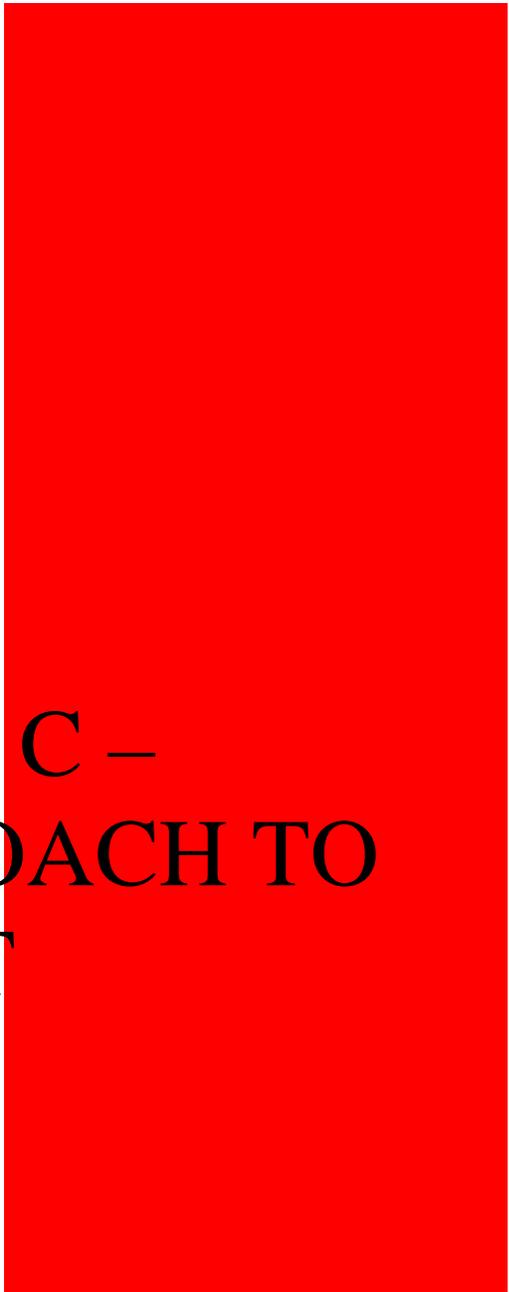
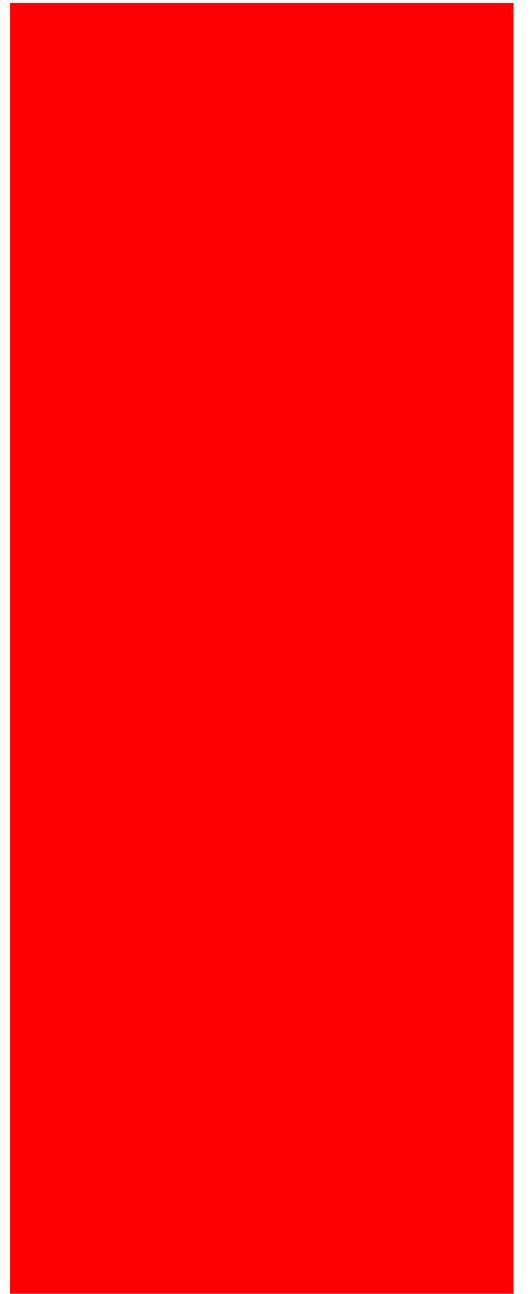


34 SECTION C –
PLANNED APPROACH TO
PROJECT



35 C.1



Section C: Planned Approach to Project

Describe how you will launch a network and set up operations capable of supporting its membership and meeting the requirements of the RFP by January 1, 2012 for GSA "A", March 1 of 2012 for GSA "B", and May 1 of 2012 for GSA "C".

C.1 Discuss your approach for meeting the implementation requirements and include:

- **A detailed description of your project management methodology. The methodology should address, at a minimum, the following:**
 - **Issue identification, assessment, alternatives analysis and resolution;**
 - **Resource allocation and deployment;**
 - **Reporting of status and other regular communications with DHH, including a description of your proposed method for ensuring adequate and timely reporting of information to DHH project personnel and executive management; and**
 - **Automated tools, including use of specific software applications.**

A detailed description of your project management methodology

Aetna Better Health[®] utilizes the Project Management Institutes (PMI) project management methodologies and standard deliverables. As an implementation progresses Aetna Better Health's implementation team works in conjunction with certified Project Management Professionals (PMP) to see that PMI standards are adhered to. Areas addressed in the project plan are as follows:

- Schedule
- Scope
- Costs
- Resource planning
- Quality assurance and controls
- Communications
- Risk management
- Procurement Management

Aetna Better Health is committed to providing the resources needed to successfully implement a new health plan in Louisiana. We understand the complex nature of implementing a new Medicaid Coordinated Care Network health plan where none currently exist. We recognize that we have approximately five months from contract award to go-live. We are confident we can meet this timeline and are prepared to put in place a project management plan that will direct us as we work towards meeting the state's following go-live dates for all Geographic Service Areas (GSA):

- GSA A – January 1, 2012
- GSA B – March 1, 2012
- GSA C – May 1, 2012

The essential components needed to succeed in implementing the Louisiana Coordinated Care Network (CCN) Program are our experience, inter-departmental openness/communication and systematic project tracking tools. The Aetna Better Health Implementation Lead Team is a multi-disciplinary team responsible for managing the implementation and ensuring that all aspects of a fully-functioning health plan, making sure Department of Health and Hospitals (DHH) requirements and expectations are implemented successfully. All health plan functional areas, which include claims, encounters, medical management, provider and member services, network development, IT, human resources, compliance, finance, enrollment and training, are represented on the Lead Team.

Aetna Better Health recently implemented Medicaid Managed Care health plans in Illinois, Pennsylvania, Connecticut, Florida and Missouri. Lisa Baird, the Implementation Manager and the Aetna Better Health Implementation Lead Team Director for the Louisiana implementation, was in similar roles during our Illinois and Pennsylvania implementations. We utilize Ms. Baird's knowledge and experience as we plan for and react to implementation activities and risks. We also benefit from the experience of our Systems Implementation Director, Laura Mayne. Ms. Mayne has extensive knowledge of our systems and the processes required to implement our systems. She led the Florida implementation and oversaw the Illinois systems implementation, which has been one of our most successful systems implementations to date. Additionally, we have a vast collection of experience throughout our organization that we pull from as we manage the implementation activities and the risks inherent in the process.

Within our culture of openness, individuals are empowered and encouraged to bring concerns to leadership or address them directly with the Lead Team as they occur. We have multiple forums available to express concerns or barriers. Having this mindset, combined with our previous successful implementations and our systematic tracking tools, we have developed a seasoned and efficient implementation and risk management approach.

Our systematic approach to implementations focuses on delivering high quality on time and within scope for all new health plan implementations. We work within an agile environment, constantly evaluating all deliverables and their supporting functions while monitoring outcomes for quality. Within our implementation project we respond to task dependencies and continually verify that the critical path is on track to meet DHH's requirements. We will manage our project work plan and update it through status reports, the tracking log, and updates to our risk management plan during each step of the implementation. We maintain a Project Collaboration Team site on a Microsoft Office SharePoint Server farm and store all documents related to the implementation project on this internal site.

Implementation Lead Team

The implementation of the Louisiana CCN Program will be directed by our Implementation Lead Team. Ms. Baird, the Lead Team Director, provides status reports to the Regional Senior Vice President, Jan Stallmeyer, and the health plan CEO, Pat Powers, and COO, Ruth Sirotnik. Using this team model has proven to be highly effective in previous implementations.

Our Lead Team's guiding principles are:

- The Implementation Manager directs the team and reports to the Regional Senior Vice President and Health Plan CEO and COO

- All functional areas are represented on the lead team
- All lead team members are accountable to the executive leadership and the Regional Senior Vice President for the success of the implementation; a percentage of each team member's annual compensation is dependent on the success of the implementation

The Lead Team will develop sub-groups that work with subject matter experts on all roles and processes as needed in order to accomplish the actions assigned to them. The overall project is monitored and managed by documentation and review of the implementation project work plan. The team and its sub-groups are developed through a pooling of corporate and health plan experience, subject matter expertise, knowledge, and proven leadership abilities.

Early in the implementation process, bi-weekly meetings are scheduled to bring together the Lead Team members. Through our experience, we have developed an efficient and well-structured meeting management process. This process ties in all areas by documenting activities and deliverables, while also providing on our Project Collaboration Team site the meeting minutes and meeting agenda. During these meetings, the lead team addresses project scope, establish and approve policy, review and resolve issues, and make certain that tasks and contractual obligations are assigned and being executed timely. Members of the lead team also define the duration of tasks, add dependencies to tasks and identify critical paths within the work plan.

The Lead Team includes the following people and a short description of their roles, responsibilities and qualifications is available in section C.5.

Title	Name
Regional Senior Vice President	Jan Stallmeyer
Regional Vice President of Business Development	Taira Green-Kelley
Chief Executive Officer	Patrick Powers
Chief Operating Officer and Provider Services	Ruth Sirotnik
Implementation Manager, Contract Compliance Officer and Lead Team Director	Lisa Baird
Compliance	Hillarie Weiss
Encounters Information Technology	Cathy Jackson-Smith
Enrollment	Diana Atchley
Finance	Lauren Edgington
Human Resources	Debbie Hillman
Information Technology	Greg Krause
Medical Director	John Esslinger MD
Medical Management	Dawn Reed
Member Services/Marketing/Community Outreach	Taira Green-Kelley
Network Development	Jamie McCarrick
Claims/Claims Audit	Jennifer Hayes
Provider Data Services	Stacey Hilgart
Reporting/Appeals/Grievances	Patrice Jackson
Training	Mike Rogers

Issue identification, assessment, alternatives analysis and resolution

Aetna Better Health addresses and works to resolve all issues through the Lead Team. Issues are identified by those involved in the implementation process using the weekly status reports and updating the issues log. Both the weekly status report and the issues log are located on our Project Collaboration Team site, stored on the Aetna intranet, and are available to all implementation personnel. In addition to these reports, the Lead Team members have frequent meetings with their functional sub-group where issues and concerns directly affecting the production of the sub-group are reviewed in greater detail. This administrative structure allows a unique and productive opportunity to bring together the group of multi-disciplinary experts to effectively resolve issues and concerns with the implementation and oversight of the plan. Operations and network development are both included within these reports.

Weekly Status Reports

Weekly Status Reports are a key tool used to quickly and accurately identify and address issues and delays in implementing the new health plan. These reports are submitted through our Project Collaboration Team site and are available to the personnel working on the implementation. All functional areas are required to update the lead team on their status using these reports. By using the weekly status reports, we have consistently identified issues early, worked through the available resolutions quickly and effectively, and stayed on track to meet the required go-live date.

Weekly status reports include an update on the overall completion percentage, status of their portion of the project, accomplishments during the week, at-risk tasks with explanations, and any adjustments to the budget or assigned project timeframe. After the reports are submitted they are reviewed by the Lead Team at least once per week. If a risk is identified, risk mitigation is discussed and a plan is developed and implemented. Project plan documents are updated as needed including the Risk Management plan.

Issues Log

Our Issues Log, located on the Project Collaboration Team site, is a simple-to-use tool that tracks issues and potential problems noticed by any of the implementation personnel. The issues log is dynamic in that it allows any implementation staff member to respond to outstanding issues or add their own.

The issues log is owned by the Implementation Manager, who coordinates with the Regional Senior Vice President, CEO and COO to make sure that everything is reviewed weekly by the Lead Team in addition to on-going reviews by the implementation personnel. These reviews result in either immediate resolution or assignment to a sub-group. Real-time notifications of the changes to the log are sent to the Lead Team and subject matter experts. Through the issues log and the Project Collaboration Team site, we keep a database of questions and resolutions for reference. Additionally, this database serves as a valuable reference tool to previous decisions for the Lead Team, assisting them in maintaining consistency and conformity to the Louisiana and Federal regulations.

Issue Resolution Process

During the Lead Team meetings the concerns and risks on the weekly status reports and issues log are addressed, options and alternatives are presented, and then the issue is either marked as resolved, or goes to DHH as a question. For each issue addressed during the Lead Team meeting,

resolutions are presented and a decision is made after considering all the available options and responses. Decisions will consider the cost effectiveness, effect on implementation timeliness, and the practicality of implementing the available options and responses.

The Lead Team model creates a single forum for oversight, where all issues are resolved at one time, with clear knowledge of the interdependencies. The Lead Team members understand the Louisiana CCN Program requirements and are capable of making decisions about the health plan by incorporating this knowledge and their expertise. Each issue is thoroughly addressed, understood and resolved allowing decisions to be made and next steps determined.

Once a decision is made for resolution, it is communicated through the Lead Team meeting minutes, updates to the issues log, and during follow up meetings with the Lead Team member's functional area. As issues are identified, the Lead Team works to identify the critical paths within the final fully approved Microsoft Project work plan and anticipate the effect the issue may have on future activities and overall completion. Once that plan is designed, they act on it by assigning tasks and responsibilities to the experts and managers over the respective areas, and by follow-up until completion.

Members of the lead team empower everyone involved in the implementation process to raise concerns and share ideas, as well as identify issues, gaps, and tasks exceeding the work plan time frame. This is done through our issues log, which is posted on our Project Collaboration Team site for review and decision making. This process supports individuals within the plan management and the lead team by identifying any issues and questions that need to be sent to the state for guidance or discussion. Also, using the Project Collaboration Team site, subject matter experts and other team members can include cross-functional dependencies in each log entry.

Additionally, our network development team uses GeoAccess reports to identify its own issues, risks, and concerns. These reports will be used to identify network adequacy deficiencies and issues that are reported to the Lead Team on the weekly status report and the issues log.

Resource allocation and deployment

Aetna Better Health is committed to assigning the resources necessary to develop and execute a hiring plan and a systems development plan, which includes the implementation of our claims processing system, eligibility and enrollment processing system, service authorization management system, provider enrollment and data management system, and conversion of core transaction management system.

As we assign resources we consider their tasks and role while evaluating evaluate their total utilization, aiming for maximum capacity at minimum cost. Throughout the implementation we also consider our resource limitations and the status of our critical path to decide if we need to increase the amount of resources for a particular task.

The Aetna Better Health Implementation Lead Team is critical in determining and arranging available resources as they work to manage department and individual resource capacity. Early in the implementation and development of our operations and network, the Lead Team members finalize their portion of the Microsoft Project work plan and document their needed resources. Both documents are approved by the Lead Team, which can now assess the availability of resources by frequently monitoring the Microsoft Project work plan, weekly status reports, and available outside resources.

Our final, approved Microsoft Project work plan is used to assign resources, track the utilization of those resources and their respective team's progress towards the implementation milestones. Individual teams are organized into sub-groups which, in turn, partner with subject matter experts as needed to accomplish the actions assigned to them. Our experience shows that this pairing of the sub-groups and the subject matter experts has yielded greater efficiency in the use of resources and the completion of assigned tasks. We review and monitor the critical path during the implementation process. Through our analysis of resource availability, the Lead Team can make decisions on the allocation of resources.

The weekly status reports submitted by each functional area within the implementation indicate need for additional resources. The Lead Team also looks for at-risk items listed within the weekly status reports and determines if additional resources are needed to prevent a delay in implementation.

In addition to the vast resources available in our many health plans and within our corporate office we also have the ability to bring in outside contractors and consultants to work on the implementation. We have existing contracts with many of these outside resources and can therefore quickly bring them in to support the implementation process. The Lead Team monitors the use of and expenses incurred by consultants, but this is only done in a way that neither hinders the completion of, nor the compliance with, the Louisiana CCN Program requirements and due dates.

An example of how we manage resources during the implementation process is in how we build a compliant and competitive provider network. Our network development team, led by Jamie McCarrick and overseen by Bob Nolan, is staffed with experienced Medicaid managed care professionals. Our telephonic national recruitment center, located in our corporate offices, works with the network development personnel in Louisiana to build an adequate network. Ms. McCarrick reports the status of our network on her network development weekly status report. The weekly status report, then pulls information from the recently run GeoAccess reports in order to determine adequacy. If the weekly status report states that an adequate network build is at risk, or that they're having delays converting LOI's to contracts, then Ms. McCarrick will contact available external resources and have them immediately begin assisting in the network build.

If the above example does occur, we can incorporate our, "Feet on the Street," campaign. This campaign targets providers that have been unresponsive to letters and phone calls. The goal for "Feet on the Street" is to provide an in-person presence in the communities and doctor's offices to answer questions and help the providers take the next step in executing a contract with Aetna Better Health.

Reporting of status and other regular communications with DHH, including a description of your proposed method for ensuring adequate and timely reporting of information to DHH project personnel and executive management

Aetna Better Health uses a communication plan as part of our implementation project plan. It is our experience that the use of a communication plan allows for a predictable and timely forum to discuss issues and obtain answers as we move forward in the implementation.

Communication Plan

Aetna Better Health proposes the following communication plan:

What	Who/Target	Purpose	When/Frequency	Type/Method(s)
Initiation Meeting	All stakeholders*	Gather information for Initiation Plan	FIRST Before Project Start Date	Meeting
Distribute Project Initiation Plan	All stakeholders*	Distribute Plan to alert stakeholders of project scope and to gain buy in.	Before Kick Off Meeting Before Project Start Date	Document distributed electronically.
Project Kick Off	All stakeholders*	Communicate plans and stakeholder roles/responsibilities. Encourage communication among stakeholders.	At or near Project Start Date	Meeting
Status Reports	All stakeholders and Project Office	Update stakeholders on progress of the project.	Weekly	Distributed electronically via e-mail to DHH.
Aetna Better Health/DHH Team Meetings	Aetna Better Health Implementation Team DHH Representative and/or Committee	To review detailed plans (tasks, assignments, issues, and action items).	Weekly	Conference Call Agenda will be sent out 24 hours prior to meeting time. Meeting notes will follow meeting within 2 business days.

What	Who/Target	Purpose	When/Frequency	Type/Method(s)
System Team Meetings	Aetna Better Health Implementation System Team DHH Representative and/or Committee	To review system related tasks, issues, and action items.	Weekly	Conference Call Agenda will be sent out 24 hours prior to meeting time. Meeting notes will follow meeting within 2 business days.
Operation Team Meetings	Aetna Better Health Implementation Operation Team DHH Representative and/or Committee	To review operations related tasks, issues, and action items.	Weekly	Conference Call Agenda will be sent out 24 hours prior to meeting time. Meeting notes will follow meeting within 2 business days.
Leadership Meetings	Aetna Better Health Implementation Lead Team Director State Medicaid Director	To review implementation tasks, issues, and action items.	Weekly	Conference Call Agenda will be sent out 24 hours prior to meeting time. Meeting notes will follow meeting within 2 business days.

Automated tools, including use of specific software applications

Aetna Better Health uses a combination of software tools that have enabled us to successfully implement numerous health plans around the country:

Project Collaboration Team Site

Our internal Project Team Collaboration site is hosted on our internal Microsoft Office SharePoint Server farm. Through this site we log and store weekly project status reports for all functional areas, issue logs, deliverables reports, and other metrics-related reports. This allows all internal implementation personnel to stay up to date with the implementation process by viewing the previously mentioned reports, recent meeting minutes, an up-to-date Microsoft Project work plan, and other implementation related materials. The Project Collaboration Team

site provides a single point of reference for all implementation personnel ensuring that they have all the information available on the implementation.

Microsoft Live Meeting

Microsoft Live Meeting is used by all members of the Lead Team in order to collaborate in real-time. Any on-going project or activity can be done in Live Meeting. This software is integrated with Microsoft Outlook and other Microsoft software. This program is used so multiple users can view one persons screen. Live Meeting is often used in issue identification and issue resolution by working simultaneously on the same task. Throughout the implementation process, several lead team members will be working remotely and the use of Live Meeting allows them to improve productivity without the cost of travel.

Microsoft Project

Microsoft Project plays a critical role in the design, administration, and implementation of all work plans and projects for the implementation of our health plan. We use Microsoft Project to create and track the implementation work plan. We can view and manage our Gantt chart, critical path and dependencies. We utilize our issue identification and analysis process as a part of the work plan development. Using Project to create and track milestones and individual work plans for the different functional areas has been a key aspect of our success along with other implementations and projects undertaken. The work plan will be adjusted throughout the implementation as needed.

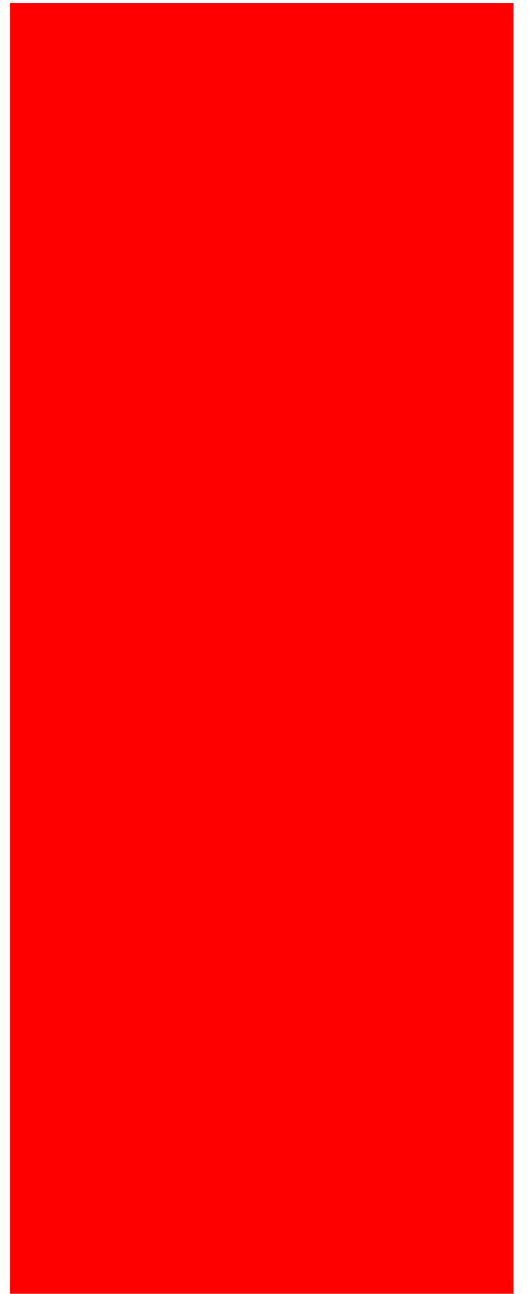
GeoAccess

GeoAccess is used to monitor potential provider network gaps and prioritize regional recruitment efforts. We repeat and review our GeoAccess reports weekly and identify any remaining gaps and continue our development efforts until the network meets the needs of our members. Throughout the implementation phase, Aetna Better Health will periodically conduct GeoAccess studies to monitor geographic access and travel time by geographic area and provider type to identify any gaps that require additional network development efforts. After the health plan begins accepting members we continue to run and evaluate our GeoAccess reports ensuring that our network is adequate and competitive.

National Recruitment Database

The National Recruitment Database is a proprietary tool used in our provider recruitment and configuration processes. This tool is used to smoothly manage providers throughout the negotiation, contracting, and credentialing process. Within the database are separate data repositories that identify hospital, physician, and ancillary targets for proposed markets, which can be used to improve outreach and reporting for adequacy. All provider contacts can be tracked. Additionally, we use this tool to manage where providers are along the continuum throughout the LOI, contracting and credentialing process. In turn, we can effectively analyze and answer the providers' questions and give them needed updates.

36 C.2



C.2 Provide a work plan for the implementation of the Louisiana Medicaid CCN Program. At a minimum the work plan should include the following:

- **Tasks associated with your establishment of a “project office” or similar organization by which you will manage the implementation of the CCN Program;**
- **An itemization of activities that you will undertake during the period between the awarding of this procurement and the start date of the CCN Program. These activities shall have established deadlines and timeframes and as needed conform to the timelines established under this RFP for deliverables.**
 - **All activities to prepare for and participate in the Readiness Review Process; and**
 - **All activities necessary to obtain required contracts for mandatory health care providers as specified in this RFP.**
- **An estimate of person-hours associated with each activity in the Work Plan;**
- **Identification of interdependencies between activities in the Work Plan; and**
- **Identification of your expectations regarding participation by DHH and/or its agents in the activities in the Work Plan and dependencies between these activities and implementation activities for which DHH will be responsible. (In responding the CCN shall understand DHH shall not be obligated to meet the CCN’s expectation.)**

Aetna Better Health has a strong track record of successful Medicaid Managed Care health plan implementations. The three key parts to our implementation process is our experience, inter-departmental openness, and utilization of systematic project tools.

The implementation work plan works in conjunction with our Microsoft Project Work Plan but also includes the following project documents as recommended by the Project Management Institute:

- The Project Scope Statement
- The Cost Management Plan
- The Schedule Management Plan
- The Communications Management Plan
- The Enterprise Environmental Factors
- Organizational Process Assets, and
- The Risk Management Plan

Our implementation project team personnel will include PMP certified project managers that are experienced in implementing new Medicaid Managed Care health plans.

We will be conducting a staggered approach to prepare for transition of three Geographic Service Areas (GSAs) as defined in the RFP as follows: GSA “A,” consisting of Department of Health and Hospitals (DHH) Administrative GSAs 1 and 9; GSA “B” consisting of DHH Administrative GSAs 2, 3 and 4; and GSA “C” consisting of DHH Administrative GSAs 5, 6, 7 and 8.

Tasks associated with your establishment of a “project office” or similar organization by which you will manage the implementation of the CCN Program

As a national Medicaid health plan administration, Aetna Better Health has a dedicated project management office, which manages major business initiatives and services as a center of excellence for project management. The personnel and management of the Project Management Office (PMO) have specialized training and substantial experience in several business areas and competencies, including project management, application development and system development life cycles, health plan administration and operations, and business process improvement methodologies such as Six Sigma.

Additionally, within our PMO, we have established a dedicated Implementation Lead Team to direct and support the management of the implementation of new Medicaid programs. The primary roles of this team are to lead the project management of the implementation and to provide the health plan operational management during the implementation until the new health plan leadership is ready to assume management. Based on their skills, knowledge and experiences, our Implementation PMO has established a set of methodologies, practices and tools for the project management and implementation of a new program.

On this foundation, we will execute the following tasks to establish the implementation project management and project management for the Coordinated Care Network (CCN) Program.

- Assign the dedicated Implementation Manager and Implementation Chief Operating Officer within the Implementation PMO
- Assign the members of the Implementation PMO their primary roles and responsibilities for the program implementation
- Identify the members of the Implementation Lead Team and schedule their meetings
- Identify the members of the Implementation Council and schedule their meetings
- Establish the Implementation Project Collaboration Team site based on our standard implementation project management templates and customized for the CCN Program requirements

Establishing the Implementation Lead Team

We recognize that setting up an effective strategic project office is the means by which we can optimize our resources and our capability to meet the DHH CCN Program deadlines as provided in the RFP. Our success is defined by our ability to deliver acceptable results on time and within budget.

This success is most evident in the structure of our Implementation Lead Team, and the strength of our team is dependent upon proven leaders who direct both the team and the steps involved in a Medicaid Managed Care implementation. Our Implementation Manager and the director for the Implementation Lead Team for the Louisiana implementation, Lisa Baird, will fulfill this role. Ms. Baird possesses an impressive skill set and a significant background in implementation management, and has served most recently as the director on our Illinois and Pennsylvania implementations. Her demonstrable strengths and experience fortifies our ability to successfully plan for and react to implementation risks. In similar fashion, our entire team consists of a group

of equally experienced managers whose collective expertise covers a wide spectrum of subject areas, which we draw from as we manage the implementation and the risks inherent in the process.

The Lead Team then addresses the task of creating sub-groups that work with the subject matter experts of all roles and processes to accomplish the actions assigned to them.

Our culture of openness, the empowerment of every team member leads to an ability to quickly react to the concerns and issues that invariably arise in such a process. Individuals are encouraged to bring concerns to leadership or address them directly with the Lead Team as they occur. This mindset, combined with our history of previous successful implementations and our systematic tracking tools, has cultivated a seasoned and efficient approach to implementation and risk management.

The Meeting Process

Our next task is to implement weekly meetings of the Lead Team members. During these meetings, the Lead Team reviews the project scope, establishes and approves policy, reviews and resolves issues, and verifies that contractual obligations are being met in a timely manner. The Lead Team will also assign additional tasks, define the duration of tasks, add dependencies to tasks and identify critical paths within the work plan as needed.

Initiating and implementing various systematic project tracking tools is another task that is vital to the successful flow of this process. Central to this area is our utilization of our Project Collaboration Team site, a proprietary intranet Microsoft web application. Through this site, we generate several key logs and reports crucial to the successful management of the implementation process.

Key Logs and Reports

We will incorporate an issues log and a weekly status report to track the status of the implementation and manage our priorities. The issues log and the weekly status report will be available on the Project Collaboration Team site. The issues log will be implemented and generated for a weekly team review and is the responsibility of the Implementation Manager. The Lead Team reviews the issues log for the purpose of either immediately resolving any issues, or assigning them to the relevant workgroup for resolution. The lead team is updated on the progress of all functional areas via the weekly status reports, which include the progress of the overall completion percentage status of each portion of the project, accomplishments during the week, at-risk tasks with explanation, and any effects their status will have on budget or timeframe.

Establishment of the Health Plan Office

Our Member Services Manager is responsible for the acquisition and preparation of the physical health plan office space. As part of this task, they manage and review the office space preparation resources, and are required to provide assurances to the Lead Team that there are enough resources available at the right levels, time, and location.

The Member Services Manager identifies risks and resolution strategies throughout the process of planning and building the health plan office. Risks are identified and addressed on both the Risk Management Plan and the weekly status reports

Staffing Tasks

Tasks related to the staffing of this office include thorough training of all employees. Our Risk Management plan includes subgroups directly related to both hiring and training of employees. We oversee and review the available hiring and training resources and a designated team member will provide assurances to the Lead Team that there are enough resources available at the right levels, time, and location for both staffing related subgroups. We identify risks and their mitigation strategies as we hire and begin training the new health plan employees. Risks are monitored on both the Risk Management Plan and the weekly status reports.

An itemization of activities that you will undertake during the period between the awarding of this procurement and the start date of the CCN Program. These activities shall have established deadlines and timeframes and as needed conform to the timelines established under this RFP for deliverables.

Our systematic project tracking methods revolve around the utilization of a Microsoft Project work plan. Through our work plan, we will create a work breakdown structure by which we identify manageable subgroups. This process of itemization assists us in more precisely allocating resources and establishing the critical path of this process.

As outlined in the Scope of Work requirements in the RFP, our activities will include, but not be limited to:

- Have a license or certificate of authority issued by the Louisiana Department of Insurance (DOI) to operate as a Medicaid risk bearing entity pursuant to Title 22:1016 of the Louisiana Revised Statutes no later than July 15, 2011, and submit to DHH within 30 days from the date the CCN signs the contract with DHH
- Be certified by the Louisiana Secretary of State, pursuant to R.S. 12:24, to conduct business in the state, and submit to DHH within 30 days from the date the CCN signs the Contract with DHH
- Meet solvency standards as specified in federal regulations and Title 22 of the Louisiana Revised Statutes
- Meeting NCQA or URAC Health Plan Accreditation requirements and maintaining accreditation through the life of this Contract
- Confirming our network capacity to enroll a minimum of 75,000 Medicaid members into the network in each DHH designated GSA for which a proposal is being submitted
- Performing due diligence to avoid an actual or perceived conflict of interest that, in the discretion of DHH, would interfere or give the appearance of possibly interfering with its duties and obligations under this Contract or any other contract with DHH, and any and all appropriate DHH written policies

Additional standard milestones have been established in our work plan, outlined in the table below. By systematic execution of and adherence to this plan, we are confident of our ability to provide all deliverables in an expedient manner.

Activity	Timeframe
Initiate Lead Team Start Project	June 2011
Legal Review Submit required information to the applicable regulatory office Obtain approval from regulatory office and receive licensure	June 2011
Network Development Contracting providers to meet network adequacy Credentialing providers Loading providers into QNXT™ system Auditing provider information added to system Publish paper provider directory Provide provider data for on line provider web search	GSA A - October 2011 GSA B - November 2011 GSA C - January 2012 GSA A - October 2011 GSA B – January 2012 GSA C - March 2012
QNXT™ Configuration Initiate a system environment Configure system according to benefits, prior authorization requirements and payment mechanisms (based on DHH guidance) Unit Test system End to End testing of system Promote environment to a Live status	June 2011 – December 2011
Application Development Build applications according to Business Requirement Document Test Application Promote application to a Live status	June 2011 – December 2011
File Development Build files according to Business Requirement Document (based on DHH system companion guide) Test Files with DHH Promote Files to a Live status	June 2011 – December 2011

Activity	Timeframe
<p>Reporting</p> <p>Build reports according to Business Requirement Document (based on DHH requirements)</p> <p>Test reports with DHH</p> <p>Promote reports to a Live status</p> <p>Submit reports according to DHH timelines</p>	<p>June 2011 – December 2011</p>
<p>Policies and Procedures (Non-Medical Management)</p> <p>Create policy and procedures according to contractual requirements</p> <p>Review policy and procedures</p> <p>Submit policy and procedures to DHH for approval</p>	<p>June – September 2011</p>
<p>Medical Management</p> <p>Create policy and procedures according to contractual requirements</p> <p>Review policy and procedures</p> <p>Medical Director signs policies</p> <p>Submit policy and procedures to DHH for approval</p> <p>Implement Care Management system</p>	<p>June – September 2011</p>
<p>Compliance</p> <p>Create/Update Fraud and Abuse plan according to contractual requirements</p> <p>Submit Fraud and Abuse/Compliance plan to DHH for approval.</p>	<p>June – September 2011</p>
<p>Marketing</p> <p>Design member materials</p> <p>Send member material to DHH for approval</p> <p>Distribute member materials</p>	<p>June – September 2011</p>
<p>Finance/Actuary</p> <p>Obtain checking account information</p> <p>Submit banking information for system configuration</p> <p>Distribute approved health plan budget to appropriate parties</p> <p>Obtain required insurances</p>	<p>April – October 2011</p>

Activity	Timeframe
File fully executed insurances with DHH Receive insurance approvals from DHH	
Member Services Create member handbook according to contractual requirements Submit member handbook to Marketing Department for design Create welcome scripts and send to DHH for approval	June – September 2011
Aetna Better Health Provider Services Create provider handbook according to contractual requirements Submit provider handbook to marketing for design Create external provider training material Educate providers on CCN-P program	June – September 2011
Encounters Receive connectivity requirements from DHH Receive companion guides from DHH Receive application and approval from FI Define encounters requirements for vendors Test encounters data with vendors Tier 1 Testing Tier 2 Testing Tier 3 Testing Implement Encounters Dispute Resolution process Move EMS into Production Monitor Encounters Quality Review, Update or Develop procedures	April 2011 – July 2012
Human Resources and Recruitment Recruit and Hire Key and other employees for CCN-P program	April 2011 – March 2012

Activity	Timeframe
Real Estate and Equipment Determine space requirements Identify available space Design floor plan Execute lease Construction Build VDC room Install furniture & work surfaces Identify equipment needs (Fax, Scanners, Phones, Computers)	May – August 2011
Telecom Services Order 800# Order & install T1 lines Build call recording Develop Active Call Distribution (ACD) Build & program call flow Record call flow scripts Test call flow	June – August 2011
New Hire Training Develop Training Schedule Identify and assign trainers Develop curriculum Submit training curriculum to DHH Identify rooms for training Train Marketing Reps on Member’s Rights & Responsibilities and Grievance & Appeals Conduct all required training	June – October 2011
Patient-Centered Medical Home Identify any non-standard PCMH requirements Outline PCMH Implementation Plan Send PCMH Implementation Plan to DHH Initiate PCMH Implementation	June 2011 – April 2012

Activity	Timeframe
NCQA Develop NCQA work plan Submit NCQA work plan	June – September 2011
Enrollment Identify 834 Business Requirements for file processing Define PCP Auto Assignment requirements Define vendor enrollment processing requirements Identify all enrollment reporting requirements Obtain access to DHH's online eligibility verification portal Define COB requirements and dbase Train enrollment & COB personnel	August – November 2011
Readiness Review Create and review policy and procedures, plan programs and committee structures Review the DHH Readiness Review assessment tool Establish communication tools, FTP and File transfer protocols or readiness review submissions Submit all required documentation to DHH for review Coordinate with DHH regarding logistics of on site readiness review Conduct Readiness Review	July 2011 – March 2012

Activities related to the development of the network will include:

- Obtaining contract approval from DHH
- Testing, evaluating and approving network adequacy, and
- Addressing any network inadequacies by taking steps such as recruiting new providers, providing transportation outside the member's community to a qualified provider, and promoting Patient-Centered Medical Homes to improve care coordination and the exchange of member information.

Our IT implementation activities will strictly adhere to the RFP specifications for Systems and Technical requirements. Oversight of this functional area is the responsibility of our Information Management and Systems (IMS) Director. Responsibilities of this role includes oversight for all aspects of corporate EDI processes including Claims, Eligibility, Encounters, and the implementation of all HIPAA related transaction code sets. Our IMS Director will also guide and manage technology project implementations, systems support and problem resolution and providing IT support to operations and business units. Under the direction of our IMS Director,

an IT Risk Management Plan will be developed and administered. This plan will identify risks and their mitigation strategies as we continue building and designing the core systems and will further monitor the IT resources.

In preparing the IT area, Aetna Better Health will comply with the standards set forth in the RFP including all hardware and software requirements, utilization of standardized forms and formats, network and backup capabilities, data exchange, connectivity, and contingency plan preparations.

All activities to prepare for and participate in the Readiness Review Process

Aetna Better Health will fully comply with DHH's readiness review process. We recognize that this review may include, but not be limited to review of our proper licensure, our operational protocols, and systems readiness.

The Readiness Review project management process will include the following activities:

- Appoint a Readiness Review Coordinator
- Review RFP for Readiness Review activities
- Create and review policy and procedures
- Create and Review Committee structure and Plan programs
- Review Readiness Review assessment tool
- Communicate and coordinate responses to the Readiness Review assessment tool
- Establish communication, FTP and file transfer protocols with DHH
- Prepare system and documentation for demonstrations
- Submit all required documentation to DHH for review
- Update documentation based on DHH suggested revisions if needed
- Coordinate with DHH on logistics of On-Site Readiness Review
- File all approved documentation in Health Plan SharePoint site
- Conduct Readiness Review

In conducting the Readiness Review, Aetna Better Health will meet all requirements established by DHH within the time frames provided by DHH. We will provide all materials required to complete the readiness review by the dates established by DHH and/or its Readiness Review contractor. Aetna Better Health acknowledges that we have overall responsibility for the timely and successful completion of each of the Transition Period tasks.

Per the RFP specifications, we will work diligently to fully prepare all components for the DHH's on-site readiness reviews that are scheduled both during the implementation process and as an ongoing activity during the Contract period. Our work will include, but not be limited to, preparation of focus areas including:

- Administrative capabilities
- Governing body

- Subcontracts
- Provider network capacity and services
- Provider complaints
- Member services
- PCP assignments and changes
- Enrollee grievances and appeals
- Health education and promotion
- Quality improvement
- Utilization review
- Data reporting
- Coordination of care
- Claims processing, and
- Fraud and abuse.

We will provide proof of adequate coverage of insurance by a certificate of insurance during the Readiness Review process and annually thereafter, or upon change in coverage and/or carrier. Furthermore, we will provide the following reports or files to DHH, as required by the RFP:

- Network Provider and Subcontractor Registry
- Provider Directory Template
- Referral Policies
- Marketing Plan
- CCMP Reports, Predictive Modeling Specifications, and Program Evaluation
- Emergency Management Plan
- Network Provider Development and Management Plan
- Various Quality Assurance (QA) components, including description and QAPI Plan, impact and effectiveness of QAPI program evaluation, Performance Improvement Project descriptions, Performance Improvement Projects Outcomes, Early Warning System Performance Measures, Level I and Level II Performance Measures and PCP Profile Report

Administration and Key CCN Personnel

Aetna Better Health is designating and identifying Key Personnel that meet the requirements of the contract, as outlined in section B. We have supplied resumes of each Key Aetna Better Health Personnel, and will also submit organizational information that has changed relative to this Proposal, including updated job descriptions and updated organization charts, updated Management Information System (MIS) job descriptions and an updated MIS staff organizational chart, when applicable. We will similarly provide the organization chart for such Subcontractor(s).

No later than the Contract execution date, we will update the information above and provide any additional information as it relates to the Coordinated Care Network (CCN) Program.

Financial Readiness Review

In order to complete a Financial Readiness Review, we acknowledge DHH's requirement that we update information submitted in this proposal and/or any other requirements specified in the RFP. This information will include the requirements specified in the Proposal Submission and Evaluation Requirements, and/or all relevant corporate and identification and information, including:

- A copy of our current Louisiana Department of Insurance Certificate of Authority to provide HMO services
- If any changes of ownership of our company is anticipated during the 12 months following the Proposal due date, we will describe the circumstances of such change and indicate when the change is likely to occur.
- Corporate and ownership information, including the names of officers and directors.
- The state in which we are incorporated and the state(s) in which we are licensed to do business as an HMO. We will also indicate the state where we are commercially domiciled, if applicable.
- Confirmation that we have not had a contract terminated or not renewed for non-performance or poor performance within the past five years.
- Information pertaining to our National Committee for Quality Assurance (NCQA) or American Accreditation HealthCare Commission (URAC) accreditation status.

Subcontractor Information

Aetna Better Health will submit the following for each proposed Subcontractor, if any:

- 1) A completed attestation of commitment from each Subcontractor that states the Subcontractor's willingness to enter into a Subcontractor agreement with Aetna Better Health and a statement of work for activities to be subcontracted. Attestations must be provided on the Subcontractor's official company letterhead and signed by an official with the authority to bind the company for the subcontracted work.
- 2) The Subcontractor's legal name, trade name, or any other name under which the Subcontractor does business, if any.
- 3) The address and telephone number of the Subcontractor's headquarters office
- 4) The type of ownership (e.g., proprietary, partnership, corporation).
- 5) The type of incorporation (i.e. for profit, not-for-profit, or non-profit) and whether the Subcontractor is publicly or privately owned.
- 6) If a Subsidiary or Affiliate, the identification of the parent organization.
- 7) The name and address of any sponsoring corporation or others who provide financial support to the Subcontractor and type of support, e.g., guarantees, letters of credit, etc. Indicate if there are maximum limits of the additional financial support.
- 8) The name and address of any health professional that has at least a five percent (5%) financial interest in the Subcontractor and the type of financial interest.

- 9) The state in which the Subcontractor is incorporated, commercially domiciled, and the state(s) in which the organization is licensed to do business.
- 10) The Subcontractor's federal taxpayer identification number.
- 11) Confirmation that Aetna Better Health has not had a contract terminated or not renewed for non-performance or poor performance within the past five years.
- 12) Whether Aetna Better Health has ever sought, or is currently seeking, National Committee for Quality Assurance (NCQA) or American Accreditation HealthCare Commission (URAC) accreditation status, and if it has or is, indicate:
 - A) is current NCQA or URAC accreditation status; if NCQA or URAC accredited, its accreditation term effective dates; and if not accredited, a statement describing whether and when NCQA or URAC accreditation status was ever denied to Aetna Better Health.

Other Information

- 1) We will confirm that Aetna Better Health has never be subject to any regulatory action, sanctions, and/or fines imposed by any federal or Louisiana regulatory entity or a regulatory entity in another state within the last three (3) years.
- 2) No later than thirty (30) days after the Contract Effective Date, we will submit documentation that demonstrates that we have secured the required insurance and bonds in accordance with DHH requirements.
- 3) We will submit annual audited financial statement for fiscal years 2010 and 2011 (2011 to be submitted no later than six months after the close of the fiscal year).
- 4) We will submit an Affiliate Report containing a list of all Affiliates and for DHH's prior review and approval, a schedule of all transactions with Affiliates that, under the provisions of the Contract, will be allowable as expenses in the Financial Report for services provided us by the Affiliate. Those should include financial terms, a detailed description of the services to provided, and an estimated amount that will be incurred by us for such services during the Contract Period.

System Testing and Transfer of Data

Aetna Better Health will have hardware, software, network and communications systems with the capability and capacity to handle and operate all MIS systems and subsystems.

During the Readiness Review task, we will accept into its system any and all necessary data files and information available from DHH or its contractors. We will install and test all hardware, software, and telecommunications required to support the Contract. We will define and test modifications to our system(s) required, supporting the business functions of the Contract.

We will produce data extracts and receive data transfers and transmissions. We will be able to demonstrate the ability to produce encounters file. If any errors or deficiencies are evident, we will develop resolution procedures to address the problem identified. The Aetna Better Health will provide DHH, or designated contractor, with test data files for systems and interface testing for all external interfaces. This includes testing of the required telephone lines for Providers and Members and any necessary connections to the Enrollment Broker and External Quality Review

Organization. We will demonstrate its system capabilities and adherence to Contract specifications during readiness review.

System Readiness Review

Aetna Better Health will verify that system services are not disrupted or interrupted during the Operations Phase of the Contract, as defined in the Information Systems Availability section of the RFP. We will coordinate with DHH and other contractors to verify the business and systems continuity for the processing of all healthcare claims and data as required under this Contract.

We will submit to DHH descriptions of interface and data and process flow for each business processes described in the ***CCN-P Systems Companion Guide***. We will clearly define and document the policies and procedures that will be followed to support day-to-day systems activities. We will develop and submit for DHH review and approval, the following information no later than 30 days after the Contract is signed

- Disaster Recovery Plan
- Business Continuity Plan
- Systems Quality Assurance Plan

We will confirm that our System shall be able to transmit, receive and process data in current HIPAA compliant or DHH specific formats and/or methods, including, but not limited to, secure File Transfer Protocol (FTP) over a secure connection such as a Virtual Private Network (VPN), that are in use at the start of our systems readiness review activities.

Demonstration and Assessment of System Readiness

We will provide documentation on systems and facility security and provide evidence or demonstrate that it is compliant with HIPAA, as specified in the Information Security and Access Management section and as otherwise stated in the RFP. We will also provide DHH with a summary of all recent external audit reports, including findings and corrective actions, relating to our proposed systems. We shall promptly make additional information on the detail of such system audits available to DHH upon request.

In addition, we expect DHH to provide to Aetna Better Health a test plan that will outline the activities that need to be performed by us prior to the Go-Live Date of the Contract, as outlined in the CCN-P Systems Companion Guide. We will be prepared to verify and demonstrate system readiness. We will execute system readiness test cycles to include all external data interfaces, including those with Subcontractors.

DHH, or its contractors, may independently test whether our MIS has the capacity to administer a Coordinated Care Network. This Readiness Review of our MIS may include a desk review and/or an onsite review. Based in part on the our assurances of systems readiness, information contained in the Proposal, additional documentation submitted by us, and any review conducted by DHH or its contractors, DHH will assess our understanding of our responsibilities and our capability to assume the MIS functions required under the contract.

We acknowledge that we are required to provide a Corrective Action Plan in response to any Readiness Review deficiency no later than ten (10) calendar days after notification of any such deficiency by DHH. If we document to DHH's satisfaction that the deficiency has been corrected

within ten (10) calendar days of such deficiency notification by DHH, we understand that no Corrective Action Plan will be required.

Operation Readiness

We will clearly define and document the policies and procedures that will be followed to support day-to-day business activities related to Louisiana Medicaid members, including coordination with contractors. We will be responsible for developing and documenting its approach to quality assurance.

Readiness Review includes all plans to be implemented in one Geographic Service Area (GSA) on the anticipated Operational Start Date. For each GSA, as outlined in the RFP Schedule of events, our preparations will specifically include the following components:

- Assembling the GSA Network adequacy documentation
- Submission of Aetna Better Health's Network and Contract to CMS
- Preparation of Network Provider Directory and One Page Brochure for Enrollment Broker
- Preparation of Choice Letters for Members
- Deadline for Member Enrollment established

At a minimum, we will:

- 1) Develop operations procedures and associated documentation to support our proposed approach to conducting operations activities in compliance with the contracted scope of work.
- 2) Submit to DHH, a listing of all contracted and credentialed Providers, in a DHH approved format including a description of additional contracting and credentialing activities scheduled to be completed before the Go-Live Date.
- 3) Prepare and implement a Member Services personnel training curriculum and a Provider training curriculum.
- 4) Prepare a Coordination Plan documenting how we will coordinate its business activities with those activities performed by DHH contractors and our Subcontractors, if any. The Coordination Plan will include identification of coordinated activities and protocols for the Transition Period.
- 5) Develop and submit to DHH the draft Member Handbook, draft Provider Manual, draft Provider Directory, and draft Member Identification Card for DHH's review and approval. The material must at a minimum meet the requirements specified in the Request for Proposal.
- 6) Develop and submit to DHH our proposed Member complaint and appeals processes.
- 7) Provide sufficient copies of final Provider Directory to the DHH's Enrollment Broker in sufficient time to meet the enrollment schedule.
- 8) Demonstrate toll-free telephone systems and reporting capabilities for the Member Services Hotline and Provider Service Hotline.

- 9) Submit a written Fraud and Abuse Compliance Plan to DHH for approval no later than 30 days from the date the Contract is signed. As part of the Fraud and Abuse Compliance Plan as described in this RFP, we will:
 - a) Designate a compliance officer and essential personnel to attend mandatory training in fraud and abuse detection, prevention and reporting. Executive and essential fraud and abuse personnel means Aetna Better Health staff persons who supervise personnel in the following areas: data collection, provider enrollment or disenrollment, encounters data, claims processing, utilization review, appeals or grievances, quality assurance and marketing, and who are directly involved in the decision-making and administration of the fraud and abuse detection program within our organization
 - b) Designate an officer within the organization responsible for carrying out the provisions of the Fraud and Abuse Compliance Plan.
 - c) We are held to the same requirement and must confirm that, if this function is subcontracted to another entity, the subcontractor also meets all the requirements.

During the Readiness Review, DHH may request from us certain operating procedures and updates to documentation to Coordinated Care Network Services. DHH will assess our understanding of our responsibilities and our capability to assume the functions required under the Contract, based in part on the our assurances of operational readiness, information contained in the Proposal, and in Transition Period documentation submitted by us.

We will promptly provide a Corrective Action Plan as requested by DHH in response to Operational Readiness Review deficiencies identified by us or by DHH's contractors. We will promptly alert DHH of deficiencies, and must correct a deficiency or provide a Corrective Action Plan no later than ten (10) calendar days after DHH's notification of deficiencies. If we document to DHH's satisfaction that the deficiency has been corrected within ten (10) calendar days of such deficiency notification by DHH, we understand that no Corrective Action Plan is required.

Assurance of System and Operation Readiness

In addition to successfully providing the Deliverables described in the RFP, we will verify to DHH that all processes, MIS systems, and staffed functions are ready and able to successfully assume responsibilities for operations prior to the Go-Live Date. In particular, will use reasonable efforts to verify that Key CCN Personnel, Member Services personnel, Aetna Better Health Provider Services personnel, and MIS personnel are hired and trained, MIS systems and interfaces are in place and functioning properly, communications procedures are in place, Provider Manuals have been distributed, and that Provider training sessions have occurred according to the schedule approved by DHH.

All activities necessary to obtain required contracts for mandatory health care providers as specified in this RFP

Aetna Better Health understands that building and implementing an adequate network is critical to the success of the CCN program. We have already begun actively recruiting the required provider types from the RFP and we will continue to do so through the contract award.

The first priority in our contracting activity is to recruit providers that are currently providing Medicaid services, especially the Significant Traditional Providers (STPs). Then, we build outward from their existing referral network. We develop and leverage these referral patterns by working with our contracted providers to identify the providers to whom they typically refer patients and then reach out to those providers. This process allows us to establish an efficient and comprehensive network based on existing network relationships. This pattern-driven approach has proven a significant part of providing quality and convenient services to our members.

We will submit our Network Development and Management Plan within 30 days of CCN contract execution. We will also submit our contracts for final approval within 30 days of CCN contract execution.

Aetna Better Health is recruiting providers with an emphasis on contracting. If a provider is unwilling to contract until after the bid has been awarded, we work with that provider to draft a Letter of Intent (LOI) and then offer a contract after the award. Our current provider contracts are compliant with existing DHH rules and policies and also have unilateral amendment authority to conform to DHH requirements.

In addition to Medicaid providers, we also recruit non-Medicaid providers to fill adequacy gaps and accessibility concerns. The options available to identify these providers include the following:

- Commercial providers contracted or previously through our parent company and affiliates,
- The NPI registry
- Competitor online provider directories (where possible)

When contracting with providers, our standard practice is to send out an initial contract by mail. We will then follow-up by phone, fax, and email as we see fit. Additionally, we can send network representatives into the provider offices with our medical director or health plan CEO to finalize contracting. We also do in-office visits in areas where our network is inadequate, the provider is a high volume Medicaid provider, or they have requested a visit prior to contracting. Finally, we take advantage of our parent and affiliate organizational relationships by using them to facilitate provider meetings when necessary.

An estimate of person-hours associated with each activity in the Work Plan

We recognize that managing resource constraints is an important part of any project, especially one as large as implementing a new health plan. Our methods have proven to be effective in managing highly skilled and high-price resources. We will be diligent in monitoring our commitment of resources, including people, to each task of the implementation as outlined above.

A thorough analysis and design of the work item is undertaken in order to provide the most reasonable and reliable estimate of person-hours. We strive to provide a balance between providing a reliable guideline while also maintaining a realistic view of anticipated progress.

Our estimate takes into account numerous factors, including productive hours per day, multi-tasking productivity loss for part-time resources, the number of resources applied to each activity, available working days within the schedule, calculation of delays and lag-times, and the documentation of all assumptions upon which our estimate is based.

Based on the scheduled time commitments of the dedicated management and personnel assigned to the CCN program implementation, the estimated person-hours associated with the major tasks of the implementation is 51,710. The complete set of tasks required to successfully implement a new program extends across a significant number of business processes and units within Aetna Medicaid and Aetna. Consequently, some tasks are completed through standard business practices and operating procedures in dedicated units who perform these tasks according to service level commitments. An example of these tasks is the establishment of a toll-free phone number. The person-hours associated with these activities are not included in the estimate above.

Identification of interdependencies between activities in the Work Plan

The interdependencies located within our Microsoft Project work plan will identify a project critical path. We will utilize the critical path method to define and distinguish between critical and non-critical tasks within the implementation process. The critical path(s) are those tasks or series of tasks consisting of the longest time frame(s) within the overall project timeframe, which if delayed would place the implementation deadline in jeopardy. The steps we will take to apply this method are:

- Defining and listing the required tasks for implementation in a sequenced list
- Creating a flowchart to determine which tasks have interdependencies,
- Determining what the expected completion or execution time will be for each task
- Determining if the critical path can be shortened via alternative methods, i.e. with additional resources or by carrying out more tasks in parallel

Activities	Interdependencies
Build Network	Contract with Providers Receive provider data Credential providers Enter provider data into system Create Provider files Paper and Web provider directory created Run Provider Reports
QNXT™ and ancillary application configuration	Receive and review information from DHH system companion guide Receive reimbursement guidance from DHH Configure benefits, prior authorization requirements, eligibility codes Receive letter approval from DHH Unit Testing End to End testing Go Live Process claims

Activities	Interdependencies
	Internal Audit Check Run Encounters Process HEDIS ^{®1} and EPSDT reporting
Staffing	Recruitment Interviewing Training
Enrollment	DHH System Companion Guide 834 Business Requirement Document QNXT™ System Configuration Unit Testing End to End Testing Receipt of 834 files from DHH Update Member Module in QNXT™ system PCP Assignment Process ID Card Processing Welcome Packet Distribution Eligibility transferred to subcontractor and other ancillary application
Encounters	Connectivity Review DHH Companion Guide System Set up Testing (Tier 1-3) Go live Submission of timely, accurate and complete encounters
Reporting	Identify reporting requirements, business owners and data sources Complete business requirements document Build reports in system Test reports Deploy reports Submit reports to DHH according to documented schedule

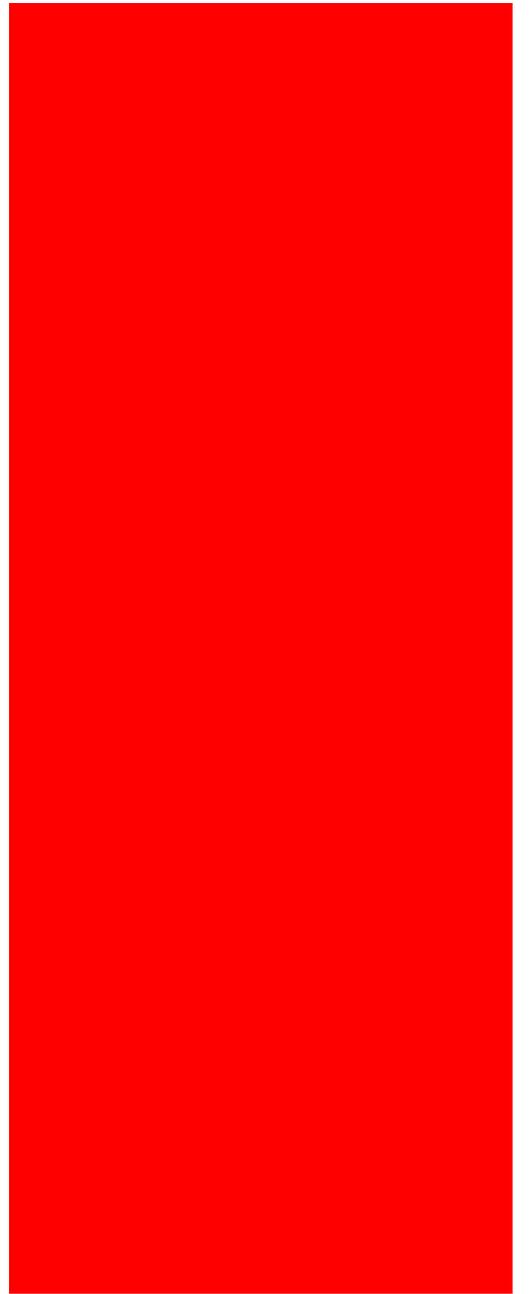
¹ HEDIS[®] is a registered trademark of the National Committee for Quality Assurance.

Identification of interdependencies between activities in the Work Plan; and Identification of your expectations regarding participation by DHH and/or its agents in the activities in the Work Plan and dependencies between these activities and implementation activities for which DHH will be responsible. (In responding the CCN shall understand DHH shall not be obligated to meet the CCN’s expectation.)

It is Aetna Better Health’s goal to have communication at the subject matter expert level for both participants during the implementation. Below is a listing of tasks that we have identified interdependency’s with DHH.

Task	Interdependency
Encounters Build	DHH System Companion Guide
Reimbursement mechanisms	DHH fee schedules and other payment mechanisms
HIPAA and Proprietary Files	DHH System Companion Guide and Supporting Documentation
Connectivity	DHH
Application Development (Letter Approval)	DHH
Questions/Clarity	DHH
File Testing	DHH
Policy and Procedure, Member Material approval	DHH

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C.3 Describe your Risk Management Plan.

- **At a minimum address the following contingency scenarios that could be encountered during implementation of the program:**
 - **Delays in building the appropriate Provider Network as stipulated in this RFP;**
 - **Delays in building and/or configuring and testing the information systems within your organization's Span of Control required to implement the CCN program;**
 - **Delays in hiring and training of the staff required to operate program functions;**
 - **Delays in the construction and/or acquisition of office space and the delivery of office equipment for staff required to operate program functions;**
 - **Delays in enrollment processing during the implementation of CCN; and**
 - **Delays in the publication of marketing and related materials and/or the delivery of these materials to DHH and/or its agents.**
- **For each contingency scenario identified in the Proposal, at a minimum the Risk Management Plan must include the following:**
 - **Risk identification and mitigation strategies;**
 - **Risk management implementation plans; and**
 - **Proposed or recommended monitoring and tracking tools.**

The Aetna Better Health Risk Management Plan is an integral part of the overall project plan and ties in to all parts of the implementation process. Through our risk identification process, we determine all risks, their probability of occurrence, and their possible impact. As risks are identified, we rank them by priority, assign ownership, and then develop a strategy to reduce their impact or likelihood of occurrence. All items in this process will be evaluated and monitored by the Aetna Better Health Implementation Lead team. The ongoing risk analysis and management has already begun and continues through the implementation.

Aetna Better Health has an active, continuous improvement methodology with regards to risk identification, assessment, planning, monitoring, and management. The Risk Management Plan has been continually refined through our recent Medicaid Managed Care implementations in Illinois, Pennsylvania, Connecticut, Florida and Missouri. We utilize the experience and knowledge of our Implementation Manager, Lisa Baird, to proactively manage inherent and potential implementation risks. Additionally, throughout our organization we have a wealth of experience that we draw on as we manage the implementation and the risks involved. We will continue to refine our risk identification, assessment, planning, monitoring, and management processes throughout the implementation.

Our systematic project management and tracking processes utilize Microsoft Project and Microsoft SharePoint tools located within our Project Collaboration Team site. The Risk Management Plan is a component of the overall project plan and incorporates the project scope, budget, schedule and communication plans.



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Pairing our proactive and empowered implementation team with capable risk analysis and follow up tools allows us to efficiently manage our Medicaid Managed Care implementations. This in turn allows all resource areas involved in the implementation to participate in the building and evaluation of the Risk Management Plan. This Plan is located on our Project Collaboration Team site and is available to all internal implementation contributors. Using this site provides accessible, real-time updates to the Plan, while facilitating widespread participation.

Risk Management Plan Details

The Risk Management Plan will be maintained as a list on the Project Collaboration Team site where each identified risk is listed with the following components:

- Factor ID:
 - A sequential number for risk factors in this project. New factors are assigned the next available sequential number.
- Risk Factors:
 - The potential risks to this project
- Probability:
 - The likelihood that the potential risk will occur on a scale of 1 – 3 – 5
 - ◇ 1 – Low probability of occurrence
 - ◇ 3 – Medium probability of occurrence
 - ◇ 5 – High probability of occurrence
- Impact:
 - The damage that the potential risk will create on a scale of 1 – 3 – 5
 - ◇ 1 – Low impact
 - ◇ 3 – Medium impact
 - ◇ 5 – High impact.
- Priority:
 - Calculation based on the probability and impact
- Event Trigger:
 - The event that will cause a Risk Factor to occur. No other actions come between an event trigger and the Risk Factor.
- Risk Owner:
 - The person, a member of the Aetna Better Health Implementation Lead Team, responsible for identifying the Event Trigger and implementing the Contingency Strategy.
- Mitigation Strategy:
 - The steps taken to mitigate impacts of a potential risk, not all options are available for all Risk Factors. The options are:
 - ◇ Transference – Assigning ownership of the risk to an entity external to the project



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- ◇ Avoidance – Preventing or lowering the probability that the risk will occur
- ◇ Reduction – Decreasing the impact of the potential risk
- ◇ Acceptance – Accepting some or all of the impact from a potential risk
- Contingency Plans
 - Action Steps necessary to implement the mitigation strategy
- Last Risk Audit Date:
 - Risk Factors will be periodically reviewed to determine if their propensity or impact has changed and to re-evaluate their priority and impact.
- Date of Next Risk Audit Review
 - The risk factors will be scheduled for their next review, ensuring that each risk is analyzed throughout the implementation process

Risk Monitoring and Tools (Risk Audits)

Risk audits include current status, updates on probability and/or impact, and review of mitigation strategies. High priority risks are escalated by the risk owner to the appropriate Aetna Better Health senior leadership team as necessary. The risk audits are tracked and monitored using the Microsoft SharePoint web-based collaborative site for all project risks.

Risk audit frequency is as follows:

- Weekly project team status reports,
- Bi-weekly review by Implementation Leadership Team, and
- Periodic review by risk owners.

(1) Delays in building the appropriate Provider Network as stipulated in this RFP;

Risk Identification and Mitigation strategy examples

Risk Identification	Mitigation strategy	Applies to GSA A, B or C?
Prior to go-live, it is determined that a key Medicaid provider in a rural area is unwilling to execute a contract.	Avoidance – Key providers including STP providers are targeted early in our recruiting process. As these providers are recruited we make every reasonable effort available to us to include them in our network. We will provide transportation to our members to other in network providers until an agreement can be reached.	All
Accessibility to cardiologists is determined to be insufficient.	Acceptance – Allow for referral to non-participating cardiologist within a member’s service area, at no cost to the member.	All
A member in a rural service area requests a second opinion but only one provider is available within their area.	Acceptance/Avoidance – We are working to exceed the required network standards where possible. Otherwise, we will provide transportation to the nearest specialist as needed. The specialist may be par or non-par, but the member will have no cost in	All



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Risk Identification	Mitigation strategy	Applies to GSA A, B or C?
	either situation.	

Risk management implementation plans:

Jamie McCarrick, Director of Network Development, is responsible for the network development Risk Management Plan. She is also responsible for overseeing and reviewing the network development resources and is required to provide assurances to the Lead Team that there are enough resources available at the right levels, time, and location.

Ms. McCarrick will identify risks and the mitigation strategies as we continue building an adequate network and throughout the implementation process. Risks are monitored on both the Risk Management Plan and the weekly status reports. If a risk is triggered, Ms. McCarrick will immediately notify Ms. Baird and Bob Nolan, the Senior Vice President Network Operations. This process is similar for the implementation of each GSA.

Proposed or recommended monitoring and tracking tools.

Aetna Better Health uses multiple reports to regularly monitor network capacity and prevent network gaps prior to go live and ongoing thereafter. These reports include GeoAccess, Adequacy by parish and specialty, Open PCP Panels, PCP capacity, Percentage of contracted significant traditional providers and more. However, if a concern about network adequacy does occur, we will modify the network development strategy by implementing immediate short-term, as well as long-term, interventions to resolve the adequacy concern.

Our final, internally approved Microsoft Project work plan is used to monitor the progress against the agreed upon due dates. Due dates are monitored using our Lead Team Issues Log and Status Reports. Bi-weekly, the Lead Team discusses each area that is at-risk for on-time completion. Also, each owner for the risks mentioned in this section will make periodic reviews to see that the risk hasn't been triggered, and to verify that the mitigation strategy is up to date.

(2) Delays in building and/or configuring and testing the information systems within your organization's Span of Control required to implement the CCN program;

Risk Identification and Mitigation strategy

Risk Identification	Mitigation strategy	Applies to GSA A, B or C?
PCP Auto-Assignment fails during end-to-end testing	<p>Transference – Work with system vendor to identify root cause of failure and secure their assistance in order to quickly resolve the issue.</p> <p>Acceptance – Utilize the Aetna Better Health regional enrollment center to identify resources for manual PCP assignment until the issue is resolved.</p>	A



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Section C: Planned Approach to Project

Risk Identification	Mitigation strategy	Applies to GSA A, B or C?
Significant error in claims processing identified during testing with limited time to fix	Acceptance – Manually process claims that would otherwise be processed incorrectly. Request additional corporate support to process claims within required time period until error is corrected.	A
Ancillary Application not fully developed by go-live due to critical dependency on DHH's approval of notification letters	Reduction – Develop as much of the application in advance, prior to letter finalization. Acceptance – Manually produce the approved letters until application is fully developed and tested.	A

Risk management implementation plans:

Greg Krause, Vice President of Management Information Systems, is responsible for the IT Risk Management Plan. He will also be responsible for overseeing and reviewing the IT resources and is required to provide assurances to the Lead Team that there are enough resources available at the right levels, time, and location.

Mr. Krause will identify risks and the mitigation strategies as we continue building and designing the core systems. Risks are monitored on both the Risk Management Plan and the weekly status reports. If a risk is triggered Mr. Krause will immediately notify Ms. Baird and Laura Mayne, the Systems Implementation Director. This process is similar for the implementation of each GSA.

Proposed or recommended monitoring and tracking tools.

Our final, internally approved Microsoft Project work plan is used to monitor the progress against the agreed upon due dates. Due dates are monitored using our Lead Team Issues Log and Status Reports. Bi-weekly, the Lead Team discusses each area that is at-risk for on-time completion. Also, each owner for the risks mentioned in this section makes periodic reviews to see that the risk hasn't been triggered, and to verify that the mitigation strategy is up to date.

(3) Delays in hiring and training of the staff required to operate program functions;

Risk Identification	Mitigation strategy	Applies to GSA A, B or C?
Trainer's arrival delayed	Reduction – The training materials are saved in several accessible locations on shared network drives. Any other trainer can access and deliver the training via our distance learning tools. Avoidance – Trainers schedule their flights the prior day, allowing time to reschedule.	A



Part Two: Technical Proposal

Section C: Planned Approach to Project

Risk Identification	Mitigation strategy	Applies to GSA A, B or C?
System access issues: Trainers or Trainees not able to access systems.	Avoidance – Access is tested weeks before the training is schedule to begin. IT personnel are on-call to troubleshoot any issues. Acceptance – Hard copies of all training materials are made available.	A
Office space is unavailable for scheduled training (due to weather, plumbing, construction, etc.).	Acceptance – Locate and procure conference space at a nearby hotel to conduct training.	A
Unable to identify and hire a candidate within the required/necessary time frame.	Avoidance – Positions are prioritized and hired according to the priority level of each position. Multiple people involved in the Implementation take part in the interviewing process and decisions are made quickly. Reduction – Staff available from the corporate office or other health plans can fulfill the required functions until the position is filled.	A, B and C
Candidate rescinds acceptance of the offer.	Acceptance – Immediately identify existing candidates (internal/external) who have previously applied. Utilize resources available from the corporate office or other health plans to step in as needed.	A, B and C

Risk management implementation plans:

Debbie Hillman, Human Resource Manager, is responsible for the hiring Risk Management Plan. She is also responsible for overseeing and reviewing the needed hiring resources and is required to provide assurances to the Lead Team that there are enough resources available at the right levels, time, and location.

Ms. Hillman will identify risks and the mitigation strategies as we continue developing and acting on a hiring plan. Risks are monitored on both the Risk Management Plan and the weekly status reports. If a risk is triggered Ms. Hillman will immediately notify Ms. Baird; Jan Stallmeyer, Regional Senior Vice President; Pat Powers, CEO and; Ruth Sirotnik, COO. This process is similar for all GSAs.

Mike Rogers is responsible for the training Risk Management Plan. He is also responsible for overseeing and reviewing the available training resources and is required to provide assurances to the Lead Team that there are enough resources available at the right levels, time, and location.

Mr. Rogers will identify risks and the mitigation strategies as we hire and begin training the new health plan employees. Risks are monitored on both the Risk Management Plan and the weekly status reports. If a risk is triggered Mr. Rogers will immediately notify Ms. Baird and Patrick Powers, CEO. This process is similar for the implementation of all GSAs.



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Section C: Planned Approach to Project

Proposed or recommended monitoring and tracking tools:

Our final, internally approved Microsoft Project work plan is used to monitor the progress against the agreed upon due dates. Due dates are monitored using our Lead Team Issues Log and Status Reports. Bi-weekly, the Lead Team discusses each area that is at-risk for on-time completion. Also, each owner for the risks mentioned in this section make periodic reviews to see that the risk hasn't been triggered, and to verify that the mitigation strategy is up to date.

(4) Delays in the construction and/or acquisition of office space and the delivery of office equipment for staff required to operate program functions;

Risk Identification	Mitigation strategy	Applies to GSA A, B or C?
Office is damaged by a storm or other natural disaster preventing normal day-to-day functions	Reduction – Provide laptops to all employees enabling them to work from home. Secure a backup facility and work to temporarily transfer calls and other health plan functions to other Aetna Better Health facilities.	A, B and C
Employee computers are not available or have not been shipped on time.	Reduction – For new health plans we typically lease laptops that need to be prepared at our corporate office and then shipped. We do the following to reduce the impact, 1) Identify a hardware back up vendor, 2) Use existing stock temporarily from corporate office, and 3) Plan to have computers arrive a month and a half before go-live.	A
Furniture and desks are not prepared by the time employees are hired.	Acceptance – We are prepared to use temporary office space including a hotel conference center. Reduction – Temporary furniture can be provided and used until office furniture is ready.	A

Risk management implementation plans:

Taira Green-Kelley, Regional Vice President of Business Development, is responsible for the acquisition and preparation of the health plan office space and the related Risk Management Plan. She is also responsible for overseeing and reviewing the office space preparation resources and is required to provide assurances to the Lead Team that there are enough resources available at the right levels, time, and location.

Ms. Green-Kelley will identify risks and their mitigation strategy as we continue building planning and building the health plan office. Risks are monitored on both the Risk Management Plan and the weekly status reports. If a risk is triggered, Ms. Green-Kelley will immediately notify Ms. Baird and Mr. Powers. This process is similar for all GSAs.



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Proposed or recommended monitoring and tracking tools:

Our final, internally approved Microsoft Project work plan is used to monitor the progress against the agreed upon due dates. Due dates are monitored using our Lead Team Issues Log and Status Reports. Bi-weekly, the Lead Team discusses each area that is at-risk for on-time completion. Also, each owner for the risks mentioned in this section make periodic reviews to see that the risk hasn't been triggered, and to verify that the mitigation strategy is up to date.

(5) Delays in enrollment processing during the implementation of CCN; and

Risk Identification	Mitigation strategy	Applies to GSA A, B or C?
Problems with receiving the enrollment file	Avoidance – The implementation IT team will work with DHH IT staff to provide appropriate access to secure FTP site is established, understanding of the file format, time frames for file availability, and notification and/or escalation process when file is not received.	All
Problems with reconciling the enrollment file	Avoidance – After the implementation IT team imports the enrollment file into the Aetna business processing system, an exception report of the fall out is generated in addition to a system records reconciliation summary. The Aetna Better Health Enrollment Department researches and resolves all the exceptions. Upon completion, the Enrollment Representative signs off on the system records reconciliation summary and gives the summary to an Enrollment Supervisor. The Supervisor signs and files the summary in binder to document completion. Should the Enrollment Representative encounter an issue that he/she can not resolve, Aetna Better Health will follow an escalation process until resolution is achieved.	All
Problems with DHH sending the enrollment file	Avoidance – Aetna Better Health IT staff will work DHH IT staff to provide appropriate access to secure FTP site, understanding of the file format, time frames for file availability, and notification and/or escalation process when file is not available. Testing will begin as early as possible.	All

Risk management implementation plans:

Diana Atchley, Head of Medicaid Enrollment, is responsible for the enrollment Risk Management Plan and Jody Miller, IT Manager, is responsible for the enrollment processing Risk Management Plan. Ms. Miller is also responsible for overseeing and reviewing the



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enrollment processing development team resources and is required to provide assurances to the Lead Team that there are enough resources available at the right levels, time, and location.

Both Ms. Atchley and Ms. Miller identify risks and their mitigation strategies as we continue building and preparing to enroll new members. Risks are monitored on both the Risk Management Plan and the weekly status reports. If a risk is triggered, Ms. Atchley or Ms. Miller will immediately notify Ms. Baird and Ms. Mayne. This process is similar for all GSAs.

Proposed or recommended monitoring and tracking tools:

The Aetna Better Health Enrollment Department has documented policies, procedures, and sign off requirements to see that enrollment related tasks are completed within contractual timeframes. In addition, the staff in the Enrollment Department are cross-trained over several health plans to provide adequate coverage during plan peak volume times and employee absences

Our final, internally approved Microsoft Project work plan is used to monitor the progress against the agreed upon due dates. Due dates are monitored using our Lead Team Issues Log and Status Reports. Bi-weekly, the Lead Team discusses each area that is at-risk for on-time completion. Also, each owner for the risks mentioned in this section will make periodic reviews to see that the risk hasn't been triggered, and to verify that the mitigation strategy is up to date.

(6) Delays in the publication of marketing and related materials and/or the delivery of these materials to DHH and/or its agents.

Risk Identification and Mitigation strategy

Risk Identification	Mitigation strategy	Applies to GSA A, B or C?
Internal legal approval delays completion of marketing and member materials	Avoidance – Legal advises on marketing and member materials throughout their development	All
Unable to deliver the provider directory hard copy, abbreviated version, to the Enrollment Broker within the required time frame due to printing issues.	Reduction – Aetna has a pool of capable vendors that can quickly receive, print and ship needed documents. This can be completed within the required time frame.	All
Member materials printer is unable to print and ship the needed member materials on time	Reduction – Aetna has the ability to change print vendors on short notice and print the materials within Louisiana to shorten the shipping days. All member materials are available on the Aetna Better Health website.	All
A member's ID card is sent to the wrong address	Reduction – If new address is received from the member to the health plan the documentation is sent to DHH for update. Avoidance – Welcome Packets are sent first class to the address provided in the enrollment file by DHH.	All



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Delay in translation of member materials ultimately delaying the production of bi-lingual materials	Avoidance – Aetna maintains the ability to contract with one of several qualified translation vendors. Member services will have an available translation service to address any of our member’s questions.	A
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Risk management implementation plans:

Ruth Sirotnik, Chief Operating Officer, is responsible for the member and marketing materials Risk Management Plan. She is also responsible for overseeing and reviewing the member and marketing materials team resources and is required to provide assurances to the Lead Team that there are enough resources available at the right levels, time, and location.

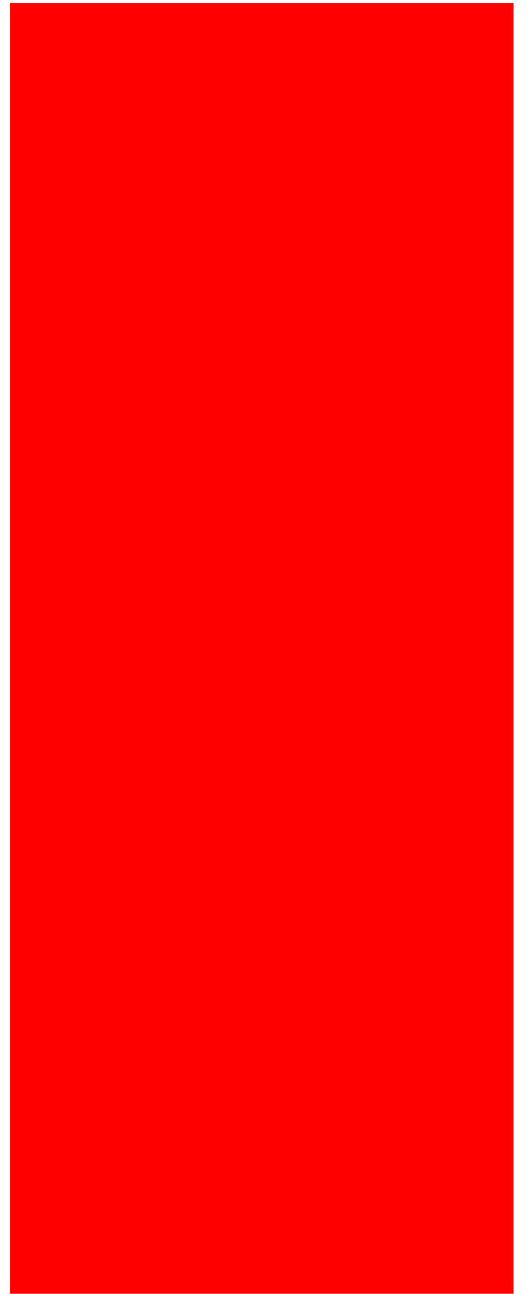
Ms. Green-Kelley will identify risks and their mitigation strategies as we continue designing, writing and preparing the member and marketing materials. Risks are monitored on both the Risk Management Plan and the weekly status reports. If a risk is triggered, Ms. Sirotnik will immediately notify Ms. Baird and Mr. Powers. This process is similar for all GSAs.

Proposed or recommended monitoring and tracking tools.

Our print procurement team uses the P3 Software to quote, award, manage, track and maintain all print jobs. This software provides a simple way to manage the schedule and stay up to date on the processes involved in the printing and delivery of our member materials.

The final, internally approved Microsoft Project work plan is used to monitor the progress against the agreed upon due dates. Due dates are monitored using our Lead Team Issues Log and Status Reports. Bi-weekly, the Lead Team discusses each area that is at-risk for on-time completion. Also each owner for the risks mentioned in this section will make periodic reviews to see that the risk hasn’t been triggered, and to verify that the mitigation strategy is up to date.

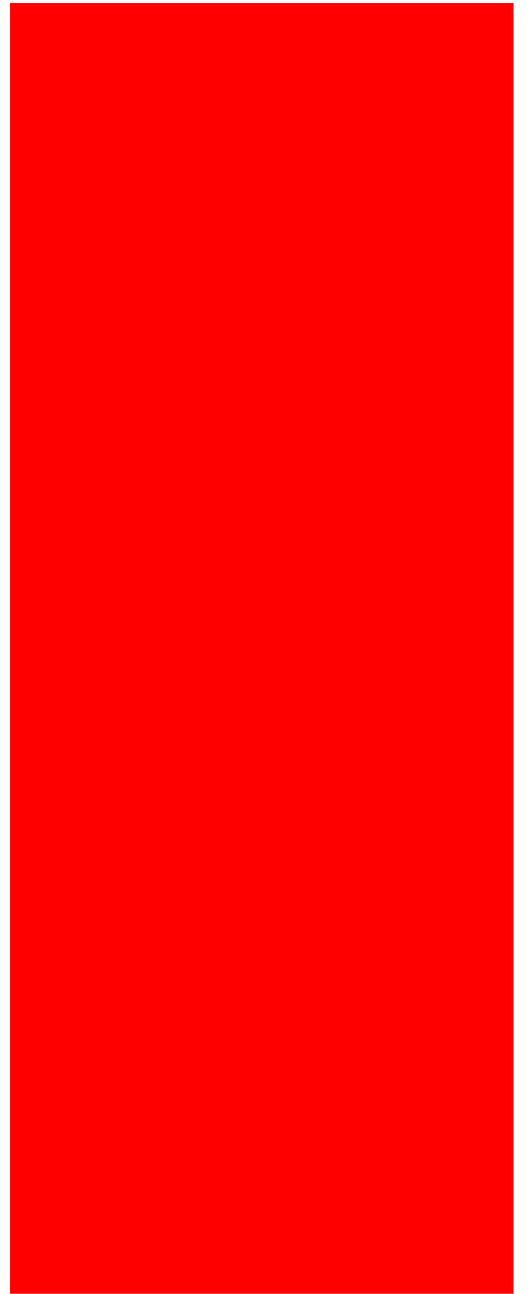
38 C.4



C.4 Provide a copy of the Work Plan, generated in Microsoft Project or similar software product that includes the aforementioned implementation activities along with the timeframes, person-hours, and dependencies associated with these activities.

Please see Appendix P for a copy of the Work Plan which includes the aforementioned implementation activities along with the timeframes, person-hours, and dependencies associated with these activities.

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C.5 Provide a roster of the members of the proposed implementation team including the group that will be responsible for finalizing the Provider network.

Implementation Team

Aetna Better Health’s Implementation Lead Team is led by the Chief Executive Officer and the Implementation Manager. This team will consist of corporate subject matter experts and health plan staff. The role of the implementation team will be to implement the health plan, and make certain that the health plan can meet all contract requirements.

The table below delineates the corporate personnel who will support and assist with the timely and complete implementation process.

The Implementation Lead Team

Name and Title	Role and Function	Background and Expertise of Personnel
<p>Janet Stallmeyer, MBA, MSN, BSN</p> <p><i>Senior Vice President, Market Executive for Medicaid, Central Region</i></p>	<p>Oversight of Central Region Medicaid Operations. She will work with the Chief Executive Officer and leadership team to oversee the development, implementation and ongoing operation of the Integrated Care Program.</p>	<p>Ms. Stallmeyer has over 20 years of experience in care management and has long been an innovator in managed care services, combining new approaches with established best practices to achieve strong results.</p> <p>Her career has spanned a number of clinical settings and geographies; a community hospital and family practice setting in eastern Kentucky, a Federally Qualified Community Health Center in Alabama, the University of Cincinnati Medical Center, and one of the first community based staff model HMOs.</p>
<p>Patrick Powers</p> <p><i>Chief Executive Officer, Market Executive for Medicaid, Louisiana</i></p>	<p>Provides oversight of Louisiana Medicaid Operations. He will work with the Senior Staff in Louisiana to oversee the development, implementation and ongoing operation of the Integrated Care Program and to insure that goals and objectives of the Coordinated Care Network Contract are met.</p>	<p>Working in the insurance and healthcare fields for 30+ years, Mr. Powers has a great wealth and depth of experience. He has been extensively involved in the development and operations of regional healthcare delivery systems, regional health care networks, health maintenance organizations and preferred provider organizations.</p> <p>Mr. Powers also developed and operated ComplyMax, a firm that developed and marketed HIPAA compliance products to small and medium-sized providers; and Powers</p>

Name and Title	Role and Function	Background and Expertise of Personnel
		Consulting Services, a healthcare services consulting firm that worked with third party administrators, regional health systems, employer coalitions on health and other entities related to the delivery and financing of healthcare.
<p>Dr. John Esslinger <i>Chief Medical Officer</i></p>	<p>Provides oversight of all medical management activities including prior authorization, utilization review, health services, etc. and will be involved in directing, developing, and implementing medical programs and reviewing trends.</p>	<p>Dr. Esslinger has 6 years experience in Medicaid and over 22 years health care experience. Dr. Esslinger has his Bachelor of Science in Microbiology and his M.D. from University of Minnesota. He also received his Masters in Medical Management from Tulane University.</p>
<p>Ruth Sirotnik <i>Chief Operating Officer</i></p>	<p>Provides oversight of all plan operations activities including support services.</p>	<p>Ms. Sirotnik has over 35 years of experience in the health care industry and has extensive experience with start up plans. She has worked with Medicaid plans in various states for the past 10 years with heavy emphasis on system configuration, claims, encounters, reporting, member services, provider services, finance, etc.</p>
<p>Lauren Edgington, M.S. <i>Chief Financial Officer</i></p>	<p>Provides oversight for the Medicaid finance team, including financial reporting, planning and forecasting processes. Support strategic planning, new business development/implementation and leadership initiatives.</p>	<p>Ms. Edgington has more than 8 years experience in Health Plan finance. She holds a Masters and a B.S. in Economics.</p>
<p>Taira Green-Kelley <i>Business Development/ Member Services</i></p>	<p>Provides oversight to Member Services, advocacy, marketing, and community relations. Also responsible for leading new health plan planning, coordination, development and financial implications.</p>	<p>Ms. Green-Kelley has more than 16 years experience in Medicaid and Healthcare services. She has a Bachelors of Science degree in Public Relations.</p>
<p>Lisa Baird, CPC, CPC-H <i>Implementation Manager/ Contract Compliance Officer</i></p>	<p>Provides leadership and oversight for all aspects of a health plan implementation. Responsible for providing operational direction, project management, contract compliance and leading the implementation of the</p>	<p>Ms. Baird has over 22 years in the health care field with the last 13 being solely focused on Medicaid managed care. Ms. Baird has successfully led the implementation of two Aetna Better Health Medicaid</p>

Name and Title	Role and Function	Background and Expertise of Personnel
	new health plan operations. She will be the primary point of contact for DHH.	plans during her time at Aetna.
<p>Laura Mayne, MBA, MHP <i>Systems Implementation Director</i></p>	<p>Responsible for identifying business requirements for connectivity, HIPAA and Proprietary file development, systems and ancillary application configuration, and testing. She provides oversight for real estate, telecom and hardware functions. She will be the point of contact for systems related questions.</p>	<p>Ms. Mayne has over 20+ years experience in the health care arena of which 14 years have been spent in managed care. She holds a Masters in Business Administration, a B.S. degree in Accounting. And holds a designation of Managed Healthcare Professional.</p>
<p>Hillary Weiss <i>Compliance</i></p>	<p>Provides compliance oversight and management for the Aetna Better Health Louisiana implementation. Works with corporate compliance to develop the Compliance Program and related policies. Develops strategy, process improvement, project management, and oversight of day to day activities of the several Aetna Better Health and CHIP Plans nationwide. Assures policy and procedure development, compliance committee activities and fraud and abuse processes are in place.</p>	<p>Ms. Weiss has worked in the Law and Regulatory Affairs Department of Aetna for 16 years. She holds a Masters Degree in Health Care Administration. She has held many compliance positions in the company including Medicaid and Medicare manager, and Regional Compliance Director, and has managed regulatory exams, audits and corrective action plans, implementation of new health plans in several states, interactions with regulators, regulatory inquiries, development of compliance strategy, compliance due diligence for potential acquisitions, and internal compliance assessments, and has hired, trained and managed compliance staff.</p>
<p>Cathy Jackson Smith <i>Encounters IT</i></p>	<p>Provides oversight of encounters implementation, requirements, development, testing and overall compliance setup.</p>	<p>Ms. Jackson-Smith has over 22 years experience in the health care industry, including extensive encounters/claims experience.</p>
<p>Diana Atchley <i>Head of Medicaid Enrollment</i></p>	<p>Provides oversight for the Medicaid Enrollment and Coordination of Benefits Department (COB). Responsible for the implementation of Enrollment and COB for new Aetna</p>	<p>Ms. Atchley has over 30 years experience in the Health Care industry primarily focused on Customer Service, Claims, and Enrollment with over 25 of those</p>

Name and Title	Role and Function	Background and Expertise of Personnel
	Better Health Medicaid Health Plans.	years in management. Ms. Atchley has an AAS degree in Business Management and Marketing.
<p>Debbie Hillman <i>Human Resource Manager</i></p>	<p>Provides support for the “human capital” implications of the business strategies our segments are charged with executing. Responsible for driving human capital planning, organization design, change management, annual performance and development processes, employee survey, succession planning and workforce planning.</p>	<p>Ms. Hillman has over 11 years of health care experience, nine years in talent acquisition and over six years of Medicaid experience. She possesses a Bachelors of Art in Speech Communication.</p>
<p>Greg Krause, MBA <i>Vice President, Management Information Systems, Aetna Medicaid</i></p>	<p>Provides oversight for all aspects of corporate EDI processes including Claims, Eligibility, Encounters, and the implementation of all HIPAA related transaction code sets. Responsible for technology project implementations, systems support and problem resolution and providing IT support to operations and business units.</p>	<p>Mr. Krause has over 19 years experience in systems operations and management. He possesses a Masters in Business Administration, as well as a Bachelor of Arts degree in Economics and Communication.</p>
<p>Dawn Reed, BSN <i>Medicaid Medical Management, Implementation Specialist, Central Services</i></p>	<p>Provides expertise and oversight of the Medical Management aspects of the implementation process of new and existing health plans including utilization review, prior authorization and care management through development of Policies and Procedures in compliance with the contract, state laws and regulations and Aetna Better Health. This also includes on-site oversight, management and support during training, go-live and post-go live.</p>	<p>Ms Reed is a Registered Nurse with over 20 years of experience in Utilization Management and Case Management. She has worked in a variety of settings that include Medical hospitals, Behavioral Health hospitals and Health Plans that included both Commercial and Medicaid plans. Ms Reed has broad based skills in Policy and Procedure Development, development of training materials, training of Utilization Management along with expertise in Utilization Management and Case Management systems. She most recently led the Medical Management implementations of our Florida, Pennsylvania and Illinois health plans.</p>

Name and Title	Role and Function	Background and Expertise of Personnel
<p>Jamie McCarrick <i>Director, Network Development</i></p>	<p>Provides oversight for network development and implementation management of provider networks and contract management.</p>	<p>Ms. McCarrick has extensive network development experience including the last 9 years spent focusing solely on Medicaid managed care products. She heads a network configuration team for the post contracting process, but she's also held a role for several years of a Network Lead in a live Medicaid Health Plan.</p>
<p>Jennifer Hayes <i>Manager, Business Application Management</i></p>	<p>Responsible for oversight of design and configuration of data reference and decision support of claims information system for new plan implementations.</p>	<p>Ms. Hayes has over 18 years experience in the healthcare industry, with 15+ years management and 7+ years configuration and design experience. Ms Hayes holds a Bachelor of Science Degree in Marketing.</p>
<p>Stacey Hilgart <i>Provider Data Services Manager</i></p>	<p>Manages a provider data services unit and oversees maintenance of the provider data (demographic and contractual) for all network and non-network providers. Sees that all provider information is accurately recorded and maintained to provide for proper reimbursement and member access (i.e., directory listings). Develops and maintains standards for database integrity, corrective actions, database alignment, and manages communication processes with other departments regarding database improvements that may include audit staff or technical staff for the business operation.</p>	<p>Ms. Hilgart has over 15 years management experience with 10+ years in the health care industry having worked both the clinical side, systems build and data maintenance.</p>
<p>Patrice Jackson BS FS <i>Senior Implementation Manager for Grievance and Appeals, Complaints and Reporting</i></p>	<p>Provides oversight and is accountable for the development of Appeal/Complaints and Grievance processing and training materials ensuring compliance with applicable Federal and State</p>	<p>Ms. Jackson has over 16 years experience in the health care industry, including extensive quality management experience. Within Quality Management she was responsible for HEDIS^{®2} and other</p>

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

Name and Title	Role and Function	Background and Expertise of Personnel
	<p>regulations.</p> <p>Accountable for the development and set up of the State deliverables library for the health plan and provides oversight in the development of required reports across all functional areas.</p>	<p>clinical programs for 10 NCQA Accredited health plans. Ms. Jackson has extensive experience with data analysis and report development.</p> <p>She has experience in start-up corporate environments and possesses a B.S., Family Studies.</p>
<p>Michael Rogers, M.S. <i>Manager, Learning and Performance</i></p>	<p>Manages all learning development, training delivery, and performance improvement for provider services, member services, enrollment, and medical management.</p>	<p>Mr. Rogers has over 15 years experience in learning and performance with the majority of that time in management and director level positions. He possesses a Bachelors of Science degree in Sociology and Psychology and a Masters of Science in Instructional Technology from Utah State University.</p>

Network Development

The following individuals are responsible for finalizing the Provider network:

Name and Title	Role and Function	Background and Expertise of Personnel
<p>Robert Nolan <i>Senior Vice President, Network Operations, Aetna Medicaid</i></p>	<p>Provides oversight for Network development, management of Network Management, Quality Management, Medical Economics, and Contract Management.</p>	<p>Mr. Nolan is a health care executive with extensive experience in start-up and turnaround corporate environments. He is highly accomplished in negotiating and managing medical costs representing over \$6 billion in annual medical expenses for 2.7 million lives. Mr. Nolan possesses broad based skills in Product Development, Strategic Planning, Sales, Marketing, Finance, Organizational Restructuring, and Management Consulting.</p>
<p>Jamie McCarrick <i>Director, Network Development, a member of the Lead Team</i></p>	<p>Provides oversight for network development and implementation management of provider networks and contract management.</p>	<p>Ms. McCarrick has extensive network development experience including the last 9 years spent focusing solely on Medicaid managed care products.</p>

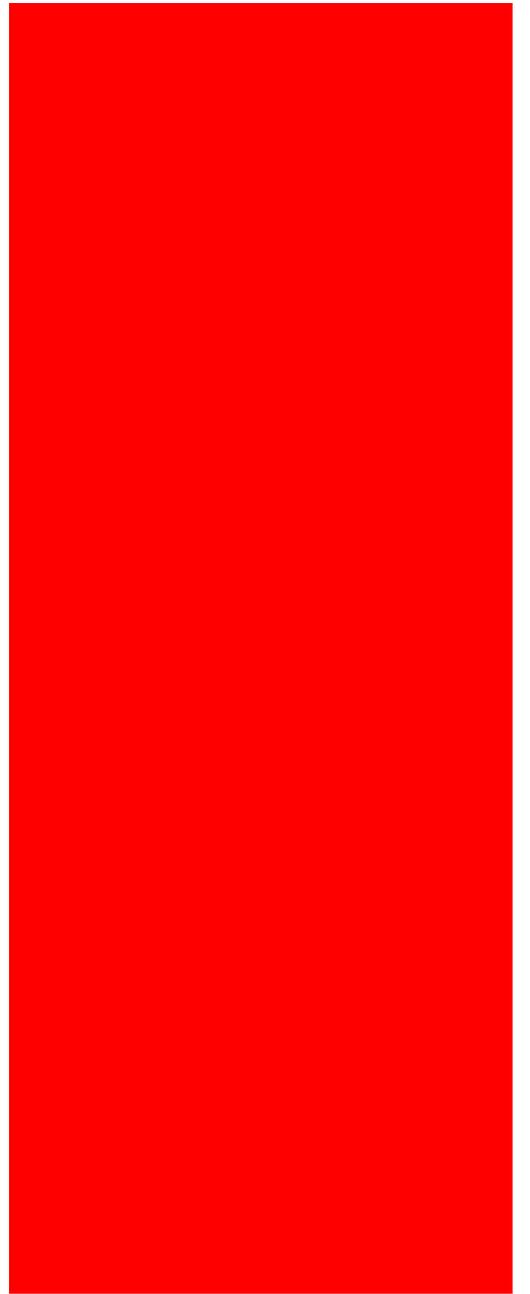
Name and Title	Role and Function	Background and Expertise of Personnel
		She heads a network configuration team for the post contracting process, but she's also held a role for several years of a Network Lead in a live Medicaid Health Plan.
<p>Vincent Liscomb Jr. <i>Senior Network Manager</i></p>	<p>Network development and implementation, project management, reporting, provider and vendor contracting.</p>	<p>Mr. Liscomb has over 20 years experience in provider network development and management with extensive expertise in provider contracting, medical cost management strategies and leadership in a number of states.</p>

Implementation Support – Other corporate subject matter experts

Name and Title	Role and Function	Background and Expertise of Personnel
<p>Thorne Clark <i>Counsel</i></p>	<p>Mr. Clark serves as in-house counsel and is responsible for monitoring litigation and Medicaid Fair Hearing actions, negotiating and drafting various contracts and operational documents, and providing general legal guidance regarding various employee relations, benefits, contract interpretation and day-to-day operational matters. Mr. Clark also serves as a legal resource in connection with the preparation of Request for Proposal (RFP) submissions and subsequent implementations.</p> <p>In addition, Aetna Better Health consults with Aetna's Legal Department and outside counsel regarding matters relating to Aetna Better Health's proposed participation in the Integrated Care Program, including review of contract, compliance and regulatory obligations. Aetna's Legal Department also develops proposed provider and subcontract templates for use in connection with the</p>	<p>Prior to joining Aetna, Mr. Clark was an associate attorney with the Phoenix office of Squire, Sanders & Dempsey, L.L.P. and the New York office of Hawkins Delafield & Wood LLP. Mr. Clark received his law degree from the University of Pennsylvania, and his bachelor's degree from Columbia University.</p>

Name and Title	Role and Function	Background and Expertise of Personnel
	Integrated Care Program.	
<p>Brad Dirks, ASA, MAAA <i>Vice President, Actuarial Services</i></p>	<p>Provides oversight for all aspects of actuarial analysis, including claims reserving, trending/ forecasting, pricing, and new business development.</p>	<p>Mr. Dirks has over 18 years experience as a health care actuary. He is an Associate in the Society of Actuaries and a member of the American Academy of Actuaries. He also earned a Bachelor of Science degree in Applied Mathematics.</p>
<p>Mark Douglas, J.D., M.S.N., F.N.P., R.N. <i>Medical Management Coordinator</i></p>	<p>Provides oversight of utilization review, prior authorization, health services, quality management, disease management, and care management; directing, developing, and implementing programs; and monitoring medical trends.</p>	<p>Mr. Douglas has 20 years experience in the health care industry, including extensive management experience. He is a Registered Nurse and a Nurse Practitioner he also holds a Masters of Science in Nursing and Juris Doctorate.</p>
<p>Patricia Simpson, M.B.A. <i>Corporate Compliance</i></p>	<p>Provides compliance oversight and management for Aetna Better Health's Compliance Program. Develops strategy, process improvement, project management, and oversight of day to day activities of the several Aetna Better Health and CHIP Plans nationwide. Assures policy and procedure development, compliance committee activities and fraud and abuse processes are in place.</p>	<p>Ms Simpson has nearly 11 years experience in Medicaid and over 8 years experience in Medicaid compliance. She has a Bachelor of Science degree in Management and a Masters of Business Administration with an emphasis on Health care Administration.</p>

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C.6 Provide the resume of the Implementation Manager (the primary person responsible for coordinating implementation activities and for allocating implementation team resources).

Please see Appendix Q for a copy of the Implementation Manager resume, the primary person responsible for coordinating implementation activities and for allocating implementation team resources.