud and abuse.
- Training, both classroom and web-based training, on the components, requirements, and specifications of our compliance policies, programs, disciplinary standards, and operational guidelines.

Direct access to our CO or compliance employees is available for both reporting of compliance issues including, but not limited to, fraud and abuse and for use as a resource regarding questions about our compliance program.

***Written Policies, Procedures, and Standards of Conduct***

Our compliance program is based on written policies and procedures, a code of conduct articulating Aetna Better Health's commitment to comply with DHH's and CMS' regulations and contractual requirements. Our written policies, procedures, and code of conduct:

- Implement the compliance program that complies with federal, state, and local law, rules, and regulations .
- Provide guidance to employees, providers and other stakeholders on how to deal with potential compliance issues.
- Identify how, when and to whom to communicate compliance issues.
- Describe how compliance issues are investigated and reported.
- Describe consequences for failing to report suspected compliance issues or participating in non-compliant behavior.

In addition to our policies, procedures, and standards of conduct, each provider contract describes the provider's responsibilities related to our compliance program, including

- Complying with applicable federal, state and local laws, rules and regulations
- Notifying Aetna Better Health of any credentialing, licensure or admission privilege(s) change
- Maintaining professional standards
- Maintaining and providing requested records and documents as required by law, rule and regulation

- Abiding by applicable laws, rules, regulations, provider contract and Aetna Better Health subcontract provisions
- Preventing and reporting of fraud and abuse
- Training their personnel on the Deficit Reduction Act of 2005 and Federal False Claim Act provisions

***Confidentiality and Non-Retaliation Protections***

We understand that our employees, members, providers, and contractors are more likely to report suspected or known fraud and abuse issues if they feel it is a safe and confidential process. As a result, all complaints reported by employees, members, providers, contractors, or other persons will be kept confidential by Aetna Better Health to the extent that is possible during and following the investigation.

We have a zero-tolerance policy for any retaliation against employees, members, providers, contractors or other persons who make reports regarding known or suspected violations of federal, state and local laws and regulations. Retaliation for reporting is prohibited and violators will be subject to disciplinary action. Aetna Better Health employees who retaliate against any employee, member, provider, contractor, or other person are subject to disciplinary action up to and including termination. Employees who believe they have been retaliated against are encouraged to inform their supervisor, but may also contact Aetna Better Health's CO or other executive, DHH, or the Louisiana OIG. Members, providers, and contractors who believe they have been retaliated against are encouraged to contact Aetna Better Health, DHH, or the OIG.

***Compliance Training and Education***

Aetna Better Health promotes the importance of education and training as a method to be compliant with legal, contractual and fraud and abuse requirements. As a result, we have developed a training program designed to promote compliance at all levels of our organization and within our provider network as well as assisting and empowering our members in recognizing and reporting fraud and abuse.

**Employee Training and Education**

Aetna Better Health employees across all levels of the organization are expected and required to comply with all provisions of our compliance program including, but not limited to, fraud and abuse. All employees must complete our compliance training program upon hire, annually, and on an ad hoc basis as needed.

Fraud and abuse training topics include, but are not limited to, the following:

- Aetna Better Health's commitment to the compliance including Health Insurance Portability and Accountability Act (HIPAA) requirements
- Standard of Conduct for employees in preventing, reducing, detecting, correcting, and reporting fraud and abuse violations
- Prevention, detection, and reporting of known or suspected fraud and abuse through the following:
  - Aetna Better Health's Compliance Officer contact information
  - Aetna Better Health's 24 hour, toll-free number for reporting

- The Medicaid fraud hotline toll-free number for reporting
- Louisiana’s PIU for reporting via written correspondence
- Louisiana’s fraud reporting fax line for reporting via written correspondence
- DHH’s website reporting capability
- Corrective action guidelines
- Deficit Reduction Act of 2005 and Federal False Claim Act provisions
- Non-retaliation protections

Upon completion of initial and ongoing compliance training, our employees acknowledge they; 1) participated in the training; 2) understood the information provided; and 3) will adhere to compliance program requirements. Aetna Better Health maintains attendance and participation records in accordance with DHH record retention standards.

### **Member Education**

Our member handbook and website serve as one of the main sources for communicating the details of the F&A Plan to our members. Our member handbook and website provide information on types of fraud and abuse including, but not limited to, identification card fraud, emergency room abuse, and prescription drug misuse/abuse. These also educate members on their responsibilities, the responsibilities of others, the definition of fraud and abuse, and how and where to report suspected or known fraud and abuse through the following:

- Aetna Better Health’s Compliance Officer contact information
- Aetna Better Health’s 24 hour, toll-free number for telephonic reporting
- The Medicaid fraud hotline toll-free number for telephonic reporting
- Louisiana’s PIU for reporting via written correspondence
- Louisiana’s fraud reporting fax line for reporting via written correspondence
- DHH’s website reporting capability

Aetna Better Health case managers have direct contact with our members and are responsible for providing information to our members and members’ families/caregivers regarding the process for detecting and reporting potential fraud and abuse as needed. Periodic articles on fraud and abuse are published in quarterly member newsletters, providing additional examples of behaviors to watch for and emphasizing the responsibility of members’ to report potential fraud and abuse.

### **Provider Training and Education**

Aetna Better Health’s Provider Services personnel, provider manual, and website educate providers on our compliance program including providers’ respective responsibilities, the responsibilities of others, the definition of fraud and abuse, and how and where to report suspected or known fraud and abuse. Aetna Better Health Provider Services personnel schedule an orientation with each provider to review the health plan requirements within 30 days of contracting. This orientation includes an overview of the F&A Plan and specific examples of provider fraud, such as up-coding, billing for services not provided, and submitting false encounter data. Aetna Better Health’s Claims Educator conducts ongoing telephonic and on-site communication with contracted and non-contracted providers. These communications include

information on appropriate claims submission requirements, coding updates, electronic claims transactions and electronic fund transfers. Our network providers receive a hardcopy of our provider manual and information on how to locate regular fraud and abuse updates on our website.

Our fraud and abuse provider training includes, but is not limited to, the following:

- Aetna Better Health’s commitment to compliance including Health Insurance Portability and Accountability Act (HIPAA) requirements
- Standard of Conduct for providers in preventing, identifying, and reporting compliance violations
- Prevention, identification, and reporting of known or suspected fraud and abuse including the availability of the following:
  - Aetna Better Health’s Compliance Officer contact information
  - Aetna Better Health’s 24 hour, toll-free number for telephonic reporting
  - The Medicaid fraud hotline toll-free number for telephonic reporting
  - Louisiana’s PIU for reporting via written correspondence
  - Louisiana’s fraud reporting fax line for reporting via written correspondence
  - DHH’s website reporting capability
- Corrective action guidelines
- Deficit Reduction Act of 2005 and Federal False Claim Act provisions
- Confidentiality and non-retaliation protections

Periodic articles on fraud and abuse are published in quarterly provider newsletters, providing additional examples of behaviors to watch for and emphasizing the responsibility of providers in preventing, detecting, and reporting potential suspected and known fraud and abuse.

#### ***Utilization of Internal Monitoring and Auditing Procedures***

Our CO collects and analyzes information from various departments within our organization to monitor and identify potential compliance violations. In addition to the prevention and detection of fraud and abuse, our compliance program conducts internal monitoring of our system-wide compliance with federal, state, and local laws and regulations, as well as contract requirements. Aetna Better Health uses the following strategies to monitor and audit for fraud and abuse:

- Claims system edits are designed to prevent, reduce, and detect potential fraud. These edits include, but are not limited to, reviews for 1) member eligibility, 2) covered services, 3) medically unlikely services for age or gender, 4) duplication of services, 5) prior authorization, 6) invalid procedure codes and 7) duplicate claims. Claims edited through our automatic editing process that are identified as fraudulent in nature are denied.
- Medical management activities (e.g., prior authorization, concurrent review, utilization management, discharge planning, retrospective review and provider profiling) serve as a first line of defense to prevent and detect fraud and abuse. These activities include: 1) verifying member eligibility, 2) reviewing the medical necessity of the service, 3) determining the appropriateness of the service being authorized; 4) verifying that the service is covered and

5) referring members to appropriate providers. Should the prior authorization process indicate fraud or abuse, the prior authorization will be denied, a notice of action will be sent to the provider and member, and a report will be sent to the CO. Our CO reviews, trends and will report findings to DHH as necessary. In addition, medical management reports allow the department to have multiple points of data to review and verify unusual patterns that may indicate potential fraud or abuse. Any unusual incident is documented and reported immediately as required by our policies and procedures.

- Provider Services and Quality Management employees are trained to be aware of probable indicators of fraud and abuse so that issues may be identified during routine office visits. For example either the provider service representative, during routine office visits, or the Quality Management employee during a provider ambulatory medical records review may, identify care rendered by an unlicensed person in a physician's office or a member obtaining DHH services illegally.
- Member complaints, grievances and appeals (including member survey results) are tracked and documented by the Member Services department to identify potential trends or patterns of fraud.
- Provider credential validation is conducted to prevent contracting with providers previously convicted of fraud or abuse. Aetna Better Health validates the credentials of all providers at initial and for recredentialing in accordance with National Committee for Quality Assurance (NCQA) criteria, as well as state and federal standards. As part of this process, we collect and evaluate information about providers from a variety of sources (e.g., National Practitioners Data Bank, OIG list of Excluded Individuals or Entities, and applicable state professional licensure boards).
- Random statistically valid (RSV) audits are conducted on a routine and periodic basis. These audits identify and detect inappropriate claims and potential provider fraudulent billing. Audit findings are provided to the CO for review and referral to DHH. At a minimum, the audit examines if: 1) the provider was contractually allowed to provide the service being billed; 2) the service provided is covered for the member; 3) the appropriate level of care was used for the presenting condition; 4) the provider billed correctly for the services rendered; 5) the charges for services are reasonable and 6) there was no evidence of excessive testing or referrals.

### **Fraud and Abuse Plan**

Aetna Better Health's Fraud and Abuse Plan (F&A Plan) is an integral part of our overall compliance program and is designed to effectively guard against and respond to suspected or known fraud and abuse in compliance with federal, state, and local laws and regulations. We have a variety of established mechanisms for our employees, members, providers, and contractors to report suspected or known fraud and abuse issues without fear of reporting diversion or retaliation.

Aetna Better Health responds to all suspected and detected fraud and abuse offenses in a timely manner and will report these offenses to DHH's PIU. Aetna Better Health will coordinate and communicate with the PIU to review and investigate fraud and abuse issues in a timely manner including, but not limited to, fraud and abuse issues identified through our Utilization Management (UM) Program.

See the response to Question O.1 of this Request for Proposals (RFP) for an in-depth description of the Aetna Better Health F&A Plan.

***Preventing, Reducing and Detecting Fraud and Abuse***

Aetna Better Health expects and requires our employees, members, providers, and contractors to participate in the prevention, reduction, and detection of fraud and abuse. We utilize the following tools to effectively communicate the requirements of our fraud and abuse plan in accordance with federal, state, and local regulations:

- Established lines of authority and reporting responsibilities for the Board of Directors, CEO, Compliance Officer, Committees, and other Aetna Better Health personnel
- Written policies, procedures, and standards of conduct including clear disciplinary guidelines
- Effective lines of communication
- Confidentiality and non-retaliatory protections
- Availability of several well publicized paths for reporting suspected or known fraud and abuse
- Organization-wide initial, annual, and ad hoc trainings
- Internal monitoring and auditing procedures

***Responding to Fraud and Abuse***

Aetna Better Health trains, expects, and requires our employees to respond to and report suspected or known fraud and abuse. Our CO and Board of Directors provide oversight to all reports of suspected or known fraud and abuse. Our written P&Ps promote the timely response to suspected and detected fraud and abuse offenses. Aetna Better Health's CO reports all suspected and known fraud and abuse offenses to DHH's PIU. Aetna Better Health will coordinate and communicate with the PIU to review and investigate fraud and abuse issues.

***Coordinating Fraud and Abuse Complaints and Referrals***

Aetna Better Health's CO will allow the PIU access to relevant information, documentation, electronic data, and preliminary investigations findings to the PIU as follows:

- 1) Complaints received by Aetna Better Health regarding a member's eligibility are referred to the PIU in writing within three (3) business days of referral receipt for review and investigation.
- 2) Complaints received by Aetna Better Health regarding a member's utilization of benefits or against a health care provider are reviewed and investigated by Aetna Better Health. Should this investigation determine that a fraud and abuse offense may exist, Aetna Better Health reports this information to the PIU in writing within three (3) business days.
- 3) Complaints received by Aetna Better Health regarding a network provider or contractor are reviewed and investigated by Aetna Better Health. Should this investigation determine that a fraud and abuse offense may exist, Aetna Better Health reports this information to the PIU in writing within three (3) business days. All suspected or known provider fraud and abuse issues that warrant investigation referred to the PIU will include the following:
  - Name, type, and contact information of the provider suspected of fraud and abuse

- Source of the fraud and abuse complaint or allegation
  - Nature and type of complaint
  - Information regarding the suspected value of the violation
  - Investigation findings and/or disposition of the violation
- 4) Aetna Better Health immediately initiates an investigation upon receipt of a fraud and abuse complaint. Should the preliminary investigation indicate that a fraud or abuse incident may have occurred; Aetna Better Health refers this information to the PIU in writing within three (3) business days. We submit preliminary investigation findings and other relevant information and coordinate with the PIU during the investigation as needed.

***Correcting Fraud and Abuse***

Aetna Better Health takes compliance violations very seriously and is committed to enforcing our written policies, procedures, and standards of conduct through our comprehensive, well-publicized disciplinary guidelines. Employees are educated on required adherence to our compliance program and the resulting discipline following compliance violations during initial and annual training. Disciplinary guidelines are consistently made available to employees through our policies and procedures manual and the employee portal on our website. Aetna Better Health personnel in executive, managerial, and supervisory positions are responsible for understanding, enforcing, and holding employees accountable for compliance with federal and state standards in their respective areas of responsibility. These personnel are responsible for preventing, identifying, reporting, and administering corrective action for compliance violations.

Aetna Better Health will fully support DHH during the evidentiary and corrective action process for any employee, member, provider, contractor, or other party identified as violating fraud and abuse laws, regulations, or requirements. Should Aetna Better Health determine or be notified by DHH that an Aetna Better Health employee has committed a fraud and abuse violation, we will implement the following corrective action as appropriate:

- Retraining
- Written warning
- Performance improvement plan
- Termination
- Criminal prosecution

Upon determination that a provider is in violation of fraud and abuse laws, regulations, or requirements, Aetna Better Health will terminate the provider's contract. We will report the contract termination to DHH and the enrollment broker. We will report the violation to the National Practitioner Data Bank and Health Care Integrity and Protection Data Bank. Aetna Better Health will query the National Practitioner Data Bank and the Health Care Integrity and Protection Data Bank on a monthly basis to identify excluded providers.

***Reporting Fraud and Abuse***

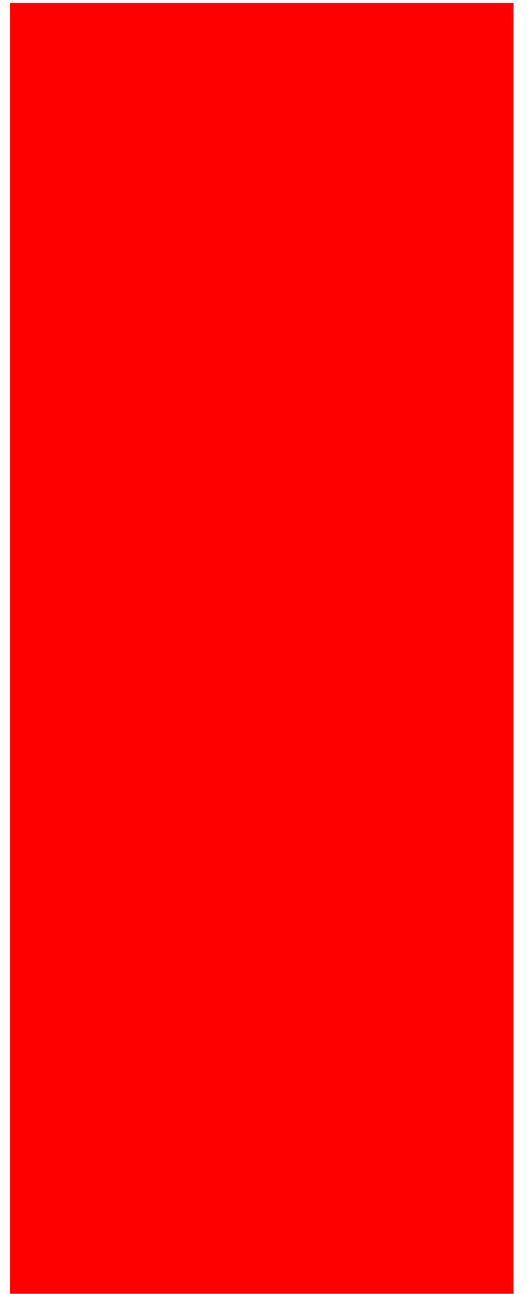
Aetna Better Health takes fraud and abuse very seriously and we understand that reporting potential and suspected fraud and abuse issues to the appropriate entities is key to improving our

processes. Our CO follows our established policies and procedures in reporting fraud and abuse complaints, investigation findings, and violations to the following entities in a timely manner:

- DHH Program Integrity Unit
- Aetna Better Health Board of Directors
- Aetna Better Health CEO
- Aetna Better Health committees including the QMOC, QM/UM, and SIC
- Louisiana OIG as appropriate
- CMS as appropriate

Aetna Better Health will provide a fraud and abuse activity report on a quarterly basis and an annual summary report to DHH. The Aetna Better Health CO will meet with the DHH PIU and the Louisiana Attorney General Medicaid Fraud Control Unit on a quarterly basis for the purpose of exchanging information, collaborating on suspected fraud and abuse activities, and identifying opportunities for improving our processes for preventing, reducing, detecting, correcting, and reporting suspected or known fraud and abuse.

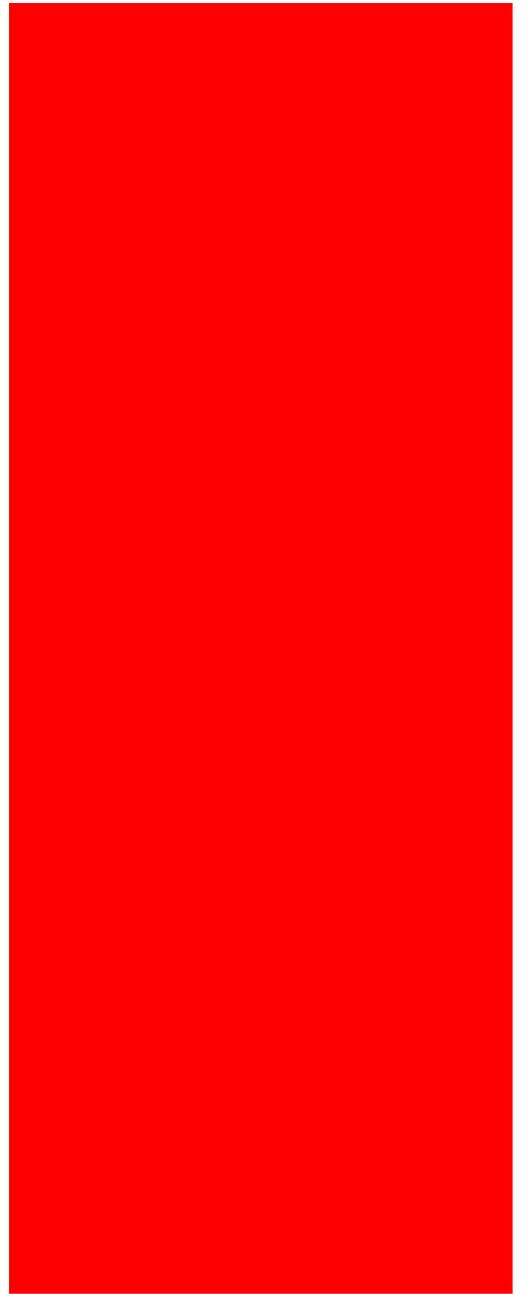
15 B.13



**B.13 Provide copies of any press releases in the twelve (12) months prior to the Deadline for Proposals, wherein the press release mentions or discusses financial results, acquisitions, divestitures, new facilities, closures, layoffs, significant contract awards or losses, penalties/fines/ sanctions, expansion, new or departing officers or directors, litigation, change of ownership, or other very similar issues, Do not include press releases that are primarily promotional in nature.**

Please see Appendix H for copies of press releases from the last 12 months.

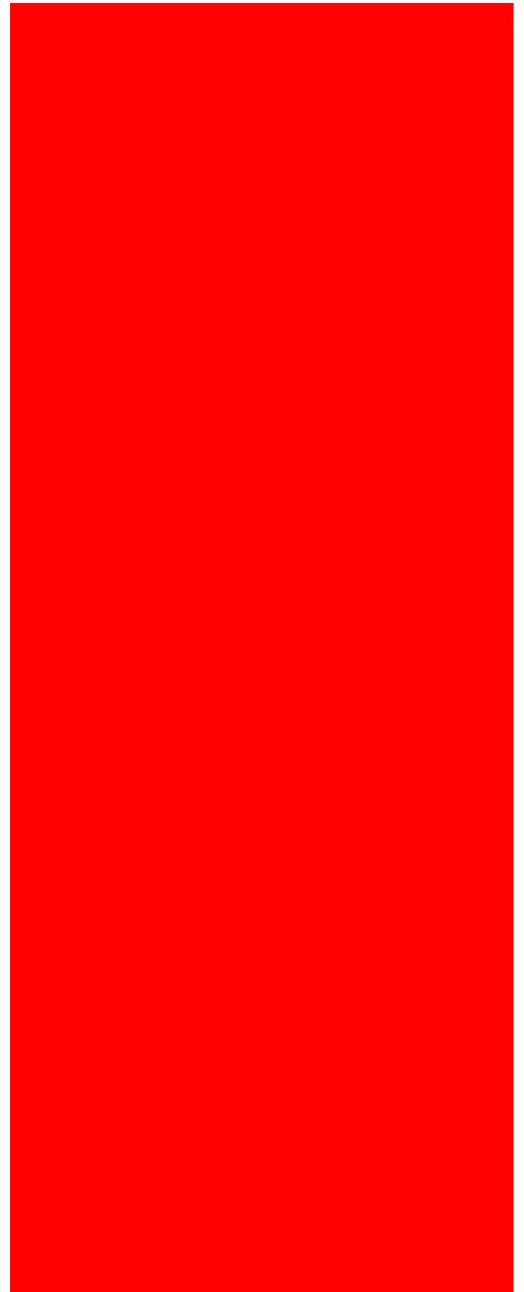
16 B.14



**B.14 Describe your plan for meeting the Performance Bond, other bonds, and insurance requirements set forth in this RFP requirement including the type of bond to be posted and source of funding.**

Aetna Better Health, Inc., a Louisiana corporation, d/b/a Aetna Better Health (“Aetna Better Health”) agrees to secure and maintain bond and insurance requirements in accordance with the RFP for as long as we have contract related liabilities: 1) a performance bond in accordance with the RFP, 2) a blanket fidelity bond on all personnel in its employment in compliance with the RFP, 3). Workers’ Compensation Insurance, 4) commercial liability insurance, 5) Reinsurance, 6) Errors and Omissions Insurance, 7) insurance covering special hazards , 8) licensed and non-licensed motor vehicle and, 8) subcontractor’s insurance.

17 B.15



**B.15 Provide the following information (in Excel format) based on each of the financial statements provided in response to item B:31: (1) Working capital; (2) Current ratio; (3) Quick ratio; (4) Net worth; and (5) Debt-to-worth ratio.**

Please refer to the electronic CD-ROM for the Microsoft Excel version of items 1 through 5 mentioned above.

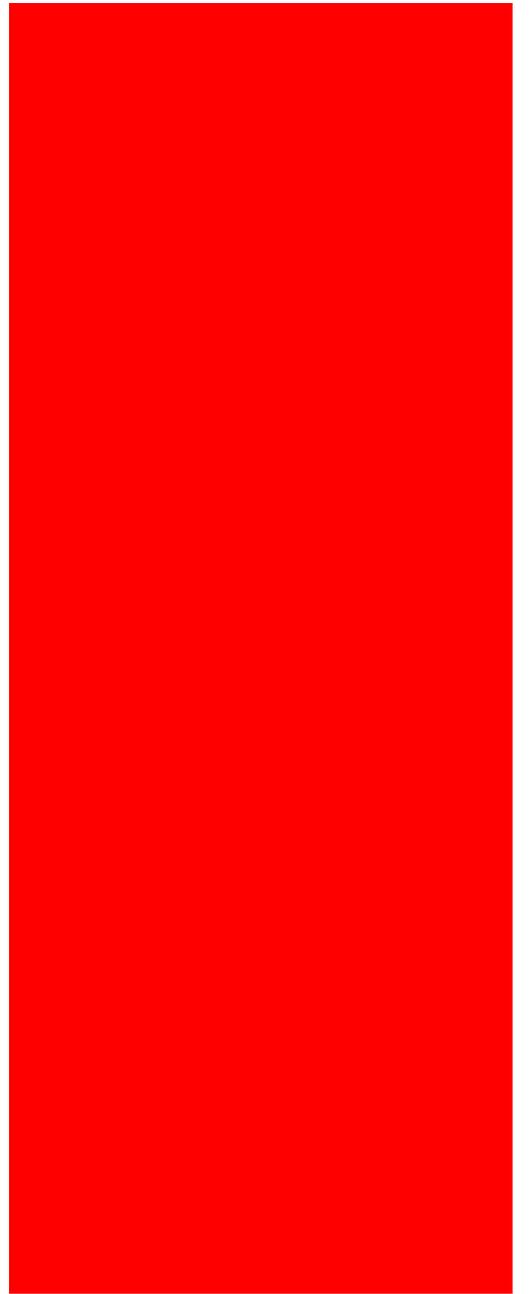
**Aetna Better Health, Inc. - Louisiana Financial Ratios**

	March 30, 2011
Working Capital (in millions)	3,005,246
Current Ratio	1,278.7
Quick Ratio	1,278.7
Net Worth (in millions)	3,005,246
Debt-to-Capital Ratio	No debt

**Aetna Inc. Financial Ratios**

	Dec 31, 2010
Working Capital (in millions)	\$ (1,742.7)
Current Ratio	0.8
Quick Ratio	0.8
Net Worth (in millions)	\$ 9,890.8
Debt-to-Capital Ratio	31%

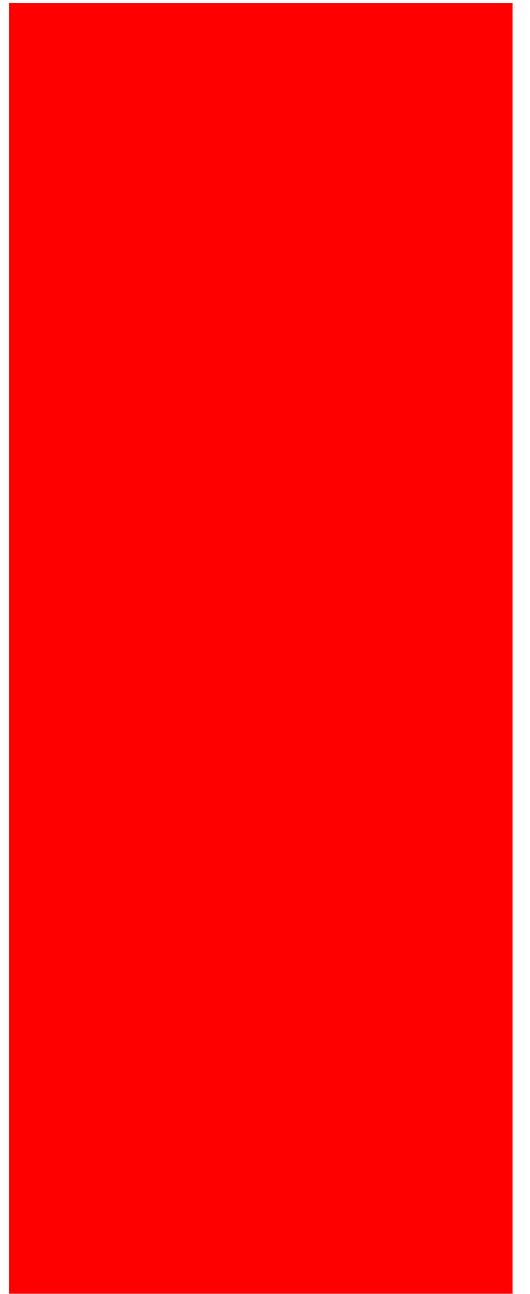
18 B.16



**B.16 Identify, in Excel format, all of your organization's publicly-funded managed care contracts for Medicaid/CHIP and/or other low-income individuals within the last five (5) years. In addition, identify, in Excel format your organization's ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP and/or other low-income individuals within the last five (5) years. For each prior experience identified, provide the trade name, a brief description of the scope of work, the duration of the contract, the contact name and phone number, the number of members and the population types (e.g., TANF, ABD, duals, CHIP), the annual contract payments, whether payment was capitated or other, and the role of subcontractors, if any. If your organization has not had any publicly-funded managed care contracts for Medicaid/SCHIP individuals within the last five (5) years, identify the Proposer's ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP individuals within the last five (5) years and provide the information requested in the previous sentence. Include your organization's parent organization, affiliates, and subsidiaries.**

Aetna Better Health, Inc., a Louisiana corporation, d/b/a Aetna Better Health ("Aetna Better Health") currently holds no managed care contracts. Aetna Better Health's affiliates have operated or administered the Medicaid and CHIP programs as set forth in the chart below. Aetna Better Health's affiliates also offer non-publicly funded, commercial health plans across the country.

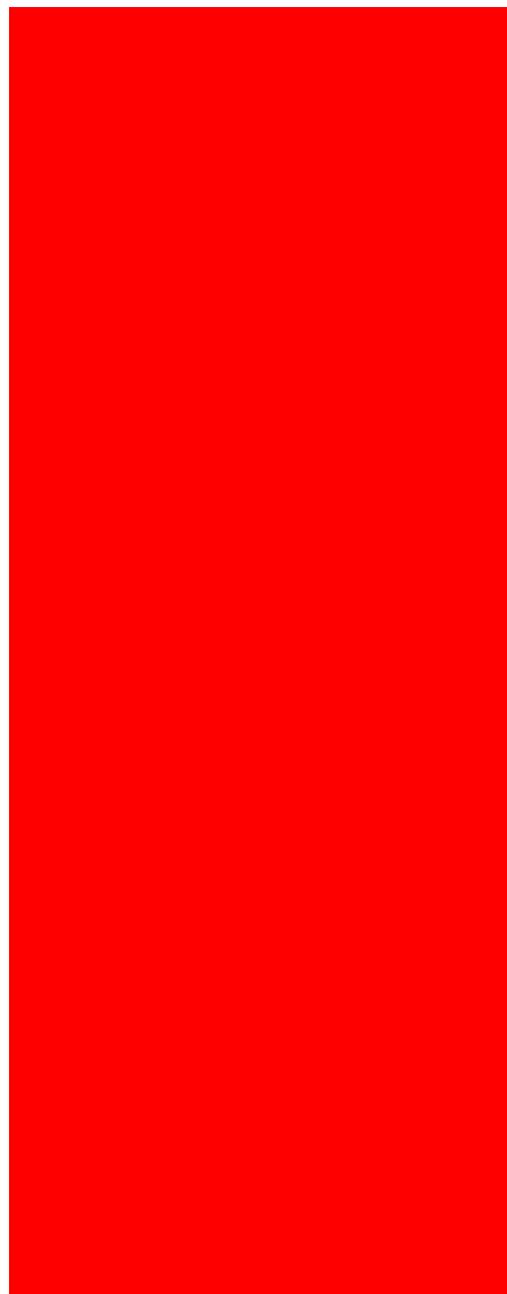
19 B.17



**B.17 Identify whether your organization has had any contract terminated or not renewed within the past five (5) years. If so, describe the reason(s) for the termination/nonrenewal, the parties involved, and provide the address and telephone number of the client. Include your organization's parent organization, affiliates, and subsidiaries.**

Aetna Better Health, Inc. has not had any contracted terminated or not renewed within the past five (5) years. As affiliates of a national health carrier company, the evolution of the business cycle of Aetna's affiliates and that of its customers involve terminations of contracts. These instances are initiated by both Aetna affiliates and the customer. While infrequent, contract terminations are not an unnatural aspect of the business cycle of Aetna's affiliates. We are not aware of any terminations or nonrenewal of any material contracts that were caused by Aetna's non-performance or poor performance. We have never had any Medicaid contract terminated for non-performance or poor performance.

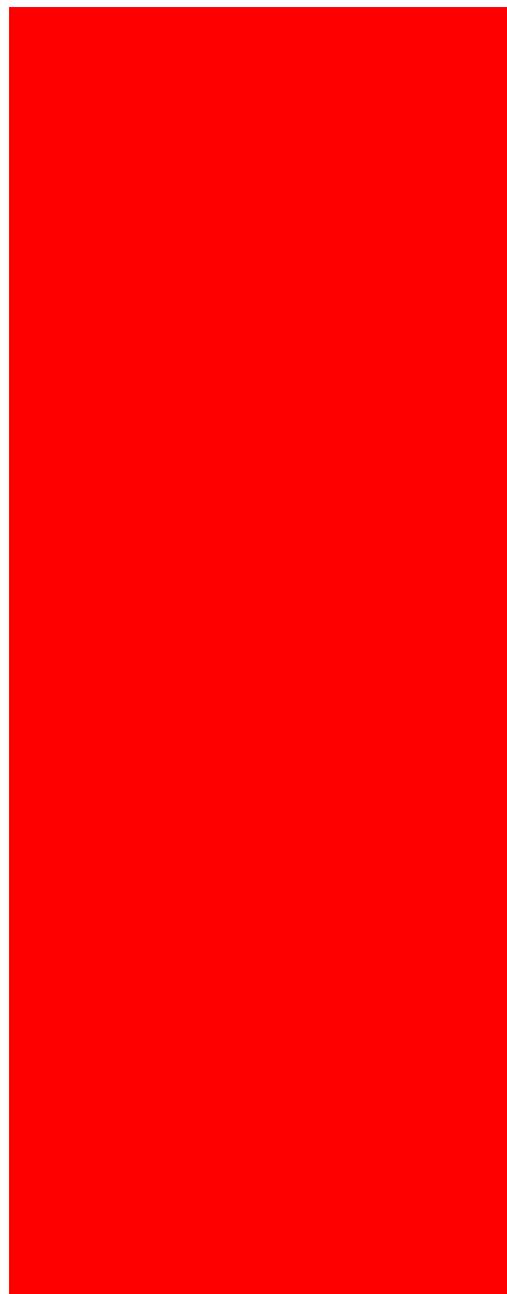
20 B.18



**B.18 If the contract was terminated/non-renewed in B.17 above, based on your organization's performance, describe any corrective action taken to prevent any future occurrence of the problem leading to the termination/non-renewal. Include your organization's parent organization, affiliates, and subsidiaries.**

Not applicable to Aetna Better Health, Inc. As affiliates of a national health carrier company, the evolution of the business cycle of Aetna's affiliates and that of its customers involve terminations of contracts. These instances are initiated by both Aetna affiliates and the customer. While infrequent, contract terminations are not an unnatural aspect of the business cycle of Aetna's affiliates. We are not aware of any terminations or nonrenewal of any material contracts that were caused by Aetna's non-performance or poor performance. We have never had any Medicaid contract terminated for non-performance or poor performance.

21 B.19



**B.19 As applicable, provide (in table format) the Proposer’s current ratings as well as ratings for each of the past three years from each of the following:  
AM Best Company (financial strengths ratings);  
TheStreet.com, Inc. (safety ratings); and  
Standard & Poor’s (long-term insurer financial strength).**

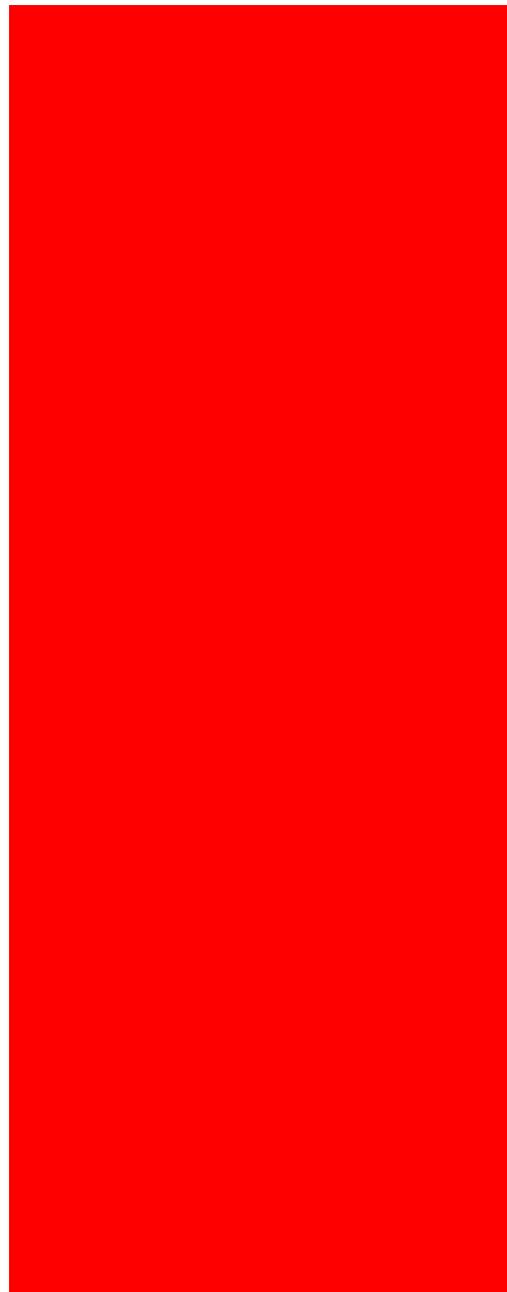
**Aetna Financial Ratings**

	A.M. Best		
	2011	2010	2009
ALIC Financial Strength	A	A	A
Aetna Inc. Long-Term Senior Debt	bbb+	bbb+	bbb+

	Standard & Poor's		
	2011	2010	2009
ALIC Financial Strength	A+	A+	A+
Aetna Inc. Long-Term Senior Debt	A-	A-	A-

	TheStreet.com / Weiss Rating		
	2011	2010	2009
ALIC Financial Strength	B	B	B

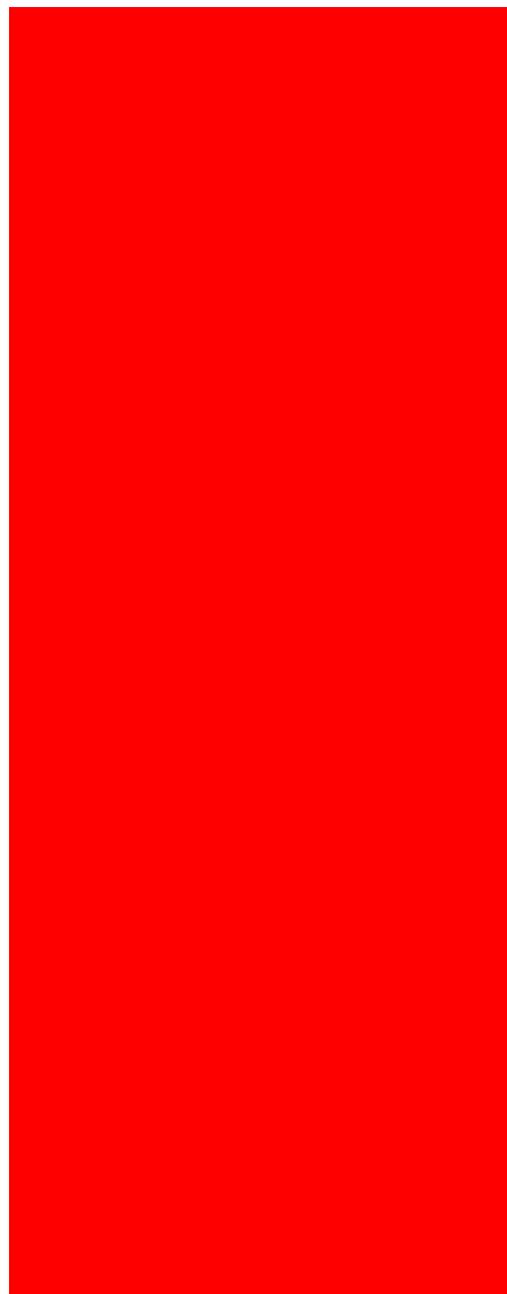
22 B.20



**B.20 For any of your organization's contracts to provide physical health services within the past five years, has the other contracting party notified the Proposer that it has found your organization to be in breach of the contract? If yes: (1) provide a description of the events concerning the breach, specifically addressing the issue of whether or not the breach was due to factors beyond the Proposer's control. (2) Was a corrective action plan (CAP) imposed? If so, describe the steps and timeframes in the CAP and whether the CAP was completed. (3) Was a sanction imposed? If so, describe the sanction, including the amount of any monetary sanction (e.g., penalty or liquidated damage) (4) Was the breach the subject of an administrative proceeding or litigation? If so, what was the result of the proceeding/litigation? Include your organization's parent organization, affiliates, and subsidiaries.**

Aetna Better Health, Inc. is not currently the subject and has never been the subject of a criminal or civil investigation by a state or federal agency. The Aetna organization's current and past business practices are subject to review by various state insurance and health care regulatory authorities and other state and federal authorities, including Attorneys Generals. As a leading national managed care organization, the Company and its affiliates regularly are the subject of such reviews and several such reviews currently are pending, some of which may still be pending. These reviews may result in changes to or clarifications of the Company's and its affiliates' business practices, and have in the past, and in the future may, result in fines, penalties or other sanctions.

23 B.21



**B.21 Indicate whether your organization has ever sought, or is currently seeking, National Committee for Quality Assurance (NCQA) or American Accreditation HealthCare Commission (URAC) accreditation status. If it has or is, indicate current NCQA or URAC accreditation status and accreditation term effective dates if applicable.**

### **Accreditation Status**

Aetna Life Insurance Company was the first national insurer to hold National Committee for Quality Assurance (NCQA) Preferred Provider Organization (PPO) Full Accreditation. Since that initial review in 2007, we have undergone a renewal survey and achieved a three year accreditation designation applicable to all 50 states and Washington DC for the national commercial PPO plan and all of our 22 local Medicare PPO plans in existence at the time of the review. Accreditation designation varies by entity based on HEDIS<sup>®4</sup> and CAHPS<sup>®</sup> results. Thirteen currently hold the Excellent accreditation designation and 31 hold the designation status of Commendable. This accreditation is effective December 22, 2010 through December 22, 2013.

Our national commercial PPO plan also achieved Distinction in both of the Quality Plus modules, (1) Member Connections and (2) Care Management & Health Improvement. These standards assess health plan efforts to provide information and useful resources to help members make better-informed decisions about their health care. Also, our 22 Medicare Advantage PPO plans have achieved PPO Medicare Advantage Deemed Status from NCQA. A health plan achieves Deemed Status based upon the review of standards approved by the Centers for Medicare & Medicaid Services (CMS).

Aetna Better Health is currently seeking accreditation for its Health Plans serving the Medicaid population in Missouri and Pennsylvania. The accreditation application for our Missouri Plan was submitted May 23, 2011 and our application for our Pennsylvania plan is scheduled for submission on September 28, 2011. Upon contract award, Aetna Better Health will submit an application for accreditation for our Louisiana plan at the earliest possible date allowed by NCQA and once achieved, maintain accreditation through the life of the contract. We will provide the Department of Health and Hospitals (DHH) with a copy of all correspondence with NCQA or URAC regarding the application process and the accreditation requirements.

Aetna Better Health takes a proactive approach in preparing for NCQA accreditation. To that end, we use external reviewers to conduct mock audits to assess our policies, processes, and procedures against NCQA standards. A recent mock audit conducted for our Missouri plan revealed that our systems are consistent with NCQA requirements. We will utilize these same preparations in pursuing NCQA accreditation for our Louisiana program.

Regarding Aetna's commercial HMO health plans, all are accredited by NCQA. Accreditation designation varies by entity based on HEDIS<sup>®</sup> and CAHPS<sup>®</sup> results. Eleven currently hold the Excellent accreditation designation and nine hold the designation status of Commendable. In addition, all of these plans also achieved Distinction in both of the Quality Plus modules, (1) Member Connections and (2) Care Management & Health Improvement. Our Medicare

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4 HEDIS is a registered trademark of the National Committee for Quality Assurance.

Advantage HMO plans are all accredited as well. Six of them currently hold Excellent accreditation status, 13 hold the designation status of Commendable, and one is Accredited. All of our 22 Medicare Advantage HMO plans have achieved Medicare Advantage Deemed Status from NCQA.

The following network areas hold NCQA Provisional Physician Quality Review effective until September 2011, the time of our next review:

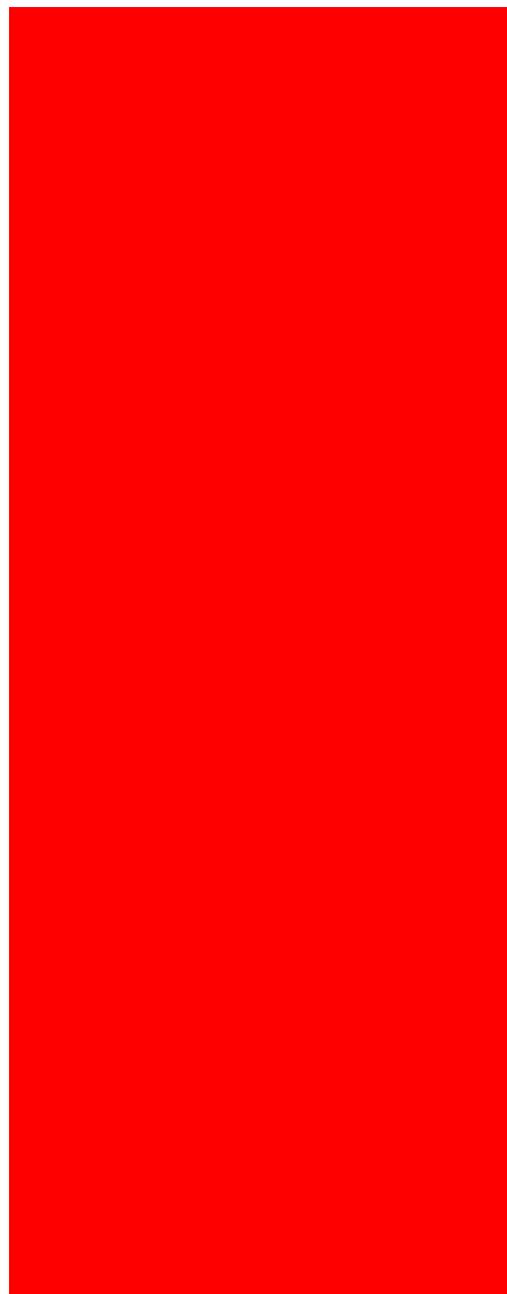
- Atlanta
- California (Los Angeles, San Diego)
- Cincinnati
- Connecticut
- Houston
- Metro DC (Maryland, Northern Virginia and Richmond)
- New York (reviewed by New York Attorney General in February 2009)
- Northern New Jersey
- Oklahoma (Oklahoma City and Tulsa)
- Seattle

Our Credentialing and Application Management (CAM) unit is certified under the NCQA Credentials Verification Organization (CVO) certification program for 10 out of 10 certification options. Certification for these options is considered current and in good standing until January 27, 2013. Our CAM unit has held URAC CVO accreditation since 2003, and current accreditation is effective until October 1, 2012. This unit will be providing credentialing support to our Louisiana program.

Aetna Behavioral Health Utah holds NCQA Full Accreditation status effective through December 2, 2013 for both HMO and PPO Products. Aetna Behavioral Health Pennsylvania also holds NCQA Full Accreditation status effective through January 7, 2014.

Aetna Pharmacy Management holds Full 3 Year Pharmacy Benefit Management Accreditation from URAC. This is effective through November 1, 2013. Additionally, our disease management program received NCQA certification for asthma, CHF, COPD, and diabetes in 2006 and depression in 2010. The current certifications were granted on August 30, 2010 and expire on August 30, 2012.

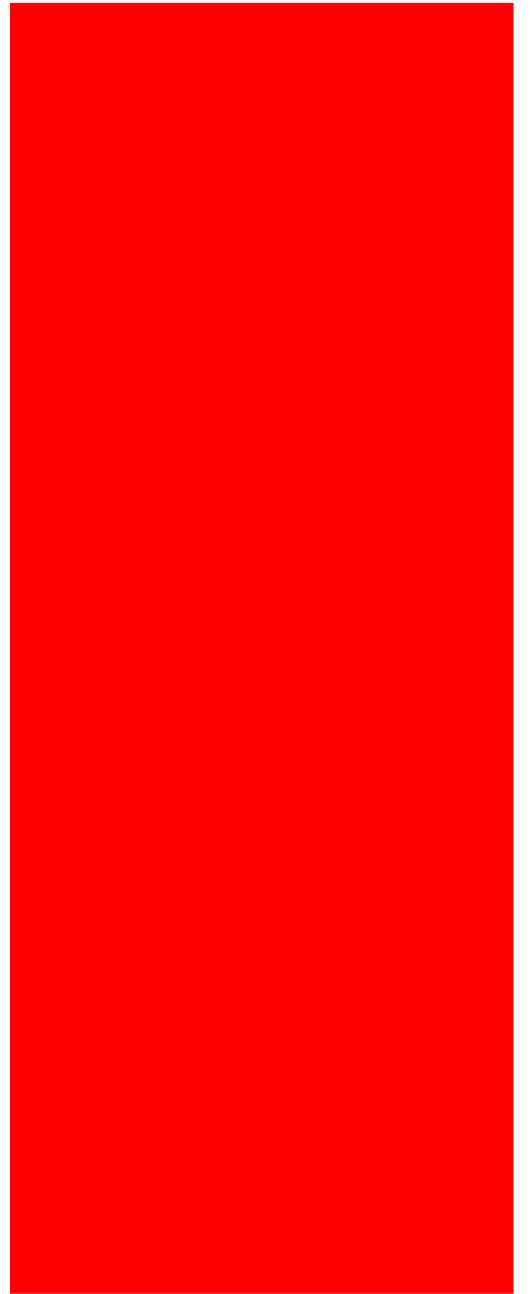
24 B.22



**B.22 Have you ever had your accreditation status (e.g., NCQA, URAC,) in any state for any product line adjusted down, suspended, or revoked? If so, identify the state and product line and provide an explanation. Include your organization’s parent organization, affiliates, and subsidiaries.**

Aetna Better Health, Inc., a Louisiana corporation, d/b/a Aetna Better Health (“Aetna Better Health”) has not had its accreditation status in any product line adjusted down, suspended, or revoked by NCQA.

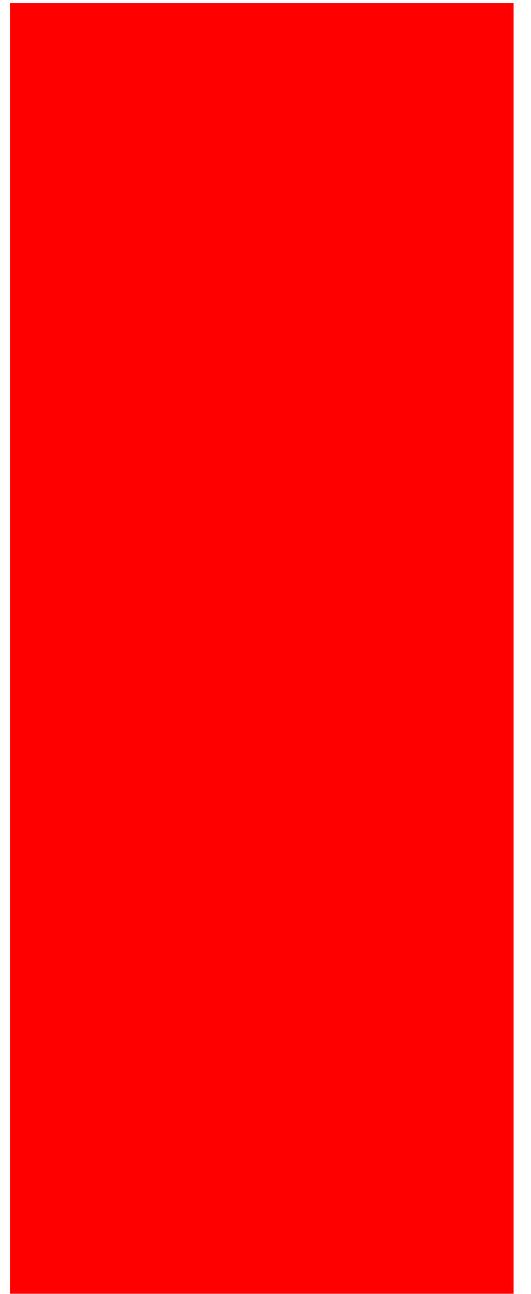
25 B.23



**B.23 If you are NCQA accredited in any state for any product line, include a copy of the applicable NCQA health plan report cards for your organization. Include your organization's parent organization, affiliates, and subsidiaries.**

Please see Appendix I for Aetna Better Health's applicable NCQA health plan report cards.

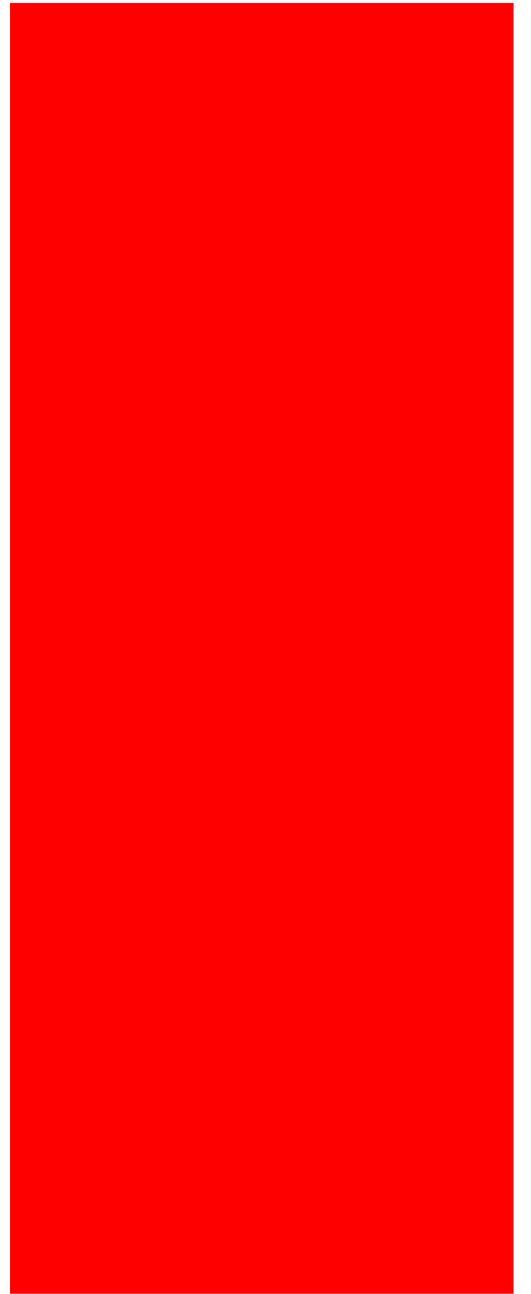
26 B.24



**B.24 Provide (as an attachment) a copy of the most recent external quality review report (pursuant to Section 1932(c)(2) of the Social Security Act) for the Medicaid contract identified in response to item B.16 that had the largest number of enrollees as of January 1, 2011. Provide the entire report. In addition, provide a copy of any corrective action plan(s) requested of your organization (including your organization's parent organization, affiliates, and subsidiaries) in response to the report.**

Please see Appendix I & K for a sample copy of Aetna Better Health's most recent external quality review report and associated corrective action plan.

*27 B.25*



**B.25 Identify and describe any regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against your organization within the last five (5) years. In addition, identify and describe any letter of deficiency issued by as well as any corrective actions requested or required by any federal or state regulatory entity within the last five (5) years that relate to Medicaid or CHIP contracts. Include your organization's parent organization, affiliates, and subsidiaries.**

### Medicaid-related Fines

Date	State	Type	Description	Amount	Company
07/18/2007	TX	Liquidated Damages	Liquidated Damages Assessed by Texas Health and Human Services Commission (This payment was a contract remedy for liquidated damages under our Medicaid contract in Texas. Liquidated damages are not intended to be penalties but are intended to be reasonable estimates of the state's projected financial loss under the contract.)	20,500	Aetna Health Inc.
10/22/2007	TX	Liquidated Damages	Liquidated Damages Assessed by Texas Health and Human Services Commission (This payment was a contract remedy for liquidated damages under our Medicaid contract in Texas. Liquidated damages are not intended to be penalties but are intended to be reasonable estimates of the state's projected financial loss under the contract.)	10,000	Aetna Health Inc.
11/23/2007	AZ	Failure to Comply	Missing Data Validation Records	47,000	Schaller Anderson, LLC
04/01/2008	AZ	Fine	The AZ Health Care Cost Containment System Division of Health Care Management (AHCCCS)(DHCM) imposed monetary penalty for not including specific reasons for denial within 3/11/08 Notice of Action letter. Sanctions amount was withheld from monthly capitation payment made from AZ to Schaller Anderson.	10,000	Southwest Catholic Health Network Corporation dba Mercy Care Plan
05/13/2008	AZ	Fine	The AZ Health Care Cost Containment System Division of Health Care Management (AHCCCS)(DHCM) imposed monetary penalty for not including specific reasons for denial	50,000	Southwest Catholic Health Network Corporation dba Mercy



Date	State	Type	Description	Amount	Company
			within 5 Notice of Action letters dated 9/17/07 -11/27/2007. Sanctions amount was withheld from monthly capitation payment made from AZ to Schaller Anderson.		Care Plan
05/28/2008	AZ	Fine	The AZ Health Care Cost Containment System Division of Health Care Management (AHCCCS)(DHCM) imposed monetary penalty for failing to comply with grievance system requirements described in 3/21/08 and 5/5/08 letters. Sanction amount was withheld from monthly capitation payment made from AZ to Schaller Anderson.	100,000	Southwest Catholic Health Network Corporation dba Mercy Care Plan
05/28/2008	AZ	Fine	The AZ Health Care Cost Containment System Division of Health Care Management (AHCCCS)(DHCM) imposed monetary penalty for untimely notification of request for state FAIR hearing. Sanctions amount was withheld from June monthly capitation payment made from AZ to Schaller Anderson.	10,000	Southwest Catholic Health Network Corporation dba Mercy Care Plan
03/09/2009	TX	Liquidated Damages	Deliverable Requirement-Provider Hotline -Texas Health and Human Services Commission (THHSC) assessed a fine for non-compliance with a performance measure in the State Medicaid/CHIP Contract. In accordance with Attachment B-1, Section 8.1.4.7 & 8.1.15.3, the HMO must ensure that the call abandonment rate is 7% or less. The performance achieved for the first quarter 2009 was 13.83%. THHSC assessed liquidated damages of \$2,400. Check was overnighted to the state on 3/9/09.	2,400.	Aetna Health Inc.
06/05/2009	TX	Fine	Texas Health and Human Services Commission assessed a fine for non-compliance with contract performance for the Aetna Medicaid risk business.	63,380	Aetna Health Inc.
02/05/2010	AZ	Contract Sanction	On January 14, 2010, Mercy Care Plan was notified of a \$10,000 sanction for one Notice of Action letter that did not meet regulatory standards. The letter was identified as deficient through a	10,000	Mercy Care Plan



Date	State	Type	Description	Amount	Company
			routine audit conducted by the Arizona Health Care Cost Containment System (AHCCCS). AHCCCS is the single state agency responsible for oversight of Arizona's Medicaid program. The \$10,000 sanction will be withheld from the February capitation payment, which will occur on Friday, February 5, 2010.		
06/18/2010	TX	Contract Sanction	Texas Health and Human Services Commission (THHSC) assessed a fine for non-compliance with contract performance measures for our Aetna Medicaid (TPA) business	9,859	Parkland Community Health Plan
07/01/2010	TX	Contract Sanction	Texas Health and Human Services Commission (THHSC) assessed a fine for non-compliance with contract performance measures for our Aetna Medicaid risk business.	10,000	Aetna Better Health, Inc.
07/09/2010	TX	Contract Sanction	On June 23, 2010, Texas Health and Human Services Commission (THHSC) assessed fines for non-compliance with contract performance measures for our TPA business (Parkland Community Health Plan).	9,975	Parkland Community Health Plan
07/12/2010	PA	Contract Sanction	Aetna's PA CHIP product (under AHI) - capitation is being withheld (Pennsylvania CHIP will need to withhold the dental portion of Aetna's CHIP reimbursement rates effective August 1, 2010 until Aetna provides the dental claims/encounter data. Since Aetna's CHIP rates are not being adjusted, the CHIP Enrollees' monthly payments should not be adjusted. Eventually, Aetna will receive the full CHIP PMPM rates and the Enrollees should be paying their percentage of the full PMPM rate, accordingly.)	No Fines	Aetna Health Inc. (PA CHIP)
09/29/2010	MD	Contract Sanction	Aetna (under Schaller Anderson, LLC) is the administrator for the Medicaid plan, Maryland Physicians Care (MPC). MPC was sanctioned, such that we will not be auto-assigned members in one service area for the month of Oct. I'm not sure whether we need to report this action to other state DOIs. Note: the MD sanction is not a sanction against	No Fines	Maryland Physicians Care

Date	State	Type	Description	Amount	Company
			Aetna or Schaller Anderson rather a sanction against MPC the health plan which is not an Aetna owned Health plan.		
09/30/2010	TX	Contract Sanction	Parkland Community Health Plan must comply with the contract requirements and performance standards as described in the HHSC Uniform Managed Care Contract. For the 3rd Quarter 2010 Parkland Community Health Plan. was below the performance standard.	17,500	Parkland Community Health Plan

### Commercial Business Fines

Date	State	Type	Description	Amount	Company
02/08/2006	CT	Utilization Review	Failure to provide notification of a determination not to certify care within two (2) business days of the request for service; failure to provide notification of an appeal determination within 30 days of the appeal request; failure to provide Connecticut external appeal language; failure to provide written appeal responses to the provider of record; failure to provide accurate statistical information to the Department for the period of 01/01/04 to 12/31/04.	4,000	Aetna Health Management, LLC (DE)
02/15/2006	NY	Prompt Pay Law	Failure to pay certain claims within the time limitations specified in the prompt payment law Section 3224-a for the period of 04/05/05 - 09/30/05; Companies agreed to review overdue claims and pay interest.	37,900	Aetna Health Inc. (NY) - \$32,200. Aetna Life Insurance Company - \$5,500. Aetna Health Insurance Company of NY - \$200.00
02/23/2006	WA	Failure to File	Failure to timely file its calendar year loss ratios for 1999, 2001, 2002, 2003, and 2004	5,000	Aetna Health Inc. (WA)
03/01/2006	OR	Claim Settlement	Failure to acknowledge and act promptly upon communication about a claim ORS 746.230(1)(b) and for failure to promptly and equitably settle a claim ORS 746.230(1)(f).	5,000	Chickering Claims Administrators, Inc.

03/20/2006	AZ	Market Conduct Exam	Targeted Market Conduct Exam of life and disability insurance: Violation of ARS §20-461(A)(17) and (B) for the period of 09/01/02 through 08/31/04 by improperly limiting the benefit payable on claims for spinal services/treatment for covered benefits provided by licensed providers. A cease and desist order was issued.	7,500	Aetna Life Insurance Company (ALIC)
03/28/2006	PA	Utilization Review	Utilization Review Audit Report for year 2005 by Bureau of Managed Care of the Department of Health: For violation of §991.2181(a) and (d) commonly referred to as "Act 68". This provision requires records and documents that are part of any complaint or grievance be made available to insurance department upon request.	10,500	Aetna Health Inc. (PA)
04/03/2006	NV	Administrative	Failure to provide \$25.00 filing fee; failure to Annual Report verified by two (2) officers; failure to provide client list including names and addresses of clients.	500	Strategic Resource Company
04/25/2006	CT	Market Conduct Exam	Market Conduct Exam of the period of 01/03/2005 through 10/29/2005 for violation of agent appointment practices; failure to pay claims within 45 days; failure to pay interest on claims over 45 days; failure to pay claims without conducting a reasonable investigation; failure to maintain sufficient complaint handling procedures; failure to adequately document appeal decisions; failure regarding EOB issue; failure to include mandated behavioral health benefit language on conversion policy submissions; failure to maintain sufficient documentation for regulatory review and to take corrective action for producer appointments, as required under complaint, stipulation, and final order executed on 04/03/01.	47,500	Aetna Health Inc. (CT)

04/25/2006	CT	Market Conduct Exam	Market Conduct Exam of the period of 01/03/2005 through 10/29/2005 for violation of agent appointment practices; failure to pay claims within 45 days; failure to pay interest on claims over 45 days; failure to pay claims without conducting a reasonable investigation; failure to maintain sufficient complaint handling procedures; failure to adequately document appeal decisions; failure regarding EOB issue; failure to maintain sufficient documentation for regulatory review.	28,500	Aetna Life Insurance Company (ALIC)
04/28/2006	PA	Prompt Pay Law	Failure during 2005 of its third party administrator, Magellan Behavioral Health Systems LLC to pay clean claims and the uncontested portions of a contested claim of subsection (d) of Title 31, Pennsylvania Code, Section 154.18, submitted by a health care provider for services provided on or after 01/01/1999 within 45 days of the licensed insurer's or managed care plan's receipt of the claim from the health care provider. A cease and desist order was issued.	45,000	Aetna Health Inc. (PA)
06/13/2006	NJ	Market Conduct Exam	Failure to conform to all of the requirements of the Prompt Pay regulations regarding paying clean mailed claims within 40 days and electronically submitted claims within 30 days during the period of 04/01/2000 through 03/31/2001.	200,000	Aetna Health Inc. (NJ)
06/16/2006	DE	Administrative	Failure to report an administrative action taken by another state to the Delaware Insurance Department. Specifically, the 04/03/2006 administrative fine by the State of Nevada Business & Industry, Division of Insurance for failure to provide \$25.00 filing fee; failure to Annual Report verified by two (2) officers; failure to provide client list including names and addresses of clients.	200	Strategic Resource Company

06/20/2006	NE	Clean Claim	Violations regarding paying clean claims within 15 days after receiving initial claim submission and regarding failure to send a claim's delay letter within 15 days from when the proof of loss was received.	7,500	Chickering Claims Administrators, Inc.
07/05/2006	CA	Knox-Keene Act	Failure to accept and resolve the enrollee's oral grievance within 30 calendar days of receipt as required by statute.	2,500	Aetna Health of California, Inc.
08/01/2006	NY	Conducted Surveys	Violations of Article 44 of the Public Health Act and 10NYCRR Part 98 regarding Statements of Deficiencies based on surveys issued by the State of New York Department of Health in 2002, 2003, and 2005.	6,000	Aetna Health Inc. (NY)
08/08/2006	CA	Enrollee Grievances	Failure by the Plan to communicate and resolve employee grievances including 30-day grievance resolution and appeal violations, failure regarding timely acknowledgement of grievances, not including plan contact information, not including required language and regarding Urgent Grievance System violations.	30,000	Aetna Dental of California
08/24/2006	CA	Knox-Keene Act	Continuing to be in violation in a follow up medical survey in January of 2005 of file dates 04/2004 through 08/2004. In particular, the follow up survey found acknowledgement letters were not sent to the complainant within five (5) calendar days of the receipt of the grievance as required. Grievance resolution letters were not issued to complainant within 30 days of receipt of the grievance. These deficiencies were brought to the Plan's attention in 2003.	40,000	Aetna Health of California, Inc.
09/14/2006	NH	Targeted Market Exam	Desk Review Targeted Market Exam: Failure to pay claims in a timely manner and by failing to pay the proper amount of interest on overdue claims in violation of RSA 420-J:8-a, III (a).	2,500	Aetna Life Insurance Company (ALIC)
09/18/2006	KY	Prompt Pay Law	Violation of the Prompt Pay Act for its failure to meet the standards for the payment of clean claims as set forth in KRS 304.99-123(2) as reported for the second quarter of 2005.	5,000	Aetna Life Insurance Company (ALIC)

09/18/2006	KY	Prompt Pay Law	Violation of the Prompt Pay Act for its failure to meet the standards for the payment of clean claims as set forth in KRS 304.99-123(2) as reported for the third quarter of 2005.	5,000	Aetna Life Insurance Company (ALIC)
09/26/2006	NY	Prompt Pay Law	Failure to pay interest as required under Section 3224-a of the Insurance Law on claims between 04/01/2006 and 06/01/2006. Each respondent acknowledges that this stipulation and any admission therein may be used against them in future proceedings.	8,400	Aetna Health Inc. (NY) - \$6,000.00 Aetna Life Insurance Company (ALIC) - \$2,200. Aetna Health Insurance Company of NY - \$200.
10/24/2006	CA	Late Paid Claims	Violation of Health and Safety Code Section 1371 and 1372.35 by failing to correctly calculate and pay interest on specific late-paid claims. Additionally Aetna failed to pay penalties in accordance with the \$10.00 fee that is paid to claimants for late-paid claims that did not include interest.	150,000	Aetna Health Inc. of California
12/07/2006	WA	Rate Filing	Use of conversion rates that were different than those approved by the OIC.	7,000	Aetna Health Inc. (WA)
<b>2007</b>					
01/09/2007	AR	Failure to Notify	For failure to notify removal of representative (due to termination of employment)	200	Strategic Resource Company
01/18/2007	KY	Prompt Pay Law	For failure to meet the standards for payment of clean claims as set forth in KRS 304.99-123(2), as reported for the fourth quarter, 2005	17,000	Aetna Life Insurance Company
02/02/2007	OH	Market Conduct Exam	Market Conduct Exam for the period 01/01/02 – 12/31/03: For noncompliance with requirements regarding certificates of creditable coverage; conversion issues and policy language.	30,000	Aetna Health Inc. (OH)
02/06/2007	OH	Market Conduct Exam	Market Conduct Exam for the period 01/01/02 – 12/31/03: For noncompliance with requirements regarding certificates of creditable coverage; conversion issues and policy language.	30,000	Aetna Life Insurance Company

03/21/2007	NY	Prompt Pay Law	For failure to process certain claims within the time limitations specified in Section 3224-a of the Insurance Law	11,700	Aetna Health, Inc. - \$10,400. Aetna Life Insurance Company (ALIC) - \$1,000. Aetna Health Insurance Company of NY - \$300.00
03/28/2007	OH	Prompt Pay Law	Prompt Pay: Failure to Timely Pay Tax and Failure to File or Timely File a Report	3,985	Strategic Resource Company
04/26/2007	NV	Administrative Fine	For failure to file its Annual Operation Report for the Small Employer Market due March 1, 2005 pursuant to NAC 689C.160(1).	1,500	Corporate Health Insurance Company
05/10/2007	NV	Administrative Fine	For failure to file its Annual Operation Report for the Small Employer Market by the due date of March 1, 2005, pursuant to NAC 689C.160(1).	1,500	Aetna Health Inc.
05/18/2007	PA	Act 68 Audit	Audit Conducted by Bureau of Managed Care of the Department of Health pursuant to its responsibilities under section 2181(a) and (d) of the Insurance Company Law of 1921, commonly referred to as "Act 68."	18,000	Aetna Health Plan, Inc.
06/07/2007	MD	Disciplinary Action	Disciplinary Action stemming from a complaint concerning language used in a specific appeal letter dated September 11, 2006.	500	Aetna Life Insurance Company
06/12/2007	TX	Failure to Identify	Failure to Identify and Reprocess routine OB ultrasound claims that were denied incorrectly	45,000	Aetna Health Inc.
07/26/2007	NY	Prompt Pay Law	Prompt Pay Laws: for failure to process certain claims within the time limitations in NY Insurance Law	9,200	Aetna Health Inc. - \$4,600. Aetna Life Insurance Company (ALIC) - \$4,400. Aetna Health Insurance Company of NY - \$200.

08/03/2007	CA	Enforcement Action	Enforcement action for deficiencies relater to appeals letter content and timeliness.	2,500	Aetna Health of California, Inc.
08/13/2007	FL	Market Conduct Exam	Limited Scope Market Conduct Exam for the period 04/01/05 – 09/23/05: Deficiencies related to an exam over the Vital Savings Dental plan. Findings include: failure to properly execute group contracts; use of unapproved forms and agreements; refunds; incorrect font size; and lack of proper disclosures.	4,000	Aetna Life Insurance Company
08/14/2007	CT	Failure to Timely File	Failure to timely file a Consumer Report Card Survey	100	Aetna Life Insurance Company
08/14/2007	CT	Failure to Timely File	Failure to timely file a Consumer Report Card Survey	100	Aetna Health Inc.
08/16/2007	LA	Failure to Notify	Department alleged failure to file Change of Officer	1,000	Aetna Health Management, LLC
08/16/2007	FL	Failure to File	Failure to file rating manual and rate adjustment standards.	15,000	Aetna Life Insurance Company
08/21/2007	FL	Failure to File	Failure to file rating manual and rate adjustment standards.	15,000	Aetna Health Inc.
08/28/2007	MS	Failure to Timely Renew	Failure to timely renew TPA License.	50	Strategic Resource Company
09/20/2007	MD	Disciplinary Action	Disciplinary Action stemming from a provider complaint for failing to include within the denial letter information required for an appeal decision.	1,000	Aetna Health Inc.
10/19/2007	CA	Enforcement Action	Enforcement action for a specific grievance that was resolved beyond the thirty day requirement.	2,500	Aetna Health Inc.
11/28/2007	CA	Enforcement Action	Enforcement action for deficiencies within a specific notice regarding denial of authorization to participate in a clinical study.	20,000	Aetna Health Inc.
11/29/2007	CT	Market Conduct Exam	Market Conduct Exam for the period 01/01/06 – 12/31/06: Findings include: failure to provide appeal determinations and determination not to certify care within require timeframes, and failure to properly provide appeal language.	2,000	Aetna Health Management, (DE) LLC

11/29/2007	CT	Market Conduct Exam	Market Conduct Exam for the period 01/01/06 – 12/31/06: Findings include: failure to provide appeal determinations and determinations not to certify care within require timeframes, failure to properly provide appeal language, failure to notify provider of record and enrollee of appeal response, and inclusion of inaccurate information within annual statistical information provided to the Department.	4,500	Aetna Life Insurance Company
12/17/2007	CA	Failure to Comply	The Plan received the enrollee's grievance on 3/6/06 & resolved the enrollee's grievance on 6/14/06. The Plan failed to accept & resolve the grievance within 30 calendar days of receipt as required by Health & Safety Code section 1368.01 (a) & 28 CCR § 13	2,500	Aetna Health of California, Inc.
2008					
01/11/2008	n/a	Audit	ARxHD is entering into a settlement agreement with the U.S. Department of Justice to resolve civil allegations by the Drug Enforcement Administration (DEA) that ARxHD failed to keep proper records of controlled substance inventory and dispensing as required by Sections 842(a)(5) and 842(c)(1)(B) of the federal Controlled Substances Act of 1970. Aetna will be reimbursed by Pharmacare.	- 450,000	Aetna RX Home Delivery
02/14/2008	NV	Administrative Fine	Aetna Health Inc. failed to file its annual quality of health care report by the due date, 3/1/07.	500	Aetna Health Inc.
03/05/2008	MD	Administrative Fine	Aetna Health Inc. violated § 15-10A-02(f)(2)(v)1 of the Insurance Article, pursuant to §19-730 (a)(2)(i) of the Health-General Article and § 27-305 of the Insurance Article when it failed in its adverse decision letter to provide the proper statutory time frame within which a member may file a complaint with the Commissioner (i.e. 30 <b>working</b> days after receipt of Grievance Decision).	1,000	Aetna Health Inc.

03/19/2008	NY	Civil Penalties	Violation of Section 3224-a of the Insurance Law-Review all overdue claims & payments made between 10/1/07 through 12/31/07 & to pay interest at the rate of 12% per annum, to be computed from date the claim or payment was required to be made. When interest payment is less than \$2, it is not required to be paid.	3,800	Aetna Health Inc.
03/19/2008	NY	Civil Penalties	Violation of Section 3224-a of the Insurance Law-Review all overdue claims & payments made between 10/1/07 through 12/31/07 & to pay interest at the rate of 12% per annum, to be computed from date the claim or payment was required to be made. When interest payment is less than \$2, it is not required to be paid.	4,900	Aetna Life Insurance Company
03/19/2008	NY	Civil Penalties	Violation of Section 3224-a of the Insurance Law-Review all overdue claims & payments made between 10/1/07 through 12/31/07 & to pay interest at the rate of 12% per annum, to be computed from date the claim or payment was required to be made. When interest payment is less than \$2, it is not required to be paid.	100	Aetna Health Ins. Co. of NY
03/19/2008	PA	Utilization Review Audit Report	Utilization Review Audit Report for the year 2007 resulted in a \$3,000 fine which was paid on 3/19/08	3,000	Aetna Health Inc.
03/24/2008	VA	Market Conduct Exam Monetary Penalties	Market Conduct Exam found alleged violations of the Unfair Trade Practices Act, Rules Governing Advertisement of Accident & Sickness Insurance, & Rules Governing Health Maintenance Organizations	36,000	Aetna Health Inc.
04/28/2008	VA	Civil Penalties	Alleged Violations of Sections 38.2-510 A 5, 38.2-3407.1 B (claims submitted by out-of-state providers requesting payment of services provided to VA insureds) of the Code of VA and 14 VAC 5-400-60 A (requires insurer to notify the first party claimant of the acceptance or denial of a claim within 15 working days of receipt of a properly executed proof of loss).	4,000	Aetna Life Insurance Company

05/05/2008	Canada	Penalty	The Canadian Office of the Superintendent of Financial Institutions issued a Notice of Violation for not submitting "returns and related documents" timely and/or accurately during 1st quarter of 2008.	2,100	Aetna Life Insurance Company
05/28/2008	DE	Fine	Alleged violation of 18 Del. C. §1512(f) by releasing deposited assets from Commerce Bank, N.A. Delaware without first apply to and receiving the written order of the Commissioner.	2,000	Aetna Health Inc.
06/02/2008	CO	Fine	Aetna failed to provide a complete and timely response to an Insurance Department inquiry as provided by Regulation 1-1-8.	500	Aetna Life Insurance Company
06/17/2008	MD	Administrative Fine	Aetna violated §15-10A-02(i)(1)(ii)4.A. when it failed in its grievance decision letter to provide proper statutory time frame within which a member may file a complaint with the Commissioner (30 working days).	1,000	Aetna Life Insurance Company
07/09/2008	MN	Civil Penalty	Aetna failed to pay or deny a health insurance claim within 30 calendar days after receipt of the "clean" claim.	1,500	Aetna Life Insurance Company
08/18/2008	CO	Fine	Aetna failed to provide a complete and timely response to an Insurance Department inquiry as provided by Regulation 1-1-8.	500	Aetna Life Insurance Company
09/09/2008	MA	Administrative Action	SRC entity at issue is being sanctioned in their capacity as a licensed producer.	No Fines	Strategic Resource Company
09/08/2008	CA	Administrative penalty	Aetna Health of CA assessed administrative penalty for failure to identify grievance as one to be handled in expedited fashion.	2,500	Aetna Health of California
10/06/2008	OR	Civil Penalties	ALIC assessed civil penalty for violation of Prompt Pay Health Claim	2,000	Aetna Life Insurance Company
10/28/2008	WI	Administrative penalty	Failure to timely pay appointment billing fee; ordered to pay forfeiture amount of \$500.	500	Aetna Health Insurance Company
11/04/2008	IN	Fine	Failure to respond to complaint within 20 business days of receipt (Indiana Code §27-4-1-5.6)	500	Aetna Life Insurance Company
11/11/2008	CO	Fine	Failure to provide a complete and timely response to a Division Inquiry	575	Aetna Life Insurance Company

11/11/2008	CO	Fine	Failure to provide a complete and timely response to a Division Inquiry	575	Aetna Life Insurance Company
11/21/2008	CO	Fine	Failure to provide a complete and timely response to a Division Inquiry	575	Aetna Life Insurance Company
11/21/2008	CO	Fine	Failure to provide a complete and timely response to a Division Inquiry	575	Aetna Life Insurance Company
12/30/2008	FL	Administrative Costs	Aetna Life Insurance Co. violated section 624.318 of Florida statutes in which no policy is delivered or issued for delivery unless such application has been taken through a duly licensed and appointed agent.	3,000	Aetna Life Insurance Company
12/30/2008	FL	Administrative Costs	Aetna Health Inc. violated section 624.318 of Florida statutes in which no policy is delivered or issued for delivery unless such application has been taken through a duly licensed and appointed agent.	3,000	Aetna Health Inc.
<b>2009</b>					
01/15/2009	NY	Attorney General Administrative Action (09-005)	The NY Attorney General initiated an industry-wide investigation into certain health insurer's business practices relating to out-of-network benefit payments. Aetna Life Insurance Company allegedly violated Section 349 of the NY General Business Law prohibiting deceptive acts or practices in the conduct of any business, Section 2601(a) of the NY Insurance Law prohibiting insurers from engaging in unfair claims settlement practices and NY Executive Law Section 63(12) alleging repeated fraudulent and illegal conduct. An Assurance of Discontinuance was entered into January 15, 2009. Aetna agreed to no longer use the Ingenix database in determining out-of-network reimbursements. Aetna paid \$60,000 for costs incurred in the cost of the investigation.	No Fines	Aetna Inc.

02/02/2009	NY	Attorney General Administrative Action (09-007)	The NY Attorney General initiated an industry-wide investigation into certain health insurer's business practices relating to student health plan benefit payments. Aetna Life Insurance Company & Chickering allegedly violated Section 349 of the NY General Business Law prohibiting deceptive acts or practices in the conduct of any business, Section 2601(a) of the NY Insurance Law prohibiting insurers from engaging in unfair claims settlement practices and New York Insurance Law, section 3224-a, requiring claims to be paid within 45 days. An Assurance of Discontinuance was entered into February 2, 2009. Aetna agreed to no longer use the Ingenix database in determining benefit payments.	No Fines	Aetna, Inc. The Chickering Group (Aetna Student Health) Chickering Claims Administrators, Inc. Chickering Benefit Planning Insurance Agency, Inc.
02/02/2009	MD	Market Conduct Exam	Maryland Insurance Administration conducted a comprehensive examination of business from 1/1/2003 - 12/31/2004. The examination concluded that there was numerous violations of the MD Insurance Article. Aetna paid an administrative penalty of \$75,000	75,000	Aetna Life Insurance Company
02/05/2009	TX	Attorney General	Aetna Life Insurance Company & Chickering allegedly violated Deceptive Trade Practices-Consumer Protection Act, Texas Business & Commercial Code and the Texas Insurance Code, Chapter 541, by failing to update data used to determine the reasonable charge for payment of out-of-network services provided by physicians and other providers on student health insurance claims. An Assurance of Voluntary Compliance Under Executive Law §63(15) was entered into on February 5, 2009 and \$30,237.00 in investigation costs and expenses were paid.	No Fines	Aetna Life Insurance Co. Chickering Claims Administrators, Inc. Chickering Benefit Planning Insurance Agency, Inc. The Chickering Group (Aetna Student Health)

02/19/2009	MD	Market Conduct Exam	The Maryland Insurance Administration conducted an investigation relating to benefit summaries in the marketing materials to determine if they accurately describe out-of-network benefits. The conclusion was that Aetna Life Insurance Company violated Md. Insurance Article §27-202(1) and § 19-729(a)(5). Aetna Life Insurance Co. will ensure that all Summaries will clearly define the member's obligation & how reimbursement for out-of-network services are calculated. Aetna Life Insurance Company paid an administrative penalty of \$50,000.	50,000	Aetna Life Insurance Company
02/24/2009	MD	Administrative Penalty	The Maryland Insurance Administration conducted an investigation relating to benefit summaries in the marketing materials to determine if they accurately describe out-of-network benefits. The conclusion was that Aetna Health Inc. violated Md. Insurance Article §27-202(1) and § 19-729(a)(5). Aetna Health will ensure that all Summaries will clearly define the member's obligation & how reimbursement for out-of-network services are calculated. Aetna Health Inc. paid an administrative penalty of \$50,000.	50,000	Aetna Health Inc.
03/11/2009	KY	Civil Penalty	A consumer complaint investigation by the KY DOI revealed non-compliance with KRS 304.17A-150(8) regarding unfair claims settlement. Aetna Health Inc. agreed to correct deficiencies in EOBs. Aetna Health Inc. will also resolve all computer glitches to ensure that all insureds receive an explanatory letter when applicable. Aetna Health Inc. paid a \$5,000 civil penalty for engaging in unfair trade practices.	5,000	Aetna Health Inc.

03/13/2009	NY	Civil Penalties	Aetna Health, Inc., Aetna Life Insurance Company & Aetna Health Insurance Company of NY failed to pay certain claims within the time limitations specified in Section 3224-a of the Insurance Law for the period from 10/1/07 - 09/30/08.	72,500	Aetna Health Inc. - 24,750. Aetna Life Insurance Company - 44,750. Aetna Health Insurance Company of NY - 3,000.
03/19/2009 (note: added 3/03/2010)	CA	Administrative Penalty	Aetna Health of California, Inc. failed to resolve an enrollee's grievance within 30 days (violation of Health and Safety Code section 1368.01, subdivision (a) and California Code of Regulations, title 28, section 1300.68, subdivision (d)(3) and assessed the Company \$2,500 in connection with Enforcement Matter Number 08-405.	2,500	Aetna Health of California, Inc.
03/27/2009	NY	Civil Penalties	The deficiency is a result of the NY DOH 2007 Operation Survey. Acceptance of the final Plan Of Correction was completed in January, 2009. The fine is due to repeat findings of deficiencies with provider contracts. Deficiencies are being addressed and DOH has scheduled a follow-up survey for May 27 - 29, 2009.	6,000	Aetna Health Inc.
03/27/2009	NJ	Administrative Penalty	Aetna Health Inc. may have committed certain violations under NJ insurance law regarding certain health benefit plans for services and treatments rendered by network providers and out-of-network providers. Aetna conducted affirmative outreach to each members at issue providing assurance that they are not responsible for any balance billings other than network copayments, coinsurance & deductibles and Aetna has cooperated and voluntarily undertook remedial steps to protect its members from potential balance billing from out-of-network providers. Administrative Penalty paid by wire transfer.	2,500,000	Aetna Health Inc.

04/02/2009	PA	Settlement	PA Department of Health conducted a complaint and grievance audit for 2008. Aetna signed the Settlement of 2008 Complaint and Grievance Audit and paid \$8,000 on 4/2/09. The Plan of Correction was submitted on 3/20/09.	8,000	Aetna Health Inc.
04/24/2009	CA	Administrative Penalty	CA DMHC proposed an administrative penalty in connection with Enforcement Number 09-214 in the amount of \$5,000 for failure to resolve a member's grievance within 30 days and failure to acknowledge receipt of the grievance within 5 days.	5,000	Aetna Health of California, Inc.
04/30/2009	NV	Fine	Strategic Resource Company's 2006 annual report was not received by the 7/1/2007 deadline resulting in a violation of NRS 683A.08528(1).	500	Strategic Resource Company
05/07/2009	NV	Consent to Fine - administrative fine	Chickering Claims Administrators, Inc. 2006 annual report was not received by the 7/1/2007 deadline resulting in a violation of NRS 683A.08528(1).	500.00	Chickering Claims Administrators, Inc.
05/12/2009	FL	Late Fees	Reimbursement for late fees incurred to the state of Florida for scripts reported late by AWCRx on behalf of Aequicap. AWCRx paid to Aequicap for scripts that were reported beyond the 45-calendar day filing requirement for initial submission. The reason for the late filing was due to conversion issues. Breakdown: Aequicap Property & Casualty Ins. Co. - \$25; Rockwood Casualty - \$10; Aequicap Medical-AIC \$60,	95	Aetna Workers' Comp Access, LLC
05/13/2009	CO	Fine	Colorado DOI alleged that Aetna Life Insurance Co. violated Colorado Insurance Regulation 1-1-8 when it failed to provide a complete response in writing within the timeframe specified.	575	Aetna Life Insurance Company
06/22/2009	WI	Fine	An order was issued to AHI for failing to pay the 2008 company appointment billing and failing to respond promptly to inquiries from OCI. AHIC paid the forfeiture but never provided payment for the appointment billing.	2,000	Aetna Health Insurance Company (formerly Corporate Health Insurance)

06/19/2009	NV	Fine	Strategic Resource Company's 2005 annual report was not received by the 7/1/2006 deadline resulting in a violation of NRS 683A.08528(1).	500	Strategic Resource Company
07/31/2009	NY	Fine	SRC violated Section 2110(i) of the NY Ins. Law when it failed to report to the Superintendent within 30 days of the final disposition of the NV fine on April 4, 2006.	500	Strategic Resource Company by and through Kathleen Patricia Schneider, sublicensee
08/25/2009	PA	Market Conduct Exam	Claim handling practices & procedures, including clean claim & interest, related to alcohol and substance abuse and mental illness coverage (Act 106) from January 1, 2007 to December 31, 2007.	30,000	Aetna Health Inc.
08/05/2009	FL	Administrative Penalty	Chickering failed to file its 12/31/07 audited financial statements by June 1, 2008, in violation of Florida statutes § 626.89(2). Chickering paid administrative penalty of \$12,200 plus costs of \$3,000.	15,200	Chickering Claims Administrators, Inc.
08/17/2009	CA	Administrative Penalty	Aetna Health of California, Inc. failed to resolve an enrollee's grievance (Enforcement #09-163) within 30 days (violation of Health and Safety Code section 1368.01, subdivision (a) and California Code of Regulations, title 28, section 1300.68, subdivision (d)(3).	2,500	Aetna Health of California, Inc.
08/18/2009	AZ	Compliance Exam	AZ Dept. of Ins. conducted a compliance examination covering 7/1/2004 through 6/30/2006 of utilization review and health care appeals, as well as provider timely payment and provider grievances.	57,250	Aetna Life Insurance Company
08/13/2009	FL	Fine	SRC failed to file its 12/31/07 audited financial statements by June 1, 2008, in violation of Florida statutes § 626.89(2). SRC paid administrative penalty of \$7,500 plus costs of \$3,000.	10,500	Strategic Resource Company
08/25/2009	IN	Fine	IN DOI fined ALIC for not responding to a complaint within 20 days in violation of IN Code §27-4-1-5.6.	500	Aetna Life Insurance Company



08/31/2009	NM	Civil Administrative Penalty	NM Insurance Division fined ALIC for failure to timely remit compensation for external review services pursuant to NMAC 13.10.17.31(C)(3)	1,000	Aetna Life Insurance Company
10/28/2009	AZ	Compliance Exam	AZ Dept. of Ins. conducted a compliance examination covering 7/1/2004 through 6/30/2006 of utilization review and health care appeals, as well as provider timely payment and provider grievances.	199,250	Aetna Health Inc.
11/03/2009	CO	Fine	The fine was levied against Aetna Health Insurance Company for its failure to file a complete Colorado Health Cost Report.	2,420	Aetna Health Inc.
11/19/2009	NV	Administrative Penalty	Strategic Resource Company's 2007 annual report was not received by the 7/1/2008 deadline resulting in a violation of NRS 683A.08528(1).	500	Chickering Claims Administrators, Inc.
11/19/2009	NV	Administrative Penalty	Strategic Resource Company's 2007 annual report was not received by the 7/1/2008 deadline resulting in a violation of NRS 683A.08528(1).	500	Strategic Resource Company
12/08/2009	CA	Administrative Penalty	The Office of Enforcement of the Department of Managed Health Care determined that Aetna Health of California, Inc. failed to resolve an enrollee's grievance within 30 days, a violation of health and Safety Code section 1368.01(a) and California Code of Regulation, title 28, section 1300.68(d)(3) and assessed the Company \$2,500 in connection with Enforcement Matter Number 09-257.	2,500	Aetna Health of California, Inc.
12/08/2009	CA	Administrative Penalty	The Office of Enforcement of the Department of Managed Health Care determined that Aetna Health of California, Inc. failed to resolve an enrollee's grievance within 30 days, a violation of health and Safety Code section 1368.01(a) and California Code of Regulation, title 28, section 1300.68(d)(3) and assessed the Company \$2,500 in connection with Enforcement Matter Number 09-259.	2,500	Aetna Health of California, Inc.

12/08/2009	CA	Administrative Penalty	The Office of Enforcement of the Department of Managed Health Care determined that Aetna Health of California, Inc. failed to resolve an enrollee's grievance within 30 days, a violation of health and Safety Code section 1368.01(a) and California Code of Regulation, title 28, section 1300.68(d)(3) and assessed the Company \$2,500 in connection with Enforcement Matter Number 09-309.	2,500	Aetna Health of California, Inc.
12/08/2009	CA	Administrative Penalty	The Office of Enforcement of the Department of Managed Health Care determined that Aetna Health of California, Inc. failed to resolve an enrollee's grievance within 30 days, a violation of health and Safety Code section 1368.01(a) and California Code of Regulation, title 28, section 1300.68(d)(3) and assessed the Company \$2,500 in connection with Enforcement Matter Number 09-337.	2,500	Aetna Health of California, Inc.
12/10/2009	WA	Fine	Aetna Health Inc. violated RCW 48.20.025(5) by failing to timely file its annual loss ration filing for individual health plans for 2008.	750	Aetna Health Inc.
<b>2010</b>					
01/04/2010	CA	Administrative Penalty	The Office of Enforcement of the Department of Managed Health Care determined that Aetna Health of California, Inc. failed to resolve an enrollee's grievance within 30 days, a violation of Health and Safety Code section 1368.01(a) and California Code of Regulation, title 28, section 1300.68(d)(3) and assessed the Company \$5,000 in connection with Enforcement Matter Number 09-391.	5,000	Aetna Health of California, Inc.
01/15/2010	NY	Civil Penalty	New York State Insurance Department conducted an investigation which revealed violation of New York Insurance Law in connection with the Healthy New York Program.	750,000	Aetna Health Inc.

01/25/2010	CA	Administrative Penalty	The Office of Enforcement of the Department of Managed Health Care determined that Aetna Health of California, Inc. violated Health and Safety Code 1386(b)(3), which requires that a plan must provide basic health care services to its enrollments to the terms of EOC; CA Code of Regulations, title 28, section 1300.67(b) defines blood and/or blood products as a basic medical service.	7,500	Aetna Health of California, Inc.
01/27/2010	VA	Monetary Penalty	The Virginia Bureau of Insurance assessed the Company a monetary penalty of \$3,000, stating that the Company violated 14 VAC 5-215-20 when it failed to timely stop using an obsolete form.	3,000	Aetna Life Insurance Company
02/05/2010	AZ	Contract Sanction	On January 14, 2010, Mercy Care Plan was notified of a \$10,000 sanction for one Notice of Action letter that did not meet regulatory standards. The letter was identified as deficient through a routine audit conducted by the Arizona Health Care Cost Containment System (AHCCCS). AHCCCS is the single state agency responsible for oversight of Arizona's Medicaid program. The \$10,000 sanction will be withheld from the February capitation payment, which will occur on Friday, February 5, 2010.	No Fines	Mercy Care Plan
02/15/2010	WA	Fine	Aetna Health failed to file timely the signature page for its 3/3/2009 & 6/30/2009 electronic quarterly statements.	2,000	Aetna Health, Inc.
06/12/2010	CO	Market Conduct	Aetna Health, Inc. was fined a civil penalty of \$294,000.00 (plus a surcharge of \$20,000) by the Colorado Division of Insurance for findings related to a market conduct examination covering the period January 1, 2008 through December 31, 2008.	294,000	Aetna Health, Inc.

03/15/2010	CO	Market Conduct	Aetna Life Insurance Company (ALIC) was fined a civil penalty of \$330,000.00 (plus a surcharge of \$20,000) by the Colorado Division of Insurance for findings related to a market conduct examination covering the period January 1, 2008 through December 31, 2008.	330,000	Aetna Life Insurance Company
05/25/2010	TX	Administrative Penalty	ALIC holds a Texas Continuing Education Provider Registration. TX DOI alleges that ALIC violated the insurance laws by providing a course, Broker Financial Training Program, to students after the course certification had expired.	3,400	Aetna Life Insurance Company
05/26/2010	MD	Administrative Penalty	AHI violated §15-1203(b)(5) of the MD Insurance Code when AHI termed a complainants small employer's health benefit plan because the group consisted of only one member. A required self-audit of small employer plans from 1/1/2005 - 12/31/2009 revealed 25 plans incorrectly terminated; 4 plans chose to reinstate. Aetna executed the Consent Order on 5/26/2010.	25,000	Aetna Health Inc.
06/15/2010	NY	Civil Penalty	NY Prompt Pay Review. Aetna Life Insurance Company was fined a civil penalty by the New York Insurance Department for findings (failed to pay certain claims within the time limitations specified in Section 3224-a) relating to a market conduct exam covering the period 10/1/2008 through 09/03/2009.	25,100	Aetna Health Inc. - 9,100. Aetna Life Insurance Company - 15,600. Aetna Health Insurance Company of NY - 400.
06/18/2010	TX	Contract Sanction	Texas Health and Human Services Commission (THHSC) assessed a fine for non-compliance with contract performance measures for our Aetna Medicaid (TPA) business	9,859	Parkland Community Health Plan
07/01/2010	TX	Contract Sanction	Texas Health and Human Services Commission (THHSC) assessed a fine for non-compliance with contract performance measures for our Aetna Medicaid risk business.	10,000	Aetna Better Health, Inc.

07/09/2010	TX	Contract Sanction	On June 23, 2010, Texas Health and Human Services Commission (THHSC) assessed fines for non-compliance with contract performance measures for our TPA business (Parkland Community Health Plan).	9,975	Parkland Community Health Plan
07/12/2010	CO	Monetary Penalty	The Colorado Division of Insurance fined ALIC a monetary penalty of \$500.00 (plus a 10% surcharge) for responding late to two consumer complaints.	1,100	Aetna Life Insurance Company
07/12/2010	PA	Contract Sanction	Aetna's PA CHIP product (under AHI) - capitation is being withheld (Pennsylvania CHIP will need to withhold the dental portion of Aetna's CHIP reimbursement rates effective August 1, 2010 until Aetna provides the dental claims/encounter data. Since Aetna's CHIP rates are not being adjusted, the CHIP Enrollees' monthly payments should not be adjusted. Eventually, Aetna will receive the full CHIP PMPM rates and the Enrollees should be paying their percentage of the full PMPM rate, accordingly.)	No Fines	Aetna Health Inc. (PA CHIP)
07/26/2010	CA	Administrative Penalty	The Office of Enforcement of the Department of Managed Health Care conducted an investigation regarding compliance with Health and Safety Code and California Code of Regulations, Title 28 and the Department concluded there were violations of the Knox-Keene Health Care Services Act of 1975. (Enforcement Action 09-186)	70,000	Aetna Health of California, Inc.

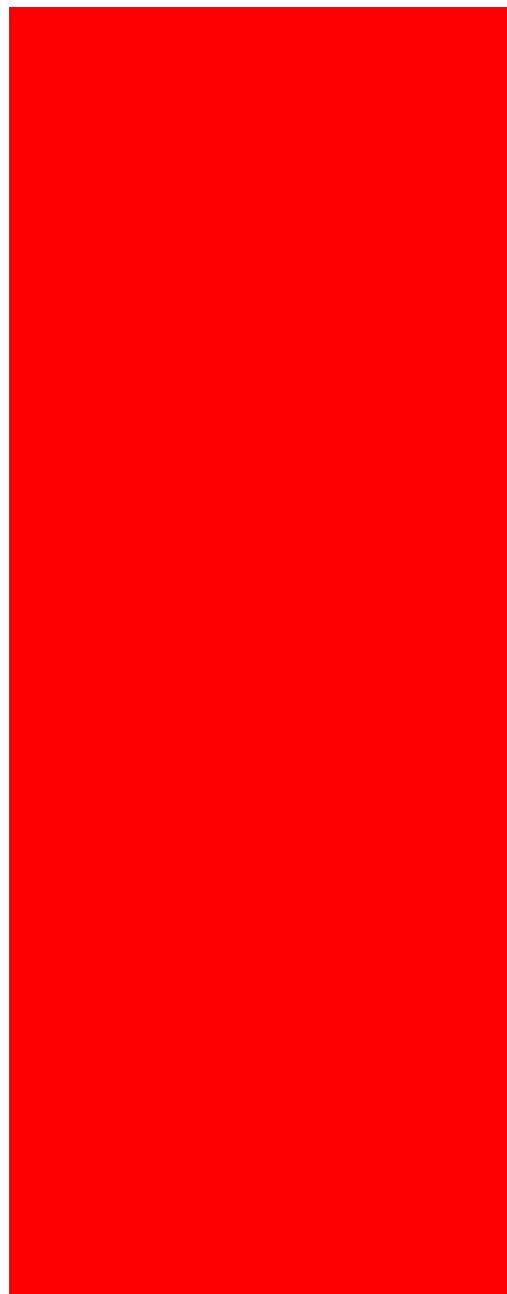
08/20/2010	NY	Monetary Penalty	Financial exam of AHI & AHIC of NY from 1/1/2003 through 12/31/2005; a market conduct exam of AHI, AHIC of NY and ALIC from 3/1/2001 through 12/31/2005; and a special market conduct exam of AHI, AHIC of NY and ALIC from 1/1/2003 through 12/30/2004. Violations include: EOBs failed to provide an explanation to members with respect to certain claims submitted by non-participating providers; EOBs contained inconsistent and/or inadequate information; EOBs failed to clearly delineate all charges & describe in clear and concise language all reductions to allowed amount; EOBs failed to contain accurate information regarding claimant's right to appeal; failing to process certain claims within 45 days of receipt; failing to deny or request additional information from claimants within 30 days of receipt of claim; failing to pay interest or incorrectly paying interest on certain claims; failing to send proper notification of the first adverse determination to subscribers and/or providers in certain cases; and failing to disseminate to prospective, new and existing members consistent, accurate and clear disclosure information.	850,000	Aetna Health, Inc. - 285,000.(Monetary Penalty) Aetna Life Insurance Company - 285,000. (Civil Penalty) Aetna Health Insurance Company of NY - 280,000. (Civil Penalty)
09/07/2010	MT	Fine	CSI alleged that ALIC violated Montana Code Ann. §49-2-309(1) by considering marital or gender status in calculating the premium for group long-term care policies.	5,000	Aetna Life Insurance Company
09/23/2010	TX	Contract Sanction	Aetna Better Health, Inc. must comply with the contract requirements and performance standards as described in the HHSC Uniform Managed Care Contract. For the 3rd Quarter 2010 Aetna Better Health, Inc. was below the performance standard.	30,000	Aetna Better Health, Inc.
09/29/2010	MD	Administrative Penalty	Member complaint from the Insurance Department - EOBs sent on 10/6/2009 & 10/28/2009 violated sect. 15D-02 by failing to include the required information.	1,000	Aetna Life Insurance Company

09/29/2010	MD	Contract Sanction	Aetna (under Schaller Anderson, LLC) is the administrator for the Medicaid plan, Maryland Physicians Care (MPC). MPC was sanctioned, such that we will not be auto-assigned members in one service area for the month of Oct. I'm not sure whether we need to report this action to other state DOIs. Note: the MD sanction is not a sanction against Aetna or Schaller Anderson rather a sanction against MPC the health plan which is not an Aetna owned Health plan.	No Fines	Maryland Physicians Care
09/30/2010	TX	Contract Sanction	Parkland Community Health Plan must comply with the contract requirements and performance standards as described in the HHSC Uniform Managed Care Contract. For the 3rd Quarter 2010 Parkland Community Health Plan. was below the performance standard.	17,500	Parkland Community Health Plan
10/05/2010	MT	Forfeiture Amount	The Missouri Dept. of Insurance conducted a targeted market conduct exam of claims between January 1, 2003 and the date of the final order. They found violations of improperly denied ambulance and emergency room claims, child immunizations claims; and improperly reprocessed "First Steps" claims.	37,400	Aetna Health, Inc.
10/11/2010	MD	Administrative Penalty	The Maryland Administration conducted a Market Conduct Exam for the period of Jan. 1, 2008 through December 31, 2008 and found violations of certain sections of the Insurance Article.	125,000	Aetna Health, Inc.

10/18/2010	OR	Civil Penalty	Oregon requires an insurer to pay a clean claim under a health benefit plan within 30 days after receiving the claim or after receiving any required additional information, whichever is later. An insurer is also required to file an annual Prompt Pay Report. On 6/11/2010, Aetna Life Ins. Co. filed its report of sampled claims for 2009; it did not include in its report of sampled claims for 2009 the date on which Aetna Life Ins. Co. requested additional information about 34 claims and received additional information about 16 claims. Oregon Dept. of Consumer & Business Services, Insurance Division, assessed a civil penalty of \$4,000.	4,000	Aetna Life Insurance Company
10/27/2010	VT	Administrative Penalty	VT Dept. of Banking, Ins., Securities & Health Care Administration conducted an investigation of Limited Benefit Policies and concluded that ALIC delivered certificates to Vermont Subscribers that did not comply with forms that were filed and approved by the Commissioner. An administrative penalty of \$125,000.00 was assessed against ALIC; reasonable costs & expenses of \$13,280.00; cease and desist selling and marketing Limited Benefits Policies of health insurance or certificates to Vermont residents; ALIC will continue to administer Limited Benefits Policies and health insurance coverage (including R. L. Vallee, Inc.) under all existing policies as issued and in effect as of the date of the Order.	125,000	Aetna Life Insurance Company
11/30/2010	CO	Monetary Penalty	The Colorado Division of Insurance assessed the Company a civil penalty of \$550.00, stating that the Company failed to provide a complete response to an inquiry requesting a complete copy of a rate filing relating to a consumer complaint.	550	Aetna Life Insurance Company

12/02/2010	CA	Administrative Penalty	The CA Dept. of Managed Health Care fined Aetna Health of CA, Inc. in connection with findings relating to claims settlement practices and dispute resolution mechanism for the periods ending March 31, 2008 and June 30, 2009. The Dept. assessed a penalty of \$300,000 of which \$150,000 was suspended contingent upon the next financial exam.	150,000	Aetna Health of California, Inc.
12/17/2010	CO	Monetary Penalty	The Colorado Division of Insurance assessed the Company a civil penalty of \$550.00, stating that the Company failed to provide a complete response to an inquiry within the timeframe specified.	550	Aetna Life Insurance Company
12/20/2010	NE	Administrative Fine	As a result of an Insurance Department Complaint, ALIC was fined \$18,025 due to a violation of the Nebraska Unfair Life, Sickness and Accident Claim Settlement Practices Rule requirement that claim expense denials reference the specific policy provision.	18,025	Aetna Life Insurance Company
12/28/2010	PA	Fine Settlement Amount	2010 Utilization Review Audit	3,000	Aetna Health Inc.

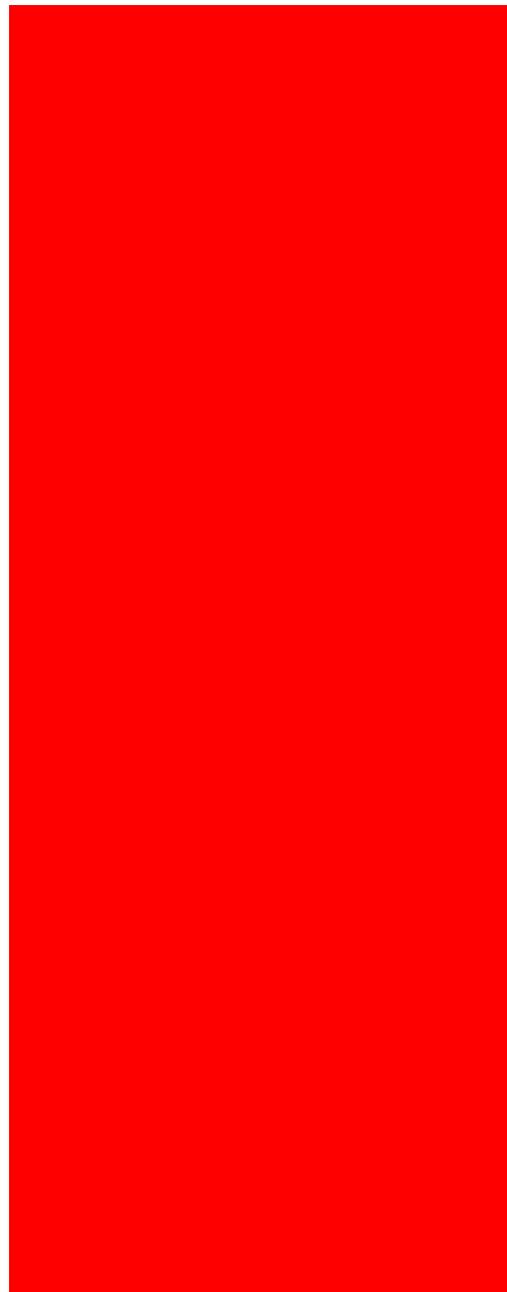
28 B.26



**B.26 Provide a statement of whether your organization is currently the subject or has recently (within the past five (5) years) been the subject of a criminal or civil investigation by a state or federal agency other than investigations described in response to item B.6. If your organization has recently been the subject of such an investigation, provide an explanation with relevant details and the outcome. If the outcome is against your organization, provide the corrective action plan implemented to prevent such future offenses. Include your organization's parent company, affiliates and subsidiaries.**

Aetna Better Health, Inc. is not currently the subject and has never been the subject of a criminal or civil investigation by a state or federal agency. The Aetna organization's current and past business practices are subject to review by various state insurance and health care regulatory authorities and other state and federal authorities, including Attorneys Generals. As a leading national managed care organization, the Company and its affiliates regularly are the subject of such reviews and several such reviews currently are pending, some of which may still be pending. These reviews may result in changes to or clarifications of the Company's and its affiliates' business practices, and have in the past, and in the future may, result in fines, penalties or other sanctions.

29 B.27



**B.27 Submit client references (minimum of three, maximum of five) for your organization for major contracts; with at least one reference for a major contract you have had with a state Medicaid agency or other large similar government or large private industry contract. Each reference must be from contracts within the last five (5) years. References for your organization shall be submitted to the State using the questionnaire contained in RFP Appendix PP. You are solely responsible for obtaining the fully completed reference check questionnaires, and for submitting them sealed by the client providing the reference, with your Proposal, as described herein. You should complete the following steps:**

- a. Make a duplicate (hard copy or electronic document) of the appropriate form, as it appears in RFP Appendix PP (for your organization or for subcontractors, adding the following customized information:**

**Your/Subcontractor's name;**

**Geographic Service Area(s) for which the reference is being submitted;**

**Reference organization's name; and**

**Reference contact's name, title, telephone number, and email address.**

- b. Send the form to each reference contact along with a new, sealable standard #10 envelope;**
- c. Give the contact a deadline that allows for collection of all completed questionnaires in time to submit them with your sealed Proposal;**
- d. Instruct the reference contact to:**

**Complete the form in its entirety, in either hard copy or electronic format (if completed electronically, an original should be printed for submission);**

**Sign and date it;**

**Seal it in the provided envelope;**

**Sign the back of the envelope across the seal; and**

**Return it directly to you.**

- e. Enclose the unopened envelopes in easily identifiable and labeled larger envelopes and include these envelopes as a part of the Proposal. When DHH the opens your Proposal, it should find clearly labeled envelope(s) containing the sealed references.**

**B.27 THE STATE WILL NOT ACCEPT LATE REFERENCES OR REFERENCES SUBMITTED THROUGH ANY OTHER CHANNEL OF SUBMISSION OR MEDIUM, WHETHER WRITTEN, ELECTRONIC, VERBAL, OR OTHERWISE.**

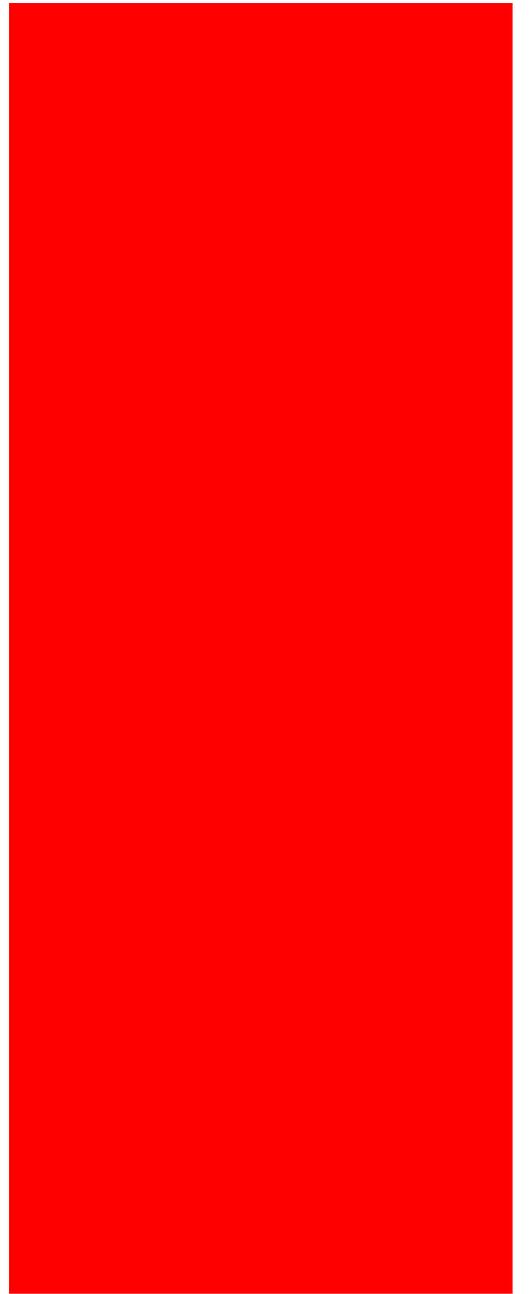
Each completed questionnaire should include:

- Proposing Organization/Subcontractor's name;
- GSA (s) for which the reference is being submitted;
- Reference Organization's name;
- Name, title, telephone number, and email address of the organization contact knowledgeable about the scope of work;
- Date reference form was completed; and
- Responses to numbered items in RFP Attachment # (as applicable).

DHH reserves the authority to clarify information presented in questionnaires and may consider clarifications in the evaluation of references. However DHH is under no obligation to clarify any reference check information.

Please see Appendix L for Aetna Better Health's<sup>®</sup> client references.

30 B.28



**B.28** Indicate the website address (URL) for the homepage(s) of any website(s) operated, owned, or controlled by your organization, including any that the Proposer has contracted to be run by another entity as well as details of any social media presence ( e.g. Facebook, Twitter). If your organization has a parent, then also provide the same for the parent, and any parent(s) of the parent. If no websites and/or social media presence, so state.

**Aetna Better Health Websites**

The following table illustrates the website addresses for the homepages that are currently operated, owned, or controlled by Aetna Better Health and our parent organization, Aetna, Inc.

Name of Website	Program Location	Type	Operated By
<a href="http://www.aetnabetterhealth.com">www.aetnabetterhealth.com</a>	Connecticut, Illinois, Pennsylvania, Texas	Owned	Aetna Better Health
<a href="http://www.chochealthalliance.com">www.chochealthalliance.com</a>	California	Owned	Aetna Better Health
<a href="http://www.delawarephysicianscare.com">www.delawarephysicianscare.com</a>	Delaware	Owned	Aetna Better Health
<a href="http://www.integralqualitycare.com">www.integralqualitycare.com</a>	Florida	Owned	Aetna Better Health
<a href="http://www.marylandphysicianscare.com">www.marylandphysicianscare.com</a>	Maryland	Owned	Aetna Better Health
<a href="http://www.mercycareplan.com">www.mercycareplan.com</a>	Arizona	Owned	Aetna Better Health
<a href="http://www.mynewhampshirecare.com">www.mynewhampshirecare.com</a>	New Hampshire	Owned	Aetna Better Health
<a href="http://chip.aetna.com/PA/CHIP_PA_index.html">http://chip.aetna.com/PA/CHIP_PA_index.html</a>	Pennsylvania	Owned	Aetna Better Health
<a href="http://www.aetnamedicaid.com">www.aetnamedicaid.com</a> *	Texas	Owned	Aetna Better Health
<a href="http://www.aetna.com">www.aetna.com</a>	Commercial - National	Owned	Aetna, Inc.
<a href="http://www.AetnaStudentHealth.com">www.AetnaStudentHealth.com</a>	Commercial - National	Owned	Aetna, Inc.
<a href="http://www.aetnatools.com">www.aetnatools.com</a>	Commercial - National	Owned	Aetna, Inc.
<a href="http://www.intelihealth.com">www.intelihealth.com</a>	Commercial - National	Owned	Aetna, Inc.
<a href="http://www.healthyfoodfight.com">www.healthyfoodfight.com</a>	Commercial - National	Owned	Aetna, Inc.

\* These websites are in the process of being converted to the Aetna Better Health website at [www.aetnabetterhealth.com](http://www.aetnabetterhealth.com)

**Social Media Presence**

Aetna Better Health does not currently participate in any social media. Our parent organization, Aetna, Inc. (Aetna), utilizes social media in an effort to educate individuals and communities about ways to develop and maintain healthy lifestyles.

### **Aetna Student Health**

Aetna has been making health and wellness easier for college students to understand through a wide range of social media channels. Aetna has combined the following social networking elements into one location:

- The Aetna Student Health Facebook page with close to 1,800 fans
- A Twitter feed with health and wellness updates
- The “Healthy You!” series of popular YouTube videos where students can watch campus interviews on how to stay fit and healthy while juggling college life
- A FREE calorie tracker mobile application with close to 1,700 downloads

Students receive tips on how to maintain a healthy lifestyle from the Twitter feed and Facebook page. Common topics include stress reduction, fitness, sexual health, drinking and smoking cessation. Daily tweets and posts help keep students informed, healthy and in tune with their surroundings. The “Healthy You!” YouTube series includes videos of campus interviews. Each clip educates students on how to stay fit and healthy while keeping up with college classes and the campus environment. Aetna’s Student Health website also provides students with the opportunity to “share” their own “Healthy You!” stories. The free Aetna Student Health Calorie Tracker mobile app helps students count calories and delivers daily nutrition and fitness tips directly to any Blackberry Smartphone. The calorie tracker features more than 70,000 food and beverage items from popular restaurants and brands.

Aetna’s student health care website is designed as a place where students can socially interact while remaining educated about their health. Information on Aetna student health care can be found at the following:

- <http://www.aetnastudenthealth.com/>
- <http://www.facebook.com/AetnaStudentHealth>
- <http://twitter.com/aetnastudent>
- <http://www.youtube.com/aetnastudenthealth>
- [http://www.aetnastudenthealth.com/stu\\_conn/blackberry.aspx](http://www.aetnastudenthealth.com/stu_conn/blackberry.aspx)

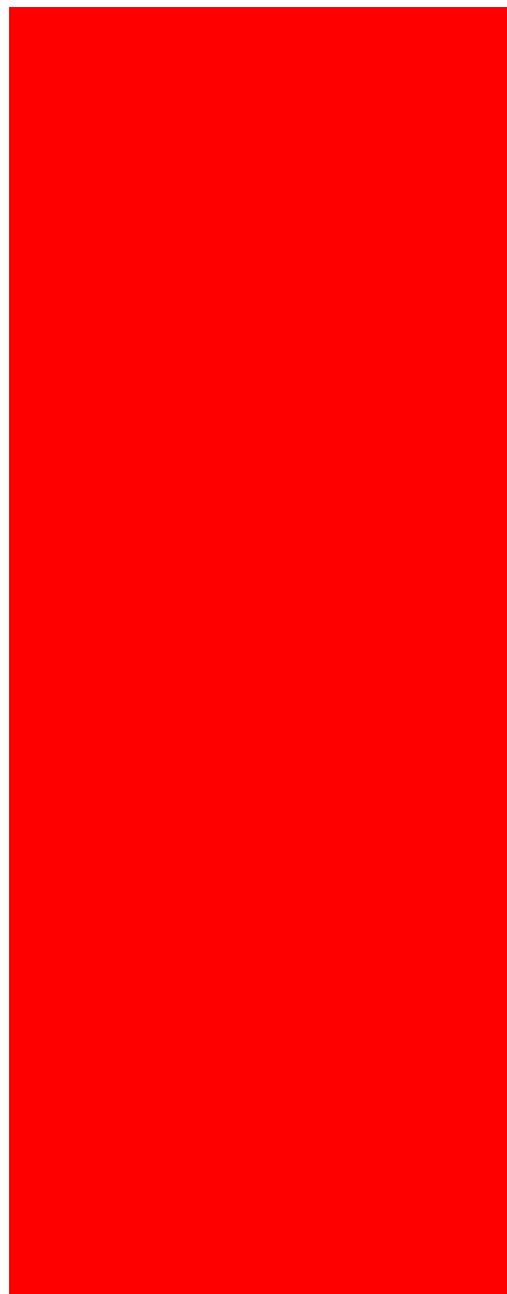
### **Aetna Healthy Food Fight**

Aetna launched the Aetna Healthy Food Fight in 2010 to spread the word about the importance of health eating in achieving better overall health. We utilize Facebook, Twitter, and YouTube to educate our members and others about the Aetna Healthy Food Fight and to create community-based dialogue around healthy eating. The Aetna Healthy Food Fight is a healthy cooking contest for anyone with an original recipe to compete on a national level. We encourage spectators to attend the events to learn about healthy cooking and eating.

The goal of the Aetna Healthy Food Fight is to spread the word that there are easy ways to incorporate healthy ingredients into cooking and eating which can have a significant impact on overall health. Information about the Aetna Healthy Food Fight can be found at the following:

- <http://www.healthyfoodfight.com>
- <http://www.facebook.com/HealthyFoodFight>
- <http://twitter.com/#!/AetnaFoodFight/>
- <http://www.youtube.com/user/HealthyFoodFight>

31 B.29

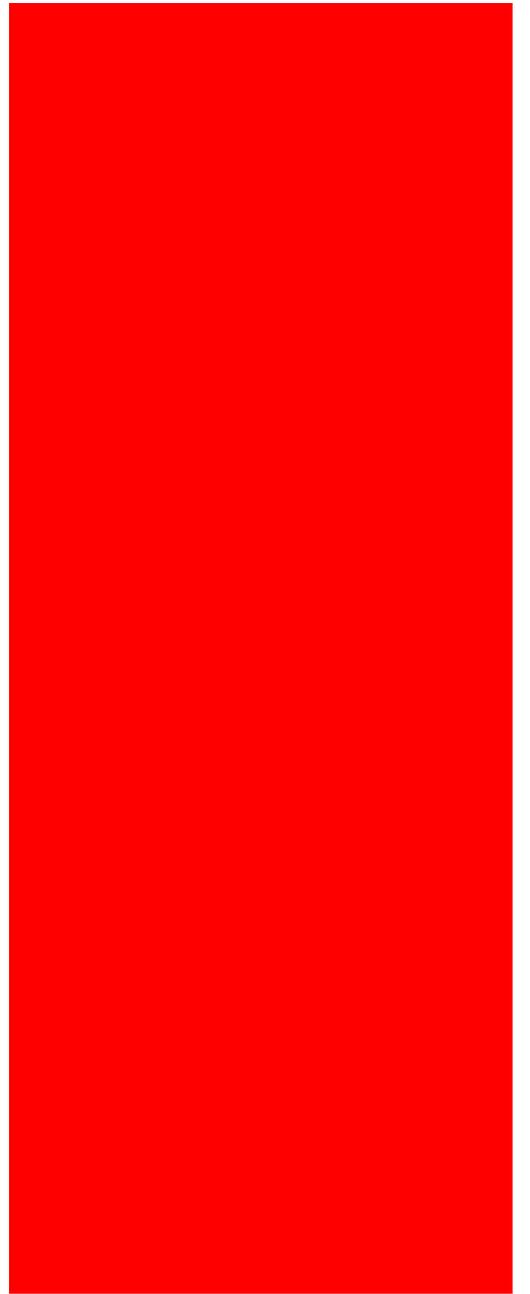


**B.29 Provide evidence that the Proposer has applied to Louisiana Department of Insurance for a certificate of authority (COA) to establish and operate a prepaid entity as defined in RS 22:1016 and in accordance with rules and regulations as defined by the Department of Health and Hospitals.**

Aetna Better Health, Inc., a Louisiana corporation, d/b/a Aetna Better Health (“Aetna Better Health”) is pleased that it has already been issued a new HMO certificate of authority to operate a Coordinated Care Network (CCN) program in Louisiana by the Louisiana Department of Insurance, a copy of which is attached hereto. Aetna Better Health made the decision to seek a new, separate HMO certificate of authority to conduct only the CCN business. This strategy permits us to provide the anticipated level of Medicaid-only financial reporting to the Department of Health and Hospitals (DHH). Accordingly, Aetna Better Health does not need to provide to DHH "proof that it has applied" for its licensing because it has already obtained all DOI licenses required to operate as a CCN-only HMO in Louisiana. Aetna Better Health believes that since it has obtained all required licenses to operate as a CCN, DHH should have no doubt about its ability to timely obtain all required licenses from DOI, or its ability to provide the segregated level of CCN-only financial reporting required by DHH.

Please refer to Appendix M for a copy of Aetna Better Health’s Certificate of Authority.

32 B.30



**B.30 Provide the following as documentation of financial responsibility and stability:**

**a current written bank reference, in the form of a letter, indicating that the Proposer's business relationship with the financial institution is in positive standing;**

**two current written, positive credit references, in the form of a letters, from vendors with which the Proposer has done business or, documentation of a positive credit rating determined by a accredited credit bureau within the last 6 months;**

**a copy of a valid certificate of insurance indicating liability insurance in the amount of at least one million dollars (\$1,000,000) per occurrence and three million dollars (\$3,000,000) in the aggregate; and**

**a letter of commitment from a financial institution (signed by an authorized agent of the financial institution and detailing the Proposer's name) for a general line of credit in the amount of five-hundred thousand dollars (\$500,000.00).**

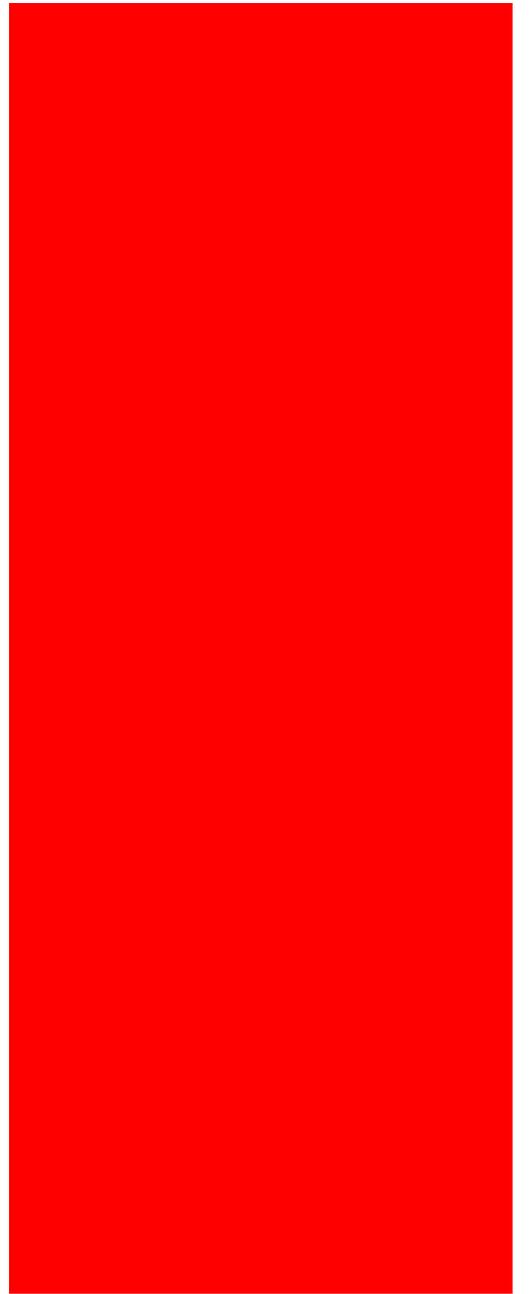
For the most recent bank reference, positive credit references, and a valid copy of insurance, please see Appendix N.

Aetna Better Health, Inc., a Louisiana corporation, d/b/a Aetna Better Health ("Aetna Better Health") is a wholly-owned subsidiary of a publicly-traded corporation, Aetna Inc. Aetna Better Health is wholly owned by Aetna Health Holdings, LLC, which is wholly owned by Aetna Inc., a publicly traded corporation.

Aetna Health Holdings, LLC will unconditionally guarantee performance by Aetna Better Health in each and every obligation, warranty, covenant, term, and condition of the contract executed by the parties. There is no maximum limit to the financial support that will be provided by Aetna Health Holdings, LLC.

The Aetna Inc. annual report is included as Appendix A. A detailed description of our \$1.5 billion revolving credit facility is included on page 15 of the annual report.

33 B.31



**B.31 Provide the following as documentation of the Proposer's sufficient financial strength and resources to provide the scope of services as required:**

- The two most recent independently audited financial statements and associated enrollment figures from the Proposer. Compiled or reviewed financial statements will not be accepted. The audited financial statements must be:
  - Prepared with all monetary amounts detailed in U.S. currency;
  - Prepared under U.S. generally accepted accounting principles; and
  - Audited under U.S. generally accepted auditing standards. The audited financial statements must include the auditor's opinion letter, financial statements, and the notes to the financial statements.
- The Proposer's four (4) most recent internally prepared unaudited quarterly financial statements (and Year-to-Date), with preparation dates indicated. The statements must include documentation disclosing the amount of cash flows from operating activities. This documentation must indicate whether the cash flows are positive or negative, and if the cash flows are negative for the quarters, the documentation must include a detailed explanation of the factors contributing to the negative cash flows.
- Verification of any contributions made to the Proposer to improve its financial position after its most recent audit (e.g., copies of bank statements and deposit slips), if applicable

**Proposer shall include the Proposer's parent organization.**

**Most Recent Quarterly and Annual Financial Statements**

The 2009 and 2010 annual financial statements and 2010 three most recent internal quarterly financial statements for Aetna Better Health, Inc, a Louisiana corporation d/b/a Aetna Better Health and its parent organization, Aetna Inc. are included as Appendix O. Aetna Better Health was formed in 2010 and can only provide the last three quarters of financial statements.

There have been no contributions made to the proposer to improve its financial position since the most recent audit.