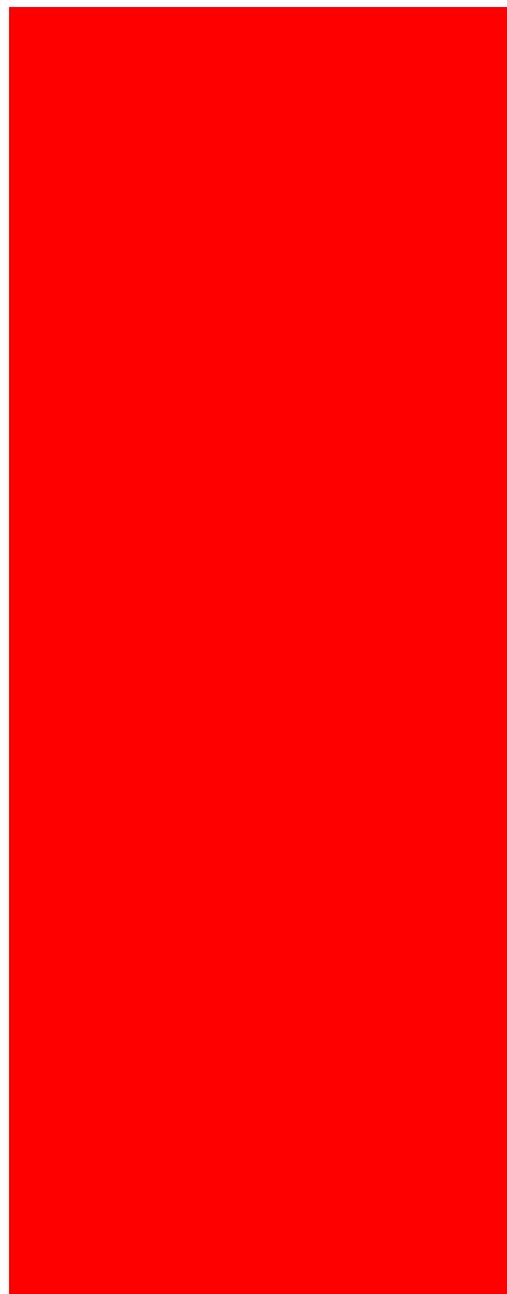


98 SECTION L –  
CUSTOMER SERVICE



99 L.1



## Section L: Customer Service (Section §12 of RFP)

### L.1 Provide a narrative with details regarding your member services line including:

- Training of customer service staff (both initial and ongoing);
- Process for routing calls to appropriate persons, including escalation; The type of information that is available to customer service staff and how this is provided (e.g., hard copy at the person's desk or on-line search capacity);
- Process for handling calls from members with Limited English Proficiency and persons who are hearing impaired;
- Monitoring process for ensuring the quality and accuracy of information provided to members;
- Monitoring process for ensuring adherence to performance standards;
- How your customer service line will interact with other customer service lines maintained by state, parish, or city organizations (e.g Partners for Healthy Babies, WIC, housing assistance, and homeless shelters); and
- After hours procedures.

Aetna Better Health, Inc., together with its affiliates, has more than 25 years experience serving 1.3 million members in 10 states. Leveraging the capabilities of our experienced personnel, Aetna Better Health® will provide an onsite, scalable solution to support the Member Services call center needs. Our Member Services Manager has extensive Medicaid experience and Louisiana specific knowledge, and is responsible for managing an efficient and responsive team of well-trained employees. Louisiana's Medicaid and CHIP members will have access to bilingual, locally based Member Services Representatives (MSRs) who are experts in the nuances of Louisiana's healthcare system and associated public sector programs. Our MSRs represent our first opportunity to give members and providers exemplary service. With a focus on best practices, Aetna Better Health trains our MSRs how to handle grievance and appeals, transfers to licensed clinicians when necessary, and access to community supports, particularly when assisting members with limited English proficiency or persons with hearing disabilities.

Aetna Better Health is fully committed to serving the most vulnerable segments of the Coordinated Care Network (CCN) population, and we are excited about the opportunity to collaborate with the state and providers in Louisiana to deliver a program that will meet the needs of this at-risk population. We will also leverage our CCN program start-up and ongoing job creation opportunities to create jobs for TANF recipients receiving cash assistance.

Aetna Better Health is developing a new program, Aetna Building Louisiana Employment (ABLE), to create value for the state of Louisiana and the Medicaid recipients we hope to serve. ABLE's objective is to reduce the number of individuals receiving cash assistance while providing long-term workforce stability through training and experience.

Aetna Better Health will leverage our CCN program start-up and ongoing job creation opportunities to create jobs for TANF recipients receiving cash assistance.

Aetna Better Health will work with a third party vendor to assist us in recruiting eligible individuals for ABLE through work and communications with workforce development agencies including:

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

Aetna Better Health has prior experience with this type of program. In April 2010, Aetna Better Health began operations in a new contract with the Pennsylvania Department of Public Welfare (DPW). As part of the contract with DPW, Aetna Better Health participates in the DPW's Contractor Partnership Program (CPP). DPW created the CPP to leverage the department's financial resources and to identify and/or create jobs for TANF recipients. The CPP has created a structured process for identifying jobs and making referrals through its work with DPW contractors and workforce development agencies, such as county assistance offices, community action agencies, and workforce investment area fiscal agents.

Aetna Better Health used a contractor to recruit, train, and manage the CPP personnel. Our commitment is to make a good faith effort to fill a portion of our new or vacation positions with TANF recipients receiving cash assistance. Our participation includes salaries, benefits, merits and bonuses for CPP team members, along with funding for community outreach and identifying staffing and training.

CPP personnel work at Aetna Better Health's Pennsylvania office. Positions held by CPP participants include Member Services Representatives, Prior Authorization Representatives, Care Coordinators, Credentialing Coordinators and administrative support. Typical CPP participants are:

- Female
- Mix of ethnicities
- Single mothers or involved in unstable relationships
- Raising more than one child
- Under 35 years old
- High school graduate, with approximately 10-15 percent having some post-high school education and 10 percent continuing on to complete college
- Heavily dependent on public transportation
- Equipped with some work experience
- Anxious for opportunities for job advancement, employment stability and success
- Generally an easy group to motivate

One year later, Aetna Better Health's participation with the Pennsylvania CPP was successful because it:

- Aligns with our mission
- Creates a loyal work force, with an employee engagement rate of 85%
- Creates value for the state by reducing the number of individuals on cash assistance and provides long-term stability in the workforce through training and experience
- Motivates managers and reinforces the purposefulness of the work and mission among all employees

We are eager to embark on a similar mission to assist TANF cash recipients in the state of Louisiana.

### **Initial and Ongoing Training of Customer Service Personnel**

Our MSRs' most important responsibility is responding to member calls and providing superior member service. Aetna Better Health requires that our MSRs have appropriate education, experience, and training to fulfill position functions prior to having contact with members. They are skilled in the use and management of the call center technology, as well as the circumstances that require escalation of calls, handling calls from hearing impaired members or those with limited English proficiency, and ensuring adherence to performance standards.

Aetna Better Health requires that all new personnel have appropriate education and experience to fulfill their functions and thoroughly screens the background of each candidate prior to hiring. Our Learning and Performance (L&P) Department Manager has responsibility for the development, implementation, and management of our Medicaid Member Services training program. L&P Department personnel dedicate 100 percent of their resources and time so that employees receive appropriate orientation, education, and training to succeed in their positions.

The L&P Department employs user friendly, comprehensive orientation, initial and ongoing training curricula to meet the different learning styles of our employees. The L&P Department develops our MSR training curriculum using the Analysis, Design, Development, Implementation, and Evaluation (ADDIE) model of instructional design. The curriculum is updated and republished biannually using interim training memoranda, and they are readily available to employees within the online resource libraries located on the Aetna intranet.

Trainings are conducted through instructor-led classroom sessions, online courses and on the job training and supported by online assessments, which are evaluated daily, using a criteria checklist to determine knowledge retention and/or the need for further training. Training course attendance is captured and monitored through our learning management system and reports for all courses are available on demand.

- ***Orientation and Initial General Training:*** Orientation to Aetna Better Health and initial training through our learning management system begin upon hire. This initial phase provides new employees with foundational information including, but not limited to: Aetna Better Health's organization and internal operations, an overview of the Department of Health and Hospitals' (DHH) requirements, cultural competency/health literacy, compliance and systems navigation, as well as contract, state, and federal requirements specific to

individual job functions. This phase is essential to the comprehensive development of our personnel in understanding their roles and responsibilities.

- **Position Specific Training:** Upon successful completion of initial training and prior to having contact with members or providers, employees attend specific training on the performance of their individual duties. During this phase, new employees must demonstrate knowledge, retention, and understanding of the material covered in the initial training. All personnel having contact with members or providers receive initial and ongoing training regarding the appropriate identification and handling of quality of care/service concerns. Employees working on potential transportation issues are trained in the geography of all Geographic Service Areas (GSAs) where Aetna Better Health holds a contract, as well as the use of GeoAccess reports and mapping search engines for the purposes of authorizing services, recommending providers, or arranging transport for members in the most geographically appropriate location. This training phase provides employees with tools, supports, and instructions that can be applied to successful performance in their specific positions.
- **Ongoing Training:** Employees participate in ongoing training, which is mandatory for compliance, business continuity planning, quality of care issues and service concerns, cultural competencies/health literacy, reporting member/provider complaints and Medicaid program changes resulting in regulatory updates to our training curriculum. Additional ongoing training needs are determined by trends in business operations, the tracking, and trending of issues in specific areas, feedback from managers, and new requirements, procedures, or policies. Ongoing training includes, but is not limited to, instructor-led training sessions, online memo reviews, in-services, e-learning courses, and presentations. Additionally, all Member Services employees receive weekly electronic training reminders and updates regarding Aetna Better Health policies and procedures.
- **Culturally Competent/Health Literacy Service Training:** Aetna Better Health develops, annually updates, and implements a company-wide cultural competency/health literacy plan. All employees receive initial cultural competency/health literacy training and attend, at a minimum, an annual refresher course. Additional training is provided to our MSRs, Provider Services Representatives, Medical Management personnel, and Case Managers (CMs) to increase awareness of diverse cultural and religious practices, racial disparities in treatment and strategies for removing cultural and linguistic barriers to care. Cultural competency/health literacy information is available in our training manuals, on our website, and in ongoing employee training and education.

Training course attendance is documented and maintained through our learning management system and is available on demand. We review and update the training curriculum on an annual basis, or as updates to our programs, DHH requirements, state and federal laws, or Medicaid regulations occur. The following table illustrates a typical training program for Aetna Better Health MSRs.

Orientation and Initial Training	Member Services Specific Training
<p>Timeframe: Begins upon hire, lasting for approximately 2 to 3 weeks.</p> <p>Purpose: Identify understanding and retention.</p>	<p>Timeframe: Two-months initial and then ongoing, classroom and on-the-job</p> <p>Purpose: Under the supervision of an assigned Member Services mentor, expand skill set.</p>
<p><u>Curriculum:</u></p> <ul style="list-style-type: none"> <li>● Introduction and Overview of: <ul style="list-style-type: none"> <li>– Aetna Better Health philosophy and structure</li> <li>– DHH philosophy and structure</li> <li>– Louisiana Medicaid</li> <li>– How to enroll a newborn</li> <li>– CMS’ Code Of Federal Regulations (CFRs)</li> <li>– Covered populations, including Medicaid, ABD, TANF, CHIP, and other included groups</li> <li>– Aetna Better Health and DHH policy and procedures manuals</li> </ul> </li> <li>● Contract, state and federal requirements specific to job function</li> <li>● Benefits, non-covered, and non-capped services</li> <li>● For CHIP members, cost-sharing information (e.g. premiums, co-pays or deductibles)</li> <li>● Cultural competency/health literacy/disparities</li> <li>● Members with special healthcare needs</li> <li>● Compliance and fraud and abuse (including HIPAA and False Claims Act Provisions)</li> <li>● Complaints/Grievance System</li> <li>● Quality of Care – identification of issues and referral to Quality Management</li> <li>● Introduction and overview of Integrated Care Management (ICM) – our care management model</li> <li>● Electronic systems navigation</li> </ul>	<p><u>Curriculum:</u></p> <ul style="list-style-type: none"> <li>● Duties, expectations, and code of conduct guidelines</li> <li>● Member eligibility, demographics, and enrollment</li> <li>● Member materials including ID cards, member handbooks, and provider directories</li> <li>● Knowledge of Geographic Service Areas (GSAs) characteristics, geography and provider network</li> <li>● Responsive and courteous customer service</li> <li>● 24/7 Language Line® assistance and how to access it on behalf of members and providers</li> <li>● In-depth cultural competency and diversity including: <ul style="list-style-type: none"> <li>– Membership ethnicities and languages spoken</li> <li>– Attitudes and beliefs common to cultures</li> <li>– Means to foster increased sensitivity to individuals from diverse socioeconomic and religious backgrounds</li> <li>– Culture-specific healthcare beliefs and barriers</li> </ul> </li> <li>● Community resource guide by parish (Amy from member education)</li> <li>● Avaya telephone system usage</li> <li>● HIPAA verification process</li> <li>● Identifying and reporting suspected fraud and abuse</li> <li>● All facets of the Aetna Better Health website to assist the member in navigating the</li> </ul>

Orientation and Initial Training	Member Services Specific Training
	website <ul style="list-style-type: none"> <li>• Web resources such as Map Quest, Yahoo Maps, etc., to assist the member in getting directions to the provider, etc.</li> </ul>

Following classroom training, Aetna Better Health uses mock calls to allow new MSRs to experience answering member questions. Next, the new MSRs go through a mentoring process, working with a more experienced operator, before they are allowed to take live calls. The new MSR must demonstrate proficiency and knowledge of the materials before they can take member calls, and every call, every day, is monitored until the MSR is proficient and comfortable serving members. Periodic peer process calls are used for practice, where Subject Matter Experts (SMEs) call new MSRs and act as members to test the MSRs’ skill in serving members.

MSR training is supplemented by online assessments of personnel understanding, knowledge, and retention. To support quality member service, we use an internal Audit Department, independent of our Provider Services and Member Services Departments, to evaluate the quality of customer service provided by our MSRs. A sample of calls is recorded and scored based upon adherence to policy, procedures, best practices, and associated system documentation requirements. The results discussed at the group or individual level, as appropriate, and actions taken to resolve identified issues at the individual representative and team level.

**Process For Routing Calls To Appropriate Persons**

Members and providers will be provided one statewide, toll-free number to call with questions or concerns, creating a virtual “one-stop shop” whereby they may access individuals who are expert in the various facets of the Louisiana Coordinated Care Program (CCN) program and Aetna Better Health. All callers will first hear an automated greeting welcoming them to the Member and Provider Services access line, followed by instructions (in English, Spanish and Vietnamese) to hang up and dial 911 for matters involving a life-threatening emergency. Callers remaining on the line will then be presented with the following automated prompts:

- Callers wishing to continue in Spanish or Vietnamese will be invited to press “3”, prompting the system to present subsequent menu options in Spanish. and Vietnamese
- Members will be asked to press “1”, forwarding them to a member-specific call menu
- Providers will be asked to press “2”, forwarding them to a provider-specific call menu

Members and providers will then have the opportunity to select additional options to access their related services, based upon their specific needs (e.g., questions regarding covered services, assistance with transportation services). MSRs who are familiar with the breadth and depth of internal and external resources alike, will then either address members’ questions and concerns directly, or facilitate their warm transfer to entities who can. If members call after regular business hours, they will be invited to leave a message and Member Services personnel will respond to all messages by the end of the next business day. The MSRs will have reference materials that detail the steps of this process made available to them in hard copy, on their computer desktop, and through on-line searchable Web copy.

### **Process for Escalating Calls to Appropriate Persons**

Relevant details, including information regarding the source of the call, the nature of the inquiry and its resolution will be documented within our call tracking software, wherein advanced workflow management tools support the manual and automatic assignment of subsequent tasks and reminders based on associated service requirements. The system provides a means to monitor “first call resolution,” affording Member Services supervisors and managers alike a tool supporting the State’s requirement that 85 percent of all issues be resolved during a member’s initial call, and the means to align resources accordingly.

If the member is not satisfied with the information that the MSR provides on the call, or if there are non-clinical issues the MSR is unable to resolve, the call is escalated to the Member Services Manager. Together, the MSR and the Member Services Manager work to resolve the issue for the member. If the call requires further escalation, the Chief Operating Officer (COO), to whom the Member Service Manager reports, will become involved. The COO reports to the CEO, and if necessary, the issue will be escalated to this level.

### **Handling Calls from Members with Limited English Proficiency**

When a member calls requesting oral interpretive services, clear, accurate communication is crucial to providing responsive service. To assist the member in accessing services, the Aetna Better Health MSR will perform standard call entry in Call Tracker, and contact Language Line, our language interpretation vendor while keeping the caller on the line. Aetna Better Health has had a relationship with Language Line since 1998. Language Line employs the professional, highly trained, culturally sensitive, Certified Medical Interpreters to serve members 24 hours a day, 7 days a week. Aetna Better Health personnel will facilitate the introduction between the vendor representative and the caller, in order to identify the requested language. The vendor representative will then facilitate a dialogue to promote the accurate exchange of information between the caller and the MSR. If a member requests material that is not in the prevalent languages, the MSR will read the material to the member through the interpreter, taking care to ascertain that the caller understands the material being read. If there is a request for materials in a language other than English, the MSR enters the request into QNXT™ and documents the call and requested services in Call Tracker.

Language Line is also available to providers who are treating Aetna Better Health members with limited English proficiency. If a member requires oral interpretation services while in the provider’s office, the provider (or their office personnel) can contact Aetna Better Health Member Services and request oral interpretation in the member’s language. Aetna Better Health shares this information as part of provider training when the provider joins our network.

Aetna Better Health offers LanguageLine® services at no cost to members or providers.

### **Handling Calls from Members Who Are Hearing Impaired**

Aetna Better Health also provides services or persons with hearing disabilities. We will accept calls from Louisiana Relay (both interpretation and video relay services for sign language) and make available Telecommunications Device for the Deaf (TDD) services and TeleTYpewriter (TTY) services, which provides interpreter capability for callers with hearing disabilities. Aetna Better Health will publicize these phone numbers in member and provider printed materials, as

well as on our website. Additionally, if a member requests it, Aetna Better Health can provide sign language interpreters for provider office visits.

Furthermore, Aetna Better Health's MSRs will provide special assistance to those members with cognitive disabilities or to their caregivers as needed.

### **Monitoring process for ensuring the quality and accuracy of information**

The Member Services Manager monitors calls for quality and accuracy of information, including the relevant details regarding the source of the call and the nature of the inquiry. This information, as well as the call's resolution will be documented within our call tracking software, wherein advanced workflow management tools support the manual and automatic assignment of subsequent tasks and reminders based on associated service requirements. The system provides a means to monitor "first call resolution," affording Member Services Supervisors and Managers alike a tool supporting the State's requirement that 85 percent of all issues be resolved during a member's initial call, and the means to align resources accordingly. Supervisors and Managers will do random monitoring of member calls to see to the provision of excellent and timely customer service to members. This includes:

- a) Random call audits (listen to live or taped calls)
- b) Listen to personnel live on the floor
- c) Routinely run phone reports to monitor answer times and rates of call abandonment

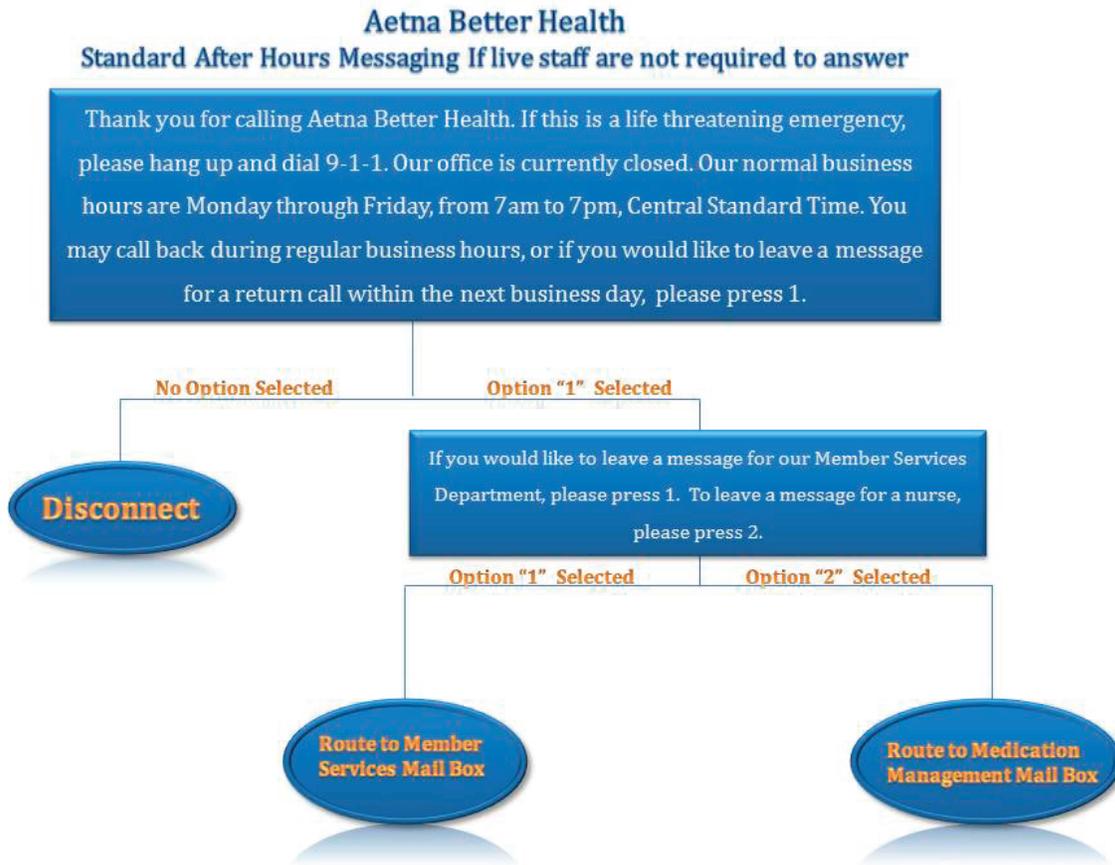
Aetna Better Health utilizes data from Avaya's CMS reporting system – capable of storing call data for up to 13 months, with automatic purging of data – as well as QNXT™'s call tracking database to track and report performance metrics including, but not limited to, the number and type of members' calls and inquiries it receives during business hours and non-business hours.

### **Interacting with Other Customer Service Lines**

Aetna Better Health will pursue a Memorandum of Understanding (MOU) with community groups to establish connectivity via e-mail and warm transfers, both to and from our Member Services line. Aetna Better Health's MSRs will have a resource list of other customer service lines for organizations, such as Partners for Healthy Babies, WIC, housing assistance, and local homeless shelters. Our MSRs will make this information available to callers. They will also refer callers to the Aetna Better Health and DHH websites where resource lists will be posted. Our MSRs will also reach out to the enrollment broker, as the agent of DHH, to facilitate communication related to outreach, education, choice counseling, enrollment and disenrollment of potential members into a CCN.

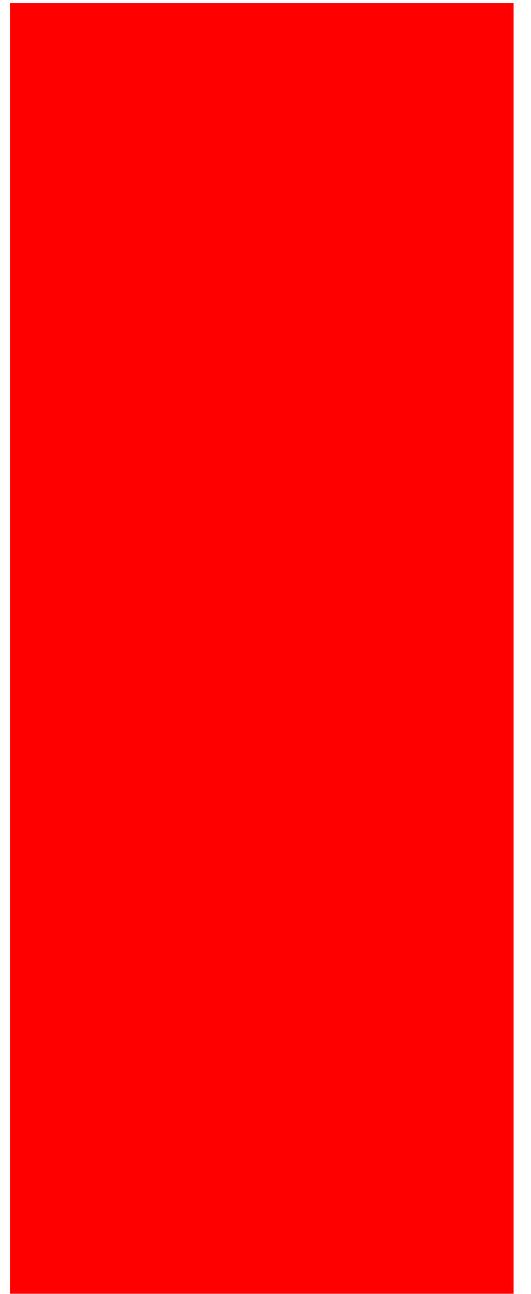
### **After Hours Procedures**

After hours and on weekends, Aetna Better Health's toll-free phone number is answered by an automated system that provides callers with information related to operating hours and instructions regarding what to do in an emergency, and instructs members to leave a message in instances that are not emergencies. Aetna Better Health's designated MSRs return calls from members and/or their representatives by the close of business on the next business day following their voice message. The following chart illustrates the after hours call flow.



Our Member Services call center has capabilities for those with hearing disabilities (TTY service), and foreign language translation for non-English speaking members through the Language Line. Member and provider calls are returned next business day, in the specified language, using Language Line. Our Avaya system will provide messages in English, Spanish, and Vietnamese, and it has the capabilities to provide recordings in other languages for non-English speaking members in major population groups should we reach the threshold where recordings in these languages would be required.

100 L.2



**L.2 Provide member hotline telephone reports for your Medicaid or CHIP managed care contract with the largest enrollment as of January 1, 2011 for the most recent four (4) quarters, with data that show the monthly call volume, the trends for average speed of answer (where answer is defined by reaching a live voice, not an automated call system) and the monthly trends for the abandonment rate.**

Aetna Better Health, Inc., together with its affiliates, has more than 25 years experience serving 1.3 million members in 10 states. We have never been sanctioned for not meeting state-required call metrics. Aetna Better Health consistently exceeds the required performance requirements in states where we provide Member Services call centers. We are fully capable of meeting the requirements of the Louisiana Coordinated Care (CCN) Program as stated in RFP section 12.16.2.

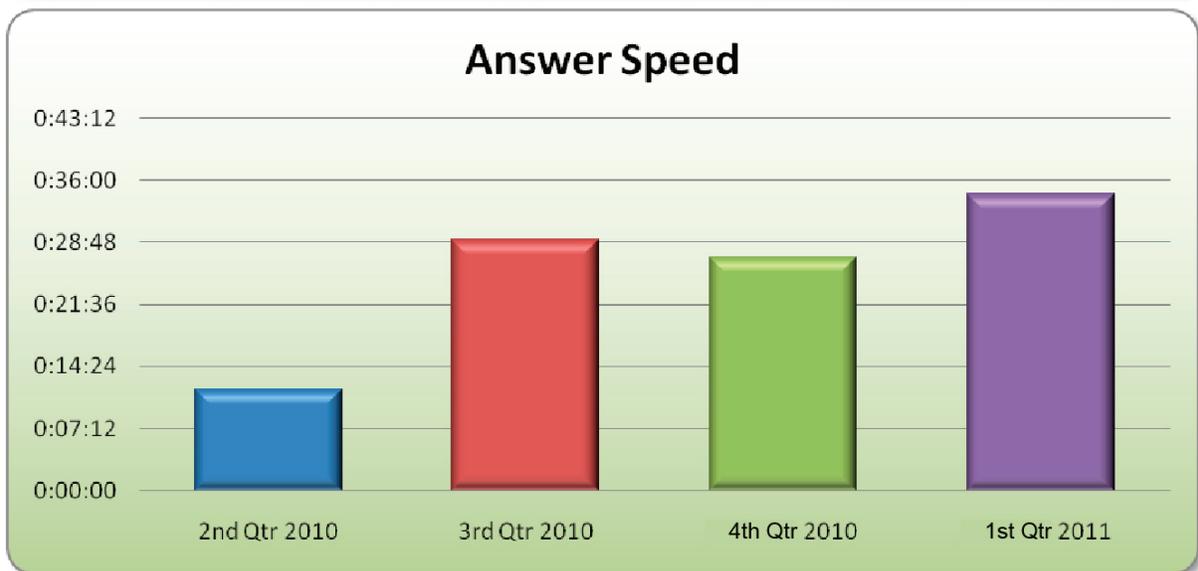
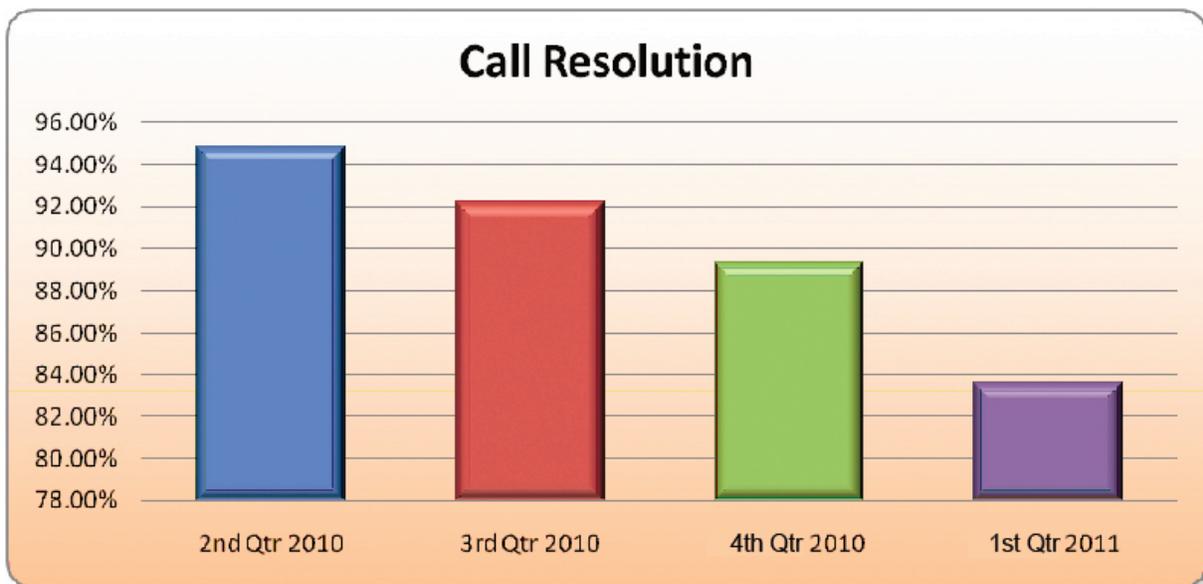
In compliance with the state’s objectives for the Louisiana Medicaid Program and as indicated in the table below, Aetna Better Health will meet or exceed the following performance standards:

- Answer 90% of calls within 30 seconds
- Maintain an average hold time of three minutes or less
- Maintain abandoned rate of calls of not more than 5%

Aetna Better Health regularly meets or exceeds the RFP call answer requirements, as demonstrated by the data for Mercy Care, our Medicaid managed care contract with the largest enrollment in the following table reflects. The associated charts illustrate the performance by Aetna Better Health’s affiliate, Mercy Care Plan (MCP) in Arizona. MCP is contracted with Arizona’s state Medicaid agency, the Arizona Health Care Cost Containment System (AHCCCS), to provide services to members in the Medicaid and TANF populations, as well as ABD individuals in the Arizona Long-Term Care System (ALTCS) and dual-eligible individuals through Mercy Care Advantage, a Medicare Advantage Special Needs Plan (SNP). In addition to being Aetna Better Health’s largest affiliate, Mercy Care Plan is the largest contracted AHCCCS plan in Arizona, with approximately 320,000 members across all lines of business.

Member Services Department	2nd Qtr 2010	3rd Qtr 2010	4th Qtr 2010	1st Qtr 2011
Abandonment Rate	1.1%	2.7%	2.3%	2.8%
Avg Answer Speed	0:11:41	0:29:09	0:27:05	0:34:26
Service Level	91.0%	80.7%	82.5%	76.9%
1st Call Resolution	94.8%	92.2%	89.3%	83.6%
Avg Abandon Time	1:12:44	2:03:28	2:05:01	1:39:16
Avg Talk Time	3:37:21	3:42:20	3:39:04	3:39:42
Avg ACW Time	0:02:20	0:02:00	0:02:00	0:02:00
Calls per 1,000 members	325.72	364.38	331.70	345.27

Member Services Department	2nd Qtr 2010	3rd Qtr 2010	4th Qtr 2010	1st Qtr 2011
<b>Avg # of Reps</b>	67.56	68.90	65.65	62.20
<b>Avg Calls per Day per Rep</b>	76.97	82.59	83.06	89.07
<b>Avg Total Calls Per Day</b>	5,200	5,690.36	5,453.19	5,539.83
<b>Working Days</b>	65.0	66.0	63.0	64.0
<b>Calls Answered</b>	334,395	365,308	335,661	344,674
<b>Calls Abandoned</b>	3,598	10,256	7,890	9,875
<b>Total Calls</b>	337,993	375,564	343,551	354,549

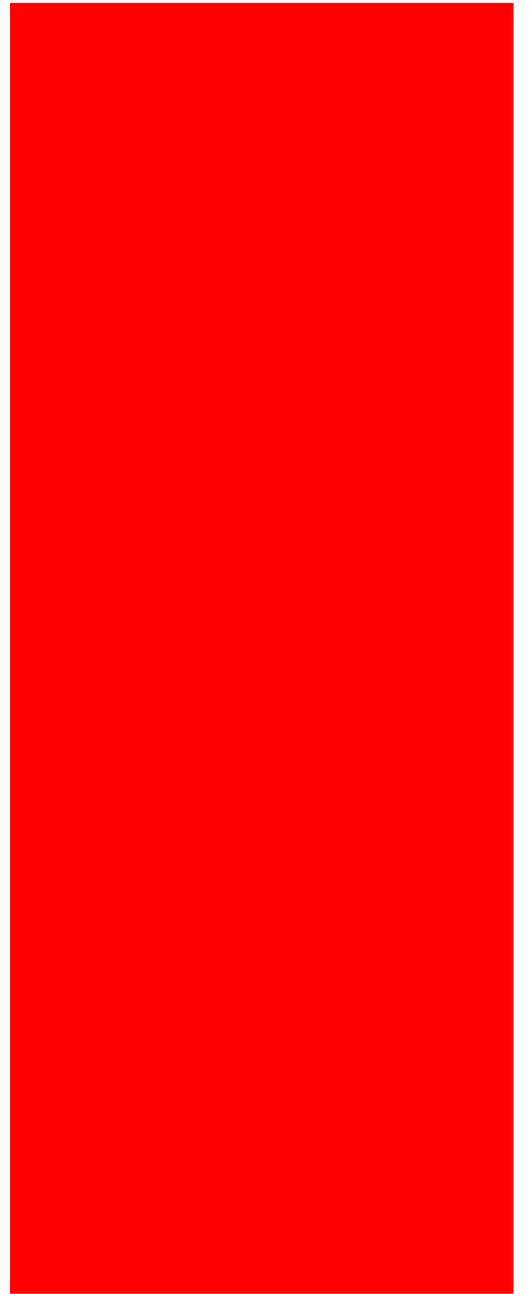




### Tracking and Trending

Aetna Better Health documents all call center activity in QNXT™, our customized care management tracking software application. Entries include information about the source of the call, the nature of the inquiry and the resolution. They also provide a readily accessible database for generating quality management and utilization management performance reports. Aetna Better Health’s quality management personnel review call center statistics on a daily, weekly, monthly and annual basis to identify and implement quality improvement initiatives. The following table and graphs illustrate the type of member hotline reports we use to track our MSR personnel performance.

101 L.3



**L.3 Describe the procedures a Member Services representative will follow to respond to the following situations:**

- **A member has received a bill for payment of covered services from a network provider or out-of-network provider;**
- **A member is unable to reach her PCP after normal business hours;**
- **A Member is having difficulty scheduling an appointment for preventive care with her PCP; and**
- **A Member becomes ill while traveling outside of the GSA.**

Aetna Better Health, Inc., together with its affiliates, has more than 25 years experience serving 1.3 million members in 10 states. Leveraging the capabilities of our experienced personnel, Aetna Better Health will provide an onsite, scalable solution to support the Member Service call center needs. Our Member Services Representatives (MSRs) will receive extensive training to acquire Medicaid and Louisiana specific knowledge that they will use to help members navigate the complex healthcare system. We train our MSRs to follow specific policies and procedures, which, along with ongoing training, enables them to align the resolutions they employ to assist the member with the member's rights and responsibilities, along with HIPAA and Medicaid regulations.

Our MSRs will assist the member in dealing with the various reasons they may have received a bill for payment of covered services from a network provider or an out-of-network provider. Based on the member's rights and responsibilities, the MSR will work with the member to understand why he or she may have liability for the bill, and under what circumstances they should not be charged, as discussed below.

**In-Network Provider Bills Member**

Aetna Better Health prohibits providers from billing or seeking fees from Louisiana Coordinated Care Network (CCN) members for any covered service, other than applicable co-pays, as set by income guidelines. If a member has received a bill for payment of covered services from a network provider, the member is encouraged to call the toll-free health plan phone number, as instructed in the member handbook. When the member calls the toll-free number, the MSR will assist the member in resolving the situation. The outcome will depend on whether the member is responsible for the charge or if the provider has erroneously billed the member, as discussed in the scenarios below:

- **Calls from Collection Agencies:** When a member gets a call from a collection agency and they are not liable for the bill, the MSR will call the collection agency on behalf of the member and ask that the collection agency call the MSR in the future. The case will be turned over to the Provider Services Representative (PSR) and the PSR will instruct the provider to stop billing the member and inform the collection agency that the account is no longer a viable collection opportunity. Finally, the MSR will contact the member to verify the issue has been resolved within 10 calendar days of notification of the provider.

- **Calls from Network Providers:** When the member calls to report a bill from a network provider, the MSR will confirm that the provider is a part of our network, and then capture all relevant provider information, including the date of service, amount billed, and provider's name and telephone number within Aetna Better Health's call tracking system. Finally, the MSR will instruct the member not to pay the bill and will advise the member to notify Member Services if the billing continues. After completing the call with the member, the MSR notifies Provider Services. A Provider Service Representative then calls the provider and requests that they submit the claim to us for processing. The representative will also review the billing procedures for covered services with the provider in question. A discussion of this prohibition is covered with providers as part of our providers' initial training. This topic is included in the Provider Manual, as well as other provider communications. Aetna Better Health's Provider Services Manager also visits network providers who do not follow network billing practices and implements corrective action. During these visits, the Provider Services Manager:
  - Determines timeframes for improvement based on the time needed to demonstrate change.
  - Continues to follow up with the providers to verify that improvement milestones are met.
  - Reports the status to our Health Plan Oversight Committee (HPOC).
  - Takes all actions to alleviate any financial responsibility on the member for inappropriate billing.
- **Billing During an Appeal on Notice of Action:** If a member is told they are at risk for the cost if the ruling is against them, and if the service is provided in those circumstances, and the member has signed an agreement, the member will be responsible for that cost.

### **Out-of-Network Provider Bills Member**

When charges are billed by an out-of-network provider, the MSR will ask the member and the provider if the member signed a document acknowledging that the member understood they were seeking services from an out-of-network provider and might, therefore, be held responsible for the bill. For example, if the member signed such a statement, the MSR will assist the member in contacting the provider's office to arrange for payment. If the member did not sign such a statement, our MSR will inform the provider that they are unable to bill for the service and reference the related Medicaid policy.

Determination of valid or invalid billing by an out-of-network provider is based upon the existence of a referral and/or a single case agreement.

- Did Aetna Better Health refer the member to the out-of-network provider?
  - If Aetna Better Health referred the member to the out-of-network provider, Aetna Better Health is liable for payment and will work with the out-of-network provider on claims submission and facilitate claims payment.
  - If Aetna Better Health did not refer the member to the out-of-network provider and the member seeks care from this provider anyway, the member is obligated to pay the claim, as stated in the Member Handbook. The exception to this rule is family planning care, for which a member is able to see any Medicaid provider willing to provide the care.

- Members can see any provider, in-network or out-of-network, without a referral for family planning, as long as the provider is a Medicaid provider.
- Did Aetna Better Health have a single case agreement with the provider?
  - If Aetna Better Health had established a single case agreement with the provider, Aetna Better Health is liable for payment and will work with the out-of-network provider on claims submission and facilitate claims payment; the member is not responsible.
  - If Aetna Better Health did not establish a single case agreement with the provider, we are not obligated to pay the claim and the member is responsible, as stated in member handbook.
- Did the member seek emergency care outside the general service area, from an out-of-network provider?
  - If the member sought care from an out-of-network provider, outside the Geographic Service Area (GSA), and the care was necessary because of an emergency, Aetna Better Health is liable for payment and will work with the out-of-network provider on claims submission and facilitate claims payment;
  - If the member sought care from an out-of-network provider, outside the GSA, for which the care was not an emergency, and Aetna Better Health did not refer the member, the member is responsible for payment.
  - If Aetna Better Health did refer the member to an out-of-network provider, outside the GSA, we would help the member establish a payment plan with the provider.

### **A Member is Unable to Reach Her Primary Care Provider (PCP) after Normal Business Hours**

If a member cannot reach her PCP after hours, we view this as a quality of care issue and we will file a grievance for, and on behalf of the member. Our process adheres to federal and the Department of Health and Hospitals (DHH) standards for resolution timeliness; follows all applicable state and federal laws and regulations; and protects our members' rights. The process has been designed to recognize that a complaint may indicate a system-wide, individual provider, or Aetna Better Health process issue that must be addressed. We inform our members about the complaint and appeals process through our Member Handbook, oral interpretation services, TeleTYpewriter (TTY) services, website, and personnel.

- When a member submits a complaint orally or in writing, the Appeals and Grievance manager contacts the member and researches the issue immediately upon receipt.
- The Appeals and Grievance manager sends an acknowledgement letter to the member within five business days of receipt of the complaint. The letter includes a description of the complaint process and the timeframes involved. It also informs the member of their right to have a third party represent with the member's written consent.
- The complaint is thoroughly researched by the Appeals and Grievance Manager and/or the Quality Management Nurse Consultant (QM Nurse), along with input from the Complaint Committee, and a response is issued within 30 calendar days of receipt of the complete complaint. Our Complaint Committee, which is comprised of a multidisciplinary panel and

**Better Health**

chaired by a Member Advocate, in consultation with the COO, meets weekly to review and resolve complaints.

- For clinical issues, a QM Nurse, a Louisiana licensed RN, reviews, evaluates, and makes recommendations at the weekly Complaint Committee.
- Quality of care complaints, covering issues such as delayed or denied care, access issues, or allegations regarding inappropriate care, are referred to our Medical Director and reviewed according to our Peer Review Policy. If there is doubt whether a complaint is related to a quality of care issue, the QM Nurse forwards it to our Medical Director for review.

**Difficulty Scheduling an Appointment for Preventive Care with Her PCP**

If a member is having difficulty scheduling an appointment for preventive care with her PCP, an Aetna Better Health MSR will assist the member in scheduling preventive care with another available PCP to provide continuity of care. Then, the MSR completes a grievance and sends it to the Quality Management team, who reviews the grievance and works with Provider Services to achieve a resolution.

- **Supporting member access:** When a member calls with difficulties scheduling an appointment for preventive care with her PCP, the MSR informs the member of Aetna Better Health's grievance process and helps the member file a grievance if they choose to do so. Regardless of whether or not the member elects to file a grievance, details pertaining to the incident are logged into the call tracking system, and automated notifications are sent to the Provider Services Department, which will work with the provider to determine if the provider has issues with appointment availability. If so, Provider Services will again educate the provider about the mandatory access requirements. If necessary, Provider Services will address the grievance directly with the provider, calling and if necessary, visiting the provider to revolve the access issue. If the provider's behavior continues, Provider Services will institute a corrective action plan. If a resolution is still not achieved, Aetna Better Health will terminate the provider's contract. Once the issue is settled, the MSR notifies the member of the resolution.
- **Guaranteed access:** If a member encounters problems scheduling preventive care appointments, the MSR attempts to connect a conference call with the member and the provider's office to schedule an appointment. If the PCP's office is unavailable, the MSR will advise the caller that we will continue to attempt to reach the PCP that same business day, and will ask the PCP to contact the member immediately to schedule an appointment. The representative will also contact our Provider Services personnel to request assistance in contacting the provider and getting the appointment scheduled. If our attempts to resolve the issue are not successful on the day in question, the member will be offered the opportunity to select a different PCP, and the MSR will assist the member in making the change. If the member needs an appointment related to family planning the MSR will assist the member in scheduling an appointment with any willing Medicaid provider.
- Prior authorization not required for well-woman examination. If the purpose of the member's PCP visit was to obtain prior authorization for a prenatal care visit or a well-woman examination, the member will be informed that Aetna Better Health does not require prior authorization for these visits. The MSR will ask if the member needs assistance

scheduling an appointment or if transportation or other services may act as a barrier to accessing care.

Aetna Better Health requires network providers to have an appointment system for core benefits and services, as well as expanded services, which are in accordance with prevailing medical community standards. Aetna Better Health requires contracted PCPs to be available to see members for preventive care within 90 days of the member's enrollment. Furthermore, our standards require that a routine non-urgent or preventative care visit should be scheduled within six weeks; a urgent visit must be scheduled within 24 hours and an emergency visit must be available immediately or upon the member's presentation to the provider's office. We inform providers of this policy in their initial training; it is included in their contract and in the Provider Manual.

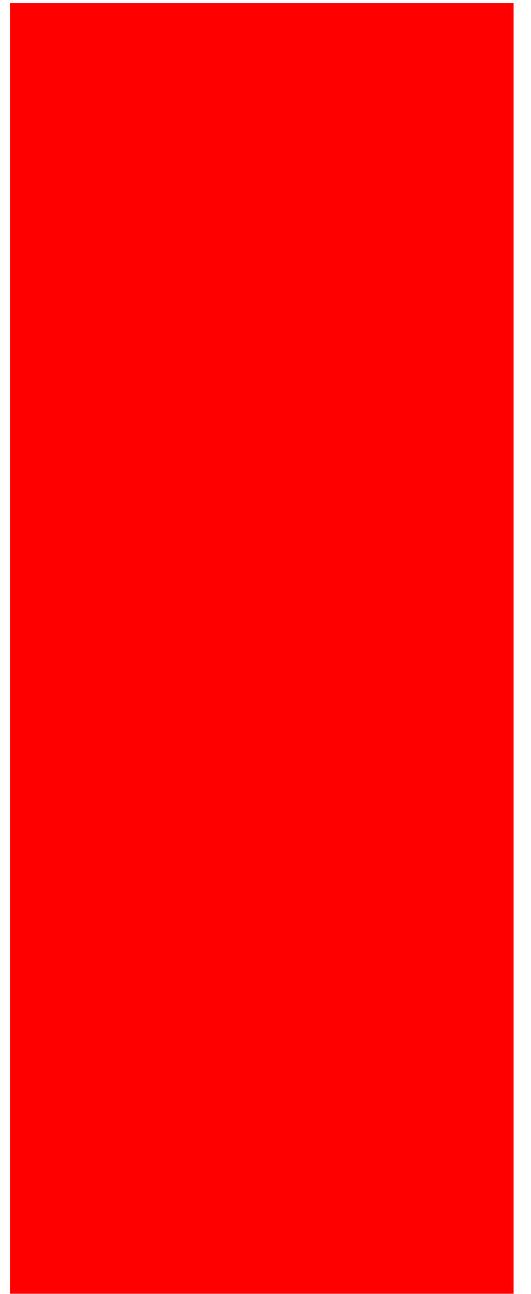
### **A Member Becomes Ill While Traveling Outside of the GSA.**

If a member becomes ill while traveling outside the Geographic Service Area (GSA), the member is covered for emergency service and Aetna Better Health will pay the claim. We will also arrange for the member to be transferred back to a facility or provider within the GSA, if the member requires medical transport.

We educate the member on what to do when becoming ill while traveling outside the GSA through our Member Handbook, member newsletter and other member communications. We advise members who become ill while traveling to seek care immediately if they believe they are having an emergency. If the member does not think their condition is an emergency, the member will be advised to contact their PCP for instructions on how to manage their symptoms while they are out of the GSA.

If a member calls Member Services for assistance in seeking care while traveling outside the GSA, the MSR will ask the member if the condition is an emergency. Members in emergent situations will be advised to seek care immediately at the nearest emergency room and the MSR will assist the member in locating a nearby hospital or urgent care center if necessary. The MSR will remind the member to show the hospital or physician their member ID card and/or their Medicaid form. If the member determines the need for an emergency room visit, our MSR will offer to talk to the Hospital Admissions Department or business office to arrange for the claim to be billed to Aetna Better Health.

102 L.4



**L.4 Describe how you will ensure culturally competent services to people of all cultures, races, ethnic backgrounds, and religions as well as those with disabilities in a manner that recognizes values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each.**

At Aetna Better Health, we put the member at the center of everything we do. As part of this core value, we have embraced an understanding of cultural competency and have evolved our programs through years of service to diverse populations. Aetna Better Health, Inc., together with its affiliates, has more than 25 years experience serving 1.3 million members in 10 states. We believe all members have the right to be treated with respect and dignity. This conviction is included in the listing of the member's rights and responsibilities, published in the Member Handbook; in printed materials, on our website, and in our interactions with members. Our MSRs are trained to treat members with respect at all times. Our MSRs receive extensive training so that they are exceptionally capable of assisting members who face linguistic and cultural barriers to navigating the complex healthcare system.

Aetna Better Health provides culturally competent, linguistically-appropriate services by employing representatives who live in Louisiana and are bilingual in English and Spanish or English and Vietnamese. We understand the importance of employing personnel that can support our members' needs, and will continue our practice of hiring MSRs who are bilingual in English and Spanish or English and Vietnamese.

Aetna Better Health understands that cultural competency means:

- 1) Recognizing the linguistic needs of our members
- 2) Understanding the attitudes and beliefs common to their cultures
- 3) Fostering sensitivity to individuals from diverse socioeconomic and religious backgrounds
- 4) Addressing specific cultural healthcare beliefs and cultural barriers to accessing care

Our Cultural Competency Plan adopts multi-faceted cultural competency, health literacy, and diversity strategies that include, but are not limited to:

- 1) Providing members with healthcare information and services in a format, language, and manner that meets their needs.
- 2) Establishing a provider network that is trained in and compatible with the cultural framework and community environment of members and their families.
- 3) Adopting and implementing culturally competent hiring, training, mentoring, and monitoring practices to support the availability of diverse personnel with an understanding of our members, their families, and the communities in which they live.

Members, providers, and personnel are at various levels of cultural awareness, knowledge, and skills because cultural competence evolves over a period of time. Our Cultural Competency Plan establishes that Aetna Better Health and our employees have a defined set of values and principles, and demonstrate behaviors, attitudes, policies, and structures that enable our providers

and personnel to work effectively cross-culturally. We value diversity, conduct self-assessment, manage the dynamics of difference, acquire and institutionalize cultural knowledge, and adapt to diversity and the cultural contexts of the communities we serve. To maintain cultural competency throughout our operations, we have developed and implemented a comprehensive cultural competency program that provides:

- **Member Education and Support:** Multi-faceted communication program including translation and interpreter services, member educational materials design that honors and is sensitive to cultural diversity, and outreach and care management programs that are geared to a multicultural environment. In addition, our Member Services personnel are 100 percent bilingual in English and Spanish. Our written materials are written at a 4th to 6th grade level in both English and Spanish. Our Member Handbook and other important information are available (in English/Spanish or English/Vietnamese) on our website for easy access. We use Language Line<sup>®</sup> services to provide interpretation of more than 170 languages, 24-hours-a-day, 7-days-a-week at no cost to our members and providers. We also utilize Louisiana Relay services for the hearing impaired and in-person interpreter services are provided as necessary.
- **Provider Education and Support:** One of the root causes of health care disparities in our society is a lack of cultural competency among healthcare providers and health care delivery systems. To bridge this gap, we provide cultural competency training and education to our provider network through a variety of channels. For example, our provider newsletters and website feature articles on cultural competency. We also review and reinforce the importance of cultural competency during provider meetings. Our Provider Manual informs and educates providers about the tools available to facilitate effective communications with their patients. We discuss cultural competency during provider onsite visits and providers are also encouraged to increase their communication skills and abilities to communicate with our members. We provide web-based, Continuing Medical Education (CME) trainings designed to assist providers in bridging cultures, building stronger relationships with members, providing more effective care to members with ethnic and minority groups, and working with members towards better health outcomes.
- **Personnel Education and Training:** We encourage respect for diversity, foster skills that facilitate communication between different cultures, and communicate the relationship between cultural competency and health outcomes. We prohibit personnel from displaying an attitude of interpersonal communication that is disrespectful to our members' cultural backgrounds. Robust employee trainings require that:
  - 1) Employees attend an orientation program which includes cultural competency training.
  - 2) Employees with direct member contact receive additional training through our comprehensive cultural competency program.
  - 3) Managers and supervisors schedule time during personnel meetings for cultural competency exercises.
  - 4) Employee newsletters and website feature articles on cultural competence.
- **Ongoing Evaluation:** Aetna Better Health has established processes to monitor and evaluate the effectiveness of our Cultural Competency Program. At least once each year, we conduct a

comprehensive evaluation of this program to measure improvement in cultural competence knowledge and practices and to identify strengths and weaknesses within the organization, enabling us to develop a plan for improvement. We utilize information received through member complaints, Primary Care Provider (PCP) change requests, member and provider satisfaction surveys, call monitoring reports, and health plan personnel self-assessments to improve our Cultural Competency Program.

### **Intervention Strategies to Avoid Health Care Disparities**

We recognize that members of certain racial and ethnic subgroups encounter greater barriers to care, higher incidence of chronic disease, lower quality of care and higher mortality than most Americans. Meeting the challenge of reducing and eliminating health care disparities requires understanding the demographics and conditions that affect our members, including, but not limited to, childhood immunization rates, obesity, low birth weight, sexually transmitted diseases, heart disease, diabetes, HIV, and tobacco-related cancers.

Key to our efforts in reducing health care disparities is capturing self-identified information from our members, such as race, ethnicity, and language information. Based on this type of information, we have implemented culturally appropriate disease management methods targeting our members with diabetes. For instance, our blood glucose monitoring program uses Spanish language services and materials to better serve and empower Spanish-speaking members with diabetes. We use this self-identified member information to:

- Develop preventive health, early detection, and disease management programs and processes
- Assess our provider networks' ability to meet race, ethnicity, culture and language communication needs and preferences of our populations
- Our provider directory includes language(s) spoken for providers within our network
- Create and deliver quality improvement, management or assessment programs and processes
- Measure the performance and outcomes of our programs and processes

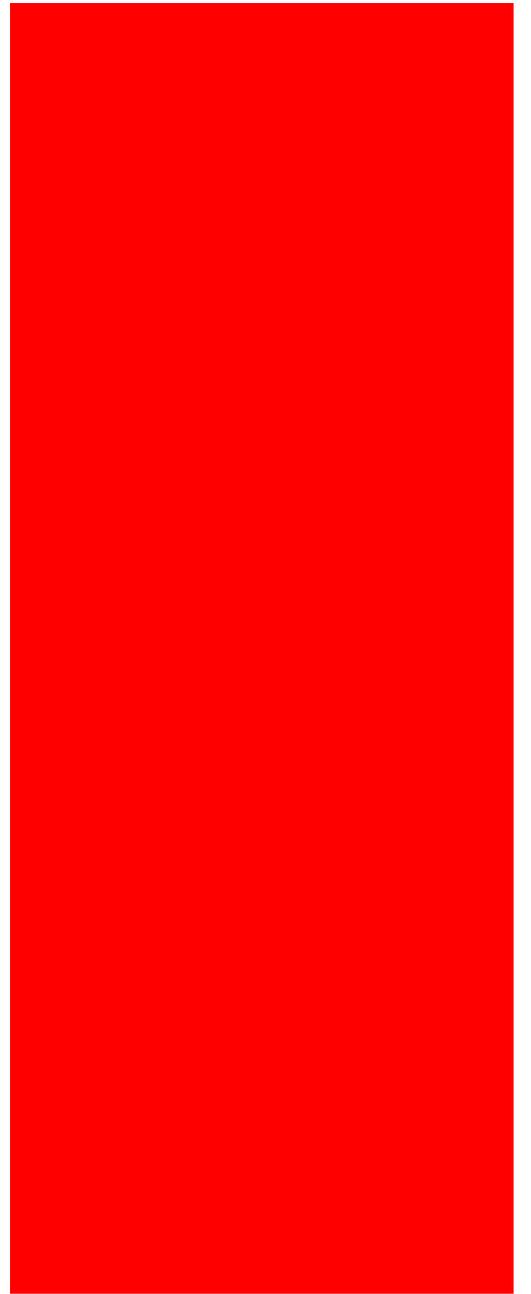
Reducing racial and ethnic disparities in health care is an important part of our Cultural Competency Plan. We utilize the following interventions to avoid disparities in the delivery of services to our members:

- Providers receive information through provider trainings, newsletters, and our website about the cultural dynamics in discussing and engaging in mental health services.
- Providers must encourage and educate members on how to participate in healthy lifestyles, timely healthcare screenings, medication adherence, and preventive care.
- Providers receive training on accessing Language Line<sup>®</sup> services designed to promote communication between healthcare providers and members in order to improve health outcomes.
- We provide Web-based, Continuing Medical Education (CME) trainings designed to provide bridge cultures, build stronger relationships with members, provide care that is more effective to members with ethnic and minority groups, and work with members towards better health outcomes.

- We monitor provider practices through verbal interaction with our members, review of member satisfaction surveys, and analysis of our hotline call reports.
- We develop corrective action plans for providers that continue to have difficulty meeting the service needs of our members in a culturally competent manner.

In addition to employee training, Aetna Better Health educates providers and other stakeholders on the importance of cultural sensitivity/health literacy to meeting members' needs. Providers receive initial and ongoing training on cultural sensitivity, health literacy, and diverse health care disparities through orientation, the provider manual, provider meetings, and in the provider section of our website. Our personnel work with providers on a daily basis to provide member-centered care that meets the needs of each member on a holistic basis and incorporates cultural competency/health literacy. Aetna Better Health also produces culturally sensitive member education materials at state-required reading levels, advising members of the tools available to assist them in navigating the health system, and informing them of their right to culturally competent care.

103 L.5



**L.5 Describe how you will ensure that covered services are provided in an appropriate manner to members with Limited English proficiency and members who are hearing impaired, including the provision of interpreter services.**

Medicaid recipients frequently have unique healthcare needs and they often experience barriers in accessing service, such as low health literacy, vision or hearing disabilities, or limited English proficiency. These challenges make it difficult for members to make their choices known. Aetna Better Health respects the diverse cultural backgrounds of our members and understands the challenges physical disabilities such as hearing impairment can present. We make Language Line available to members who have limited English proficiency, and this service is available whether the member calls our Member Service line or visits a provider and needs translation assistance. We also provide Telecommunications Device for the Deaf (TDD) services and TeleTYpewriter (TTY) services for hearing impaired members, as described below.

- **Translation Service for Members:** When a member calls requesting oral interpretive services, clear, accurate communication is crucial to responsive care of the patient. To assist the member in accessing services, the Aetna Better Health MSR will perform standard call entry in the call tracking system, and contact Language Line, our language interpretation vendor while keeping caller on the line. Aetna Better Health has had a relationship with Language Line since 1998. Language Line employs the professional, highly trained, culturally sensitive, Certified Medical Interpreters to serve members 24 hours a day, 7 days a week. Aetna Better Health personnel will facilitate the introduction between the vendor representative and the caller, in order to identify the requested language. The vendor representative will then facilitate a dialogue to promote the accurate exchange of information between the caller and the MSR. If a member requests material that is not in the prevalent languages, the MSR will read the material to the member through the interpreter, taking care to ascertain that the caller understands the material being read. If there is a request for materials in a language other than English, the MSR enters the request into QNXT™ and documents the call and requested services in Call Tracker.

In addition to our Language Line services, Aetna Better Health will also implement the following steps to help members understand their benefits, rights, and responsibilities:

- We will employ MSRs that can fluently converse with members in English, Spanish or Vietnamese, via telephone.
  - For persons who need extra assistance to understand materials, MSRs can read the materials to the member or his/her caregiver over the telephone through the Language Line service.
  - Aetna Better Health will also provide special assistance for cognitively impaired members or their caregivers as needed.
- **Translation Service for Providers:** Network providers can also access Language Line Services to answer questions from members in the member’s language, educate the member about their condition and other aspects of their health care, and encourage them to seek needed preventive or specialty care. If necessary, Aetna Better Health will also make onsite

interpretation services available to Patient-Centered Medical Home (PCMH) offices. If a member requires oral interpretation services while in the provider's office, the provider (or their office personnel) can contact Aetna Better Health Member Services and request oral interpretation in the member's language. Aetna Better Health shares this information as part of provider training when the provider joins our network.

- Language Line services are always provided at no cost to members or providers.
- **Handling Calls from Members Who Are Hearing Impaired:** Aetna Better Health also provides services or persons with hearing disabilities. We will accept calls from Louisiana Relay (both interpretation and video relay services for sign language) and make available Telecommunications Device for the Deaf (TDD) services and TeleTYpewriter (TTY) services, which provides interpreter capability for callers with hearing disabilities. Aetna Better Health will publicize these phone numbers in member and provider printed materials, as well as the website. We will also provide special assistance for cognitively impaired members or their caregivers as needed. Aetna Better Health's designated MSRs are responsible for returning calls from members and/or their representatives on the next business day following their voice message.

### **Member Materials**

Aetna Better Health's member materials are designed for ease of understanding, and translated materials will include certification that the translation is accurate and complete. The web and print materials are written at or below a 6th grade reading level and will be available in English, with notations in Spanish and Vietnamese stating that the member can request printed materials in these respective languages at no cost to them, by calling Member Services. All of our multi-page written materials will inform prospective members and actual members that oral interpretation services are available at no cost to the member and can be requested by contacting Member Services. Aetna Better Health commits to the Department of Health and Hospitals (DHH) that no written piece will be distributed to a potential member, prospective member or actual member without going through all levels of internal or DHH review, and that no written piece will ever be distributed without DHH's approval. Neither Aetna Better Health nor any of its affiliates have ever been sanctioned by any of the state Medicaid agencies we have contracted with for distributing materials that were misleading to members or misinformed members. Additionally, we have never been sanctioned for distributing materials without receiving prior written approval from the state Medicaid agencies we serve.

- **Aetna Better Health written materials requiring translation:** The DHH-approved English version will be sent to a certified professional translation company for Spanish and/or Vietnamese translation.
- **Persons who have vision disabilities:** For those members who have difficulty reading, or otherwise need assistance to understand written materials, MSRs can read the materials to the member or his/her representative over the telephone. Alternatively, Aetna Better Health can make written materials available in alternative formats, such as large print or audio CD, as needed.
- **Provider Directory includes important information.** Aetna Better Health includes the traditional information in our provider directory and adds information regarding if TTD/TTY and sign language interpretation is available through the office personnel. Please note that

sign language services are readily available to interpret in the physician's office if office personnel are unable to support this need.

Whenever a MSR believes that a caller does not understand the information, he/she will offer to assist by obtaining an interpreter, providing materials in an alternative format, reading the materials over the telephone and/or reviewing the materials with the individual to make sure that key points are understood. Our MSRs will also provide the information to a caregiver, as appropriate. If a member or prospective member requests that a family member or acquaintance act as an interpreter, the Aetna Better Health MSR will follow HIPAA regulations and will verify that this is the individual's wish, obtain informed consent from the member and then verify the age of the proposed interpreter. We will not allow anyone who is under the age of 18 to act as an interpreter. If the request occurs during a telephone call, we will accept the caller's verification of the age of the person providing interpretive services unless we have a valid reason for requesting further verification.