It is the Proposer's position that the data contained in pages:

- 2.4.1 Cover Letter: Pages 2.4.1-2, 2.4.1-3

- 2.5.1 Mandatory Qualifications: Pages 2.5-2 – 2.5-6

- Appendix A (Exhibit B): App A-1, App A-3 – A-461

- Appendix B: App B-3 – App B-128

- Appendix C (Exhibit D): App C.2-4, App C.3-7 – C.3-83

- 2.6.2 Proposer Organization and Experience: Pages 2.6.2-1 – 2.6.2-23, 2.6.2-27, 2.6.2-30 – 2.6.2-35

- 2.6.3 Enrollee Value-Added Benefits: Pages 2.6.3-1 – 2.6.3-14

- 2.6.4 Population Health: Pages 2.6.4-1 – 2.6.4-12

- 2.6.5 Health Equity: Pages 2.6.5-1 – 2.6.5-12

- 2.6.6 Care Management: Pages 2.6.6-1 – 2.6.6-15

- 2.6.7 Case Scenarios: Pages 2.6.7-1 – 2.6.7-44

- 2.6.8 Network Management: Pages 2.6.8-1 – 2.6.8-10

- 2.6.9 Provider Support: Pages 2.6.9-1 – 2.6.9-12

- 2.6.10 Utilization Management: Pages 2.6.10-1 – 2.6.10-15

- 2.6.11 Quality: Pages 2.6.11-1 – 2.6.11-15

- Appendix D: D.3-3

- 2.6.12 Value-Based Payment: Pages 2.6.12-1 – 2.6.12-10

- 2.6.13 Claims Management and Systems and Technical Requirements: Pages 2.6.13-1 – 2.6.13-21

- 2.6.14 Program Integrity: Pages 2.6.14-1, 2.6.14-5 – 2.6.14-10

- 2.6.15 Physical and Specialized Behavioral Health Integration Requirements: Pages 2.6.15-1 – 2.6.15-10

- Appendix E: App E-3

- 4.4 Veteran-Owned and Service-Connected Disabled Veteran-Owned Small Entrepreneurships (Veteran Initiative) and Louisiana Initiative for Small Entrepreneurships (Hudson Initiative): Pages 4.4-1; 4.4.2.6-3 – 4.4.2.6-5

of the proposal have been submitted in confidence and contain trade secrets and/or privileged or confidential information and such data shall only be disclosed for evaluation purposes, provided that if a contract is awarded to this Proposer as a result of or in connection with the submission of this proposal, the State of Louisiana shall have the right to use or disclose the data therein to the extent provided in the contract. This restriction does not limit the State of Louisiana's right to use or disclose data obtained from any source, including the Proposer, without restrictions.

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Board Resolution Granting Signature Authority

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CERTIFICATE

AETNA BETTER HEALTH, INC.

(a Louisiana corporation)

The undersigned, Edward C. Lee, does hereby certify that he is a duly elected officer of Aetna Better Health, Inc., a Louisiana corporation (the "Company"), having knowledge of the records of the Company and authorization to execute this certificate on behalf of the Company, does hereby certify that:

A copy of the board of directors' resolution electing Richard C. Born as President was adopted on May 12, 2020. This resolution gave Mr. Born signature authority on behalf of Aetna Better Health, Inc. (a Louisiana corporation).

IN WITNESS WHEREOF, the undersigned has executed and delivered this Certification this 17th day of August 17, 2021.

_____
Edward C. Lee
Vice President

Subscribed and sworn to this 17th day of August, 2021 and know to me to be the Vice President and Secretary of Aetna Life Insurance Company, a Connecticut corporation.

Witness my Hand Official Seal   _____
                                     NOTARY PULIC

> WENDYANN CIANCI
> Notary Public, State of Connecticut
> My Commission Expires Nov. 20, 2025

2.4 Table of Contents

At Aetna Better Health® of Louisiana (ABHLA), we help people get the care they need for their minds and bodies. **We listen. We empathize. We find solutions.**

To honor Dr. King and his extraordinary legacy, our staff continue to consider new ways of 'doing for others' to improve our collective health and wellbeing.

Table of Contents

Aetna Better Health® of Louisiana

2.4.1 Cover Letter

ABHLA partnered with CVS Health and local community-based organizations **to reduce disparities in accessing the COVID-19 vaccine.** ABHLA has the highest percentage of vaccinated enrollees of all Healthy Louisiana MCOs, and Black enrollees are getting their vaccine at a faster rate than White/Non-Hispanic enrollees.

ABHLA was the only Healthy Louisiana MCO to qualify for the initial incentive for vaccination rates.

Ali Bagbey
Louisiana Department of Health
628 N. Fourth Street
Baton Rouge, LA 70802

September 3, 2021

RE: Aetna Better Health® of Louisiana Response to RFP# 3000017417

Dear Ms. Bagbey:

Aetna Better Health of Louisiana is pleased to present its response to the Louisiana Department of Health (LDH) Request for Proposal (RFP) for Louisiana Medicaid Managed Care Organizations. We consider it a privilege to have served Healthy Louisiana enrollees since 2015. Our team lives and works in the communities we serve, giving us a strong understanding of our enrollees, our provider partners, and the health care priorities of Louisiana. We are supported by a national organization that has serviced complex Medicaid enrollees nationally for more than 35 years, which allows us to bring best-in-class services and programs to Louisiana.

Pursuant to the requirements of Section 2.4.1 of RFP# 3000017417, we provide the following information:

2.4.1.1 Location of Proposer's administrative office with full-time personnel;

2400 Veterans Memorial Blvd., Suite 200
Kenner, Louisiana 70062

2.4.1.2 Name and address of Proposer's corporate principal office registered with the Louisiana Secretary of State, email address, website URL, and telephone number;

Corporate principal office registered with the Louisiana Secretary of State:	Aetna Better Health of Louisiana Richard C. Born Chief Executive Officer 2400 Veterans Memorial Blvd., Suite 200 Kenner, Louisiana 70062
Email address:	BornR@Aetna.com AetnaBetterHealth-LA-Compliance@AETNA.com
Website URL:	www.aetnabetterhealth.com/louisiana
Telephone number:	(855) 242-0802

2.4.1.3 Name and address of the Proposer's corporate principal office for the purpose of issuing checks and/or drafts;

Aetna Better Health of Louisiana
4500 E. Cotton Center Blvd.
Phoenix, Arizona 85040

2.4.1.4 Any other name(s) under which the Proposer does, or has done within the last ten (10) years, business;

In the past 10 years, Aetna Better Health, Inc. has done business under the dba Aetna Better Health of Louisiana. It may also have done business under the name Aetna Better Health.

2.4.1.5 Ownership status (whether the bidding organization is publicly traded or privately held). If privately held, a statement listing name(s) and address(es) of principal owners who hold five percent (5%) interest or more in the organization;

Aetna Better Health of Louisiana is a subsidiary of a publicly traded company, CVS Health Corporation. The names and addresses of the principal owners that hold a five percent (5%) interest or more in Aetna Better Health of Louisiana are as follows:

Aetna Better Health of Louisiana is 100% owned by:
Aetna Health Holdings, LLC
151 Farmington Avenue
Hartford, Connecticut 06156

2.4.1.6 The type of legal entity (for example, corporation (profit or not for profit), limited partnership, general partnership, or trust), and the state where the entity is organized, including any parent organization;

Aetna Better Health of Louisiana is a for-profit corporation incorporated in Louisiana. Its direct parent is Aetna Health Holdings, LLC, which is incorporated in Delaware. Its ultimate parent is CVS Health Corporation, which is incorporated in Delaware.

2.4.1.7 If out-of-state Proposer, name and address of local representative; if none, so state;

Aetna Better Health of Louisiana is an in-state proposer.

2.4.1.8 If any of Proposer's planned personnel is a current Louisiana state employee, or was employed by the State of Louisiana within the past two (2) years, provide a listing to include the employee name, state agency, and termination date, if applicable;

The following Aetna Better Health of Louisiana personnel were previously employed by the State of Louisiana in the past two years:

2.4.1.9 Proposer's state and federal tax identification numbers, LaGov vendor number, and Louisiana Department of Revenue number, if available;

State and federal tax identification number:

LaGov vendor number:

Louisiana Department of Revenue number:

2.4.1.10 A brief statement of the Proposer's involvement in litigation related to the delivery of Medicaid benefits in the last ten (10) years;

Sincerely,

Richard C. Born
Chief Executive Officer
Aetna Better Health of Louisiana

2.5 Business Proposal

Pride is not just about our LGBTQI+ colleagues. **Pride** is also recognizing that many of our enrollees identify as LGBTQI+. We have the responsibility to ensure that the work we do is inclusive of individual preferences and to ensure a respectful enrollee experience at every touchpoint with ABHLA.

2.5.1	Mandatory Qualifications

Aetna Better Health® of Louisiana meets or exceeds all mandatory requirements.

2.5.1.1 Meets the Federal Definition of an MCO, as Defined in 42 C.F.R. §438.2;

Aetna Better Health, Inc. (Aetna[1]) dba Aetna Better Health of Louisiana (ABHLA[1]) meets the federal definition of managed care organization (MCO) as defined in **42 C.F.R. §438.2**, is a MCO entity that has qualified for a comprehensive risk contract and is: (1) A Federally qualified HMO that meets the advance directives requirements of subpart I of part 489 of this chapter; and (2) a public or private entity that meets the advance directives requirements and is determined by the Secretary to also meet the following conditions: (i) Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity. (ii) Meets the solvency standards of **§438.116**.

Aetna is a private entity that meets the advance directives requirements, provides covered services to our enrollment as accessible as those provided to other Medicaid enrollees within Louisiana, and meets the solvency standards of **§438.116**, as stated in this section. Aetna has a certificate of authority issued by the Louisiana Department of Insurance to operate as a Medicaid risk-bearing "prepaid entity" pursuant to **La. R.S. 22:1016**.

2.5.1.2 Has the capacity and willingness to perform all functions in this RFP…

Aetna and ABHLA has the capacity (as demonstrated by Aetna's 13 Medicaid contracts in states with a Medicaid Managed Care population equal to or greater than 1.5 million enrollees including Louisiana) and willingness to perform all functions in the Request for Proposals and in the Model Contract, as having successfully served Healthy Louisiana enrollees since 2015, met the capacity, and performed all functions required by that RFP and the current contract.

2.5.1.3 Is not an excluded individual or entity as described in 42 C.F.R…

We certify and attest that Aetna is **not an excluded entity**—it is not excluded, debarred, suspended, or prohibited from contracting with the federal government or receiving federal funds, either directly or indirectly as described in **42 C.F.R. §438.808(b)**.

2.5.1.4 Has a minimum of five (5) years of experience as an MCO for a…

ABHLA has proudly served Louisiana's most vulnerable populations in a Medicaid Managed Care program since February 2015; exceeding the minimum required five years of experience delivering innovative, quality, and efficient services to complex Medicaid populations. Nationally, Aetna has over 35 years of Medicaid Managed Care experience.

2.5.1.5 Has within the last thirty-six (36) months, been engaged in a contract…

Within the last thirty-six (36) months, Aetna has been engaged in Medicaid managed care contracts in the following states with Medicaid populations equal to or greater than that of Louisiana. **Table 1** breaks down the state, number of Aetna enrollees in that state, and the total state program numbers:

---

[1] For simplicity throughout this proposal, we will use "Aetna" to refer to its indirect parent Aetna Inc. and/or any Aetna Inc. subsidiary that conducts Medicaid/CHIP business or participates in any other line of business discussed in this proposal. Where clarity dictates differentiating between Aetna entities, we will refer to the entity by name, which will include using Aetna Better Health of Louisiana or ABHLA to refer to the Proposer and Aetna Inc. to refer to one of Aetna Better Health of Louisiana's indirect parents. On November 28, 2018, CVS Health Corporation acquired Aetna Inc. and its subsidiaries, including Aetna Better Health of Louisiana. Throughout the proposal, we will refer to our ultimate parent as CVS Health Corporation or CVS Health.

Table 1: Aetna and Total Medicaid Program Enrollment by State ≥ 1.5M (as of July 2021)

State	Aetna Enrollees	Total Program	State	Aetna Enrollees	Total Program
Arizona[2]	454,220	2.2 M	New Jersey	118,052	2.0 M
California	36,351	13.9 M	New York	5,960	7.0 M
Florida	220,504	4.8 M	Ohio[3]	27,814	3.1 M
Illinois	415,289	3.0 M	Pennsylvania	286,239	3.3 M
Kentucky	246,485	1.6 M	Texas	125,684	4.8 M
Louisiana	147,946	1.7 M	Virginia	230,389	1.8 M
Michigan	51,533	2.6 M			

2.5.1.6 Has its Principal Place of Business Located inside the Continental…

Aetna Better Health of Louisiana's principal office is located inside the continental United States at 2400 Veterans Memorial Boulevard, Suite 200, Kenner, Louisiana 70062.

2.5.2   Conflict of Interest

[Content redacted]

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[2] The Aetna affiliate Aetna Medicaid Administrators LLC (AMA) administers, but does not own, certain plans on behalf of Mercy Care d/b/a Mercy Care and Mercy Care Advantage ("Mercy Care"), which itself contracts with the Arizona Health Care Cost Containment System, Arizona's Medicaid agency.

[3] This membership total refers to enrollees in our dual Medicare-Medicaid Plan

[REDACTED]

2.5.2.5 Any other information that may be relevant to the Proposer's or any…
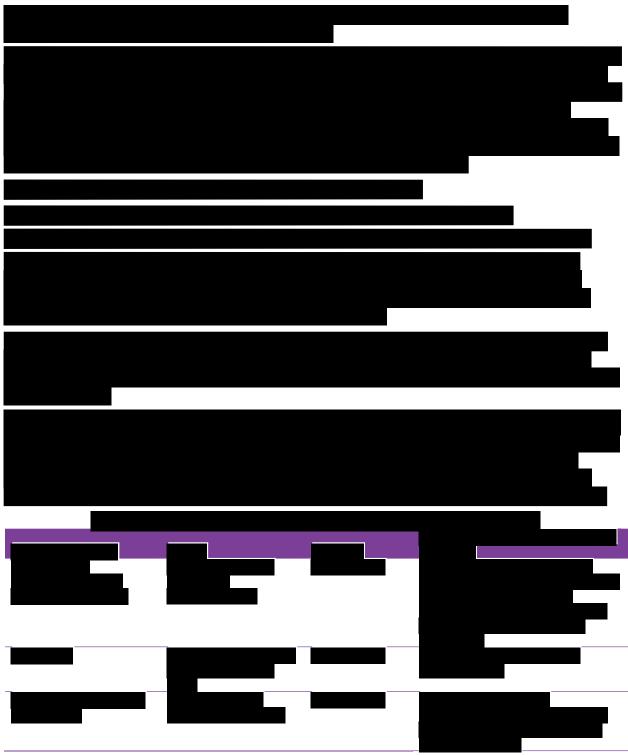
There is not any other information that may be relevant to Aetna's or any material subcontractor's financial, legal, contractual, or other business interests as they relate to the RFP and any Contract awarded to Aetna as a result of the RFP.

2.5.3   Moral or Religious Objections

Aetna Better Health, Inc. d/b/a Aetna Better Health® of Louisiana attests that it has no moral or religious objections to providing any managed care organization covered services described in the **Model Contract, Part 2, Services**.

2.5.4   Material Subcontractors

[REDACTED]

[Content redacted]

---

[4] We provided Appendix F, Material Subcontractor Response Template, for certain entities proposed to perform value-added services in compliance with **Section 2.10.2.3**. Because such entities will not provide services relating "to the delivery or payment of MCO covered services," they are outside the scope of **Section 2.9.4** and are not listed here.

[5] As reflected in **RFP Section 2.10.2.3** and **Appendix F**

2.5.4.3 Where the Proposer utilizes a material subcontractor to provide...

ABHLA has completed **Exhibit B**, Material Subcontractor Response Template, and included the executed agreement, for each material subcontractor.

2.5.4.4 The Proposer must submit a signed Exhibit A, *Certification Statement*…

Exhibit A, **Certification Statement,** attests that ABHLA:

- **2.5.4.4.1** Acknowledges it will not be relieved of any legal obligations under any Contract resulting from this RFP as a result of any contracts with subcontractors, that it is and shall be fully responsible for the subcontractor's performance, and that all partnership agreements, subcontracts, and other agreements or arrangements for reimbursement is and will be in writing and contains terms consistent with all terms and conditions of the Contract; and
- **2.5.4.4.2** Acknowledges that proposals to use subcontractors does and will not cause any additional administrative burden on LDH as a result of the use of multiple entities.
- **2.5.4.4.3** Unless provided for in the contract, ABHLA does not and shall not contract with any other party for any of the services provided for therein without the express prior written approval of the Department.

Section 2.5.5 follows Section 2.5.6 as it is excluded from the page limits.

2.5.6	Required Forms and Certifications

Aetna Better Health® of Louisiana is registered as a vendor with the Louisiana Procurement and Contract Network. We understand and comply with all State and federal laws requiring full disclosure of ownership, management, and control of Medicaid managed care organizations. We provide the following: A Proposal Compliance Matrix **(Exhibit C);** An original Certification Statement **(Exhibit A);** The Medicaid Ownership and Disclosure Form **(Exhibit D).** Please refer to the required forms attached to this application.

2.5.6.1 Exhibit C, Proposal Compliance Matrix

Exhibit C, Proposal Compliance Matrix is included herein.

2.5.6.2 Exhibit A, Certification Statement. The Proposer must be registered as…

Exhibit A, Certification Statement is included certifying that Aetna Better Health of Louisiana is registered as a vendor with the Louisiana Procurement and Contract Network under vendor identification numbers ███████████████ .

2.5.6.3 Exhibit D, Medicaid Ownership and Disclosure Form, as Federal laws…

Exhibit D, Medicaid Ownership and Disclosure Form is located on the electronic copy.

Louisiana Department of Health
Louisiana Medicaid Managed Care Organizations
RFP #3000017417

aetna®
Building a Healthier World through
Better Health, Better Care, and Lower Costs

2.5.5   Financial Condition [exempt from business proposal and total page limits]

Aetna Better Health® of Louisiana[6] and its ultimate parent organization, CVS Health Corporation (CVS Health), have adequate financial resources for performance of its required activities under the contract and provide the required financial statements and taxing authority certificate.

2.5.5.1 The Proposer shall submit documentation to demonstrate to the…

[content redacted]

2.5.5.1.1 Copies of audited financial statements for each of the last three (3) years…

Aetna has included copies of audited financial statements for each of the last three (3) years, including:

- Balance sheet, profit and loss statement, or other appropriate documentation
- Auditor's report
- Same information for Aetna's parent organization

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[6] For simplicity throughout this proposal, we will use "Aetna" to refer to its indirect parent Aetna Inc. and/or any Aetna Inc. subsidiary that conducts Medicaid/CHIP business or participates in any other line of business discussed in this proposal. Where clarity dictates differentiating between Aetna entities, we will refer to the entity by name, which will include using Aetna Better Health of Louisiana to refer to the Proposer and Aetna Inc. to refer to one of Aetna Better Health of Louisiana's indirect parents. On November 28, 2018, CVS Health Corporation acquired Aetna Inc. and its subsidiaries, including Aetna Better Health of Louisiana. Throughout the proposal, we will refer to our new ultimate parent as CVS Health Corporation or CVS Health.

Appendix A

Louisiana | Transforming Health Care | **Aetna**

Appendix A

Exhibit B: Material Subcontractor Response Template
(refer to electronic version)

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Appendix B

Louisiana | Transforming Health Care | **Aetna**

Appendix B

2.5.5.1.1 Audited Financial Statements

(refer to electronic version)

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Appendix C

Louisiana | Transforming Health Care | **Aetna**

Appendix C

2.5.6 Required Forms and Certifications

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**Building a Healthier World through
Better Health, Better Care, and Lower Costs**

Proposal Compliance Matrix

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Aetna Better Health® of Louisiana

Exhibit C: Proposal Compliance Matrix

RFP #:	3000017417
Proposer:	Aetna Better Health® of Louisiana

RFP Section	Requirement	Proposal Section	Proposal Page(s)
2.4	Table of Contents	2.4	TOC-1-TOC-2
2.4.1	Cover Letter	2.4.1	2.4.1-1-2.4.1-3
Business Proposal – Section 2.5			
2.5.1	Mandatory Qualifications	2.5.1	2.5-1-2.5-2
2.5.2	Conflict of Interest	2.5.2	2.5-2-2.5-3
2.5.3	Moral or Religious Objections	2.5.3	2.5-3
2.5.4	Material Subcontractors	2.5.4	2.5-3-2.5-5
2.5.5	Financial Condition	2.5.5	2.5-6
2.5.6	Required Forms and Certifications:		
2.5.6.1	✓ Proposal Compliance Matrix	2.5.6.1	App C.1-1
2.5.6.2	✓ Certification Statement	2.5.6.2	App C.2-1-C.2-4
2.5.6.3	✓ Medicaid Ownership and Disclosure Form	2.5.6.3	App C.3-1
Technical Proposal – Section 2.6			
2.6.2	Proposer Organization and Experience:	2.6.2	
2.6.2.1	✓ Proposer Organization	2.6.2.1	2.6.2-1-2.6.2-23
2.6.2.2	✓ Proposed Staff Qualifications and Organizational Structure	2.6.2.2	2.6.2-25-2.6.2-44
2.6.3	Enrollee Value-Added Benefits	2.6.3	2.6.3-1-2.6.3-15
2.6.4	Population Health	2.6.4	2.6.4-1-2.6.4-12
2.6.5	Health Equity	2.6.5	2.6.5-1-2.6.5-12
2.6.6	Care Management	2.6.6	2.6.6-1-2.6.6-15
2.6.7	Case Scenarios	2.6.7	2.6.7-1-2.6.7-44
2.6.8	Network Management	2.6.8	2.6.8-1-2.6.8-10
2.6.9	Provider Support	2.6.9	2.6.9-1-2.6.9-12
2.6.10	Utilization Management	2.6.10	2.6.10-1-2.6.10-15
2.6.11	Quality	2.6.11	2.6.11-1-2.6.11-15
2.6.11.6	Quality Response Template	2.6.11.6	App D.2-1
2.6.12	Value-Based Payment	2.6.12	2.6.12-1-2.6.12-10
2.6.13	Claims Management and Systems and Technical Requirements	2.6.13	2.6.13-1-2.6.13-21
2.6.14	Program Integrity	2.6.14	2.6.14-1-2.6.14-10
2.6.15	Physical & Specialized Behavioral Health Integration Requirements	2.6.15	2.6.15-1-2.6.15-10
Veteran and Hudson Initiative Programs Participation – Sections 1.44 and 4.4			
4.4	Veteran and Hudson Initiatives Response	4.4	4.4-1

Certification Statement

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Aetna Better Health® of Louisiana

EXHIBIT A: CERTIFICATION STATEMENT

The undersigned hereby acknowledges she/he has read and understands all requirements and specifications of the Request for Proposals (RFP), including attachments.

OFFICIAL CONTACT. The State requests that the Proposer designate one person to receive all documents and the method in which the documents are best delivered. The Proposer should identify the Contact name and fill in the information below: (Print Clearly)

Official Contact Name:	Richard C. Born, Chief Executive Officer
E-mail Address:	bornr@aetna.com
Facsimile Number with area code:	504-667-4730
US Mail Address:	2400 Veterans Memorial Blvd., Suite 200, Kenner, LA 70062

Proposer shall certify that the above information is true and shall grant permission to the State or Agencies to contact the above named person or otherwise verify the information provided.

By its submission of this proposal and authorized signature below, Proposer shall certify that:

1. The information contained in its response to this RFP is accurate and all copies are correct and complete.
2. Proposer shall comply with each of the mandatory requirements listed in the RFP and will meet or exceed the functional and technical requirements specified therein.
3. Proposer shall accept the procedures, evaluation criteria, mandatory contract terms and conditions, and all other administrative requirements set forth in this RFP.
4. Proposer agrees to submit any additional information requested by LDH that, in LDH's judgment, may be relevant to the Proposer's financial, legal, contractual, or other business interests as they relate to the RFP and contract.
5. Proposer does not have any financial, legal, contractual, and other business interest that will conflict in any manner or degree with the performance required under the contract.
6. Proposer does not have, nor does any of the Proposer's Material Subcontractors have, any financial, legal, contractual or other business interest in LDH's Enrollment Broker or in such vendor's subcontractors, if any.
7. Proposer acknowledges it will not be relieved of any legal obligations under any contract resulting from this RFP as a result of any contracts with subcontractors, that it shall be fully responsible for the subcontractor's performance, and that all partnership agreements, subcontracts, and other agreements or arrangements for reimbursement will be in writing and will contain terms consistent with all terms and conditions of the contract.
8. Proposer acknowledges that proposals to use subcontractors shall not cause any additional administrative burden on LDH as a result of the use of multiple entities.
9. Unless provided for in the contract, the Proposer shall not contract with any other party for any of the services provided for therein without the express prior written approval of the Department
10. Proposal shall be valid for at least ninety (90) Calendar Days from the date of proposer's signature below.

11. Proposer understands that if selected as the successful Proposer, he/she will have twenty (20) Calendar Days in which to complete contract negotiations and twenty (20) Calendar Days from the date of delivery of final contract in which to execute the final contract document.

12. Proposer shall certify, by signing and submitting a proposal for $25,000 or more, that their company, any subcontractors, or principals are not suspended or debarred by the General Services Administration (GSA) in accordance with the requirements in 2 CFR §200 Subpart F. (A list of parties who have been suspended or debarred can be viewed via the internet at https://www.sam.gov.)

13. Proposer understands that, if selected as a contractor, the Louisiana Department of Revenue must determine that it is current in the filing of all applicable tax returns and reports and in payment of all taxes, interest, penalties, and fees owed to the State and collected by the LDR. Proposer shall comply with La. R.S. 39:1624(A)(10) by providing its seven-digit LDR account number in order for tax payment compliance status to be verified.

14. Proposer further acknowledges its understanding that issuance of a tax clearance certificate by LDR is a necessary precondition to the approval of any contract by the Office of State Procurement. The contracting agency reserves the right to withdraw its consent to any contract without penalty and proceed with alternate arrangements, should a prospective contractor fail to resolve any identified outstanding tax compliance discrepancies with the LDR within seven (7) days of such notification.

15. Proposer certifies and agrees that the following information is correct: In preparing its response, the Proposer has considered all proposals submitted from qualified, potential subcontractors and suppliers, and has not, in the solicitation, selection, or commercial treatment of any subcontractor or supplier, refused to transact or terminated business activities, or taken other actions intended to limit commercial relations, with a person or entity that is engaging in commercial transactions in Israel or Israeli-controlled territories, with the specific intent to accomplish a boycott or divestment of Israel. Proposer also has not retaliated against any person or other entity for reporting such refusal, termination, or commercially limiting actions. The State reserves the right to reject the response of the Proposer if this certification is subsequently determined to be false, and to terminate any contract awarded based on such a false response.

16. Proposer certifies that its proposal was independently arrived at without collusion.

Signature of Proposer or Authorized Representative:	Richard C Born
Typed or Printed Name:	Richard C. Born
Date:	08/20/2021
Title:	Chief Executive Officer
Company Name:	Aetna Better Health of Louisiana
Address:	2400 Veterans Memorial Blvd., Suite 200
City:	Kenner
State:	LA
Zip:	70062
Vendor #(1):	▮▮▮▮▮▮▮▮
Vendor #(2):	▮▮▮▮▮▮▮▮

Building a Healthier World through
Better Health, Better Care, and Lower Costs

Medicaid Ownership and Disclosure Form

(refer to electronic version)

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2.6 Technical Proposal

ABHLA provides resources for communities to grow healthy foods using sustainable practices while providing education for healthy lifestyles and empowering communities. ABHLA regularly participates in helping neighborhoods curate food hubs to address barriers for accessing nutritious foods.

2.6.2 Proposer Organization and Experience

ABHLA's pursuit of health care's **Quintuple Aim** guides our commitment to improved health and wellness for Louisianans.

2.6.2.1 Proposer Organization [2 page limit; information related to non-compliance actions are …

Aetna Better Health® of Louisiana (ABHLA) has proudly served Healthy Louisiana enrollees since 2015.

2.6.2.1.1 The Proposer should provide a brief summary of the organizational…

We have grown from 65,000 enrollees in 2015 to 147,946 in July 2021 through health care service excellence, advancing evidence-based practices, value-based payment (VBP) innovations, ensuring timely access to care, and improving enrollee health. We are promoting delivery system payment reform by decreasing fragmentation and increasing integration across provider partners and care settings.

Organizational History

ABHLA and its parent organizations have a history of serving Louisiana, giving us unparalleled experience to meet the Healthy Louisiana program requirements and **engage enrollees with the care they need when and where they need it.** Aetna Medicaid plans are community based and supported by national resources, allowing us to align with each state's program goals. We build uniquely beneficial coverage that increases health care access, reshapes the enrollee experience, and promotes healthier communities. ABHLA's deep understanding of our enrollees and the Healthy Louisiana program empowers us to provide ready access to health care and support mechanisms that improve health and care quality. Aetna Medicaid Administrators LLC, which provides plan management and administrative support, brings more than 35 years of Medicaid experience to this program.

ABHLA is wholly owned by Aetna Health Holdings, LLC, which in turn is wholly owned by Aetna Inc., which in turn is wholly owned by CVS Pharmacy, Inc., which in turn is wholly owned by and fully integrated with CVS Health, a Fortune 5 company. We draw on our parent organizations' resources and expertise in support of our Healthy Louisiana enrollees, making decisions at the local plan level to benefit our enrollees and the market.

ABHLA is privileged to provide integrated, managed care for over 255,000 Louisiana Medicaid, Medicare, Medicare Part D, and commercial enrollees, including programs for behavioral health, DSNPs, foster youth, and the justice involved. Our Louisiana offerings reflect our commitment to quality, ready access, and innovation in the state. This commitment includes maximizing enrollee health, reducing health disparities, advancing health equity for all enrollees, and addressing social determinants of health with a flexible, value-based approach.

Organizational Mission Drives Medicaid Managed Care Goals and Performance

Improving care and outcomes for our Medicaid enrollees is central to our commitment to improve health for all of us. Aetna Better Health Medicaid plans have a proven record as trusted partners for 35 years, currently **serving over 2.6 million members in 16 states**. We are driven to improve the health of our enrollees, enhance their experience of care, and effectively manage care costs.

National Medicaid Volume and States Served

Table 1 depicts our Medicaid managed care enrollment in Louisiana and other states.

Table 1: Aetna and Total Medicaid Program Enrollment (as of July 2021)[1]

State	Aetna Enrollees	Total Program	State	Aetna Enrollees	Total Program	State	Aetna Enrollees	Total Program
Arizona[2]	454,220	2.2 M	Louisiana	147,946	1.7 M	Ohio[3]	27,814	3.1 M
California	36,351	13.9 M	Maryland	50,216	1.4 M	Pennsylvania	286,239	3.3 M
Florida	220,504	4.8 M	Michigan	51,533	2.6 M	Texas	125,684	4.8 M
Illinois	415,289	3.0 M	New Jersey	118,052	2.0 M	Virginia	230,389	1.8 M
Kansas	124,270	461,000	New York	5,960	7.0 M	West Virginia	196,706	596,000
Kentucky	246,485	1.6 M						

2.6.2.1.2 The Proposer shall identify whether the Proposer, and/or its parent…

For over 35 years, the Aetna Medicaid organization has delivered innovative, quality, efficient services to complex populations. Thirteen other states we serve have overall enrollment in the past 12 months roughly equal to or greater than 1.5 million enrollees and that of Louisiana: Arizona; California; Florida; Illinois; Kentucky; Maryland; Michigan; New Jersey; New York; Ohio; Pennsylvania; Texas; and Virginia. In the last 12 months we were awarded another Medicaid contract in Ohio.

2.6.2.1.4 Proposer shall provide a brief statement if any of the following has…

In 2017, Aetna voluntarily terminated its contract with the State of Nevada prior to the contract end date. Termination was due to an extremely low enrollment distribution of fewer than 2,000 enrollees, well below the minimum number needed to ensure a viable Medicaid plan. The lead program manager is Tammy Ritter, Chief Managed Care and Quality, Division of Health Care Financing and Policy; (775) 684-3655; tammy.ritter@dhcfp.nv.gov.

Section 2.6.2.1.3 follows Section 2.6.2.1.4 as it is excluded from the page limits.

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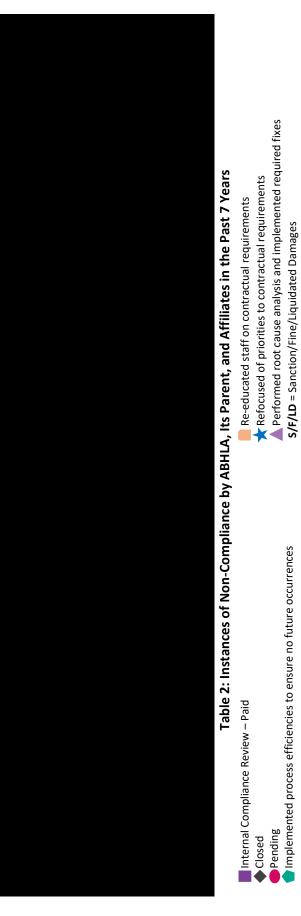
[1] July 2021 Aetna enrollment by State program
[2] ABHLA affiliate Aetna Medicaid Administrators LLC (AMA) administers plans on behalf of Mercy Care d/b/a Mercy Care and Mercy Care Advantage (Mercy Care), which holds a Medicaid contract with the Arizona Health Care Cost Containment System.
[3] This membership total refers to enrollees in our dual Medicare-Medicaid Plan.

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2.6.2.1.3 Proposer shall identify and describe any instances of non-compliance which the Proposer…

Table 2: Instances of Non-Compliance by ABHLA, Its Parent, and Affiliates in the Past 7 Years

Internal Compliance Review – Paid   ■ Re-educated staff on contractual requirements

◆ Closed   ★ Refocused of priorities to contractual requirements

● Pending   ◄ Performed root cause analysis and implemented required fixes

● Implemented process efficiencies to ensure no future occurrences   **S/F/LD** = Sanction/Fine/Liquidated Damages

Contract/Program: Aetna Better Health of Louisiana
Issuer: Louisiana Department of Health (LDH)

Type of Action	Reason for Sanction	Steps Taken
Notice of Non-Compliance	**Failure to Follow NEMT Credentialing Requirements**	●
Dates and Amounts:	8/18/21: N/A	
S/F/LD	**Transportation No Shows**	■
Dates and Amounts:	7/16/21: $5,000; 4/14/21: $5,000; 3/29/21: $5,000; 2/10/21: $5,000; 11/10/20: $35,000	
Notice of Non-Compliance	**Reporting – Other Data**	■
Dates and Amounts:	7/9/21: N/A; 1/18/17: N/A; 4/4/16: N/A	
Notice of Non-Compliance	**Failure to implement pharmacy diagnosis codes**	◄
Dates and Amounts:	3/17/21: N/A	
S/F/LD	**Recoupment Notification Requirements**	■
Dates and Amounts:	3/15/21: $10,000	
Notice of Non-Compliance	**Reporting – Encounter Data**	◄
Dates and Amounts:	3/10/21: N/A; 2/10/21: N/A	

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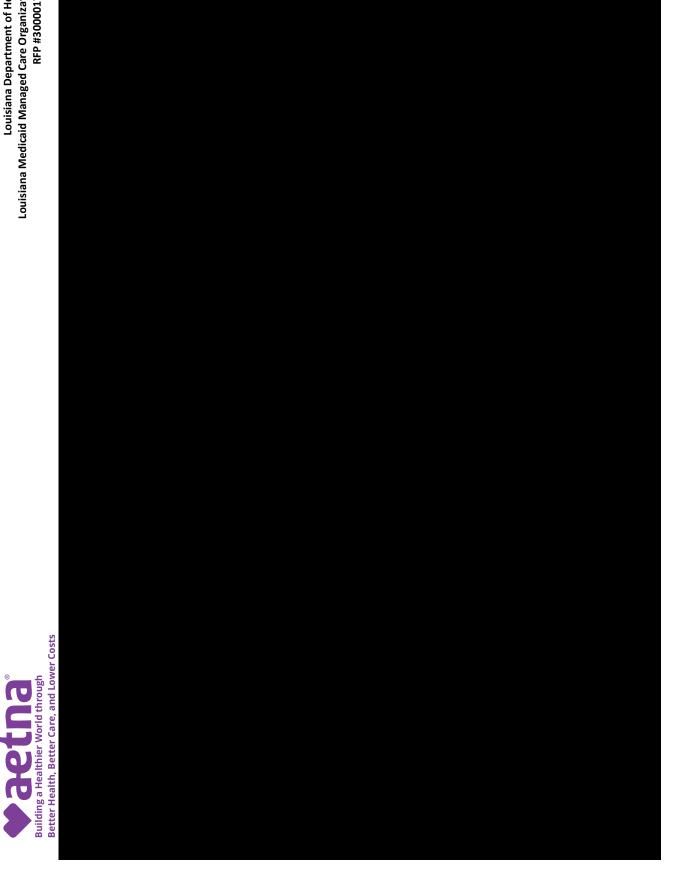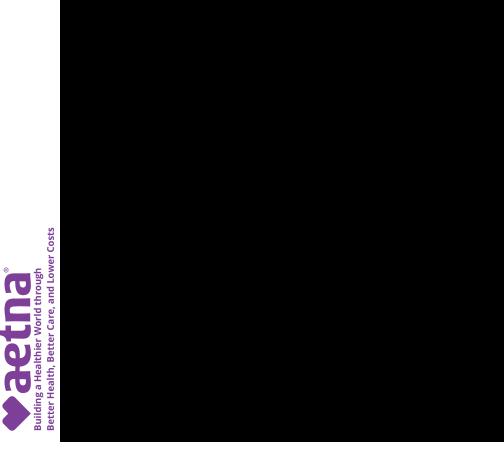
Type of Action	Reason for Sanction	Steps Taken
S/F/LD	**Provider Directory Survey Results**	■
Dates and Amounts:	2/4/21: $50,000; 10/16/20: $50,000; 2/15/19: $50,000	
Notice of Non-Compliance	**Pharmacy provider call center failed to meet the required performance standard**	◆
Dates and Amounts:	1/27/21: N/A	
S/F/LD	**Q1 Provider Directory Surveys**	■
Dates and Amounts:	1/1/21: $50,000	
S/F/LD	**Access Standards**	■
Dates and Amounts:	7/22/20: $10,000	
S/F/LD	**Provider Directory Survey Results Q4 2019**	■
Dates and Amounts:	2/20/20: $50,000	
Notice of Non-Compliance	**Access Standards**	◄
Dates and Amounts:	2/21/20: N/A; 10/21/19: N/A	
S/F/LD	**Provider Directory Survey Results Q3 2019**	■
Dates and Amounts:	1/10/20: $50,000	
Notice of Non-Compliance	**2019 External Quality Compliance Review**	◄
Dates and Amounts:	2/14/20: N/A	
Notice of Non-Compliance	**Failure to Conduct Quarterly Member Advisory Council Meetings**	★
Dates and Amounts:	3/30/20: N/A	
Notice of Non-Compliance	**Payment of Prohibited Fees Pharmacy Benefit**	⬠
Dates and Amounts:	5/15/20: N/A	
Notice of Non-Compliance	**Claims processing timeliness**	◄
Dates and Amounts:	6/30/20: N/A; 9/18/19: N/A	
Notice of Non-Compliance	**DUR Initiatives**	◄
Dates and Amounts:	9/16/20: N/A	
S/F/LD	**Provider Directory Non-Compliance**	■
Dates and Amounts:	9/6/19: $50,000	
S/F/LD	**Claims processing timeliness**	■
Dates and Amounts:	4/2/19: $105,000; 2/26/19: $15,000	
S/F/LD	**Failure to meet established benchmarks for quality improvement – performance measure outcomes**	■
Dates and Amounts:	12/4/18: $500,000	
Notice of Non-Compliance	**Failed to conduct a member satisfaction survey for the specialized behavioral health population using the LDH-established methodology and survey template**	◄
Dates and Amounts:	10/9/18: N/A	
S/F/LD	**Inaccurate Provider Directory**	■
Dates and Amounts:	6/25/18: $50,000	
Notice of Non-Compliance	**Claims processing accuracy**	◄
Dates and Amounts:	11/14/19: N/A; 6/1/18: N/A; 3/10/17: N/A	
Notice of Non-Compliance	**HCPCS code update**	◄

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2.6.2.2 Proposed Staff Qualifications and Organizational Structure [6-page limit; organizational…

Aetna Better Health® of Louisiana (ABHLA), as an incumbent, has local leadership and staff at all levels in place with established relationships with stakeholders, Louisiana Department of Health (LDH), providers, and Healthy Louisiana enrollees. Our organizational culture, decision-making, and accountability are all locally driven and aligned with LDH goals and objectives, including enhancing the enrollee experience. Our local plan is supported by our national organization, which has over 35 years of Medicaid experience. Aetna will comply with all LDH staffing requirements, the Request for Proposal, **Model Contract Section 2.2, Part 2 of the MCO Manual, and Attachment G.**

2.6.2.2.1 The Proposer should describe its process for identifying its key...

Identifying key personnel and the management structure and organization are the foundation to developing a high-performing Louisiana Medicaid MCO.

Identifying and Hiring Key Personnel to Maintain Alignment with Louisiana Values

To identify and hire key personnel, we define and align our search criteria for each position based on the required qualifications, experience, skills, and credentials. We match each position with the most qualified candidate and ensure they have the appropriate credentials, including but not limited to licensure requirements for each key personnel, per **Model Contract Section 2.2.2.4.4**. In identifying and hiring key personnel, we ensure a cultural fit with both our organization and more importantly with Louisiana's rich variety of cultures. We value diversity of experience and viewpoints in both our leadership and staff, and we work to ensure that our key personnel mirror the diverse populations we serve in Louisiana

Diversity drives who we are and our emphasis on identifying and hiring leaders who understand the overall needs of Healthy Louisiana enrollees and can design support programs that address enrollee and population-specific issues. We develop key personnel into systems thinkers who can translate LDH goals, State requirements, and Medicaid rules into functional teams that improve enrollee health, access, and outcomes. As we recruit, develop, and retain diverse qualified key personnel and staff to support the growth envisioned in the contract, we are committed to utilizing the same diligence of process to identify, attract, and hire personnel with significant Medicaid managed care experience.

Aetna Management Structure and Organization

Aetna's national Medicaid leadership team has extensive experience across 16 states with 31 contracts—governing ABHLA key team leaders and leveraging all the operational efficiencies, knowledge, processes, and supports our national organization and its ultimate parent, CVS Health, and its Board of Directors, have to offer. ABHLA itself has a great story of talent success from hiring key leaders with strong experience in their given fields of expertise, and those key leaders in turn manage divisional structures that support compliance, lessons learned, best practices, transparency, and information-sharing.

2.6.2.2.2 For each individual appointed to a key personnel role, the Proposer…

Our chief executive officer, highly experienced leadership team, and other key personnel, with over 100 collective years of Medicaid managed care experience, together lead a highly skilled team with extensive local, program-specific knowledge. ABHLA's key personnel lead and direct our health plan and actively engage and collaborate with LDH, enrollees, program stakeholders, subcontractors, legislators, and providers across Louisiana. These ABHLA leaders, whose resumes are provided at the

end of **Section 2.6.2.2 of this response**, are designated as key personnel by LDH, located in Louisiana, and exclusively serve 100 percent time to performing the roles in our local plan.

The following are our key personnel: Chief Executive Officer (CEO) Rick Born, Master of Business Administration (MBA), Certified Public Accountant (CPA), Certified Managed Care Executive; Interim Chief Operating Officer (COO) Roger Gunter; Chief Medical Officer (CMO) Madelyn Meyn, MD, MBA, Fellow of the American Academy of Pediatrics (FAAP); Behavioral Health Medical Director (BHMD) Jared Wakeman, MD, Fellow of the American Psychiatric Association (FAPA), Fellow of the American Society of Addiction Medicine (FASAM); Chief Financial Officer (CFO) David Nicosia, CPA, MBA; Pharmacy Director (PD) Vanessa Smith, Doctor of Pharmacy (DPh); Contract Compliance Officer (CCO) Emily Byrd, Juris Doctor; and Health Equity Administrator, D'Andra Odom (HEA), Master of Public Health (MPH).

ABHLA's leadership team knows the local Medicaid health care delivery system and Louisiana cultures. ABHLA has a long history of hiring statewide to serve enrollees and providers in the regions and local communities in which they live and work. **As a current Louisiana Medicaid plan with all key personnel in place**, we have hired, supported, and promoted local Louisiana health care and highly skilled personnel. Our leadership and Implementation Talent Acquisition team have built our staffing plan to align with LDH's goals and objectives and the requirements of the **Model Contract and MCO manual.**

2.6.2.2.3 The following information about the Proposer's operating structure…

ABHLA's organizational structure reflects our Louisiana-focused strategy to continuously achieve outstanding managed care performance for our enrollees by moving beyond contract requirements to build value-based payment (VBP) programs that align with State goals and objectives and serve enrollees. One example of success we shared with a Louisiana provider is that of Bryan G. Sibley, MD, who exceeded the 50th percentile in four of five of his Healthcare Effectiveness Data and Information Set (HEDIS) quality measures in 2019 as part of his patient-centered medical home VBP contract. Those measures include Adolescent Well Care (AWC), Lead Screening (LSC), Well Child Visits 15 Month Six or More Well Child Visits (W15), and Well Child Visits 3-6 Year (W34).

ABHLA Leadership and Reporting to Our Governance Structure

Our CEO, COO, CMO, and CFO comprise ABHLA's plan leadership team. Our plan and key team leadership all report to our CEO Rick Born. Our overall governance structure (presented as **Figure 1** shows that our CEO and the plan report directly to the ABHLA's Board of Directors (BOD) and to Aetna national Medicaid leadership. Aetna national Medicaid leadership report to CVS Health. Local key teams hold meetings at least weekly with their respective governance committee teams within Aetna Medicaid. Additionally, ABHLA key teams meet regularly with external partners quarterly. There are additional monthly, quarterly, and annual committee meetings to discuss strategic planning, budgeting, and operating results at the plan.

Organizational Chart of ABHLA's Operating Structure

Figure 2 provides ABHLA's organizational chart of our operating structure with all key teams performing activities under the contract and material subcontractors identified in **Section 2.5.4 of the Request for Proposal.** We include organizational staffing for behavioral health (BH) services and activities as required by **Model Contract Section 2.2.2.1.7**. ABHLA does not use material subcontractors for BH services.

Our organizational structure maintains interdepartmental relationships and lines of accountability that facilitate program operation and management and provide integration of physical and behavioral health and services in alignment with current clinical knowledge and available data on evidence-based effective

treatment aligned with **Model Contract Sections 2.2.1.1 and 2.2.2.1**. Our staffing and resource allocation achieve positive outcomes and comply with contract and MCO manual requirements. Aligned with **Model Contract Section 2.2.2.1.7**, at LDH request, and when we change an individual serving as a senior or mid-level manager, we send LDH updated organizational charts showing the individuals in these roles.
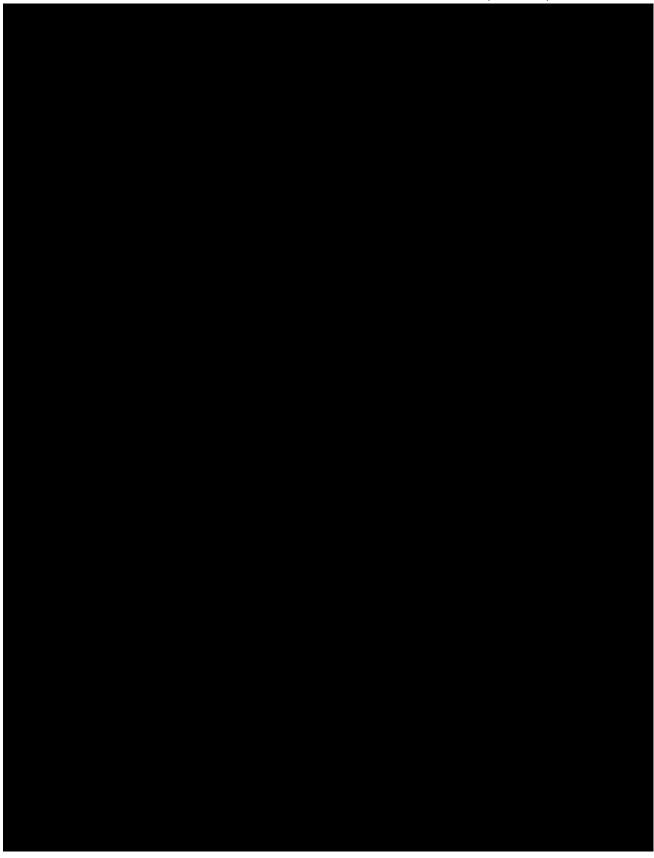
Team Roles, Accountability and Reporting
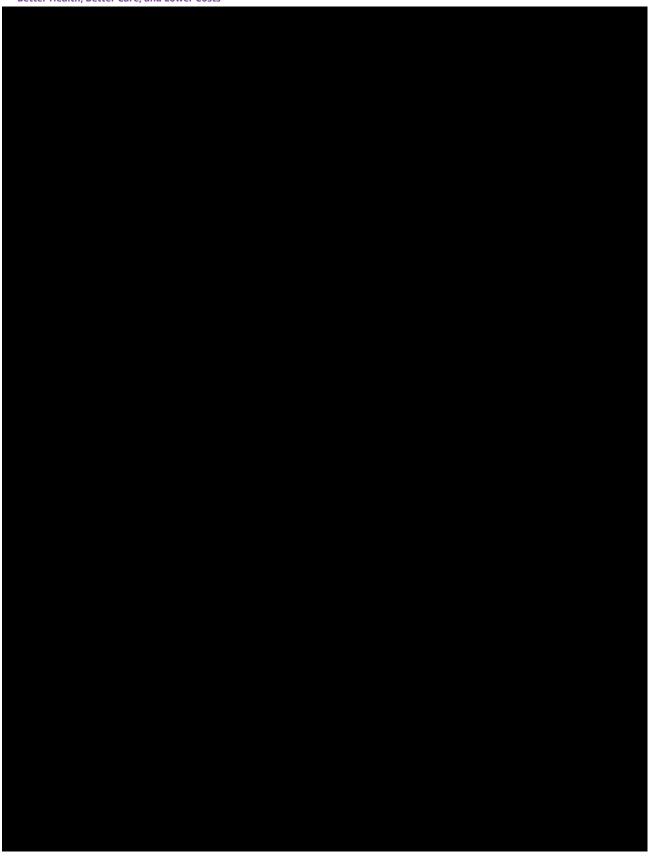
We have identified and engaged key teams to align with the requirements of the **Model Contract** pertaining to performing our operating activities, including the roles of any material subcontractors for which we are accountable, and how each key team reports to and informs decisions by leadership, as illustrated in **Table 3.**

Determining Staffing for Planned Enrollment
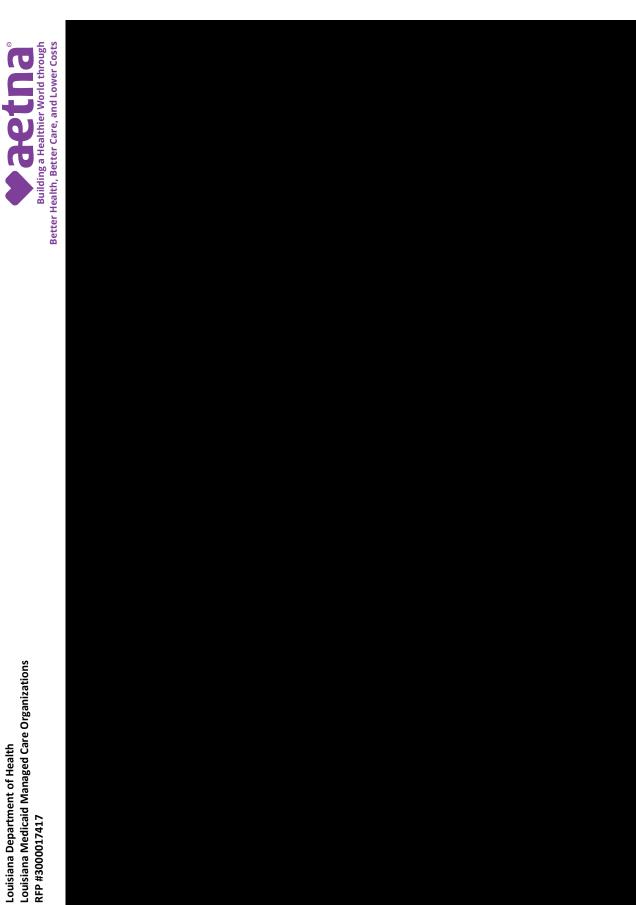
ABHLA's local organizational leadership, hiring managers, and human resource leaders all participate in the creation of our high-quality staffing plan, supported by our national Aetna team in an organization-wide effort. **Our integrated, scalable staffing model is based on the principle of Louisianans serving Louisianans and managed by local health plan leaders** to ensure quality staffing that can meet the needs of a growing enrollment or new contract requirements. For units with less enrollment-dependent workloads, we identify any indirect impacts of enrollment growth and new requirements. The result is a detailed process to identify staffing needs to meet the contract requirements. Staffing drivers for ABHLA include the following: appeals; claims; clinical outcomes; community-based organization engagements and events; compliance data; denials; enhanced enrollee experience; enrollment level and growth; grievances; HEDIS and Consumer Assessment of Healthcare Providers and Systems performance; medical trends; enrollee experience; network information; new contract requirements; population health initiatives and subpopulations within our enrollment; stratified prior authorizations for medical, behavioral health, and pharmacy; providers; quality improvement efforts; staff and performance indicators; subcontractor performance; and utilization.

Recruiting and Staffing Timeline and Process
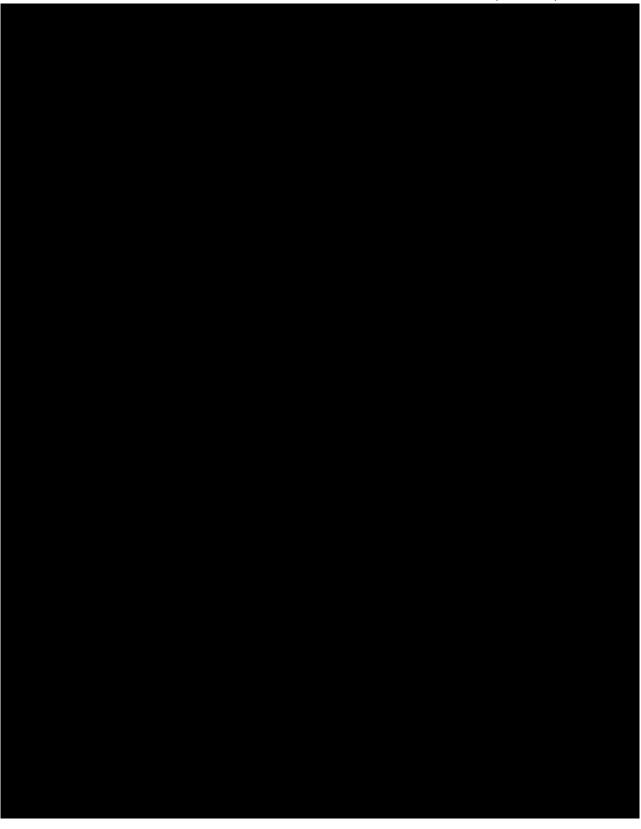
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Rick Born
Chief Executive Officer

Rick Born is an executive with more than 30 years of health care and health insurance experience with a proven record of strategic, operational, and financial success. As a respected leader of cross-functional teams, Mr. Born is known for developing innovative, sound, and creative business strategies that improve outcomes through strong skills in leadership, relationship building, financial analysis, value-based contracting, and process improvement.

Experience

Aetna Better Health of Louisiana, Baton Rouge, LA
2016–present
Chief Executive Officer

Health Alliance Medical Plans, Inc., Urbana, IL
2013–2015
Chief Operating Officer

Women's Care of Wisconsin, S.C., Appleton, WI
2007–2013
Chief Operating Officer

Coventry Health Care, Inc., Richmond, VA
2006–2007
Chief Operating Officer

Education

- St. Louis University, St. Louis, MO, Master of Business Administration
- University of Evansville, IN, Bachelor of Science in Business Administration

Licensures and Certifications

- Certified Public Accountant (inactive); Member of the American Institute of CPAs
- Certified Managed Care Executive through America's Health Insurance Plans

Board Membership

- President – Louisiana Managed Medicaid Association
- Boys and Girls Club of Metro Louisiana, including Board Member of the Year – 2019
- Louisiana Association of Health Plans, including Medicaid Chair

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Roger Gunter
Interim Chief Operating Officer

With more than 26 years of managed care experience, Mr. Gunter is a senior business executive and transformation expert with strong financial acumen, operations proficiency, and deep experience in improving health care delivery, driving operational excellence, and positively impacting profit and loss statements, medical loss ratio, cash flow, and corporate culture. His other attributes include acute knowledge and understanding of health care environments; authentic leader who values cross-functional relationships and infrastructure that allow for rapid growth and provide empathetic care to the most fragile across Medicaid, Medicare, and commercial markets; innovative agent of change, valued for analyzing complex situations and developing/delivering strategy and initiatives that lower costs, enhance earnings, and improve market share through progressive reimbursement and market access experience; visionary offering strong values to advance an organization's essential mission and business goals through use of technology, mentoring, and creative problem-solving; adept, collaborative communicator with all partners, from doctors to attorneys to systems specialists; skilled recruiter, builder, and motivator of strong, successful teams that are results-driven.

Experience

Aetna Better Health of Louisiana, Kenner, LA
August 2021–present
Interim Chief Operating Officer

Aetna Better Health of Virginia
2014–present
Chief Executive Officer, Senior Engagement Manager

Behavioral Healthcare, Inc. (BHI)
2011–2014
Chief Executive Officer, Chief Operations Officer

McKesson Health Solutions
2006–2010
Senior Director, Care Management and Program Outcomes

Colorado Access
2005–2006
Director of Finance and Actuarial Services

Colorado Department of Health Care Policy and Financing
1994-2005
Deputy Director, Medicaid Acute Care Services

Education

- University of Denver, Denver, CO, Master's Program, Health Care Systems – Strategic Healthcare Management
- University of Colorado, Boulder, Colorado, Bachelor of Science

Madelyn Meyn, MD, MBA, FAAP
Chief Medical Officer

Dr. Meyn is involved in all clinical and quality management aspects of Aetna Better Health® of Louisiana's managed care organization activities. Dr. Meyn applies both her medical and management skills in the day-to-day oversight of clinical policies and procedures while guiding all medical management administration.

Experience

Aetna Better Health of Louisiana, Kenner, LA
2019–Present
Chief Medical Officer

April 2019–September 2019
Interim Chief Medical Officer

2017–present
Medical Director

Tulane University, New Orleans, LA
2009–present
Assistant Clinical Professor

EXCELth, Inc., New Orleans, LA
2009–2016
Staff Pediatrician

Hospital Clinical Assignments
West Jefferson Medical Center, Marrero, LA
2008–2014
Pediatric Emergency Room Physician/Pediatric Hospitalist

Education

- Tulane University, New Orleans, LA, Master of Business Administration
- Wright State University School of Medicine, Dayton, OH, Doctor of Medicine
- Xavier University, Cincinnati, OH, Certificate of Pre-Medical Studies
- Colby College, Waterville, ME, International Studies

Licensures and Certifications

- American Board of Pediatrics, Board Certified, 2009–present
- Medical License, Louisiana State Medical Board, 2006–present
- CDS, Louisiana Board of Pharmacy, 2005–present
- DEA License, 2005–present
- Provider: Basic Life Support, 2008–present
- Provider: Pediatric Advanced Life Saving, 2007–present

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Jared Wakeman, MD, FAPA, FASAM
Behavioral Health Medical Director

As a dedicated and experienced behavioral health medical director, Dr. Wakeman is actively involved in all major clinical and quality management components of Aetna Better Health® of Louisiana's behavioral health services to enrollees.

Experience

Aetna Better Health of Louisiana, Kenner, LA
2018–present
Behavioral Health Medical Director

CrescentCare, New Orleans, LA
2015–2018
Outpatient Psychiatrist

Fairfax – Falls Church Community Service Board, Fairfax/Falls Church, VA
2013–2015; 2011–2012
Outpatient Psychiatrist

Inova Fairfax Hospital Comprehensive Addiction Treatment Services, Fairfax/Falls Church, VA
2012
Psychiatrist for day treatment program and intensive outpatient program

Ochsner Hospital, New Orleans, LA
2000–2003
Human Resources Specialist

Education

- Tulane University School of Medicine, New Orleans, LA; MD
- Columbia University, NY; BA in Neuroscience

Medical Licensures and Certifications

- ABPN-certified in Psychiatry, September 2011
- ABAM-certified in Addiction Medicine, December 2012
- Virginia – Expires August 31, 2022
- Louisiana – Expires August 31, 2022
- Training at George Washington University Medical Center, Washington, D.C., in Psychiatry

David Nicosia, CPA
Chief Financial Officer

David Nicosia is an accomplished, results-oriented accounting and finance professional with executive-level experience. Mr. Nicosia has demonstrated strengths in strategic and business planning, analysis-based decision guidance, accrual financial statement preparation, cost accounting, budgeting, and capital investment direction.

Experience

Aetna Better Health of Louisiana, Kenner, LA
2018–present
Chief Financial Officer

PACE Greater New Orleans, New Orleans, LA
2011–2017
Chief Financial Officer

Nicosia Consulting Services, River Ridge, LA
2009–2010
President

Ochsner Health System, New Orleans, LA
1991–2001
Vice President, Budgeting and Decision Support, 2001-2009

Ochsner Hospital – West Bank
Interim Chief Financial Officer, 2008
Director of Budgeting and Financial Analysis, 1995–2001
Financial Analyst/Senior Financial Analyst, 1991–1995

Education

- A.B. Freeman School of Business, Tulane University, New Orleans, LA, Master of Business Administration – Accounting
- Loyola University, New Orleans, LA, Bachelor of Business Administration – Finance
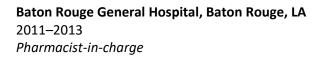
Vanessa Smith
Pharmacy Director, DPh

Vanessa Smith has over 25 years of pharmacy experience and is a practicing Doctor of Pharmacy with 6 years of managed care experience. She is an active member of the Louisiana Pharmacy Association and the Academy of Managed Care Pharmacy.

Experience

Aetna Better Health of Louisiana, Baton Rouge, LA
2018–present
Director of Pharmacy

Louisiana Healthcare Connections, Baton Rouge, LA
2013–2018
Manager of Pharmacy

Baton Rouge General Hospital, Baton Rouge, LA
2011–2013
Pharmacist-in-charge

Education

Xavier University, New Orleans, LA, Bachelor of Science – Pharmacy

Licensures and Certifications

Medication Therapy Management-certified

Emily Byrd
Contract Compliance Officer

With almost a decade of experience focusing on legal health care issues and compliance operations, Emily Byrd ensures State and health plan compliance goals by executing contract requirements and related company policies. She and her team monitor, audit, and investigate possible fraud and abuse while overseeing health plan staff training and education. Ms. Byrd's emphasis on team collaboration, annual risk assessments, and an informed annual compliance workplan confirm continuous adherence to compliance requirements safeguarding both enrollees and the State.

Experience

Aetna Better Health of Louisiana, Kenner, LA
2021–present
Contract Compliance Officer

Ochsner Health System, New Orleans, LA
2019–2021
Compliance Specialist

2015–2019
Compliance Specialist – Reimbursement Department

Peoples Health, Metairie, LA
2014–2015
Compliance Specialist – Claims Operations

Honorable Ivan L. R. Lemelle, U.S. District Court Eastern District of Louisiana, New Orleans, LA
2012–2013
Legal Judicial Extern

Naman, Howell, Smith & Lee, PLLC, Waco, TX
2012
Law Clerk

Education

- Loyola University New Orleans College of Law, New Orleans, LA, Juris Doctor
- The University of Texas at Austin, Austin, TX, Bachelor of Science in Biology

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D'Andra Bradford Odom
Health Equity Administrator

Ms. Odom is a 20-year career veteran with more than 10 years of experience collaborating with community and state leaders to develop and implement strategies that support a healthy lifestyle in minority communities. She is a top-performing health care professional who guides strategic initiatives that address poor health outcomes for populations experiencing disparities. As our tobacco cessation program manager, she has been recognized for her work with the Louisiana Department of Health to implement a 100 percent tobacco-free workplace site-wide.

Experience

Aetna Better Health of Louisiana, Baton Rouge, LA
2020–present
Health Care Equity Director

Southeast Louisiana Area Health Education Center/Louisiana Department of Health, Baton Rouge, LA
2013–2020
Minority Outreach Director – Bureau of Minority Health Access and Promotions

LA Department of Health and Hospitals – Health Promotions Team, Baton Rouge, LA
2010–2013
Lead Policy Analyst/Legislative Liaison

Academic Distinction Fund, Baton Rouge, LA
2009
Public Policy Intern

Louisiana Association of Non-Profit Organizations, Baton Rouge, LA
2008
Budget Project Public Policy Intern

Century Link, Monroe, LA
2005–2006
Quality Assurance Analyst II

United States House of Representatives
2003–2005
District Representative

Education

- Southern University A&M College, Master of Public Administration, Public Policy
- Grambling State University, Bachelor of Science, Computer Information Systems
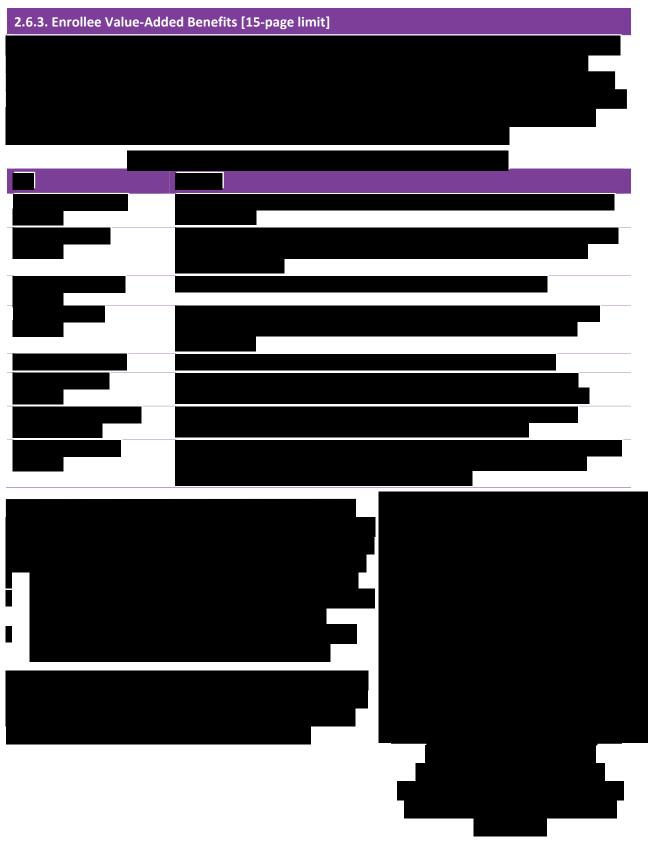
2.6.3 Enrollee Value-Added Benefits
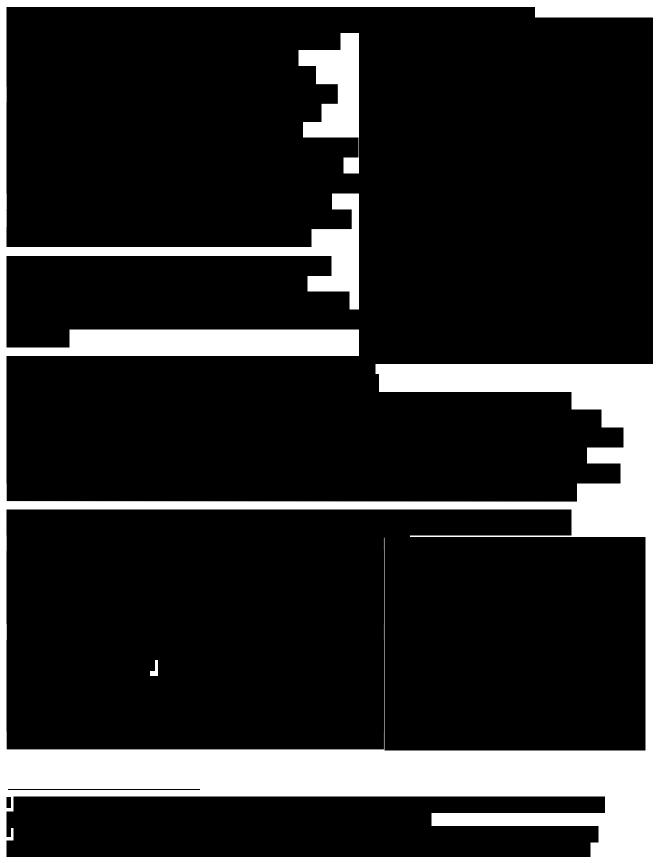
Each year, **ABHLA works with schools in underserved communities to support them throughout the school year**. We help restock school supplies that many teachers replace using their own money. Not only do we provide basics such as crayons, markers, and pencils, but we help replace other much-needed supplies like copy paper, tissue, hand sanitizer, and cleaning supplies.

2.6.3. Enrollee Value-Added Benefits [15-page limit]

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2.6.3.1.5 Vision benefits for adults, including annual exam and glasses or:

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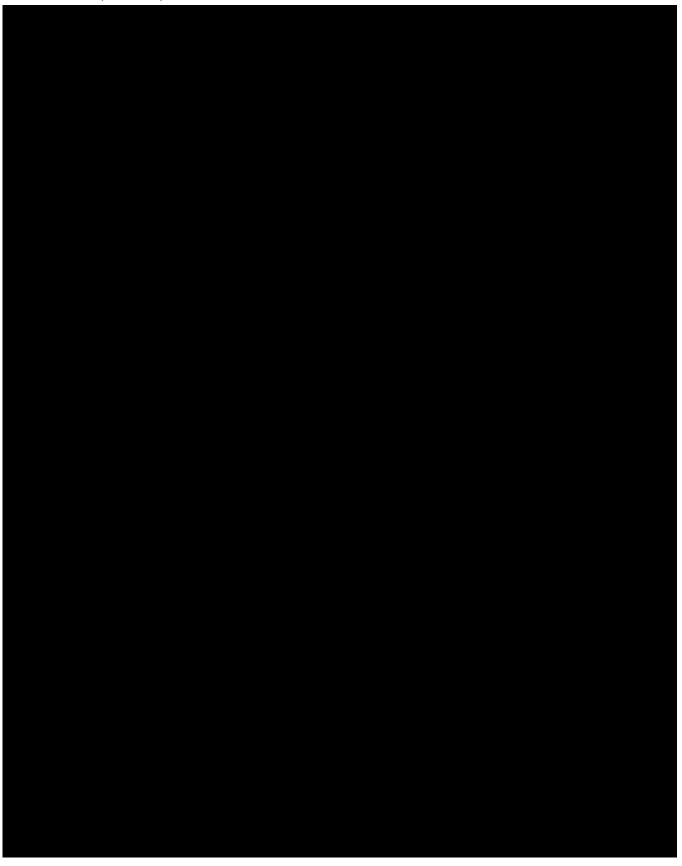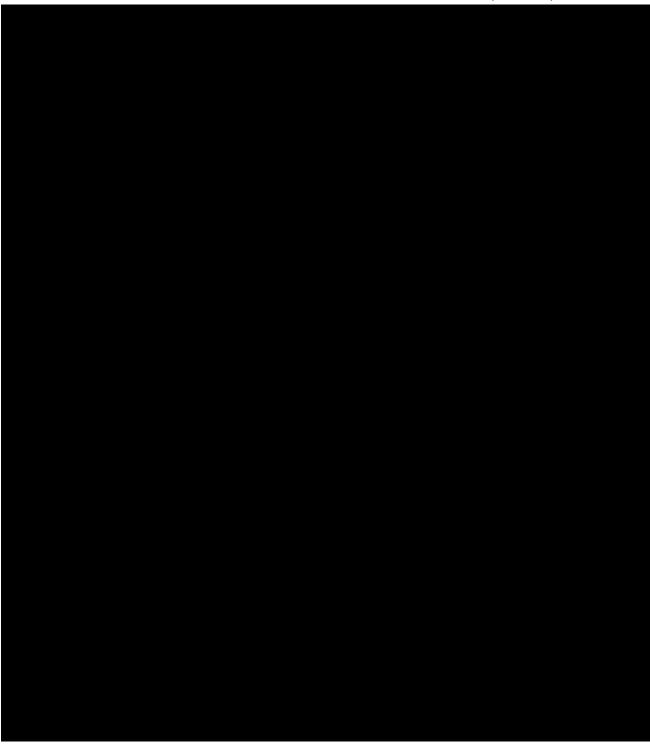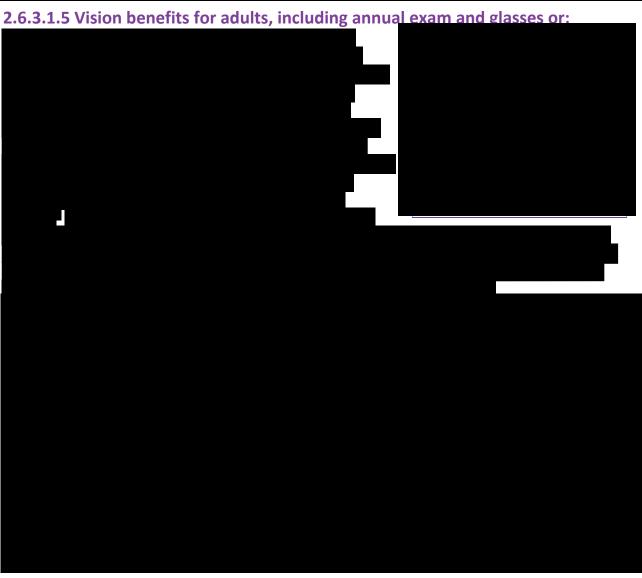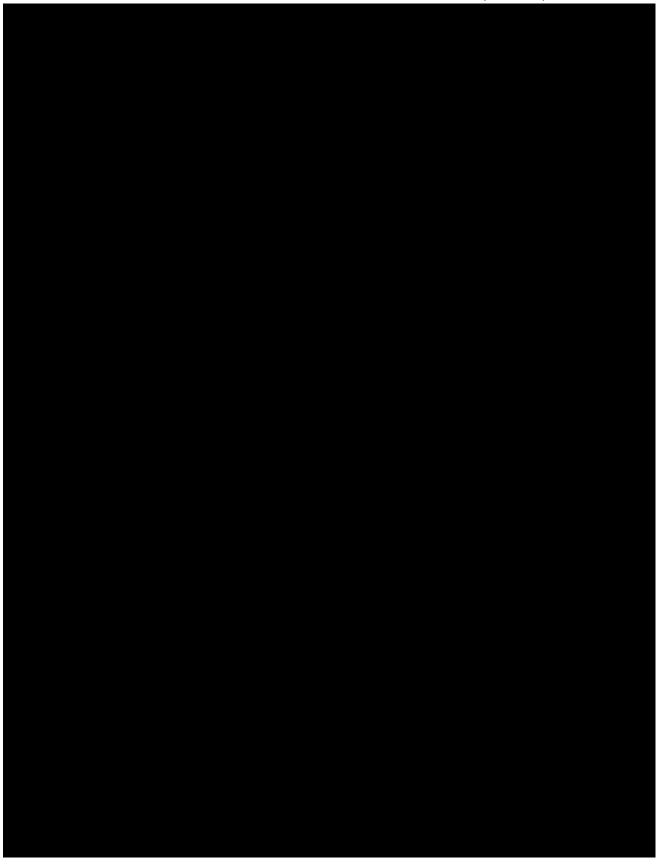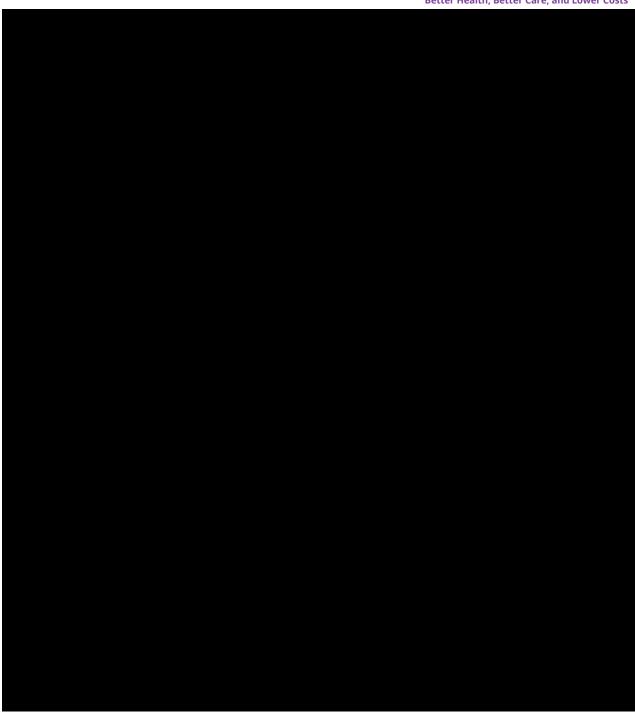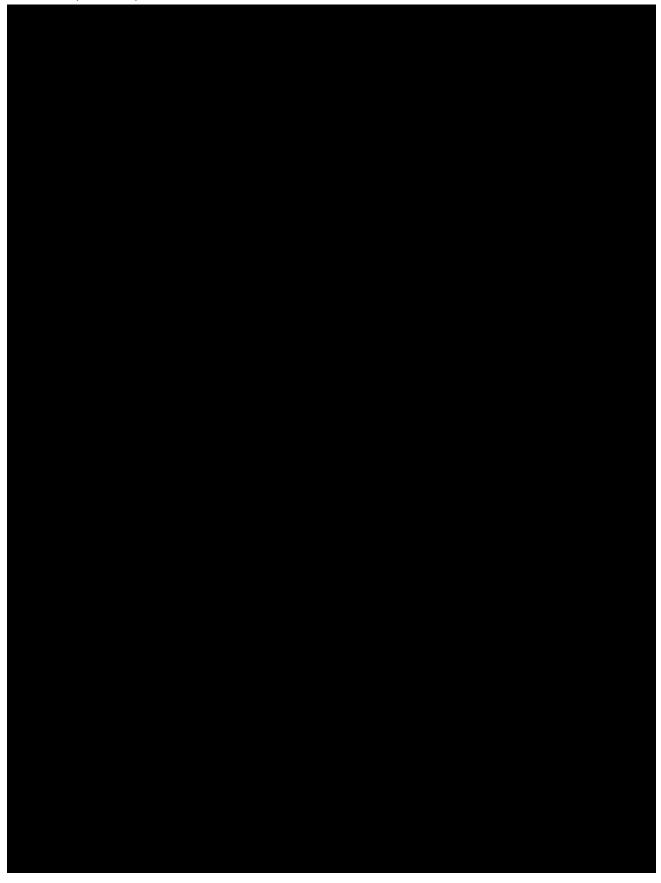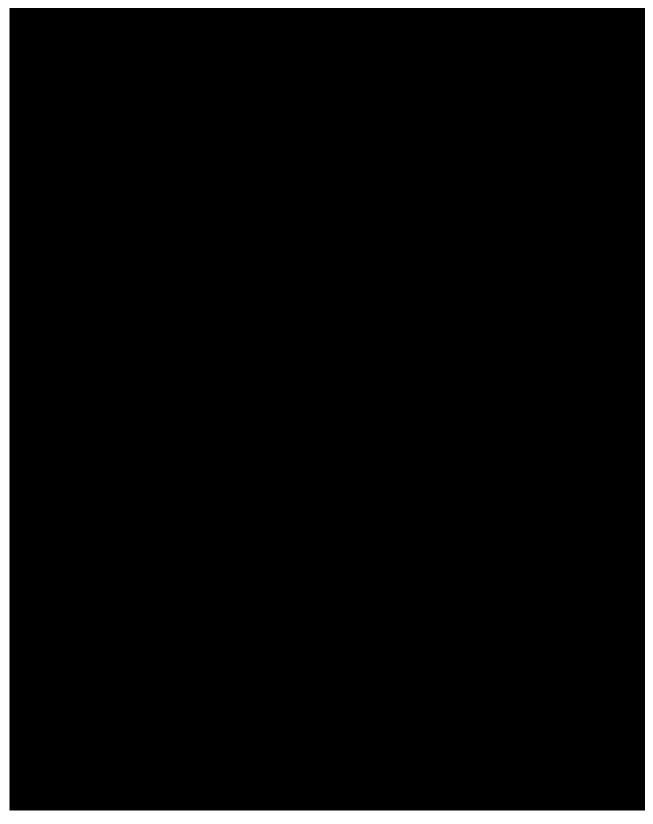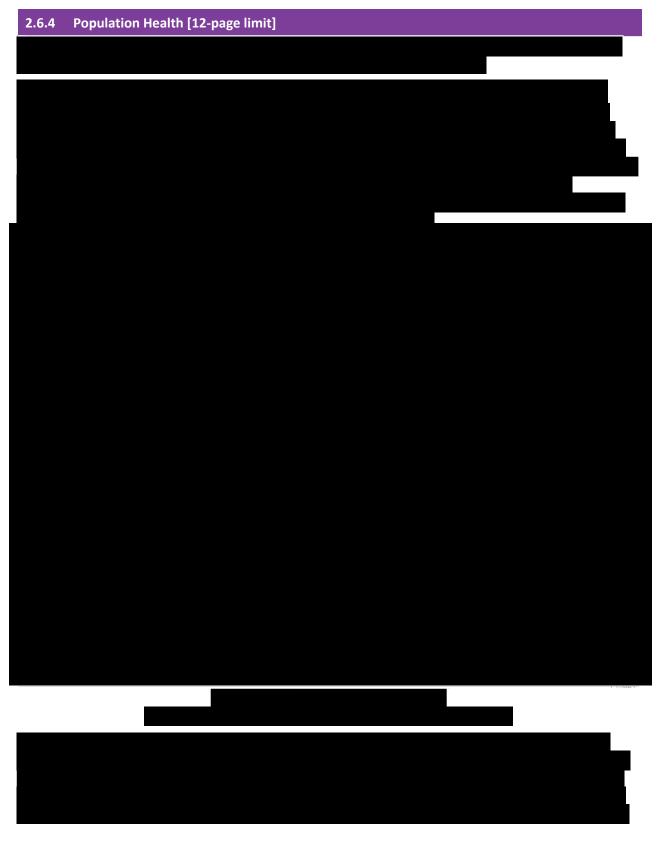
2.6.4 Population Health

ABHLA uses social determinants of health (SDOH) data and analytics **to guide our strategy to target specific subpopulations to support enrollee needs,** ultimately improving their health outcomes.

Since 2019, ABHLA has provided $779,000 in funding to organizations driving impact in reducing health and SDOH disparities in their communities such as United Way, Salvation Army, Boys & Girls Club of Greater Louisiana, and the Walls Project. ABHLA funded the Walls Project's COVID-19 Food Box program and their mural aimed to reduce teen birth rates.

2.6.4   Population Health [12-page limit]

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office to advance their ability to meet enrollee needs in real time. These organizations provide services

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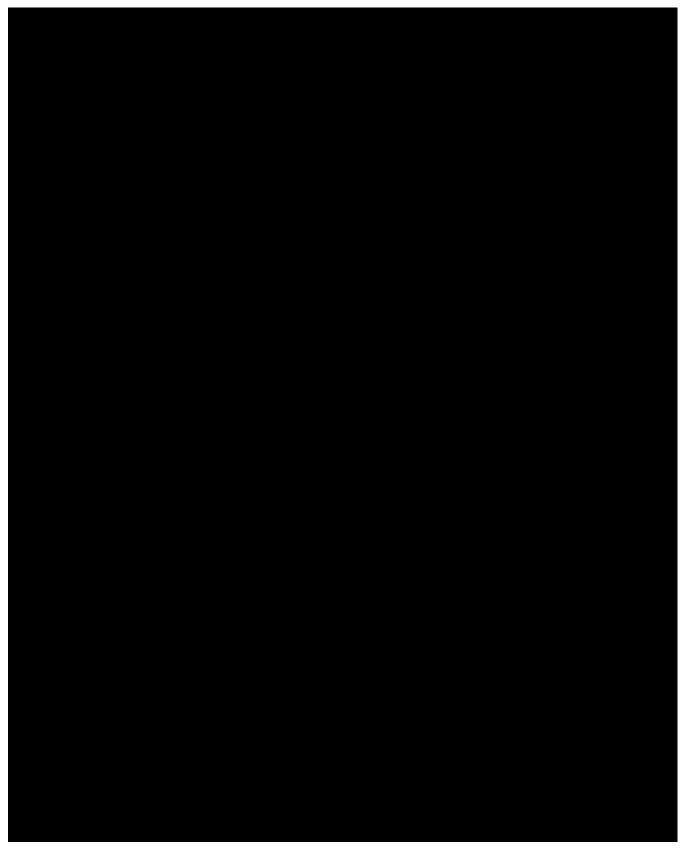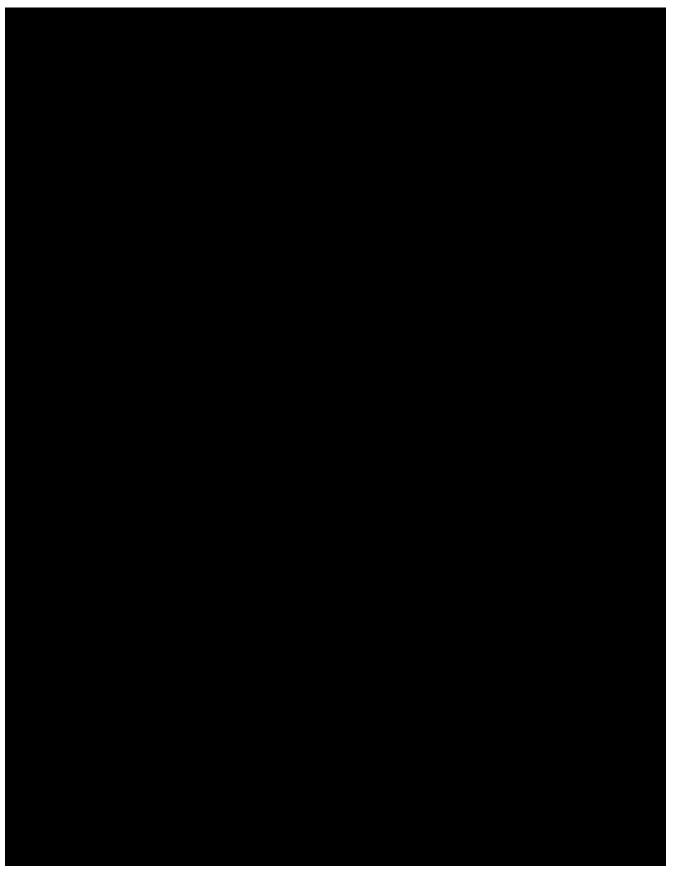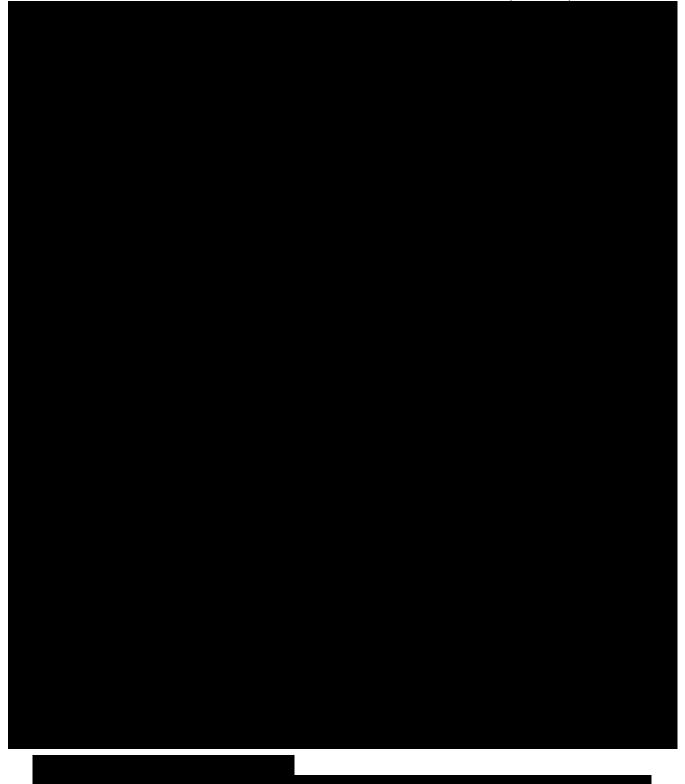
2.6.5 Health Equity
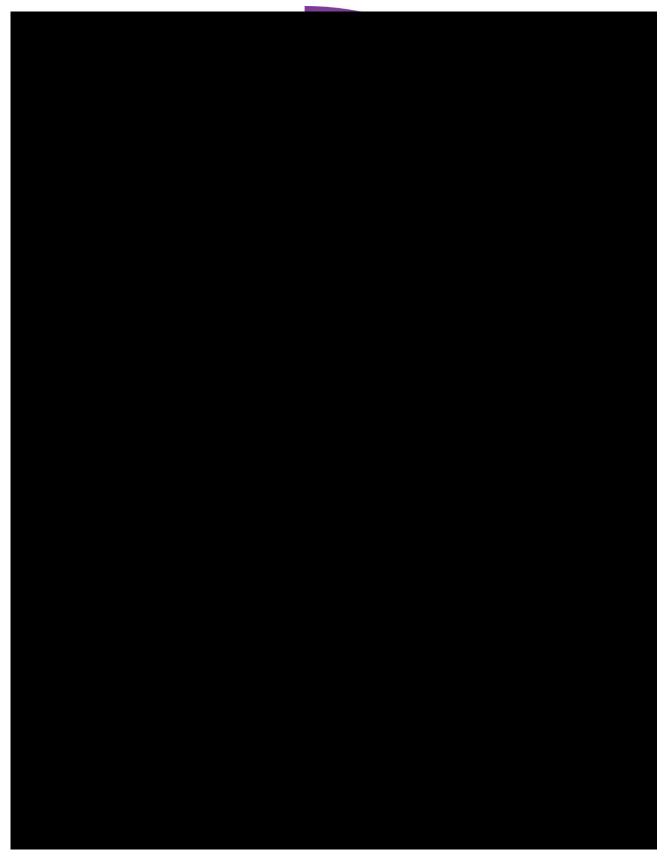
ABHLA believes in building communities in which every pregnant enrollee deserves access to quality prenatal and postnatal care regardless to ones RELD status. Our support of Kingsley House allows the organization to increase access to prenatal and postnatal emotional and physical wellness supports.

2.6.5   Health Equity [12-page limit]

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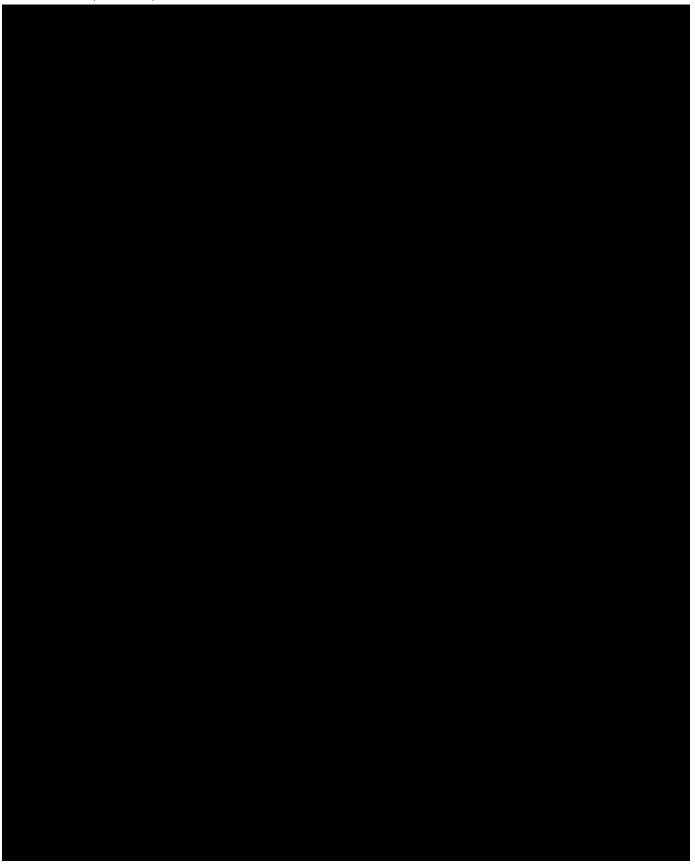
2.6.6 Care Management

Promoting diverse voices and perspectives is key to creating healthy relationships—fostering a culture rooted in human spirit, in which everyone feels respected and can reach their full potential.

2.6.6   Care Management [15-page limit]

Aetna Better Health® of Louisiana (ABHLA) knows that our Healthy Louisiana enrollees deserve a high-quality effective care management program. We have worked in Louisiana for six years, shoulder to shoulder with our enrollees, providers, and community partners to develop and deliver better health, better care and lower costs. Our Healthy Louisiana Integrated care management (ICM) program uses case managers (CMs) located throughout the Louisiana Department of Health's (LDH) nine regions to drive the best experience for our enrollees, resulting in enrollee satisfaction and improved care access and health outcomes. **Figure 16** provides an overview of ABHLA's trauma-informed, whole-person, culturally and linguistically appropriate, holistic, and evidence-based ICM program that follows the National Committee for Quality Assurance (NCQA) complex case management (CM) standards for CM, including identification, engagement, assessment, care planning, care coordination, and care monitoring. These standards guide the ICM engagement and ABHLA's approach to ensuring care and service integration for ABHLA enrollees.

Figure 16: Overview of our Healthy Louisiana ICM Program
Our ICM provides individualized support and assistance to enrollees and their families.

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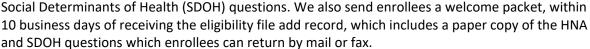
2.6.6.1 The Proposer's process for ensuring that there is success in completing …

Healthy Louisiana enrollees have diverse and complex health care needs. Successful implementation of the Health Needs Assessment (HNA) is paramount in the ability to develop specialized ICM programming to address these needs. The HNA allows us to understand the enrollees' physical, behavioral, and social needs. We use LDH's survey-based instrument as our HNA, and we provide a variety of options for enrollees to access and complete the HNA in acknowledgment of different enrollee preferences. To achieve our goal of completing a welcome call and an HNA with enrollees within 90 calendar days of their enrollment effective date **(Model Contract Section 2.7.2),** we use the following approaches:

- **Welcome Calls and Mailings:** Enrollees can complete the HNA during the Welcome Call or send a completed paper copy. We make a minimum of three welcome call attempts via phone and letters, at different times and on different days. During the welcome call we encourage enrollees, or parents or legal guardians if the enrollee is a child, to complete the HNA and Social Determinants of Health (SDOH) questions. We also send enrollees a welcome packet, within 10 business days of receiving the eligibility file add record, which includes a paper copy of the HNA and SDOH questions which enrollees can return by mail or fax.

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We store completed HNA data, with enrollee permission, in our ABHLA PHM platform. ICM staff have access to this data which minimizes having enrollees re-tell their stories repeatedly through the ICM process.

Engaging Enrollees with Special Health Care Needs to Complete the HNA

Enrollees with SHCN represent a vulnerable population for whom we make a special effort to engage for HNA completion. The information enrollees provide us through the HNA helps us understand their strengths, needs, health concerns, and living environment and supports. To maximize engagement with this population, we make a minimum of five attempts to contact the enrollee by phone and letters to

complete an HNA within 30 days of their enrollment effective date**.** The attempts occur on different days and at different times of day. We offer ICM to all enrollees with SHCN. In compliance with **Model Contract Section 2.7.3**, we will complete the comprehensive needs assessment (CNA) for at least 90 percent of enrollees that are willing to engage within 90 calendar days of SHCN identification.

Ongoing Efforts to Contact UTR Enrollees

Our commitment to our Healthy Louisiana enrollees and capturing their HNA to support their care does not end at 90 days. If we are unable to reach an enrollee through our HNA engagement approach, the ICM team uses additional contact strategies to locate better contact information or opportunities to engage. We do this through analyzing admission and discharge data, accessing pharmacy data, engaging a CHW, and outreach to providers and community partners to assist in locating UTR enrollees.

We use our biweekly inter-disciplinary rounds with high-volume physical health (PH) and behavioral health (BH) practices, such as Christus Hospital, to coordinate care for high-risk enrollees and develop strategies to locate UTR enrollees.

Culturally and linguistically appropriate and accessible supports to complete the HNA

ABHLA's policies and practices align with national culturally and linguistically appropriate standards, National Committee for Quality Assurance (NCQA) standards and the Americans with Disabilities Act. We train all new ABHLA staff in Louisiana culture (e.g., food preferences; regional racial, ethnic, and linguistic disparities; and SDOH), and our training increases skills to recognize and engage Black, Latinx, and tribal communities; seniors; lesbian, gay, bisexual, transgender, or questioning persons; people with disabilities; and individuals with low health literacy. This training gives enrollee-facing staff a working understanding of how to engage enrollees with different cultural health beliefs about privacy, decision making, treatment, gender and family roles, and personal beliefs. Enrollees can access Enrollee Services and care coordination team (CCT) staff via our toll-free Enrollee Services call center for verbal HNA completion in any language using our interpretation and American Sign Language services. We also offer video translation for enrollees with impaired vision. The HNA is available in English, Spanish, and Vietnamese, Braille, and large-print format.

2.6.6.2 What tools the Proposer will use and how the Proposer will utilize …

Accurate identification of enrollees who may benefit from CM is crucial to ensuring we deploy our resources toward enrollees who have highest need and discover enrollees at crucial moments of their health care journey, or before they begin to experience more complex health concerns. Our tools to identify those who potentially benefit from CM include a suite of data approaches and a robust referral process. In addition to identification of ICM candidates through our tools, we automatically designate certain populations with critical needs for ICM engagement: enrollees with SHCN, pregnant and postpartum enrollees, neonatal intensive care unit (NICU) babies, children in foster care, and enrollees with BH needs.

[content redacted]

Referrals to our ICM Program

There are many ways that referrals come to ABHLA's ICM team, compliant with **Model Contract Section 2.7.4**. We make it easy for enrollees and their families to understand the availability and benefits of ICM and to know how to self-refer. We monitor enrollee grievances to assess whether the enrollee may benefit from ICM participation and gain valuable information about programmatic and service needs. Referrals can also come from within ABHLA, from providers, and from other external sources including the following:

- The HNA
- Caregiver and family member referrals
- ABHLA population health programs including those focused on chronic diseases, Healthy Moms/Healthy Babies, serious mental illness, ED utilization and SDOH resolution
- State-mandated performance improvement projects—Hepatitis C, developmental screening, initiation and engagement of substance abuse treatment, and COVID-19 vaccines
- Provider referrals (including primary care, BH, maternity, pediatric, hospice, and specialists)
- State staff, including the Bureau of Health Services Financing, LDH, Office of Behavioral Health (OBH), Office of Aging and Adult Services, Office for Citizens with Developmental Disabilities, Office of Public Health (OPH), and the Department of Children and Family Services (DCFS), Department of Corrections, and Department of Justice (DOJ) transition coordinators
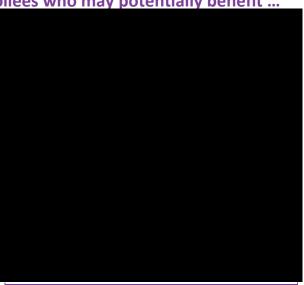
- The Health Information and Nurse Line
- ██████████████████████████████████████
- Utilization Management (UM), Quality Management, Enrollee Services, and other internal reports and programs such as the Readmission Avoidance Program, and our Opioid Use Disorder program
- Social service organizations such as food banks, churches, homeless shelters, schools, and other community-based organizations (CBOs)

2.6.6.3 How the Proposer will engage enrollees who may potentially benefit …

Our Healthy Louisiana enrollees are at the center of all we do, and they are critically at the center of our ICM engagement strategies, which are designed to build trust and highlight the benefit of ICM participation.

When we identify an enrollee as a CM candidate, we first send a warm welcome message to the enrollee via phone and text to increase the likelihood of contact success. We use evidence-based communication to promote engagement and behavior changes. Warming messages let enrollees know we will be attempting to contact them, reduce any enrollee alarm or fear of being contacted by their health plan, and plant the seed that the contact is intended to provide benefit to the enrollee.

If an enrollee is hesitant, a CM makes a follow-up contact and uses motivational interviewing (MI) to explore the enrollee's hesitancy, and respectfully guide them toward ICM engagement. The CM focuses on listening, understanding the enrollee's concerns and needs, and offering responsive solutions that customize the ICM experience to meet the enrollee's needs and preferences. If we cannot contact the enrollee, we use ABHLA's UTR strategies and deploy a CHW to locate the enrollee. We have twelve CHWs located across all nine LDH regions. We locate our ICM teams, including CHWs, throughout the community and in provider locations to meet enrollees where they live.

Enhanced Engagement Strategies

ABHLA uses enhanced strategies for engagement of enrollees in targeted and vulnerable populations. We assign engaged enrollees to qualified CMs trained to support their special population's needs.

2.6.6.3.1 Children and youth with special health care needs including behavioral…

We immediately identify children and youth with SHCN as vulnerable enrollees who will benefit from ICM participation including but not limited to those with BH needs, on waivers, who are victims of human trafficking, and who live in violent communities. Upon enrollment, or as soon as we are aware of the enrollee's status, one of our pediatric CMs contacts the enrollee or their parent or guardian to offer ICM enrollment.

Our approach to children and youth with SHCNs is informed by the Aetna Medicaid organization's experience serving as the Medicaid MCO for children in foster care and multi-system youth in multiple states. Our experience has helped us increase engagement using enrollee-first, family-centered practices and language addressing biopsychosocial needs, and integrating cultural humility into our practices.

2.6.6.3.2 Pregnant and postpartum enrollees with substance use disorder and their…

Healthy Louisiana enrollees face tremendous maternal and infant health disparities and high SDOH risks. Louisiana has the second highest maternal mortality rate, and the fifth highest infant mortality rate in the United States.

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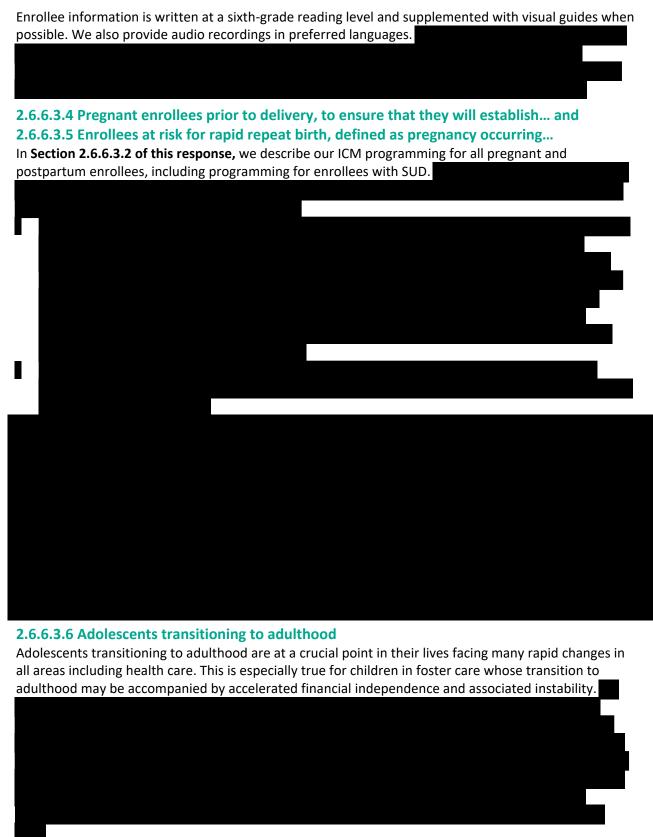
2.6.6.3.3. Children from immigrant families who may have unique cultural and…

Immigrant families have unique and varied circumstances that may, at times, create hesitancy to seek care based on different health care belief systems rooted in their cultures. We ensure that our ICM team members are not only aware of these factors but have a working understanding about how to respectfully interact with immigrant enrollees and their families toward the best health outcomes. When we identify that a child is from an immigrant family during the CNA, we pair a CHW with our CM to engage the enrollee and provide culturally relevant and responsive health and social care supports. We also build strong relationships with community providers who support immigrant communities.

Enrollees under age 18 receive a pediatric CM who best fits the families' cultural and linguistic needs and we match them with a bilingual CM when available. When a bilingual CM is not available, we use our Language Line or in-person interpreters. Our CCT team evaluates the enrollee's clinical information, UM data, and other information to ensure that the enrollee's family is informed of all available services, such as LDH's Maternal, Infant, Early Childhood Visiting program. [REDACTED]

ABHLA records language preferences in our system allowing team members to see language needs and facilitate language services. We encourage professional interpretive services as opposed to informal supports. ABHLA provides health education information in English, Spanish, Chinese, French, Tagalog and Vietnamese, and we translate critical documents, such as the POC, into any language required.

Enrollee information is written at a sixth-grade reading level and supplemented with visual guides when possible. We also provide audio recordings in preferred languages. ███████████████████████████████

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2.6.6.3.4 Pregnant enrollees prior to delivery, to ensure that they will establish… and
2.6.6.3.5 Enrollees at risk for rapid repeat birth, defined as pregnancy occurring…

In **Section 2.6.6.3.2 of this response,** we describe our ICM programming for all pregnant and postpartum enrollees, including programming for enrollees with SUD. ████████████████████

2.6.6.3.6 Adolescents transitioning to adulthood

Adolescents transitioning to adulthood are at a crucial point in their lives facing many rapid changes in all areas including health care. This is especially true for children in foster care whose transition to adulthood may be accompanied by accelerated financial independence and associated instability. ██

We have developed, and will implement, a text message campaign targeted to all enrollees aged 17 and a half. The campaign will inform these enrollees of the availability of CM services and of resources such as a smartphone through the Lifeline phone program. A smartphone gives enrollees the ability not only to make and receive calls and texts, but also access other valuable features such as email, web use, and app use.

We will offer Career & Life Skills and High School Equivalency Test (HiSET) support as a value-added benefit for enrollees 16 and older. Through this, enrollees gain access to a job skills training platform where they can get HiSET certifications and receive a voucher to pay the HiSET exam fee after passing online courses.

2.6.6.3.7 Children with type 1 diabetes mellitus

A diagnose of type 1 diabetes frequently presents acutely. Following this new diagnosis, an enrollee and their family's world can be quickly disrupted with the need for new routines, foods, activities, and insulin management.

arents need immediate and helpful information when facing their child's illness. We use integrated **motivational interviewing strategies** to listen to parents' concerns and fears and answer their questions. The CM connects families to support programs like the Maternal, Infant, and Early Childhood Visiting program through LDH or the Families Helping Families program, and ensures enrollees have access to consult with a certified dietician and nutritionist and receive SDOH screenings and supports.
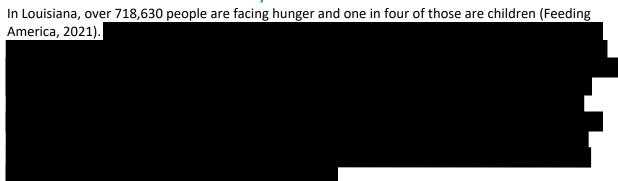
Our CHW program offers outreach and engagement to ensure the families are connected to resources in their communities such as diabetes supports groups. SDOH screening ensures access to food and nutrition and enrollment in our Nourish initiatives.

2.6.6.3.8 Children with ACEs

Our ABHLA CMs recognize that parents and legal guardians of children with ACEs may also be victims of trauma and ACEs. With this knowledge, we use TIC strategies to engage parents or legal guardians and their children in ICM. We use our CHWs, provider partners, and CBOs to assist in the engagement process. Once contact is made, we engage parents and legal guardians for their consent to complete our CNA, including the ACEs assessment and work to ensure referrals are made to providers with ACEs expertise.

2.6.6.3.9 Enrollees with food insecurity

In Louisiana, over 718,630 people are facing hunger and one in four of those are children (Feeding America, 2021).

2.6.6.3.10 Enrollees without reliable telephone access

Phone service is not a luxury—it is an essential utility for successfully navigating modern life. When we learn an enrollee is without reliable telephone or web access, we help them enroll in the Lifeline phone program, which provides a smartphone and basic services. **Phone calls and text messages to and from ABHLA's enrollee engagement supports are free and do not count against the basic service plan.** A smartphone gives enrollees the ability not only to make and receive calls and text, but also access other valuable features such as email, calendar, web use, and app use—including virtual CM visits.

2.6.6.4 How the Proposer will identify the appropriate tier of case…

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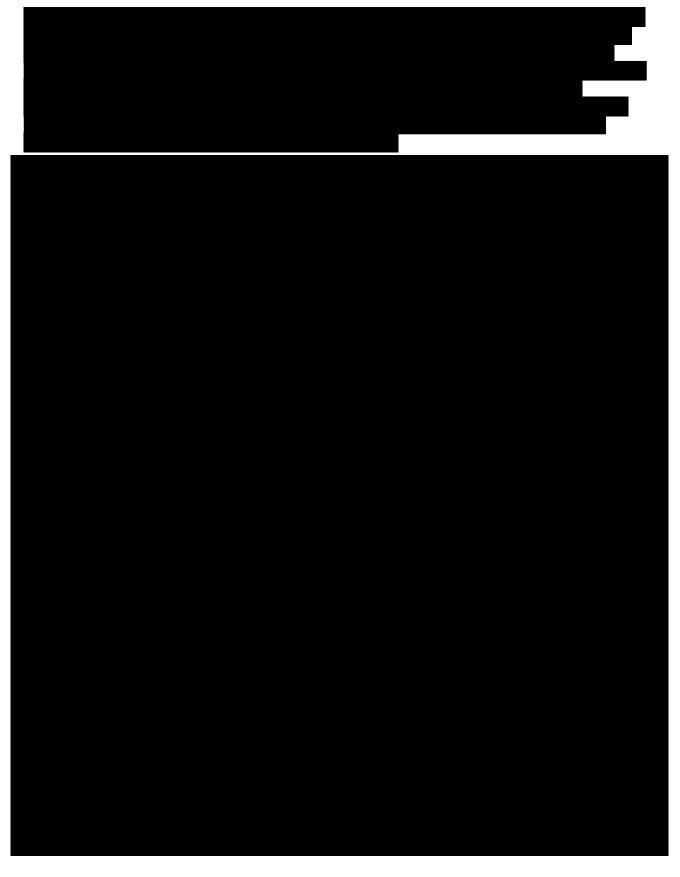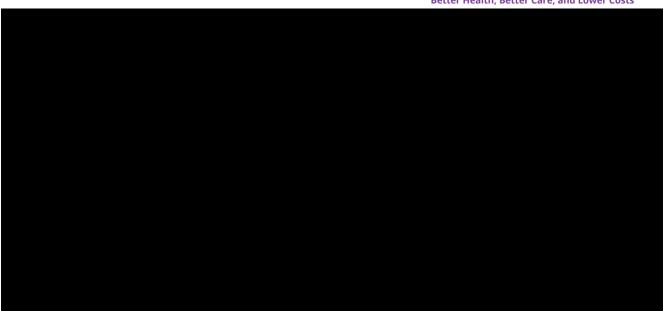
Process for Individual POC Development

Our CMs work with enrollees and an individual care team (ICT) of the enrollee's choosing to develop an individual POC. Our CMs support our enrollees by helping them identify who to involve and facilitating their involvement in POC development and subsequent coordination. Our processes are compliant with **Model Contract Section 2.7.8.**

Using Assessments in Care Planning

Our dedicated CMs, who live in the same region as their assigned enrollees, use multiple assessment tools to help guide enrollees to tell their story. Tools include the HNA and SDOH screening and a CNA triggered by HNA results or referral information. The CNA includes assessment of social supports and caregiver resources and screens for tobacco use and problem gambling. The CNA has assessment components customized based on the enrollee's age, gender, diagnoses, and population. The CNA is extensive in its evaluation of SDOH, trauma, access to and historical utilization of services, health behaviors (inclusive of substance use, physical activity, and nutrition), and medications.

Enrollee-directed Care Planning

Enrollees have the lead voice in the care planning process. Our CMs facilitate the care planning process using principles of self-determination, recovery, and resiliency. The POC requires approval by the enrollee and when required their parent or legal guardian. Enrollees have real-time access to care plans via the enrollee portal. With the enrollee's consent, we store copies of the current and prior care plans in the PHM system and provide access to the PCP and care team members via the provider portal. We actively engage the enrollee and, with consent, their family of choice, advocates, caregivers, and legal guardians to support continued involvement and feedback in the care planning process that not only includes how to address immediate needs, but plans for crisis events including disaster preparedness and emergency planning. CMs and participating enrollees develop the POC with the enrollee's identified team within 30 days of completing the initial CNA.

In addition to the PCP, members of the care team may include PH and BH providers; the housing specialist; employment specialists; transition specialists; nutritionists; CHWs; dental providers; peer support specialists;
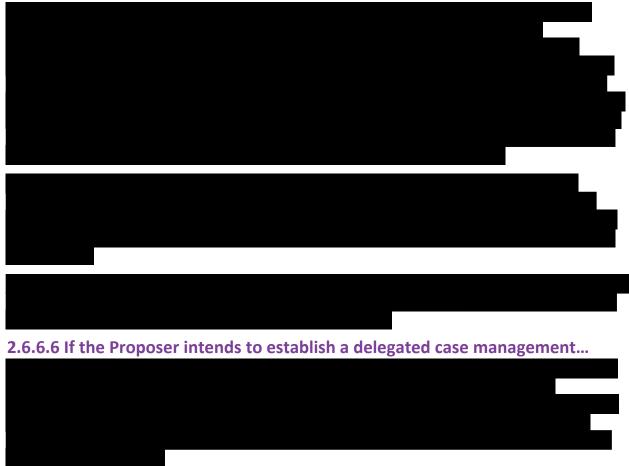
school representatives; state staff including transition coordinators, home and community based service providers and managers, and probation officers; and pharmacists, among others. When an enrollee has an established external CM and POC, our ICM team, with the enrollee's consent, collaborates with the external CM to integrate POCs and services. **The care planning process is comprehensive and focuses on coordination, integration, identifying and closing care gaps, and ensuring continuity of care.** The POC undergoes periodic review and update triggered by changes in the enrollee's circumstances. It is reviewed and revised when the enrollee's ICM tier changes, or when the enrollee's circumstances or needs change significantly, or at the request of an enrollee, their parent or legal guardian, or a member of the MDT.

Care Planning with Enrollees with Behavioral Health Needs

Our ICM team includes local BH CMs who serve as the lead CM and support the enrollee's POC inclusive of coordinated and integrated PH and BH services. When an enrollee receives services with a POC from LDH, such as home- and community-based services or services through the OPH, CMs collaborate and coordinate among the agencies. Enrollees with BH needs may receive referrals to telepsychiatry; coordination with an ACT team, when eligible; assistance with psychotropic medication; and referrals to specialized behavioral health providers. Through biweekly MDT rounds, our CCT can help address an enrollee's complex BH needs, their co-morbid physical needs, and their utilization of services, all geared to guide the ICT and the POC toward the right care, at the right time, and in the right way.

2.6.6.5 How the Proposer will coordinate with providers and State staff that…

2.6.6.6 If the Proposer intends to establish a delegated case management…

2.6.7 Case Scenarios

ABHLA supports Louisiana's health priority of promoting healthy living. **The ABHLA Community Development Outreach team hosts regular cooking and nutrition classes in our communities.** We were pleased to have local Chef Jay Ducote help us learn how to make delicious and healthy traditional Louisiana cuisine alongside ABHLA's own Ted E. Bear, M.D.™ During all of our cooking sessions, participants learn how to use ingredients they may already have in their pantry to create a healthy meal. They also leave with nutrition resources and recipe cards on how to make the dishes they were taught at the event.

2.6.7.1 The Proposer has an enrollee who is a 5-year-old boy who is noted to have several active…

Michael is a five-year-old boy with multiple physical and behavioral health issues who lives with his caregiver, Angie. Angie took Michael to his annual visit with his primary care provider (PCP), who referred Michael for diagnostic visits to an otolaryngologist and neurologist after Michael was diagnosed with mild sleep apnea and continued sleep disturbance. Unfortunately, due to the COVID-19 pandemic, the appointments were postponed. His PCP has not identified a psychiatrist willing to accept Medicaid near where Michael and Angie live.

His PCP continues to track Michael's case and contacts Angie several times over the subsequent months, but Angie does not take Michael to the subspecialist appointments. Several months later, Michael sees his PCP for a sick visit, including school discipline issues, and his PCP again attempts care coordination. When Michael returns two months later for his well-child visit, his conditions have worsened. Psychiatry services that will accept Medicaid have still not been found near Michael's home.

Michael and Angie need an advocate. ███████████████████████████████████████ ███ Donna, a pediatric nurse case manager, is assigned as Michael's family's single point of contact to coordinate all his and Angie's needs. Through our comprehensive evaluation process, as found in **Figure 18**, Aetna Better Health® of Louisiana (ABHLA) develops not only a whole-person approach but a whole-family approach, incorporating Michael and Angie's voice and choice when developing a person- and family-centered care plan to meet their individual and collective needs and strengths.

Figure 18: Understanding Michael's Circumstances and Care Plan
ABHLA takes a whole-family approach in developing a person and family-centered care plan.

2.6.7.1.1 Describe what systems the Proposer will have in place to identify...

If Michael is a new enrollee, Angie receives a welcome call and packet, sent within 10 business days of receipt of the 834-enrollment file. She is encouraged to complete the health needs assessment (HNA) and social determinants of health (SDOH) questions on behalf of Michael to assess their physical, behavioral, and social needs. The HNA can also be completed through our mobile app, enrollee portal, community health events with community health workers (CHWs), provider visits, and community resource centers.

Michael may also be referred to ABHLA care management by his provider, his school, the Department of Children and Family Services, or Angie herself. Enrollees and their parents/guardians and family of choice are empowered to identify themselves for assistance and case management.

We prioritize respect, honesty, and trust to build sustainable engagement, education, and empowerment. Our pediatric nurse case manager, Donna is trained in TIC, motivational interviewing, and integrative care management. She is also trained in using evidence-based clinical guidelines to assess Michael's medical, behavioral health, and social needs, which include the use of screening, brief intervention, and referral to treatment and substance use treatment and the stages of change model. In a scenario in which we reach Angie during the welcome call, Donna guides Angie to complete a pediatric health CNA,
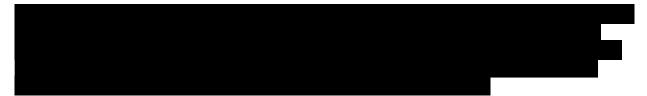
> ABHLA adapts quickly in an ever-changing health care environment, including emergencies like COVID-19. We are local, understand the local environment, and meet enrollees where they are.

including medical history, behavioral and psychosocial needs, SDOH, adverse childhood experiences, school-related needs, and COVID-19 vaccine status. Because Donna now knows that Angie missed some of Michael's appointment due to COVID-19,

Following the initial conversation with Angie, Donna contacts the PCP to learn more about Michael's current treatment plan, including diagnoses, medications, treatment providers, laboratory and diagnostic test results, and the overall approach utilized so far. She also requests information about the

specialist referrals to reach out to them as needed. Next, Donna and the PCP discuss root causes for Michael's physical issues and behavioral outbursts. Knowing that trauma or living in violent environments can mask medical problems and school difficulties, Donna explores additional TIC programs for children living with trauma, such as the Trauma and Grief Center at Children's Hospital New Orleans. Other concerns include developmental delay and SDOH, home environmental factors, and additional medical issues. Michael is automatically enrolled in our Louisiana Healthy Kids, a population health program that promotes primary and preventive care following EPSDT guidelines.
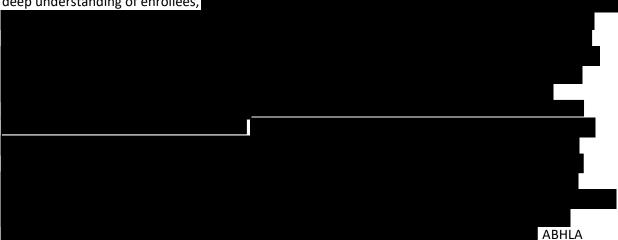
We reconcile the data received via the enrollment file with additional information provided via our Health Information Exchange (HIE) connections throughout the outreach process. HIE admission, discharge, and transfer (ADT) data include contact information provided by the enrollee at the point-of-care and may differ from the preliminary information received. ABHLA's population health platform (PHM) highlights new ADT-sourced contact information so that our team can quickly incorporate it into our outreach efforts, including a better contact number for Angie. In addition, we regularly monitor Michael's utilization data, both under and over, including claims data from Michael's well-child visits, provider referrals, and member self-enrollment data.

After the initial telephonic engagement, Donna, as the primary point of contact, quickly schedules to meet with them in the most convenient setting for Angie and Michael, face to face or virtually if needed due to COVID-19 concerns, to complete the comprehensive needs assessment and discuss her outreach to Michael's school and provider. Donna creates an evidence-based, family-centered care plan using ABHLA's integrated system of care and fully integrates Michael's circle of support to provide relevant, family-centered, and trauma-informed physical and behavioral health services.

2.6.7.1.2 Describe what process the Proposer will have in place to ensure that...

Aligned with the State's goal to ensure access to care and improving enrollee health, and based on a deep understanding of enrollees,
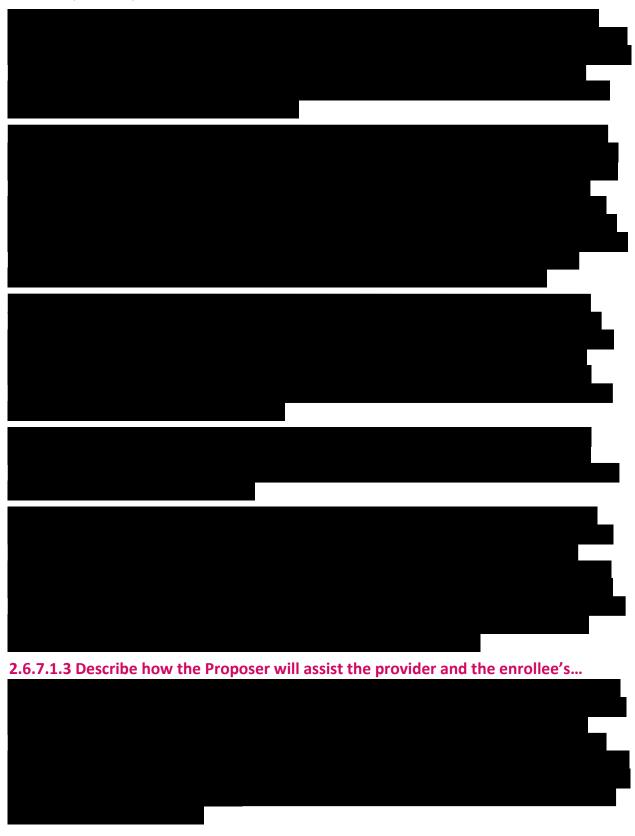
ABHLA utilization management reviewers and medical directors review any request for services for medical necessity using evidence-based criteria such as MCG, LOCUS/CALOCUS, ABHLA's clinical policy bulletins,

and Healthy Louisiana's preferred drug list. We also explore new benefits for Michael through value-adds and in-lieu-of services, including mobile crisis intervention and respite care.

2.6.7.1.3 Describe how the Proposer will assist the provider and the enrollee's...

2.6.7.2 The Proposer has an enrollee who is a 14-year-old male residing with his mother, his…

Three months ago, Carter, a 14-year-old boy, returned home from receiving treatment at a psychiatric residential treatment facility to live in Bunkie, Louisiana, with his mother, Nina, and two siblings. His transition services included medication management from his pediatrician and Community Psychiatric Support and Treatment (CPST) rehabilitation services in the home. He struggled with aggressive behaviors at school resulting in multiple suspensions. These behaviors also escalated at home. A recent episode caused his mother to contact law enforcement to intervene. This resulted in a five-day inpatient acute hospital admission.

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2.6.7.2.1 How would the Proposer assure assessment for and access to specialty and…

Maria receives a call from the hospital notifying her of Carter's planned discharge to home. The hospital social worker explains that Nina is refusing to pick him up because she disagrees with the discharge plan and feels it is unsafe. The hospital believes that Carter is stable and no longer meets the medical necessity to stay and plans to involve DCFS for abandonment. Maria recognizes the time-sensitive nature of the situation and potential ramifications for Carter, Nina, and the hospital. To gather additional details about the situation, Maria asks about the safety reasons Nina shared, confirms whether the hospital explained Nina's appeal rights and steps to have Carter's case reviewed during their discussion, and information about the discharge plan. She also determines whether the hospital submitted a referral for the Louisiana Department of Health's Children's System of Care (CSOC) for additional services, and discussed how long the family has for additional mediation and discharge planning before the hospital takes further action to call DCFS to claim abandonment. Maria confirms that Carter's records are up to date in the provider portal so she has access to the most current information and discharge plans to review them with Nina and ensure her understanding and consult with the multidisciplinary team (MDT) for recommendations. Maria advocates for additional time to facilitate the best outcome for all parties concerned.

> ABHLA believes that Medicaid enrollees should receive quality, evidence-based care in the least restrictive environment that ensures safety, for the shortest amount of time necessary, and closest to their families and communities.

Maria submits a request to convene an urgent MDT review and contacts Nina to learn about her concerns and support needs. Maria confirms that she understands her appeal rights and risks if the appeal is denied, educates her on the DCFS abandonment process, and encourages her willingness to participate in a discharge meeting discussion with Carter, the hospital team, his primary care provider (PCP), his school counselor, and the CPST, who are current members of Carter's ICT, to determine the best outcome for Carter. After gathering all the information and reviewing Carter's completed assessments and records, Maria meets with the MDT.

[redacted]

Nina, Carter, and the ICT meet at the hospital for discharge planning. Carter's PCP connects to the meeting via telephone. Maria re-introduces herself as Carter's case manager and helps facilitate the discharge planning to ensure Carter and the family's needs are met for a safe discharge. Maria conducts a comprehensive health needs assessment, the heath care equity contact assessment, screening, brief intervention, and referral to treatment, along with the adverse childhood experience assessment to understand how Carter's ADHD, PTSD, ODD, and mood regulation disorder are currently treated. Informed by the ICT, they review discharge options and interventions which include recommendations from the MDT. They review required assessments for and access to specialty and evidence-based treatment to ensure clinically indicated and medically necessary services for Carter, who should do them, and when they should occur.

[redacted]

2.6.7.2.2. If/when inpatient or residential level of care is recommended for more…

[redacted]

Ongoing care management:

2.6.7.3 The Proposer has an enrollee that is a 17-year-old girl who immigrated to New Orleans to…

Naomi is an adolescent who has experienced multiple incidents of emotional and physical trauma: surviving sexual assault, a pregnancy, the absence of her mother, the birth of an infant with a rare congenital condition and poor prognosis, an international move, and leaving behind family, friends, and prior support systems. In addition, she faces multiple barriers to care for her and her daughter Isabelle: her status as a recent immigrant, her and her family's inability to read or write in English or Spanish present language barriers, and there are cultural, economic, and other social determinants of health (SDOH) barriers.

There is a lot that we don't know about Naomi's circumstances. We don't know who the father of her baby is or whether the pregnancy was a result of an assault. We don't know her immigration status,

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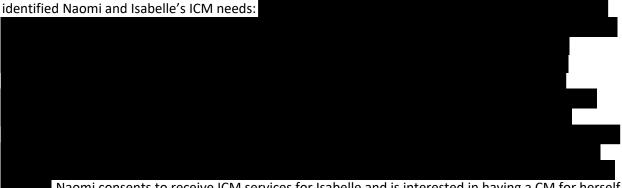
where her mother is, current family dynamics, living situation, cultural and spiritual beliefs, past medical history, education level, or learning ability. Through our trauma-informed care and enrollee-centered approach, we will listen, be consistently supportive, honor her wishes, gather needed information, provide education, identify and connect her to services, assess her needs, and utilize our experience to coordinate and maximize the effectiveness of her and her daughter's care.

2.6.7.3.1 Describe how the Proposer will provide care management for both…

We understand the impact of trauma, often across generations, not just on individuals but the entire family. We know Naomi has experienced multiple incidents of trauma and recognize that being empowered with choices is critical in helping people recover from traumatic experiences.

Identification

We understand enrollees may choose to decline ICM services but also recognize the importance of offering ICM services whenever an enrollee's situation changes, even if there were past refusals because openness to support can change over time and circumstances. In a multitude of ways, we would have identified Naomi and Isabelle's ICM needs:

Naomi consents to receive ICM services for Isabelle and is interested in having a CM for herself. Maria arranges a home visit for the day after discharge and asks to include Sofia, a CM, for Naomi.

Sofia and Maria work collaboratively as part of the family's ICT team. Maria, who built rapport with Naomi during the hospital stay, leads the ongoing engagement. Sofia reviews Naomi's records and utilization, and Maria evaluates Isabelle's. Naomi and Isabelle's care are presented during ABHLA's multi-disciplinary rounds and included in weekly rounds ongoing until their identified needs are addressed.

Engagement

If Maria did not speak Spanish, before engaging with Naomi and her family, Maria would coordinate language interpretation supports through Language Line services or an onsite interpreter paid for by ABHLA. In addition, Maria provides language access education to the family so they can access these

services ongoing. During the welcome call, Naomi's father is engaged in supporting Naomi's ongoing care coordination until he directs us to only work with Naomi or when Naomi reaches age eighteen. Sofia seeks the father's permission to enroll Naomi into ICM and build trust with the family. During all welcome calls, we inquire about COVID-19 vaccination status, discuss vaccination hesitancy if necessary, and offer supports to obtain a vaccination and any personal protective equipment needed, such as masks.

Assessment

The combination of Naomi's age, traumatic experiences, language and culture barriers, and immigration status and Isabelle's special health care needs make it essential for Sofia and Maria to understand Naomi's and Isabelle's current treatment and coordinate an effective care plan. Completing comprehensive assessments through working with Naomi and her father will allow Sofia and Maria to develop a comprehensive view of Naomi and Isabelle's individual needs, goals, preferences, and gaps in support. Sofia will lead a guided discussion so that both Naomi and Isabelle's needs are identified.

Naomi decides who she wants to involve in Isabelle's care coordination. Maria works with them to identify and determine their roles for future care coordination engagements. Maria ensures all materials provided in Spanish are read aloud and recorded, if needed, to support understanding. Topics addressed during the assessment would include the following

Naomi, supported by Sofia:

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- ███

Isabelle, supported by Maria:

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  - ██
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Maria ensures they fully understand everything that transpired prior and ensures Naomi understands Isabelle's diagnosis, prognosis, and Do Not Resuscitate order. Sofia presents information and community resources that would help them connect to beneficial resources and introduces ABHLA's CHW program. Sofia orients the family to the ICM approach, process, program, rights and responsibilities, complaints, grievances and appeals, and next steps. They agree to continue with ICM services and schedule to meet weekly. Sofia spends time educating Naomi on EPSDT for her and Isabelle, the state waivers services available to Isabelle, and benefits available to Naomi as she transitions to adulthood.
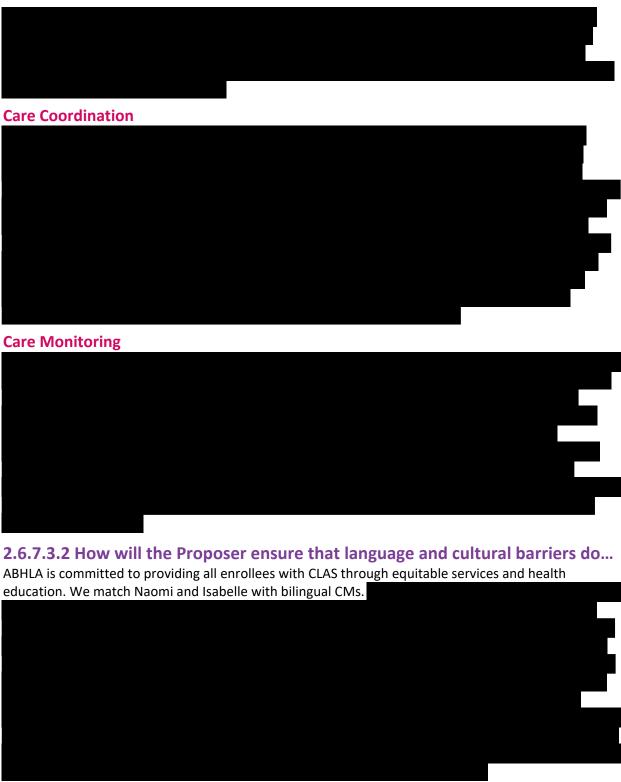
Whole Person Care Planning

Our approach to capturing Naomi's needs in a whole person care plan based on a comprehensive assessment of her needs aligns with Louisiana's Department of Health's goal of improving coordination and access to care, as shown in **Figure 21**.

Building upon her relationship with Naomi and understanding her health goals for her and her daughter Isabelle, Sofia convenes two interdisciplinary care teams, including Naomi's identified support team members, focusing on Naomi and Isabelle, respectively, so both will have a care plan.

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Care Coordination

Care Monitoring

2.6.7.3.2 How will the Proposer ensure that language and cultural barriers do…

ABHLA is committed to providing all enrollees with CLAS through equitable services and health education. We match Naomi and Isabelle with bilingual CMs.

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2.6.7.4 The Proposer has an enrollee who is a 49-year-old male. He has a history of brain injury,…
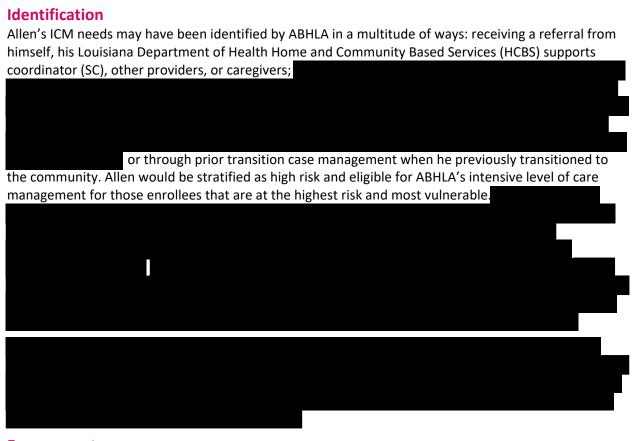
Allen is a 49-year-old man, who transitioned out of a nursing home, and is struggling with independent living. As a man living with brain injury, schizophrenia, chronic pain, limited mobility, and excessive alcohol use, he has incredibly complex physical health (PH) and behavioral health (BH) needs that require a holistic and integrated care approach and rapid action. All members of Allen's integrated care team (ICT) must understand the multidimensional impact of brain injuries and behavioral health when assessing for and supporting Allen's physical and behavioral health needs. He needs urgent support and an advocate to help him succeed.

2.6.7.4.1 How will the Proposer address this enrollee's needs?

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Identification

Allen's ICM needs may have been identified by ABHLA in a multitude of ways: receiving a referral from himself, his Louisiana Department of Health Home and Community Based Services (HCBS) supports coordinator (SC), other providers, or caregivers; ██ or through prior transition case management when he previously transitioned to the community. Allen would be stratified as high risk and eligible for ABHLA's intensive level of care management for those enrollees that are at the highest risk and most vulnerable. ██

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Engagement

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Assessment

Care Planning

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Care Coordination

Care Monitoring

2.6.7.5 The Proposer has an enrollee that is a 42-year-old woman, who lives alone with 24/7 care…

As we first think about Nora,

2.6.7.5.1 How would the Proposer address the various complex health care…

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Identification

Nora is identified from a referral for a wheelchair repair. ABHLA accepts all referrals for ICM services. Utilizing ABHLA's ICM objective measures and criteria for tier stratification, Nora is identified as a Tier 3 intensive case management and transition case management (TCM) referral due to her multiple complex chronic conditions, pending surgery, immediate DME assessment and replacement need, ongoing long-term services and support needs, and multiple social determinants of health (SDOH) barriers. Nora is assigned to Case Manager Babette,

Engagement

Assessment

2.6.7.5.2 How would the Proposer address improved access to the services…

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Care Planning

Care Coordination

[Content redacted]

Care Monitoring

[Content redacted]
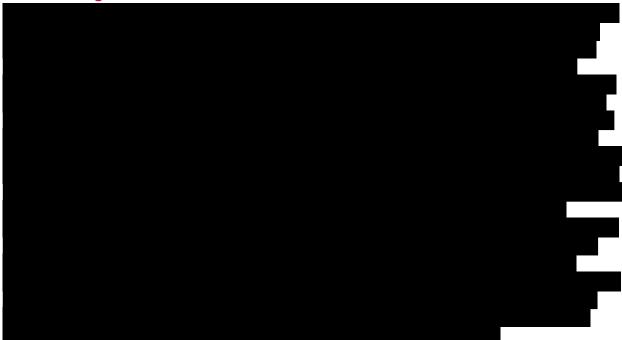
2.6.7.6 The Proposer has an enrollee that is a 13-year-old girl who recently presented for a sick...

More than 30 million people in the US will struggle with an eating disorder. █████████████████
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██ Aetna's
experience with children with special needs populations across the country uniquely positions us to best
support Julia's needs within ABHLA's network or we can leverage our national experience and
commercial and Medicare provider networks to identify specialized providers and resources for youth
with eating disorders.

2.6.7.6.1 How will the Proposer address the acute and chronic components …

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Identification

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████████████████████████████ Dr. Madelyn M. Meyn, pediatrician and chief medical officer, and Dr. Jared D. Wakeman, behavioral health medical officer, ██
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Engagement

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Assessment

Person-centered Care Planning

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[REDACTED]

Care Coordination

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[REDACTED]

[REDACTED]

[REDACTED]

Care Monitoring
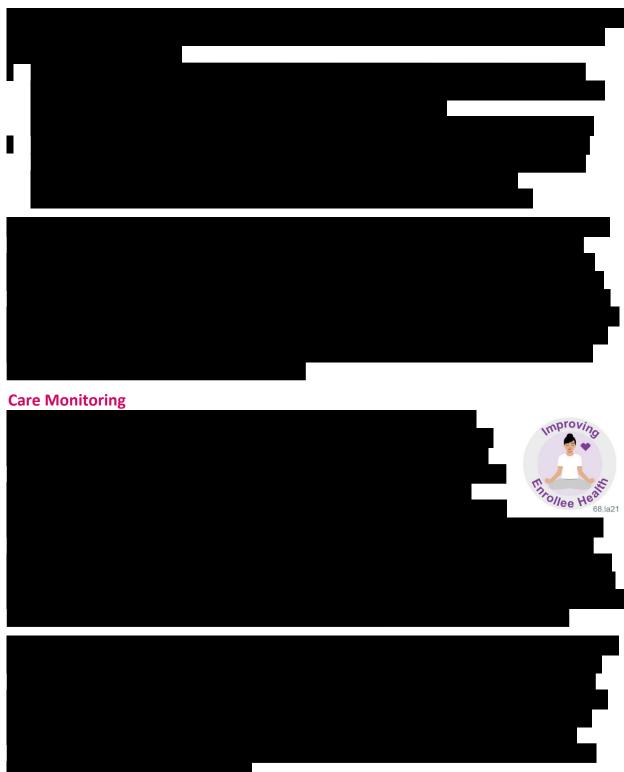
2.6.7.7 The Proposer has an enrollee that is a 25-year-old man with a past medical history of…

Joel is a twenty-five-year-old Black male with a history of sickle cell disease and a complex medical history. He has had multiple Emergency department (ED) visits for chronic pain and does not have a regular source of care. Joel believes he has been treated very unfairly and neglected by the health care system and has been the subject of discrimination because of his race, sickle cell disease, and chronic pain. He does not have a reliable mobile phone and his housing is unstable.

2.6.7.7.1 How will the Proposer address this enrollee's needs?

Understanding Joel's Needs: As Joel's advocate and partner, our partnerships with community organizations are focused on the importance of developing trusted relationships that honor his unique experience as a Black male with an incurable but manageable congenital disease impacting roughly

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3,000[1] Louisianans ███
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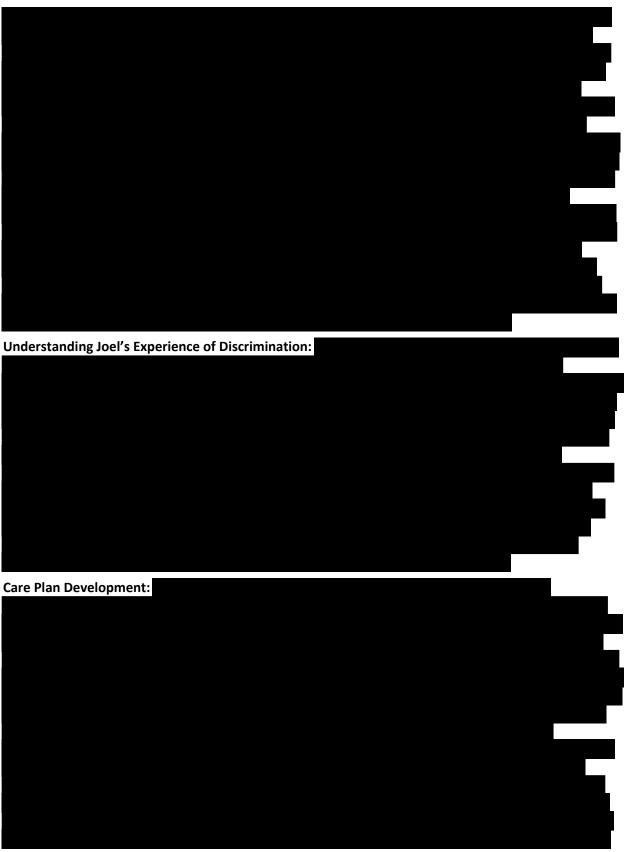
██ Through health information exchanges,
ABHLA receives admission, discharge and transfer daily information including a notification system that
alerts us of an ED visit and enrollee contact information. Our CM and population health teams monitor
this feed for increased utilization; Joel is identified for multiple ED visits. If we are unable to contact Joel
via telephone, our CM team has developed personal relationships with hospital ED staff who alert them
when Joel is in the ED so we can contact him while he is there.

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[1] https://ldh.la.gov/index.cfm/page/2710

Understanding Joel's Experience of Discrimination:

Care Plan Development:

[black redacted block]

Ongoing Care Management:

[black redacted block]

[black redacted block]

[black redacted block]

2.6.7.7.2 What systems and policies will the Proposer have in place to…

Investigate and follow-up with Joel's provider:

Feedback and ongoing support for Joel:
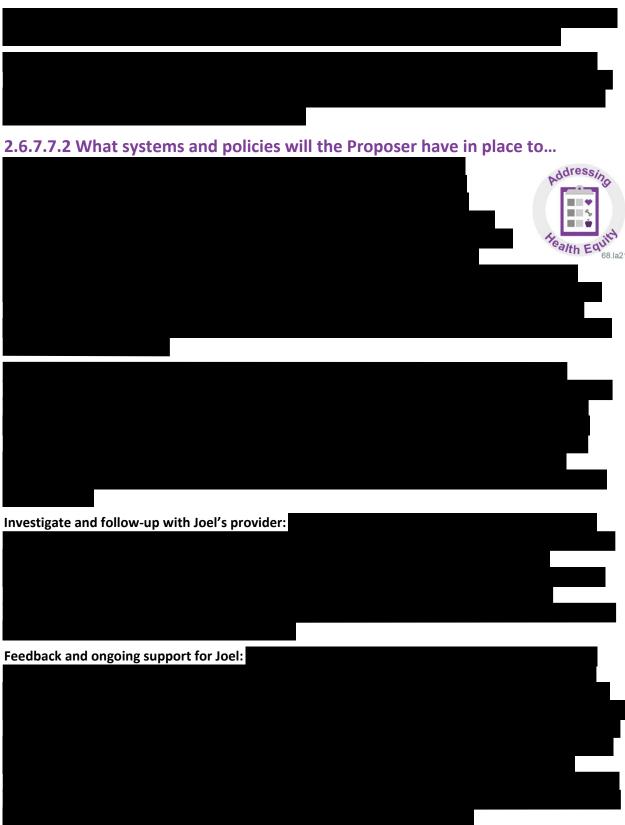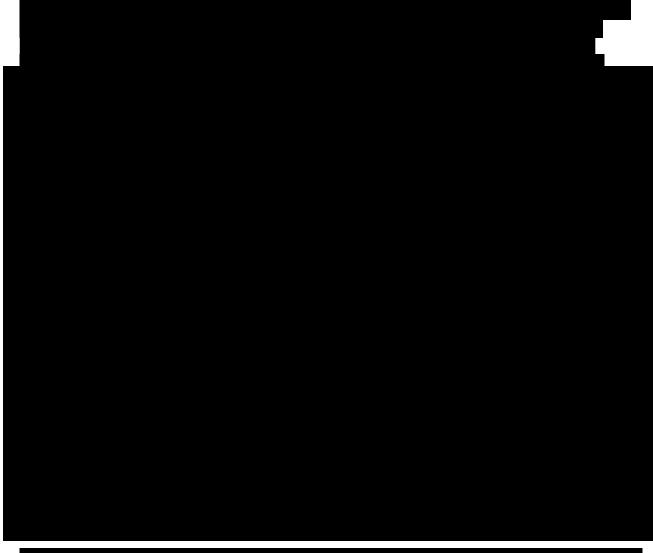
2.6.7.8   The Proposer has an enrollee that is a 25-year-old woman who is pregnant and has…

Beth is a 25-year-old pregnant woman with a history of opioid, benzodiazepine, and stimulant use disorders with comorbid schizoaffective disorder and major depression disorder with psychotic features. Beth has had multiple emergency department (ED) visits for drug intoxication or withdrawal, does not have a regular source of care, lacks transportation, and is unstably housed.

2.6.7.8.1 What systems will the Proposer have in place to be able to identify this…

ABHLA understands Louisiana has extremely high maternal and infant mortality rates.

Data Surveillance and Predictive Modeling:

Emergency Department Utilization and Outreach:

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Promoting Universal Screening, Early Detection and Provider Referrals: ██████████

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2.6.7.8.2 What specific steps will the Proposer take to address this enrollee's needs?

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2.6.7.8.3 What steps will the Proposer take, both pre- and postpartum, to ensure…

2.6.7.9   The Proposer has an enrollee that is a 57-year-old woman who has a history of poorly…

Alicia, like many Louisianans, lives with multiple chronic conditions:

2.6.7.9.1 What process would the Proposer use to understand the reasons behind…

Alicia is a 57-year-old woman who has a history of poorly controlled diabetes mellitus, hypertension, coronary artery disease, bipolar disorder, smoking, and low back pain. She has visited the emergency department (ED) 15 times and been hospitalized once for five days within the past six months.

Integrated Care Plan Development

[content redacted]
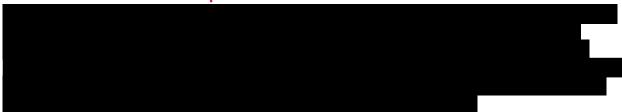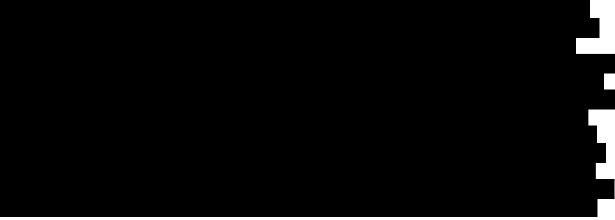
2.6.7.9.2 How would the Proposer address the enrollee's identified needs? Give…

[content redacted]

Addressing Social Needs

[content redacted]

Addressing Clinical Needs

[content redacted]

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Common Medical, Psychosocial, and Social Issues for Healthy Louisiana Enrollees

2.6.7.9.3 How would the Proposer manage this enrollee in the community to…

Population Health Programs and Value-added Benefits (VABs)

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2.6.8 Network Management
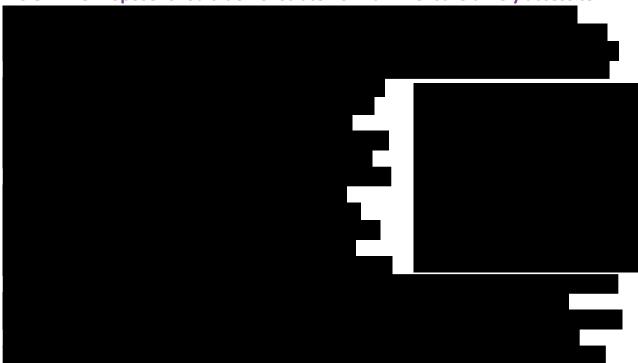
ABHLA supports Louisiana's state health assessment priority of promoting healthy lifestyles across all of Louisiana's diverse parishes. **ABHLA promotes our Ted E. Bear, M.D.™ Kids Club™ on transit buses in cities around the state.** Ted E. Bear, M.D. Kids Club promotes healthy lifestyles and physical activity to children. Enrollees have the opportunity to meet Ted E. Bear, M.D. at festivals, fairs, and health and wellness events throughout the state.

2.6.8   Network Management [10-page limit]

Aetna Better Health® of Louisiana (ABHLA) has ensured timely access to culturally competent services for Healthy Louisiana enrollees since 2015. Our comprehensive Louisiana network is easily accessible when and where enrollees need care.
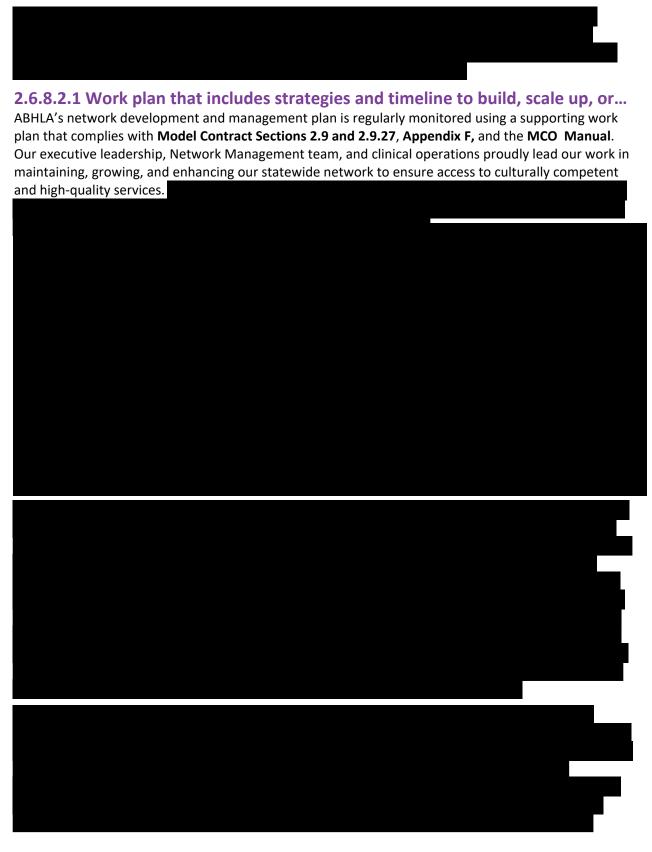
2.6.8.1 The Proposer should demonstrate how it will ensure timely access to…

An important consideration in network monitoring and analysis is identifying and understanding those contracted providers who serve few Healthy Louisiana enrollees. Our goal is to sustain the provider as an active participant in the Healthy Louisiana system of care by increasing their volume of Medicaid patients. We do that by offering those providers targeted education on ABHLA, customized data to improve enrollee outcomes, such as identified gaps in care, and orientation to ABHLA tools that are available to ease administrative burden. We work with providers to increase the number and frequency of Medicaid enrollees a provider manages.

2.6.8.2.1 Work plan that includes strategies and timeline to build, scale up, or…

ABHLA's network development and management plan is regularly monitored using a supporting work plan that complies with **Model Contract Sections 2.9 and 2.9.27**, **Appendix F,** and the **MCO Manual**. Our executive leadership, Network Management team, and clinical operations proudly lead our work in maintaining, growing, and enhancing our statewide network to ensure access to culturally competent and high-quality services.

2.6.8.2.2 Identification of network gaps (distance standards, after-hours clinic…

Our network monitoring system operates continuously and is designed to ensure access to covered services for enrollees. Plan leadership reviews data on network adequacy and performance monthly.

ased on our enrollee assessment and network monitoring initiatives, ABHLA has identified gaps described in **Table 22**.

Despite these noted gaps, we continue to provide timely access to providers to meet enrollee needs.

2.6.8.2.3 Strategies that will be deployed to increase provider capacity and meet the…

2.6.8.2.4 What you consider to be the most significant challenges to developing a…

ABHLA's comprehensive Louisiana network supports the Healthy Louisiana program by providing our enrollees with access to care when they need it.

Providers that are unwilling to accept Medicaid present a different kind of challenge.
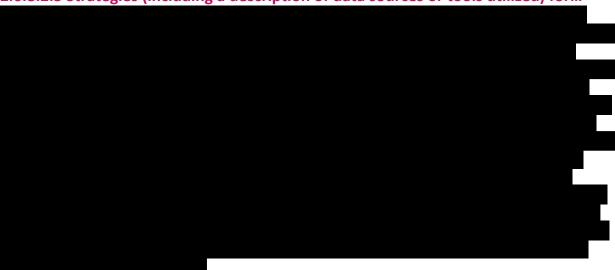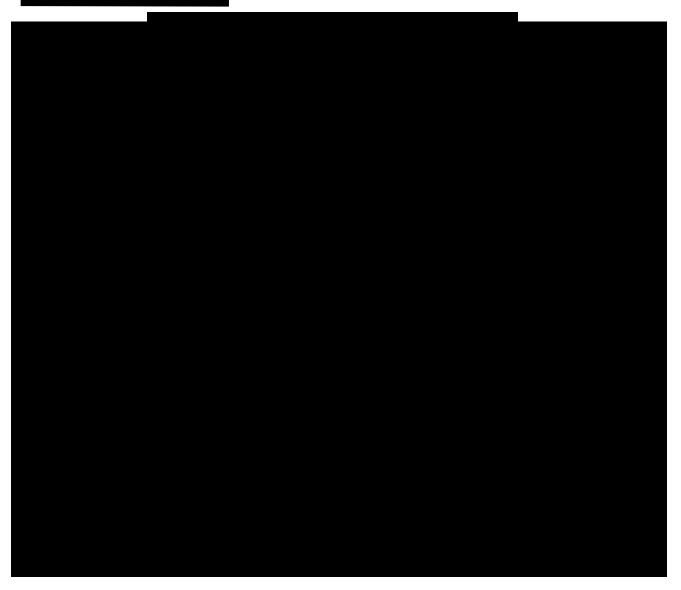
ABHLA currently delivers a comprehensive statewide provider network in Louisiana that ensures the availability and access to all MCO-covered services for the health and well-being of enrollees. Our network is built to support the LDH goals of better care, smarter spending, and healthier communities and people.

2.6.8.2.5 Strategies (including a description of data sources or tools utilized) for…

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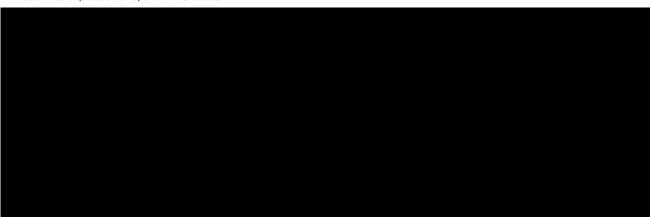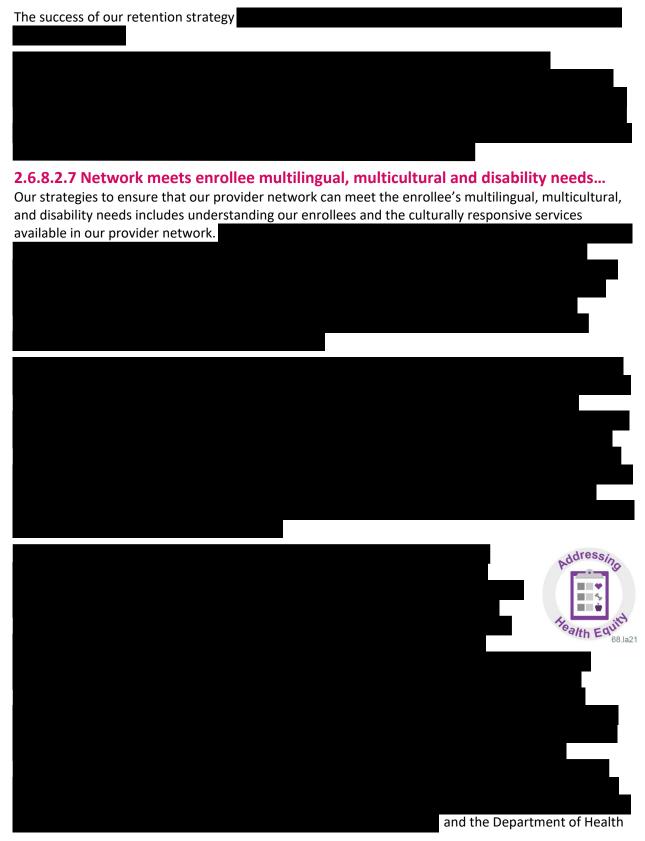
2.6.8.2.6 Strategies for recruitment and retention efforts, particularly in areas where…

ABHLA uses a series of directed strategies to engage, recruit, and retain quality providers. These strategies include the use of innovative VBP payment models, administrative simplification initiatives, and programs and tools to support the provider. ABHLA's relationships with our providers is led by our leadership team, Chief Executive Officer (CEO) Richard Born, and Chief Medical Officer Dr. Madelyn Meyn, who assist in developing new strategic provider partnerships, deepen current provider relationships, and maximize provider engagement through provider payment enhancements.

The success of our retention strategy ███████████████████████████████████████
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2.6.8.2.7 Network meets enrollee multilingual, multicultural and disability needs…

Our strategies to ensure that our provider network can meet the enrollee's multilingual, multicultural, and disability needs includes understanding our enrollees and the culturally responsive services available in our provider network. ████████████████████████████████████
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and Human Service's Office of Minority Health Cultural Competency training is also available to providers.

[REDACTED]

2.6.8.2.8 Details regarding planned protocol for terminating network providers...

ABHLA has established processes related to network terminations and in compliance with **Section 2.9.7.5 and 2.9.28 of the Model Contract and the MCO Manual.** Our preference is to maintain our network and ABHLA does not often terminate providers without cause. [REDACTED]

Notification to Enrollees and minimizing the impact

ABHLA's processes and policies ensure we notify enrollees in a timely manner and provide continued access to covered services, including continuity of care with the terminating provider where appropriate. The process is determined by the type of provider and the nature of the enrollee's relationship with the provider. Our care coordination staff is available to assist any enrollee in transitioning their care and facilitating a warm handoff to a new provider. Contact information for care coordination is included in the enrollee notification. [REDACTED]

If the provider is a PCP or a specialist serving as a PCP, our Care Coordination staff helps the enrollee select a new PCP. ABHLA provides enrollees with at least a 30-calendar day notice when possible to give them the opportunity to select a new PCP before being reassigned. Our Provider Services team coordinates with the Enrollee Services staff to start the process of enrollee notifications and maintain

access to care for enrollees impacted by the termination of a PCP. This process includes enrollees with a disabling condition, chronic illness, or who are Supplemental Security Income-eligible and have chosen a specialist physician to serve as their PCP.

[redacted]

For specialist terminations, we provide timely notifications to enrollees who have received a service from the provider within the previous 18 months. We also send the enrollee information about selecting a new specialist and how we can assist the enrollee during transition.

Notification to the Department

Our process directs us to notify LDH of any changes to our network that materially affects our ability to deliver services prior to 14 calendar days of such change. In the event of an ABHLA-prompted PCP, specialist, or facility network termination, we will notify LDH with advanced written notice prior to 14 calendar days of termination. In the event of a hospital termination, we will notify LDH immediately in compliance with the Model Service Provider Agreement. ABHLA will identify and provide an accounting of all enrollees who have received services from the impacted provider within the past 18 months.
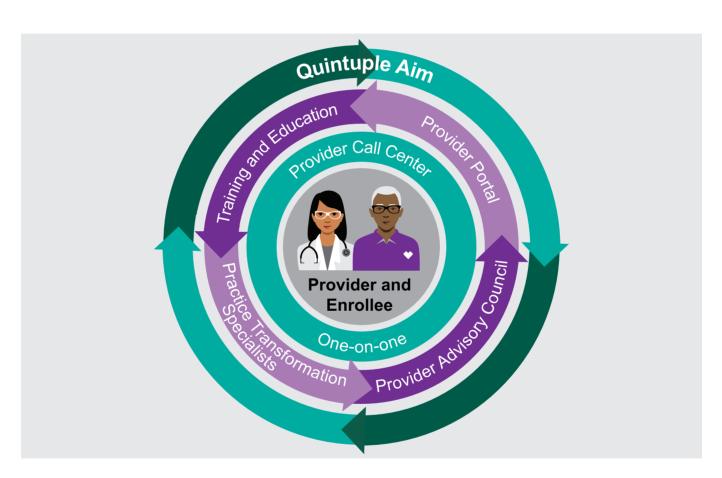
Notification to the Provider

The written notice to the provider includes the effective date of termination and the process to transition care for current patients as well as any planned or previously authorized services for patients. The focus of our processes, monitoring, reporting, and communication is to ensure covered and medically imperative services remain available and accessible to enrollees.

For hospital terminations, we send notification letters to network providers with privileges at the hospital, enrollees in the hospital's service area, and enrollees who had been seen at the facility in the last 18 months. These letters are sent within 14 days of the termination notice from the hospital with information about the change in their participation status and alternative facilities that are in network.

[redacted]

         Aetna Better Health® of Louisiana

2.6.9 Provider Support

ABHLA's multiple channels support timely communication with our provider partners.
We listen. We learn. We act. We improve.

2.6.9 Provider Support [12-page limit]

Aetna Better Health® of Louisiana (ABHLA) evaluates and improves our processes to support providers in many ways to ensure delivery of quality care to our enrollees. This includes but is not limited to providing timely payments, enhancing administrative simplification, communication, and furthering the Louisiana Department of Health's (LDH) quality goals. We acknowledge, understand, and will comply with the requirements in **Model Contract Sections 2.10** and the **MCO Manual**.

2.6.9.1 The Proposer should offer support to providers in a number of ways…

Across all Aetna markets and especially in Louisiana, our multidisciplinary approach goes beyond one-on-one and telephonic engagements.

Providers also have access to webinars and in-person seminars attended by plan leadership, provider surveys, newsletters, and bulletins.

Our provider support program is designed to reduce burden, increase transparency, and give providers the ability to do what they do best—take care of our enrollees.

███

2.6.9.1.1 Its process to determine adequate provider relations staffing coverage for…

██████████████████████████████ Determining the optimal number and type of staff is a continuous process based on the number and type of providers and travel time to reach providers. We determine our field-based Provider Services staffing level using the number of planned engagements by provider type, number of locations, including consideration for urban versus rural regions, claims payment and accuracy trends, and volume of calls in our Provider Services and Enrollee Services call centers. We also solicit feedback on staffing from our Provider Advisory Council (PAC). ██████████████████████████████████

███ ABHLA is fully aligned with **Model Contract Sections 2.10.3.1 – 2.10.3.11 and Part 10 of the MCO Manual.**

2.6.9.1.2 Strategies to provide effective and timely communications with providers,…
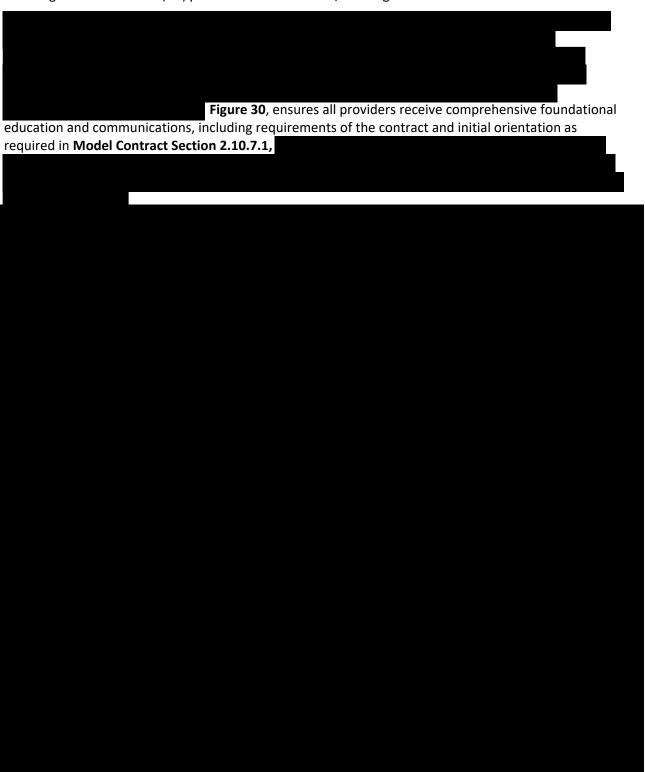
ABHLA's strategy for effective and timely communication with our providers aligns with **Model Contract Sections 2.10.4 – 2.10.7 of the Model Contract and the MCO Manual.** ███

All provider partners receive access to our policies and procedures, including instructions for accessing our grievance and appeals system and access to procedural guidelines to ensure compliance with the **Model Contract** and applicable federal and State laws, regulations, rules, policies, procedures, and manuals, including the State Plan and waivers. Providers receive training on prescriber requirements, billing and prior authorization service protocols, and orientation to the provider portal. We distribute monthly newsletters, frequent and timely notifications containing information to enhance and support efficient administration of health plan policies and procedures, and host regular in-person or virtual provider meetings. Primary care

providers (PCPs) and patient-centered medical homes (PCMH) also receive information on referral providers, including behavioral health (BH) providers to maximize PH/BH integration.

Figure 30, ensures all providers receive comprehensive foundational education and communications, including requirements of the contract and initial orientation as required in **Model Contract Section 2.10.7.1,**

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[redacted]

Effective and Timely Provider Communications

[redacted]

A vital connection to provider partners is our Provider Services call center, which offers a seamless point of entry with knowledgeable and skilled staff trained on LDH requirements and health plan policies and procedures. [redacted]

[redacted] Our toll-free Provider Services call center is available 24/7/365.

Our provider portal contains the most up-to-date enrollee and program information and is available 24/7/365 for all providers. [redacted]

Provider Training and Education Program

The goal of our provider training and education program is to support providers in improving enrollees' health outcomes. We base the design of our program on LDH program requirements, data collected through our population health and quality improvement program, and feedback from providers through one-on-one interactions and our PAC. The program is designed to ensure an understanding of ABHLA and LDH requirements, including appointment accessibility standards, to help to meet enrollee needs. We know that some enrollees have special health care needs due to limited English proficiency, cultural and social barriers, BH concerns, and physical limitations that directly impact their receiving the

appropriate health care service.

Our education program covers both broad network topics and more specialized and individualized trainings in alignment with **Model Contract Section 2.10.7.**

2.6.9.1.3 The processes that the Proposer will put in place to support providers with…

and notify our providers and the LDH within five days consistent with **Model Contract 2.18.6.**

2.6.9.1.4 The processes that the Proposer will put in place for evaluating and…

Providers can initiate a dispute via our website or Provider Services call center, in writing, or through direct contact with Provider Services staff.

Our LPSS complies with **Model Contract Section 2.10.9.**

in alignment with the provider issue resolution in the **MCO Manual** that Our policies and procedures include, at a minimum, those outlined in **Model Contract Section 2.10.9.8.** We provide policies and procedures in a readily accessible format to providers at the execution of the provider agreement and upon request. To simplify the provision of our policies and procedures, we provide a summary to the provider and make them available on our website.

aligns with the **Model Contract and MCO Manual** for timely resolutions of provider disputes.
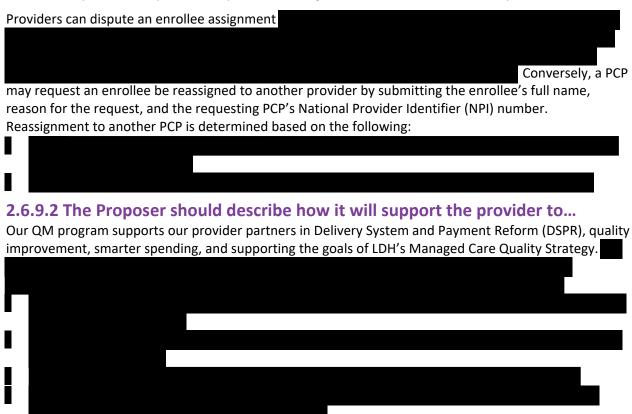
We value our relationship with our provider partners and ensure we provide strong support, a fair and accurate interpretation of their provider agreement, and never prohibit, discourage, intimidate, or in any other way take retaliatory action against a provider that reports any complaint to LDH.

Disputes Specific to Automatic Assignment Policy of Enrollees

ABHLA always prioritizes clear and timely communication with our providers including information about our enrollee attribution process and assigned enrollees. This is particularly important in certain VBP arrangements and our providers are educated on the process should they need to dispute an enrollee attribution. ABHLA's automatic enrollee assignment policy and procedure aligns with **Part 7 of the MCO Manual** and is based on available demographics for the enrollee and provider.

ABHLA undertakes a quarterly analysis and reassignment process that is critical to ensuring accuracy in our population health and VBP programs. We publish the results in our provider portal on the 15th calendar day of the second month of each quarter, adjusted for weekends and State-recognized holidays. Providers have 15 business days to review proposed changes to their rosters before changes are finalized and aligned with the **MCO Manual** provider notification requirement. Our notification includes the protocol for provider disputes, including of the results of the claim analysis.

Providers can dispute an enrollee assignment ███ Conversely, a PCP may request an enrollee be reassigned to another provider by submitting the enrollee's full name, reason for the request, and the requesting PCP's National Provider Identifier (NPI) number. Reassignment to another PCP is determined based on the following:

2.6.9.2 The Proposer should describe how it will support the provider to…

Our QM program supports our provider partners in Delivery System and Payment Reform (DSPR), quality improvement, smarter spending, and supporting the goals of LDH's Managed Care Quality Strategy. █

We established our VBPs on these strategies and key components to enhance the improvement of quality and lower costs in DSPR.

2.6.9.2.1 Strategies to support primary care providers, including but not limited to…

The best opportunity for PCPs to succeed in delivery system reform is through ABHLA's population health strategy supported by innovative tools embedded in ABHLA's population health management platform.

We work closely with our provider network to support a clinically integrated approach to enhance the provider/enrollee relationship and improve health outcomes.
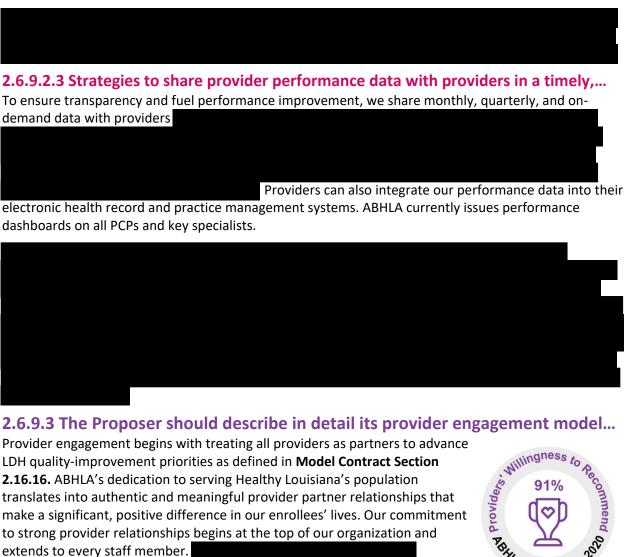
2.6.9.2.2 Strategies to support behavioral health and other specialty providers to…

ABHLA's DSPR initiatives are not just for PCPs. As we have demonstrated in Louisiana and other states, we work with all types of providers, driving DSPR, decreasing fragmentation, and addressing whole-person needs through integrated settings.

At ABHLA, integration is an institutional imperative led by our Chief Medical Officer, Dr. Madelyn Meyn, and overseen by our clinical leadership and Louisiana-based BH Medical Director, Dr. Jared Wakeman, who ensures that all aspects of integrated care come together seamlessly to enhance the care continuum from screening and diagnosis to case management and quality assurance. As we do not delegate management of our BH network or services, we can directly manage the network to align with LDH care management requirements and enrollee needs.

2.6.9.2.3 Strategies to share provider performance data with providers in a timely,…

To ensure transparency and fuel performance improvement, we share monthly, quarterly, and on-demand data with providers ██

██

████████████████████████████████ Providers can also integrate our performance data into their electronic health record and practice management systems. ABHLA currently issues performance dashboards on all PCPs and key specialists.

2.6.9.3 The Proposer should describe in detail its provider engagement model…

Provider engagement begins with treating all providers as partners to advance LDH quality-improvement priorities as defined in **Model Contract Section 2.16.16.** ABHLA's dedication to serving Healthy Louisiana's population translates into authentic and meaningful provider partner relationships that make a significant, positive difference in our enrollees' lives. Our commitment to strong provider relationships begins at the top of our organization and extends to every staff member. █████████████████████████████████
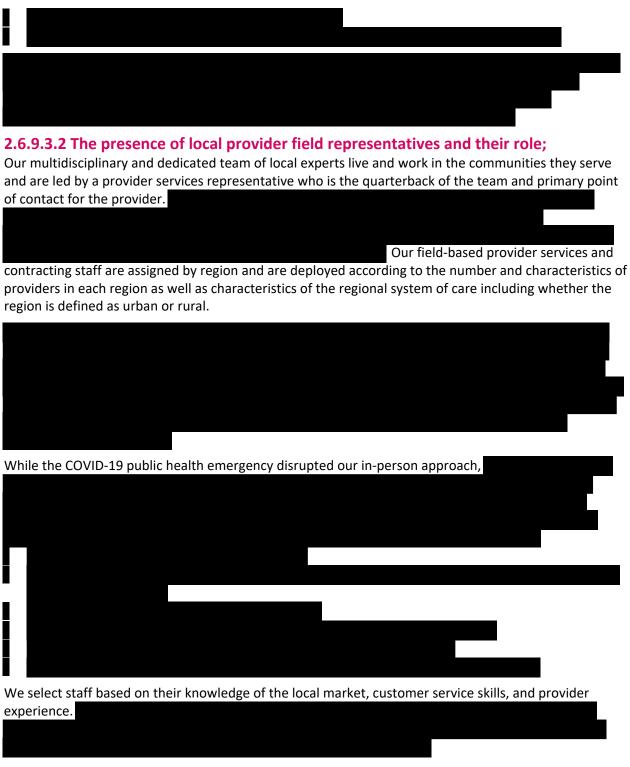
2.6.9.3.1 The Proposer's staff that play a role in provider engagement;

All ABHLA employees are accountable for provider engagement starting with plan leadership, clinicians, those staffing the Provider Services call center, and Provider Services teams. We understand the value of our provider partners in improving enrollee health. The ABHLA staff who lead our provider engagement are as follows:

- Chief executive officer, chief operating officer, and CMO
- Director of Network Management and Provider Support
- Quality director and supporting program managers
- HEDIS manager

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2.6.9.3.2 The presence of local provider field representatives and their role;

Our multidisciplinary and dedicated team of local experts live and work in the communities they serve and are led by a provider services representative who is the quarterback of the team and primary point of contact for the provider. ██

██████████████████████████████████ Our field-based provider services and contracting staff are assigned by region and are deployed according to the number and characteristics of providers in each region as well as characteristics of the regional system of care including whether the region is defined as urban or rural.

██

While the COVID-19 public health emergency disrupted our in-person approach, ███

We select staff based on their knowledge of the local market, customer service skills, and provider experience. ██████████████████████████

2.6.9.3.3 The mechanism to track interactions with providers (electronic, physical ...

[content redacted]

2.6.9.3.4 How the Proposer collects and analyzes utilization data and provider...

[content redacted] ur staff regularly monitor provider grievances, disputes, complaints per **Model Contract Section 2.10.9,** [content redacted] nce our analysis is complete, we develop training strategies and actions plans to remediate issues, as required.

[content redacted]

2.6.9.3.5 The metrics used to measure the overall satisfaction of network providers;...

ABHLA conducts several surveys to inform our provider engagement and support program by monitoring providers' satisfaction with our services and supports. [content redacted]

██████████████████████████████████████ as well as functions outlined in **Section 2.10.8 of the Model Contract.** Our provider satisfaction surveys are conducted by a third party and results are based on a statistically significant sample of contracted providers. ██ We have prioritized improvements in provider satisfaction through our investments in Provider Services staffing, administrative simplification efforts, our programs and tools designed to support our providers in caring for our enrollees, and our innovative payment arrangements. ██

2.6.9.3.6 The approach and frequency of provider training on MCO and Louisiana…

ABHLA's providers' satisfaction is positively impacted by our approach and frequency of provider training. We have designed our provider training based on many years of experience serving Healthy Louisiana enrollees. Our network providers and their staff receive comprehensive, initial, and ongoing education and training on LDH requirements and ABHLA clinical, operational, and transactional processes. Our training program meets the requirements outlined in **Model Contract Section 2.10.7** as shown in **Table 26**.

2.6.10 Utilization Management

Following the state's priorities to address obesity and unhealthy eating through the elimination of food deserts, **ABHLA provides resources for the creation of community gardens** and offers healthy eating options in local schools, community centers, and places of worship.

2.6.10 Utilization Management [15-page limit]

Aetna Better Health® of Louisiana's (ABHLA) utilization management (UM) program facilitates the delivery of high-quality, cost-efficient, and effective care for all managed care organization (MCO) covered services to our enrollees. The program's purpose is to ensure care utilizes evidence-based clinical best practices and is appropriate and medically necessary. Our UM program is part of ABHLA's Quality Assessment and Performance Improvement (QAPI) program, which promotes quality improvement activities through continuous monitoring and evaluation of care. The program complies with **Model Contract Section 2.12**.

2.6.10.1 The Proposer should describe how it will satisfy the requirements for…

ABHLA's Louisiana-based UM team makes determinations on physical health (PH) and behavioral health (BH) authorization requests using evidence-based medical necessity criteria and collaborates with our Integrated Care Management (ICM) team to ensure comprehensive assessment of enrollees' needs—
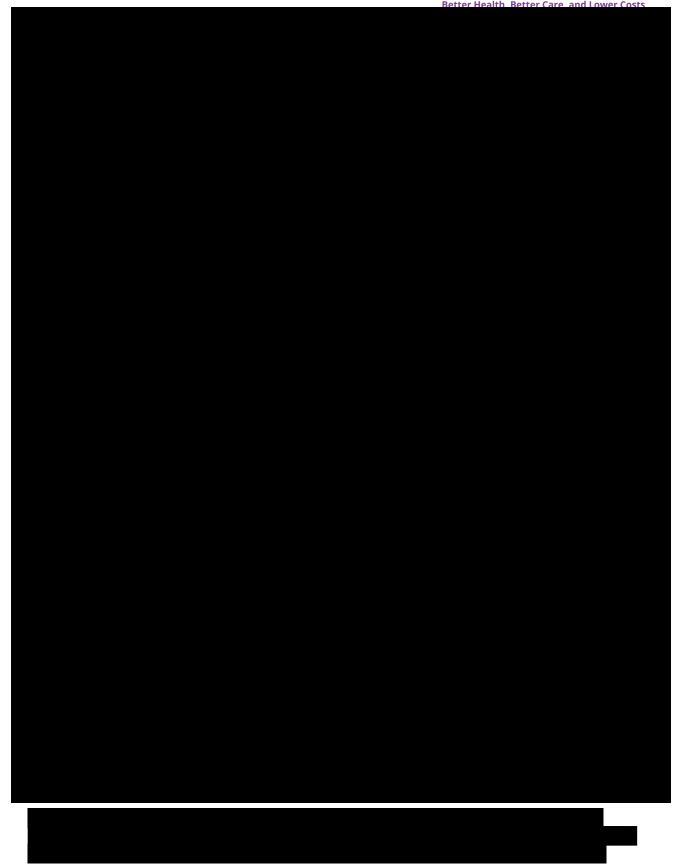
We use strategic partners to augment our UM team.

ABHLA maintains policies and procedures (P&Ps) governing processing of authorization requests, and which comply with **42 C.F.R. §438.210,** the **MCO Manual,** and court-ordered requirements of LDH. Chief Medical Officer (CMO) Madelyn Meyn, MD, MBA, FAAP, and our UM Committee (UMC) are responsible for these P&Ps, which we update at least annually. **Our P&Ps facilitate efficient and accurate processing of requests to ensure enrollees have access to the right care, at the right time, in the right place—and also reduce provider administrative burden**.
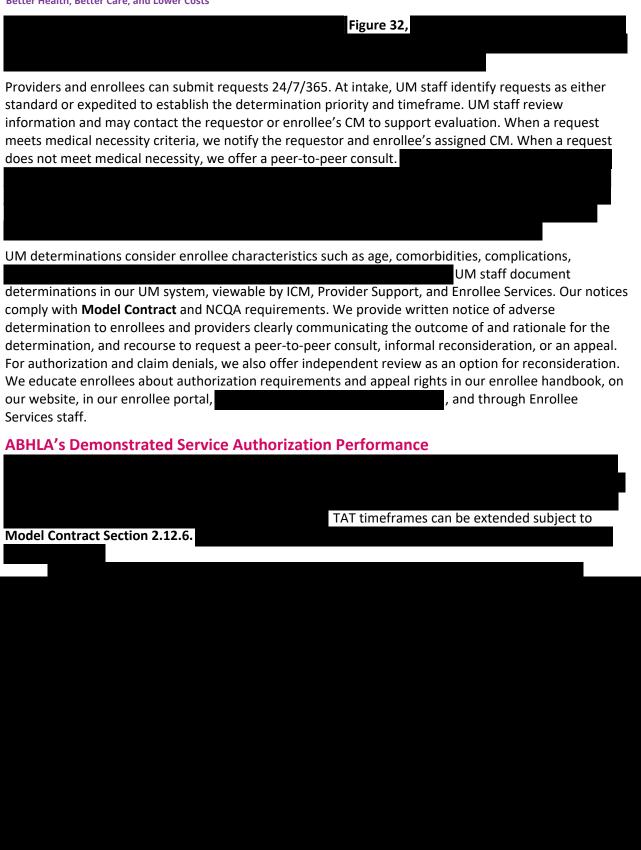
ABHLA's Services Authorization Process

Our local, Louisiana-experienced, and qualified UM staff review authorization requests to determine appropriateness of treatment and site of treatment, applying the appropriate clinical criteria. Our authorization requests are completed timely and efficiently in compliance with **Model Contract Section 2.12.3-2.12.8** and within established NCQA turnaround times and requirements in **42 CFR and 438.210(d).**

Figure 32, █████████████

Providers and enrollees can submit requests 24/7/365. At intake, UM staff identify requests as either standard or expedited to establish the determination priority and timeframe. UM staff review information and may contact the requestor or enrollee's CM to support evaluation. When a request meets medical necessity criteria, we notify the requestor and enrollee's assigned CM. When a request does not meet medical necessity, we offer a peer-to-peer consult. ████████████████

UM determinations consider enrollee characteristics such as age, comorbidities, complications, ███████████████████████████████████ UM staff document determinations in our UM system, viewable by ICM, Provider Support, and Enrollee Services. Our notices comply with **Model Contract** and NCQA requirements. We provide written notice of adverse determination to enrollees and providers clearly communicating the outcome of and rationale for the determination, and recourse to request a peer-to-peer consult, informal reconsideration, or an appeal. For authorization and claim denials, we also offer independent review as an option for reconsideration. We educate enrollees about authorization requirements and appeal rights in our enrollee handbook, on our website, in our enrollee portal, ████████████████████, and through Enrollee Services staff.

ABHLA's Demonstrated Service Authorization Performance

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███████████████████████ TAT timeframes can be extended subject to **Model Contract Section 2.12.6.** ████████████████████████

As a result of our commitment to provider training, ongoing communication on clinical evidence required for authorization approvals, and staff training on application of criteria, ███████████ ███ ███ ███████

UM System

The ABHLA UM system is customized for the Louisiana Medicaid program and integrates with other applications to efficiently coordinate integrated service delivery for enrollees:

- CM staff have immediate access to authorizations at all stages in the UM system.
- UM staff can identify if an enrollee is in ICM, supporting referral and collaboration.
- ███ ███
- The system stores and reports the times and dates of all milestones in the authorization process, determinations made regarding requests, and clinical data in support of decisions.
- Authorization determination results are automatically available to support timely claim processing and claim reviewers can see authorization information to support complex claims processing.

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Provider Experience with Authorization Request Submission and Status Monitoring

Our authorization processes minimize administrative burden and honor our commitment to medically necessary services at the appropriate level of care (LOC). **Table 29** outlines elements that ██████████ ███ ███

2.6.10.2 The Proposer should describe how it will satisfy the requirements for…

ABHLA maintains written program P&Ps with defined structures and processes that meet NCQA standards, including our governing annual UM Program Description, our UMC, and our annual UM Evaluation. Our UM P&Ps include but are not limited to those listed at **Model Contract Section 2.12.1.2**.

Our CMO, Dr. Madelyn Meyn, directs our UM program. Our BH medical director, Jared Wakeman, MD, FAPA, FASAM, is actively involved in the BH aspects of the program. Our pharmacy director, Vanessa Smith, DPh, oversees pharmacy UM.

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██; and act as a steward of Louisiana State resources.

Our UMC is part of our QAPI Committee structure and is chaired by our CMO. The UMC meets no less than quarterly and as frequently as necessary to follow up on findings and required actions. The UMC includes representation from across the plan and by participating practitioners representing a broad range of specialties.
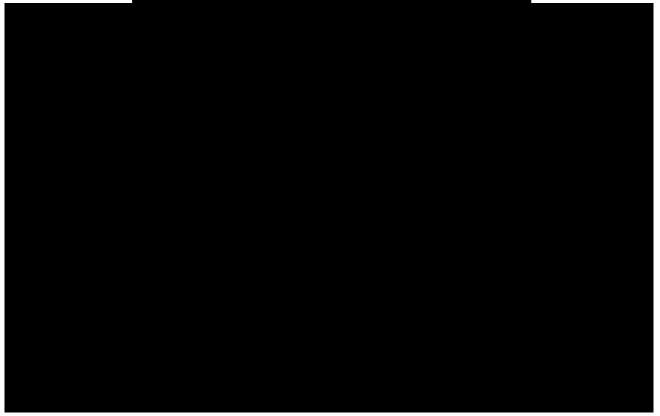
2.6.10.2.1 The proposed criteria to use in its UM process and how…

ABHLA's UM program ██ the evidence-based medical necessity criteria in **Table 30** for our Healthy Louisiana UM decision-making.

███

Our criteria are consistent with applicable federal and State laws, regulations, rules, policies, procedures and manuals, the State Plan, and waivers, and use LDH's definition of medical necessity. ██ We use an annually reviewed common hospital observation policy maintained by MCOs and LDH.

We train our UM reviewers on our CPGs. Our CPGs are nationally recognized, evidence-based guidelines from national institutions like the American Diabetes Association. The Aetna Medicaid UMSC adopts Aetna CPGs and reviews adopted policies at least every two years, or more frequently if national guidelines change. The UMSC submits policies to ABHLA for consideration by our UMC for our Healthy Louisiana UM program. The UMC reviews CPGs relative to LDH requirements and makes recommendations to our CMO, who brings them to the Quality Management Oversight Committee (QMOC) for adoption. We use CPGs in creating evidence-based care plans in ICM, reviewing charts in

Quality, educating providers, and teaching UM staff to assess for standard of care. We publish our CPGs on our website and work with our fellow Healthy Louisiana MCOs to make sure our posted CPGs are aligned to support provider adoption.

Application of Service Authorization Medical Necessity Criteria

UM clinical reviewers are licensed clinical professionals with appropriate clinical expertise. Their compensation does not provide incentives to deny, limit, or discontinue medically necessary covered services. We ensure they have no history of discipline or sanctions as outlined at **Model Contract Section 2.12.5.4**. ███ ███ as required by the **Model Contract Section 2.12.5.5**. Our ABA certified reviewer reviews for ABA services.

UM clinical staff evaluate requests based on the applicable criteria to assess appropriateness of treatment and requested site of treatment. Our clinical guidelines include criteria for medical necessity and location of care. For example, knee surgery criterion specifies it as an outpatient procedure. If it is medically necessary, we would only approve it as outpatient, unless enrollee circumstances, such as patient with cardiac issues or multiple complex chronic conditions, warrant another setting. Similarly, ASAM criteria uses a numeric rubric to specify the needed intensity of services across a continuum. The numeric result of assessment indicates intensity of needed services and appropriate location of service.
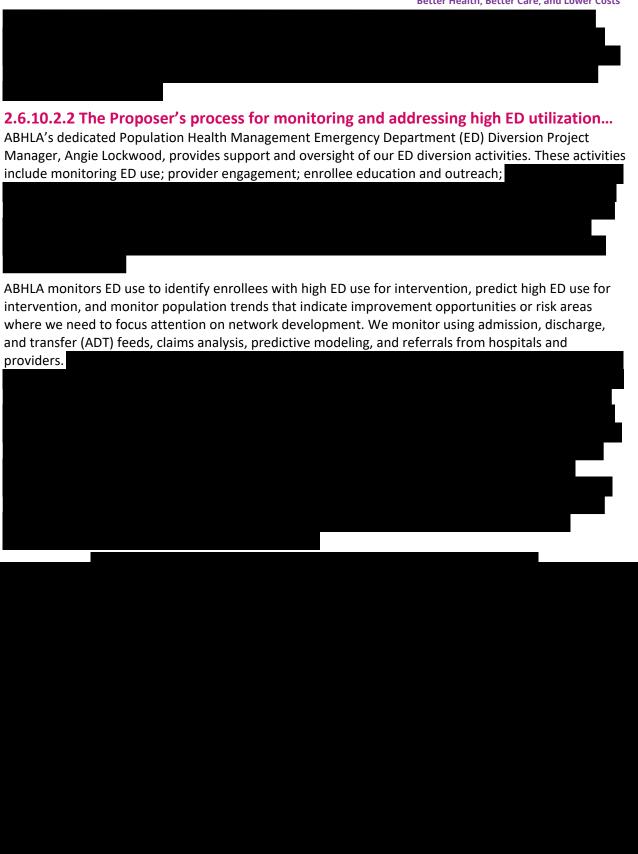
Consistent and correct application of medical necessity criteria is imperative to making certain enrollees receive the services they need timely, cost-effectively, and in the least restrictive setting. ███████ ██ ██ ██ ██

New UM staff undergo role-specific training for up to four weeks. Training includes live classroom instruction by Aetna Medicaid UM subject matter experts (SMEs) and local ABHLA UM preceptors (UM team leads); 'a day in the life' observation of senior ABHLA UM staff to see use of systems and P&P in action; and technology-based training on Medicaid and Medicaid UM. Training culminates with IRR testing. Beginning with the contract start date, ██████████████████████████████████████ ████████████████████████████ Following training, new hires complete a three-month ramp-up period during which they work with an ABHLA preceptor and transition from shadowing to being observed in completing reviews. At the close of the ramp-up period, UM staff transition to full production with standard oversight. ABHLA provides ongoing UM training to roll out new P&Ps in response to audit findings and in response to our identified needs.
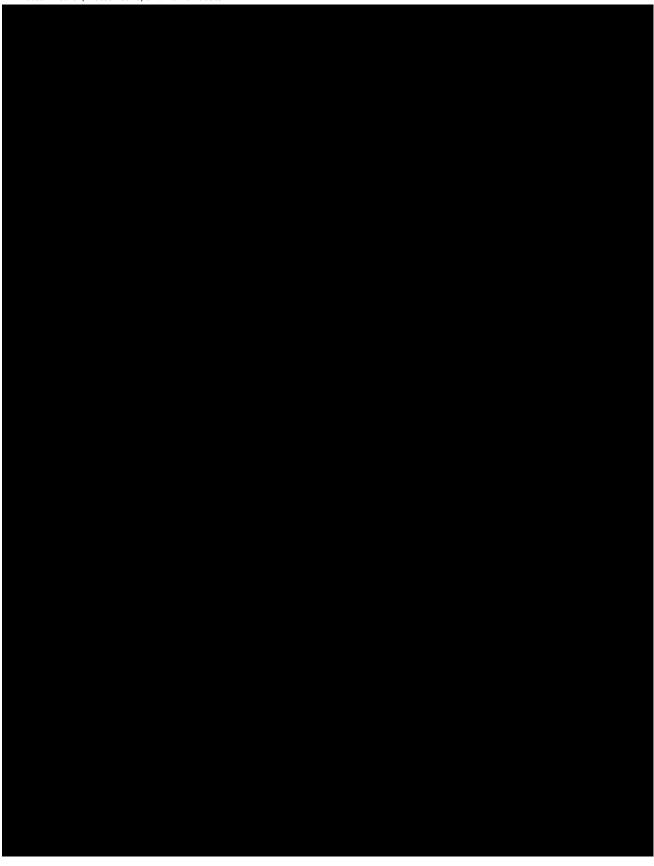
IRR testing measures the objectivity and consistency with which UM staff apply medical necessity criteria and their understanding of the criteria. Results guide performance improvement planning and monitoring. We evaluate all UM staff following initial training and annually thereafter, including the CMO, BH medical director, and all medical directors making determinations; clinical UM staff, including pharmacists and pharmacy technicians; and independent external clinical reviewers, including physicians, psychologists, and nurse practitioners, unless these practitioners are employees of a UM delegate. UM delegates complete audits and IRR testing and report to ABHLA as part of ABHLA delegate oversight and monitoring, and for discussion at Joint Oversight Committee meetings. ███████████

[black redaction box]

2.6.10.2.2 The Proposer's process for monitoring and addressing high ED utilization…

ABHLA's dedicated Population Health Management Emergency Department (ED) Diversion Project Manager, Angie Lockwood, provides support and oversight of our ED diversion activities. These activities include monitoring ED use; provider engagement; enrollee education and outreach; [redacted]

[black redaction box]

ABHLA monitors ED use to identify enrollees with high ED use for intervention, predict high ED use for intervention, and monitor population trends that indicate improvement opportunities or risk areas where we need to focus attention on network development. We monitor using admission, discharge, and transfer (ADT) feeds, claims analysis, predictive modeling, and referrals from hospitals and providers. [redacted]

[black redaction box]

2.6.10.2.3 The Proposer's process for PASRR and Concurrent Reviews

ABHLA's Pre-Admission Screening and Resident Review (PASRR) and concurrent review processes ensure the medical necessity of IP admissions, that enrollees are getting the right level and type of care for their needs, and that they are not inappropriately admitted to a nursing facility (NF) or other long-term care setting when their needs can be met in a less restrictive setting.

ABHLA's PASRR Process

ABHLA's PASRR process complies with **Model Contract Section 2.7.7** and the Department of Justice Compliance Guide. ██
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ABHLA's Concurrent Review Process

ABHLA's PH and BH UM teams complete concurrent reviews to determine medical necessity for IP admissions and continued stays using the criteria listed in **Table 32.** ████████████████████
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████████████████████████████████

Providers notify us within one business day of IP admissions and provide supporting clinical records. If our concurrent review nurses can access a hospital's electronic health record (EHR), they use the EHR to view clinical information, alleviating the provider burden of submitting clinical evidence. ████████████
████████████████████████████████ Our clinical reviewers determine the medical necessity of the admission and appropriateness of the LOC using appropriate criteria available to providers on our website. We make determinations within one calendar day of receiving notification and appropriate clinical support. Only a licensed, board-certified medical director may make an adverse determination. When a provider assesses that an enrollee requires IP days beyond the approved length of stay, the
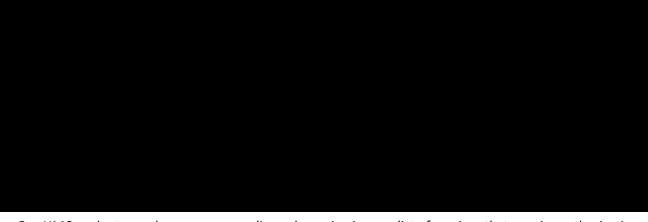
provider submits a request for continued stay with updated clinical information. Where we have EHR access, our nurses complete continued stay reviews daily, without provider request.

Our concurrent review clinicians work with hospital discharge teams and attending physicians to ensure enrollees receive cost-effective and evidence-based services provided at the appropriate LOC. This includes early discharge planning; facilitating and/or attending discharge planning meetings for enrollees with complex and multiple discharge needs; and providing hospital staff with information about network providers in keeping with the discharge plan. Concurrent review clinicians work with an enrollee's CM, for enrollees engaged in ICM, to reflect the discharge plan in the care plan, and ensure the plan includes assessment of SDOH that may affect an enrollee's successful discharge or represent a readmission risk.

2.6.10.2.4 How the Proposer complies with mental health parity requirements

We integrate Mental Health Parity and Addiction Equity Act (MHPAEA) compliance into our UM program, from how we authorize services to how we evaluate and monitor compliance. Our program is compliant with **Model Contract Section 2.2.7** and we ensure material subcontractor compliance. We conduct regular policy reviews; conduct annual utilization comparison between CPST, PSR, and PH rehabilitation services; and employ the following controls to assure parity compliance:

Our UMC evaluates and measures compliance by reviewing our list of services that require authorization at least annually. Our CMO oversees this process and reports results to the QMOC. QMOC annually reviews and approves policies on UM practices, pharmacy, appeals, and peer reviews. All ABHLA staff, including non-clinical and non-UM staff, complete mental health parity training on requirements and their roles and responsibilities relative to parity, and ABHLA adheres to the requirements in **MHPAEA 42 C.F.R. 4.8.3 (e)(1)(ii) and 438.910(b)-(d)**.

2.6.10.2.5 How the Proposer identifies and mitigates over-utilization, including any…
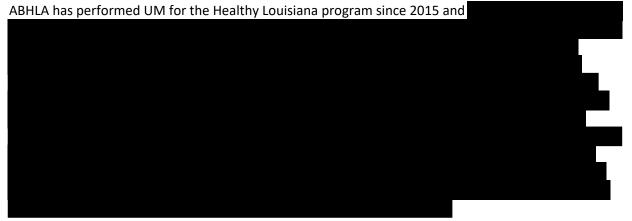
We assess utilization rates using our

Louisiana Department of Health
Louisiana Medicaid Managed Care Organizations
RFP #3000017417

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In addition to data analysis and reporting, we educate UM staff on CPGs to enable them to look for trends in over- and under-utilization. Through QMOC's governance structure, we use data analysis to detect over-utilization and develop and monitor interventions, frequently in collaboration with providers and community-based agencies. We apply continuous quality improvement principles through ongoing analysis, data-driven decision-making, and feedback from enrollees and providers. We check intervention progress and drive accountability through routine meetings and dates for task completion, and evaluate feasibility, time, and cost of proposed plans. **Section 2.6.10.3.2 herein** has examples of initiatives we use to manage high utilization.

2.6.10.3 The Proposer should describe its historical experience with utilization…

ABHLA has performed UM for the Healthy Louisiana program since 2015 and ████████████████████

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2.6.10.3.1 Challenges identified with high utilization and increasing medical trends

We are committed to working with LDH and fellow MCOs to address high utilization and trends in the increasing cost of medical care. A recent example is our participation, described in **Section 2.6.10.1 herein**, in developing an LDH policy addressing overuse of multivariant respiratory panels. We also work with the LDH on stents and procedures associated with peripheral vascular disease, wearable defibrillators, and the cost of out-of-state hospitals. Our UM and Program Integrity departments monitor and address fraud, waste, and abuse, including waste caused by inappropriate use of high-cost services and equipment when available lower cost options are equally effective. ████████████████

2.6.10.3.2 Initiatives undertaken to manage high utilization

Our locally based ICM teams, a critical component of our population health model, use a set of integrated trauma-informed services and approaches, culturally and linguistically appropriate services, and recovery principles to manage high utilization. ABHLA CMs educate enrollees and caregivers on specific PH and BH disorders, appropriate ED use, when and how to contact their PCP, and the importance of preventive care. ABHLA's approach to addressing high utilization is a collaborative endeavor between the UM and ICM teams, focusing on individualized treatment planning based on root cause analysis.

[image: Aetna logo — "Building a Healthier World through Better Health, Better Care, and Lower Costs"]

[image: "Ensuring Quality Care" badge — 68.la21]

2.6.10.3.3 Initiatives to address use of low value care

Because of the cause and effect between higher quality care and lower health care costs, we work diligently to decrease the use of low-value care.

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[REDACTED]

2.6.10.3.4 Initiatives to address long term stays of enrollees in the ED based on limited…

We address long-term stays of enrollees in the ED due to limited availability of BH services through direct engagement and through strategies to increase availability of non-ED BH services.

[REDACTED]

2.6.10.3.5 Initiatives undertaken to support providers with high PA denial rates

We use benchmarks to identify providers with high denial rates and assess for outliers. We review the data monthly within UM; quarterly interdepartmentally, including UM, Quality, and Provider Services; and quarterly at Joint Operating Committee [REDACTED]

[REDACTED]

2.6.11 Quality

ABHLA recognizes that chronic illness such as diabetes has an enormous impact on Louisiana communities. ABHLA participates in the Dragon Boat Festival each year in Monroe to **promote health and physical activity, contributing to a healthier mind, body, and spirit.**

2.6.11   Quality [15-page limit; clinical practice sample guidelines, NCQA rating attachment, and…

As a fully accredited National Committee for Quality Assurance (NCQA) managed care organization (MCO), Aetna Better Health® of Louisiana (ABHLA) customizes our Quality Management (QM) program to improve the health outcomes of the more than 146,000 Healthy Louisiana enrollees we proudly serve.

2.6.11.1 The Proposer should describe its organizational commitment to…

ABHLA's Quality Assessment and Performance Improvement
(QAPI) program is evidence-based and focuses on Continuous Quality Improvement (CQI) methodologies. ABHLA will continue to advance the Louisiana Department of Health's (LDH) Quality Strategy and incentive-based quality measures identified in **Attachment H** through the following approaches:

-

  - ABHLA's locally based QM team is led by our Chief Medical Officer (CMO) Dr. Madelyn Meyn, Behavioral Health (BH) Medical Director Dr. Jared Wakeman, and QM Director Arlene Goldsmith. They report to ABHLA Chief Executive Officer Rick (CEO) Rick Born, who reports to the ABHLA Board of Directors (BOD).
  - Our enrollee and provider engagement, incentive, and reimbursement strategies align with our quality goals and include Louisiana enrollees and providers on our advisory committees.

-

[REDACTED]
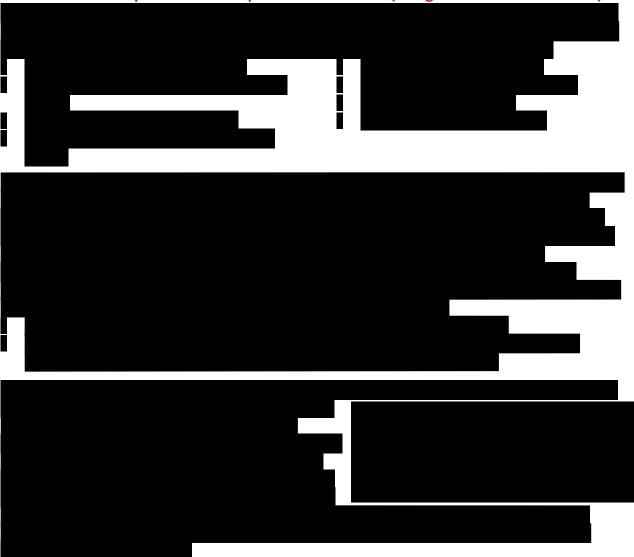
2.6.11.2 The Proposer's approach should include:

ABHLA's approach uses data from monthly appropriateness of care reports to identify trends in over- and under-utilization. Our QM team compares trends across geographies, provider partners, and utilization category to identify patterns.

2.6.11.2.1 A description of the Proposer's assessment (using available data sources)…

[REDACTED]
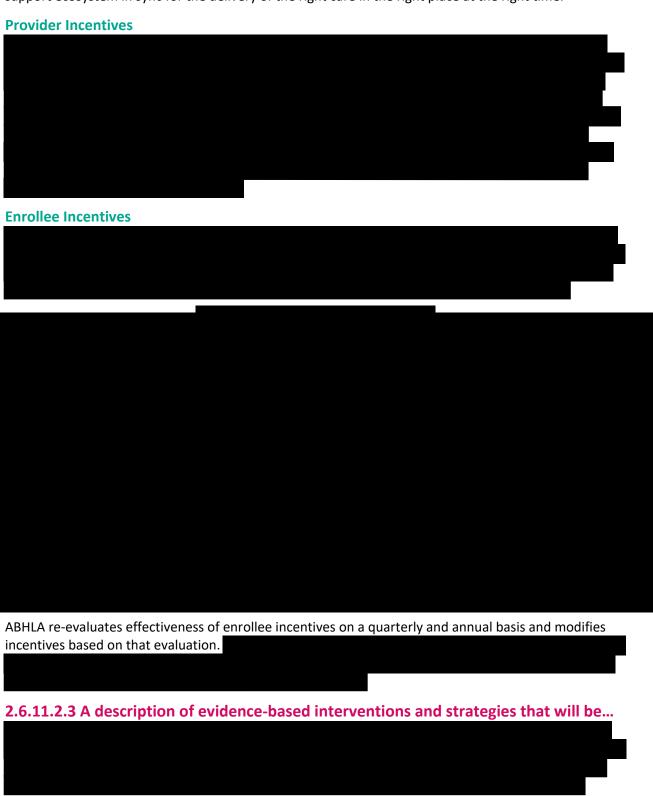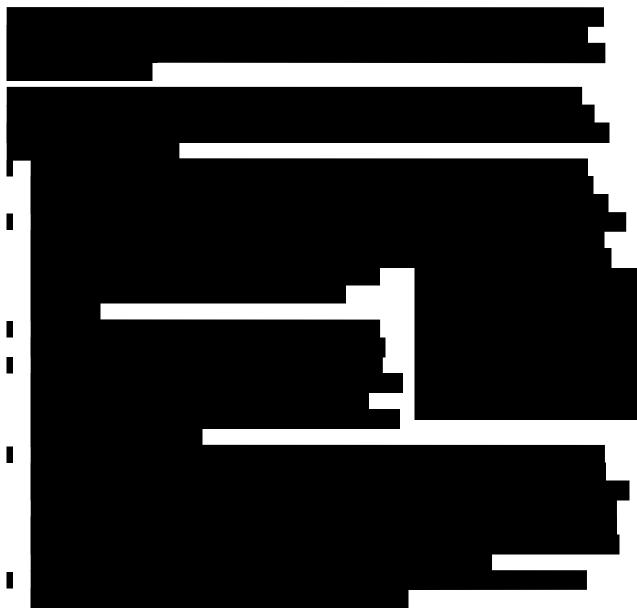
2.6.11.2.2 A description of incentives that will be implemented for providers and…

Provider, plan, and LDH incentive payment alignment is an important strategy for keeping the enrollee's support ecosystem in sync for the delivery of the right care in the right place at the right time.

Provider Incentives

Enrollee Incentives

ABHLA re-evaluates effectiveness of enrollee incentives on a quarterly and annual basis and modifies incentives based on that evaluation.

2.6.11.2.3 A description of evidence-based interventions and strategies that will be…

[redacted]
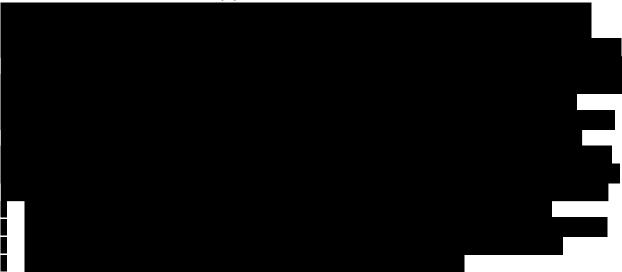
2.6.11.3 The Proposer should describe how the Proposer's Medicaid managed…

ABHLA is committed to advancing EBPs, innovation, high-value care, and health care service excellence to maximize enrollee health, advance health equity, ensure appropriate utilization of Healthy Louisiana benefits and services, and address SDOH within a customized value-based approach. We have designed, established, and implemented our QAPI program, as required by the **Model Contract** and **42 C.F.R. §438.330(a)(1)**, to **improve the health status of our covered population through organization-wide initiatives**. Our Quality Management/Quality Improvement (QM/QI) and QAPI programs align with the priorities, goals, and objectives as detailed in LDH's Medicaid Quality Strategy.

[redacted]

[black redacted box]

Describe in detail at least one (1) data-driven clinical initiative that the…

[black redacted box]

2.6.11.3.1 Analyzing gaps in delivery of services and gaps in quality of care, areas for…

ABHLA uses data to continuously identify gaps in services and care as a key component to inform our chronic condition management programs.

Analyzing Gaps in Delivery of Services and Gaps in Quality of Care

ABHLA completes data mining activities through analyzing gaps in delivery services and quality of care to develop intervention/actions focused on prevention, early detection, and management of disease and utilizations. Data capture and analysis includes the following: HEDIS performance profiles; Early and Periodic Screening, Diagnostic and Treatment (EPSDT) utilization; CAHPS results; network adequacy reporting including out-of-network usage; pharmacy and medical utilization reports; G&A data;

[black redacted box]

Areas for Improved Management of Chronic and Selected Acute Diseases or Conditions

Reduction in Disparities in Health Outcomes

Gaps in quality of care reports are important for developing the right programs to manage chronic disease and improve enrollee health through the reduction in disparities in health outcomes. ABHLA's September 2020 gap report identified a clinical opportunity for improvement

2.6.11.3.2 Identifying underlying reasons for variations in the provision of care to…

Our analytic review and CQI process play a critical role in identifying variation in the provision of care and access to EBPs, effectiveness of care rendered, chosen treatment options, frequency in use of clinical activities, and health equity.

2.6.11.3.3 Implementing improvement strategies related to analytical findings…

Our Quality Management Committee (QMC) and Quality Management Oversight Committee (QMOC) discuss analytical findings to develop improvement strategies that address the root cause of service and quality gaps and variations in the provision of care. QM program managers perform ongoing, data-driven analysis and evaluation to determine program effectiveness, enabling us to quickly remove barriers or perform program enhancements or revisions.

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2.6.11.4 The Proposer should submit an overview of its proposed approach to…
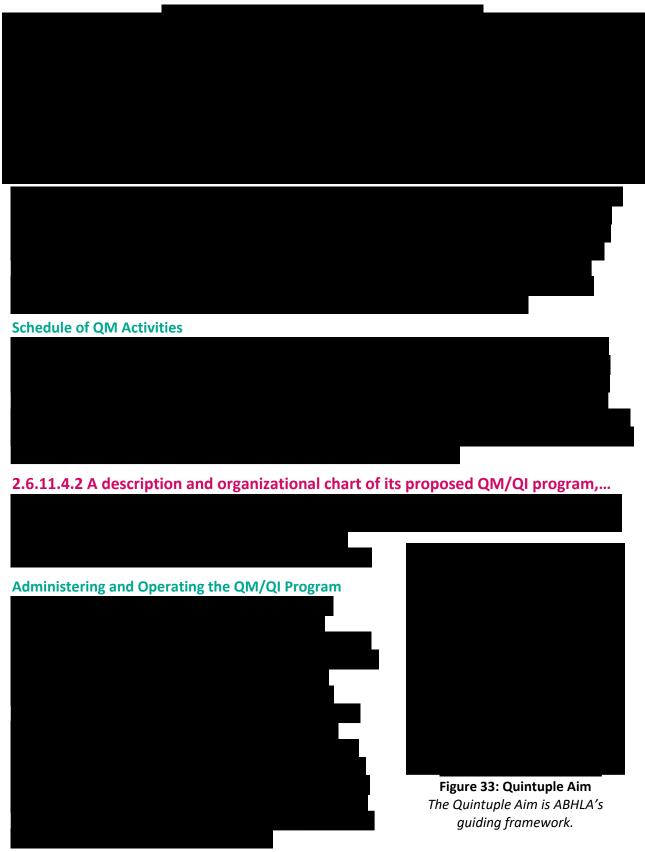
ABHLA's approach to QM/QI is rooted in national and evidence-based standards of care, PHM, transparent clinical coverage bulletins and policies, licensed and qualified staff, clear policies and procedures, CI strategies, and CQI methodologies. We are committed to consistent and accurate clinical decision-making to achieve improvement in clinical outcomes.

2.6.11.4.1 The Proposer's current QM/QI organizational plan description, goals,…

ABHLA's CMO is accountable for and leads the development and implementation of the QAPI program approach, including leading strategic activities that contribute to the performance of the plan and promote quality of care.

QM/QI Organizational Plan Description

Quality Committees

Schedule of QM Activities

2.6.11.4.2 A description and organizational chart of its proposed QM/QI program,…

Administering and Operating the QM/QI Program

Figure 33: Quintuple Aim
The Quintuple Aim is ABHLA's guiding framework.

2.6.11.4.3 The Proposer should demonstrate its capacity to participate in LDH's…

ABHLA is committed to delivering accurate and timely reporting, and has demonstrated year-over-year improvement ███

Capacity to Participate in HEDIS Measurement and Reporting

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██

ABHLA annually measures and reports to LDH our performance-based HEDIS measures designated by LDH and additional non-HEDIS performance measures listed in and as specified in **Attachment H** and submits data to LDH as specified in the **Model Contract**. ABHLA will submit annually audited HEDIS results to LDH, NCQA, and LDH's External Quality Review Organization.

Availability of Dedicated Resources

Improving HEDIS and other performance indicator rates is a ABHLA company-wide commitment.

ABHLA's CEO Rick Born is responsible for programs designed to improve the health of Louisianans in compliance with State, federal, local, and Aetna Medicaid mandates. **Table 36** describes ████████

2.6.11.4.4 The Proposer should provide an example of a recent successful quality…

Success in any quality improvement activity starts with identifying gaps-in-care. ████████████

Table 37.

███
███
███
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███

2.6.11.4.5 The Proposer should describe how it will identify quality improvement…

███

Identifying Quality Improvement Plans and Projects

███
███
███
███

Once identified, we conduct root cause analysis, develop initiatives for improvement, and design interventions.

Potential Improvement Topics

███
███

Monitoring Implementation and Outcomes of the Activity

ABHLA uses reliable and valid methods to continuously monitor and evaluate implementation and performance of the QI activity against its goals. Through rapid-cycle performance improvement (i.e., PDSA cycles), we can quickly assess progress, and pivot interventions based on results. This enables us to develop targeted, measurable interventions to evaluate the impact of an activity on our improvement goals. ABHLA conducts project evaluation at the end of the PDSA cycle in alignment with the QAPI. We scale up the project if we achieve our goals; we reevaluate and redesign if we fall short of our goals. ABHLA continuously monitors implementation and outcomes through our VBP program at the global and provider-practice level;

Example of Quality Improvement Process: Disaster Planning and Recovery Response

ABHLA identified a QI need for the effects of natural disasters on quality of care—understanding affected areas may have reduced access to care and community support. ABHLA's disaster planning and recovery response is proactive before, during, and after the event using interactive communication including texting, telephonic, and web-based outreach. In times of crisis, we stand side-by-side with our enrollees and communities by providing food, gift cards, and other essentials—all in the interest of safety, security, and stability.

2.6.11.5 The Proposer should submit a list of clinical practice guidelines…

ABHLA uses evidence-based clinical practice guidelines (CPGs) to support consistent care delivery, inform provider partners of scientific advances, and result in improved quality. ABHLA uses CPGs to evaluate over- and under-utilization of services, to create evidence-based care plans, and to educate enrollees

and provider partners to improve practice patterns. ██████████████████████████
███████████████████████████████

2.6.11.5.1 The proposed process for adopting and disseminating clinical practice…

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██

2.6.11.5.2 How scientific evidence and the opinions of in-network and out-of-…

ABHLA adopts and maintains CPGs from recognized professional sources such as the American Academy of Pediatrics, American College of Cardiology, American Diabetes Association, American Heart Association, American Society of Addiction Medicine, and the American Psychiatric Association. ABHLA adopts nationally accepted evidence-based preventive services guidelines for healthy adults and children with normal risks (Grades A and B), from the U.S. Preventive Services Task Force, the Centers for Disease Control and Prevention, and the Advisory Committee on Immunization Practices.

Through the QAPI program and the QMOC, our **CMO and BH medical director review, revise, and approve all CPGs annually.** ██████████████████████████████████████
██
██

2.6.11.5.3 How the Proposer plans to evaluate providers' adherence to clinical…

ABHLA evaluates provider partner adherence to CPGs by examining provider partner habits through clinical indicators and performance measures. ██████████████████████████
██
██

We review all measures and trends through our QMOC. When an unusual trend is identified the QM team conducts an audit of the provider charts using the NCQA 8/30 file sampling procedure. The Quality Improvement Management Committee reviews results of these audits and, as needed, develops corrective action plans for areas of concern or under-performance.

2.6.11.5.4 The ongoing evaluation process for updating and revising the Proposer's…

Aetna Medicaid and ABHLA monitor and review nationally recognized, peer-reviewed, evidence-based literature on an ongoing basis and collects input from national and local experts to determine whether new information has emerged that may warrant a revision to our CPGs to ensure consistency with current medical practice standards. The UMSC systematically reviews recommendations on CPGs for approval. Each adopted guideline is reviewed against clinical evidence at least every two years, or more frequently, if national guidelines change within the two-year period. The following factors are considered in adopting new CPGs that are needed to meet compliance with accreditation or regulatory requirements: the proposed guidelines are based on valid and reliable clinical evidence or a consensus of practitioners in the particular field; the guidelines consider the needs of the Healthy Louisiana enrollees; and the guidelines are adopted in consultation with board-certified, contracted practitioners from appropriate specialties that would use the guidelines. ABHLA also collaborates with LDH and other MCOs when we identify a needed revision to improve provider understanding and ensure high-quality care for all Healthy Louisiana Medicaid enrollees.

2.6.11.6 The Proposer should submit, as an attachment using the Quality…

The Aetna Medicaid organization's NCQA Health Insurance Plan Ratings (2019-2020) for Medicaid managed care contracts with full NCQA accreditation are attached as **Appendix D**.

2.6.11.7 The Proposer should provide a copy of its certificate of accreditation…

Please refer to **Appendix D** for a copy of ABHLA's certificate of accreditation.

2.6.11.8 Where a Proposer utilizes a material subcontractor to provide…

ABHLA does not utilize a material subcontractor to provide BH services.

Appendix D

Louisiana │ Transforming Health Care │ **Aetna**

Appendix D

2.6.11 Quality

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**Building a Healthier World through
Better Health, Better Care, and Lower Costs**

Clinical Practice Guidelines Table

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Clinical Practice Guidelines Aetna Better Health of Louisiana

Disease Management Condition	Guideline (Copy and paste link into your browser)
ADHD	American Academy of Pediatrics (AAP): ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents, October 2019 https://pediatrics.aappublications.org/content/144/4/e20192528
Alcohol Use Disorder	American Society of Addiction Medicine Alcohol Withdrawal Management https://www.asam.org/docs/default-source/quality-science/the_asam_clinical_practice_guideline_on_alcohol-1.pdf?sfvrsn=ba255c2_2 Unhealthy Alcohol Use in Adolescents and Adults: Screening and Behavioral Counseling Interventions (November 2018) https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/unhealthy-alcohol-use-in-adolescents-and-adults-screening-and-behavioral-counseling-interventions
Anxiety Disorder	National Institute of Mental Health Anxiety Disorders https://www.nimh.nih.gov/health/topics/anxiety-disorders
Asthma	National Heart, Lung and Blood Institute (NHLBI)-Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma (EPR-3) Published Aug 2007 https://www.nhlbi.nih.gov/health-topics/guidelines-for-diagnosis-management-of-asthma
Bipolar Disorder	American Psychiatric Association Practice Guideline for the Treatment of Bipolar Disorder https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/bipolar.pdf
Chronic Kidney Disease	The National Kidney Foundation Kidney Disease Outcomes Quality Initiative (NKF KDOQI™) evidence-based clinical practice guidelines for all stages of chronic kidney disease (CKD) and related complications https://www.kidney.org/professionals/guidelines/guidelines_commentaries
Chronic Obstructive Lung Disease (COPD)	Global Initiative for Chronic Obstructive Lung Disease 2019 Report https://goldcopd.org/wp-content/uploads/2018/11/GOLD-2019-v1.6-FINAL-08Nov2018-wms.pdf
Congestive Heart Failure (CHF)	2013 ACCF/AHA – Guideline for the Management of Heart Failure http://www.onlinejacc.org/content/62/16/1495 **Update:** 2017 ACC/AHA/HFSA Focused Update of the 2013 ACCF/AHA Guideline for the Management of Heart Failure http://circ.ahajournals.org/content/early/2017/04/26/CIR.0000000000000509
Coronary Artery Disease (CAD)	2019 ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease http://www.onlinejacc.org/collection/guidelines
Diabetes *ADA's current clinical practice recommendations*	2020 American Diabetes Association (ADA) Standards of Medical Care in Diabetes https://professional.diabetes.org/content-page/standards-medical-care-diabetes
Eating Disorders	American Academy of Child and Adolescent Psychiatry Committee on Quality Issues https://www.jaacap.org/article/S0890-8567(15)00070-2/pdf

Clinical Practice Guidelines Aetna Better Health of Louisiana

Hepatis C	US Preventative Task Force: Hepatitis C Virus Infection in Adolescents and Adults: Screening https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-c-screening
HIV/AIDS	Clinical Care Guidelines and Resources https://hab.hrsa.gov/clinical-quality-management/clinical-care-guidelines-and-resources
Hypertension (HTN)	Guidelines Made Simple|2017 Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults https://www.acc.org/education-and-meetings/image-and-slide-gallery/media-detail?id=BDA0F36F3160426FAB2E784B82E2629A
Immunizations *CDC Guideline*	CDC 2020 Immunizations Schedules https://www.cdc.gov/vaccines/schedules/index.html
Low Back Pain	Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline From the American College of Physicians (2017) https://annals.org/aim/fullarticle/2603228/noninvasive-treatments-acute-subacute-chronic-low-back-pain-clinical-practice?_ga=2.247433220.1028399561.1575492235-1562492790.1557437793
Major Depressive Disorder *APA Guidelines*	Management of Major Depressive Disorder (MDD) (2016) https://www.healthquality.va.gov/guidelines/MH/mdd/
Obesity	Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults: Behavioral Interventions (September 2018) https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/obesity-in-adults-interventions
Opioids for Chronic Pain *CDC Guideline*	CDC Guideline for Prescribing Opioids for Chronic Pain-United States,2016 https://www.cdc.gov/drugoverdose/prescribing/guideline.html
Pediatric Preventative Health Care	American Academy of Pediatrics https://pediatriccare.solutions.aap.org/DocumentLibrary/periodicity_schedule.pdf
Prenatal Services	**May require ACOG membership to access:** https://www.acog.org/About-ACOG/ACOG-Departments/Deliveries-Before-39-Weeks/ACOG-Clinical-Guidelines Prenatal Care, American Family Physician https://www.aafp.org/afp/topicModules/viewTopicModule.htm?topicModuleId=25#0
Preventative Screenings	U.S. Preventive Services Task Force (USPSTF) https://www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations
Schizophrenia	American Psychiatric Association Treatment of Patients with Schizophrenia https://psychiatryonline.org/doi/book/10.1176/appi.books.9780890424841
Sickle Cell Anemia	Evidence-Based Management of Sickle Cell Disease: Expert Panel Report (September 2014) https://www.nhlbi.nih.gov/health-topics/evidence-based-management-sickle-cell-disease

Clinical Practice Guidelines Aetna Better Health of Louisiana

Substance Use Disorder	American Society of Addiction Medicine Consensus Statement — Appropriate Use of Drug Testing in Clinical Addiction Medicine (Reviewed December 2019) https://www.asam.org/docs/default-source/quality-science/appropriate_use_of_drug_testing_in_clinical-1-(7).pdf?sfvrsn=2 American Society of Addiction Medicine Treatment of Opioid Use Disorder https://www.asam.org/docs/default-source/quality-science/npg-jam-supplement.pdf?sfvrsn=a00a52c2_2
Suicide Prevention	US Department of Veterans Affairs Assessment and Management of Patients at Risk for Suicide https://www.healthquality.va.gov/guidelines/MH/srb/
Tobacco Cessation	Cessation Material for State Tobacco Control Programs https://www.cdc.gov/tobacco/quit_smoking/cessation/index.htm Tobacco and Nicotine Cessation During Pregnancy ACOG. Number 807 (May 2020) https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2020/05/tobacco-and-nicotine-cessation-during-pregnancy
Trauma Informed Care	A Treatment Improvement Protocol: Trauma-Informed Care in Behavioral Health Services (2014) https://store.samhsa.gov/product/Trauma-Informed-Care-in-Behavioral-Health-Services/SMA15-4420
Women's Preventative Health Care	Women's Preventive Services Guidelines (Last Reviewed 2017) https://www.hrsa.gov/womens-guidelines-2016/index.html

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Clinical Practice Guidelines Sample

Sickle Cell

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Evidence-Based Management of Sickle Cell Disease

Expert Panel Report, 2014: Guide to Recommendations

U.S. Department of Health and Human Services
National Institutes of Health

National Heart, Lung, and Blood Institute

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www.nhlbi.nih.gov

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Table of Contents

To view the full Expert Panel Report, please visit:
http://www.nhlbi.nih.gov/health-pro/guidelines/sickle-cell-disease-guidelines/

NIH National Heart, Lung,
and Blood Institute

Table of Contents

National Heart, Lung,
and Blood Institute

D.1-14

Aetna Better Health® of Louisiana

Table of Contents

National Heart, Lung,
and Blood Institute

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Chapter 1: Introduction to the Guide to Recommendations

This report was developed by an expert panel composed of health care professionals with expertise in family medicine, general internal medicine, adult and pediatric hematology, psychiatry, transfusion medicine, obstetrics and gynecology, emergency department nursing, and evidence-based medicine. Panel members were selected by the National Heart, Lung, and Blood Institute's (NHLBI's) leadership.

The purpose of this Guide to Recommendations is to provide clinicians with a digital resource of the treatment recommendations extracted from the full report. For more information, please refer to the full report, http://www.nhlbi.nih.gov/health-pro/guidelines/sickle-cell-disease-guidelines/.

Definition of Recommendation Ratings

The expert panel evaluated the existing evidence base and made graded recommendations based on the strength of the evidence. Additional recommendations were based on statements from other organizations (consensus - adapted) or the expert panel (consensus - panel expertise) and are further defined below:

Chapter 1: Introduction to the Guide to Recommendations

Exhibit 4. GRADE Recommendations–A Closer Look

Grade of Recommendation	Clarity of Risk/ Benefit	Quality of Supporting Evidence	Implications
Strong Recommendation High-quality evidence	Benefits clearly outweigh harms and burdens, or vice versa	Consistent evidence from well-performed RCTs or exceptionally strong evidence from unbiased observational studies*	Recommendation can apply to most patients in most circumstances. Further research is very unlikely to change our confidence in the estimate of effect.
Strong Recommendation Moderate-quality evidence	Benefits clearly outweigh harms and burdens, or vice versa	Evidence from RCTs with important limitations (inconsistent results, methodological flaws, indirect or imprecise evidence), or unusually strong evidence from unbiased observational studies	Recommendation can apply to most patients in most circumstances. Further research (if performed) is likely to have an impact on our confidence in the estimate of effect and may change the estimate.
Strong Recommendation Low-quality evidence	Benefits clearly outweigh harms and burdens, or vice versa	Evidence for at least one critical outcome from observational studies, from RCTs with serious flaws, or indirect evidence	Recommendation may change when higher quality evidence becomes available. Further research (if performed) is likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.
Strong Recommendation Very low-quality evidence (very rarely applicable)	Benefits clearly outweigh harms and burdens, or vice versa	Evidence for at least one of the critical outcomes from unsystematic clinical observations or very indirect evidence	Recommendation may change when higher quality evidence becomes available; any estimate of effect, for at least one critical outcome, is very uncertain.

Grade of Recommendation	Clarity of Risk/ Benefit	Quality of Supporting Evidence	Implications
Weak Recommendation High-quality evidence	Benefits closely balanced with harms and burdens	Consistent evidence from well-performed RCTs or exceptionally strong evidence from unbiased observational studies	The best action may differ depending on circumstances or patient or societal values. Further research is very unlikely to change our confidence in the estimate of effect.
Weak recommendation Moderate-quality evidence	Benefits closely balanced with harms and burdens	Evidence from RCTs with important limitations (inconsistent results, methodological flaws, indirect or imprecise evidence), or unusually strong evidence from unbiased observational studies	Alternative approaches likely to be better for some patients under some circumstances. Further research (if performed) is likely to have an important impact on our confidence in the estimate of effect and may change the estimate.
Weak recommendation Low-quality evidence	Uncertainty in the estimates of benefits, harms, and burdens; benefits may be closely balanced with harms and burdens	Evidence for at least one critical outcome from observational studies, from RCTs with serious flaws, or indirect evidence	Other alternatives may be equally reasonable. Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.

Chapter 1: Introduction to the Guide to Recommendations

Grade of Recommendation	Clarity of Risk/ Benefit	Quality of Supporting Evidence	Implications
Weak recommendation Very low-quality evidence	Major uncertainty in the estimates of benefits, harms, and burdens; benefits may or may not be balanced with harms and burdens	Evidence for at least one critical outcome from unsystematic clinical observations or very indirect evidence	Other alternatives may be equally reasonable. Any estimate of effect, for at least one critical outcome, is very uncertain.

Source: Reprinted with permission of the American Thoracic Society. Copyright© 2012 American Thoracic Society. Schünemann HJ, Jaeschke R, Cook DJ, Bria WF, El-Solh AA, Ernst A, Fahy BF, Gould MK, Horan KL, Krishnan JA, Manthous CA, Maurer JR, McNicholas WT, Oxman AD, Rubenfeld G, Turino GM, Guyatt G; ATS Documents Development and Implementation Committee. An official ATS statement: grading the quality of evidence and strength of recommendations in ATS guidelines and recommendations. Am J Respir Crit Care Med. 2006 Sep 1;174(5):605-14. Official Journal of the American Thoracic Society.

* Exceptionally strong evidence from unbiased observational studies includes: (1) evidence from studies that yield estimates of the treatment effect that are large and consistent; (2) evidence in which all potential biases may be working to underestimate an apparent treatment effect, and therefore, the actual treatment effect is likely to be larger than that suggested by the study data; and (3) evidence in which a dose-response gradient exists

Consensus–Panel Expertise

- Systematic reviews conducted by the methodology team revealed minimal or no supporting evidence (e.g., management of acute hepatic sequestration).

- An adequate systematic review of the literature was not feasible because of anticipated low yield or no yield (e.g., comparative effectiveness of management approaches for individuals with SCD presenting with fever or worsening anemia).

- Recommendations were based on the panel's expert knowledge, practice experience, and ability to extrapolate evidence from non-SCD populations (e.g., management of chronic opioid therapy in chronic SCD pain).

Consensus–Adapted

- These recommendations were based on the panel's expert knowledge to adapt recommendations derived from existing guidelines and synthesized evidence developed by other professional societies (e.g., management of acute and chronic pain in SCD).

Chapter 2: Health Maintenance for People With Sickle Cell Disease

Prevention of Invasive Pneumococcal Infection

1. Administer oral penicillin prophylaxis (125 mg for age <3 years and 250 mg for age ≥3 years) twice daily until age 5 in all children with HbSS.
    (Strong Recommendation, Moderate-Quality Evidence)

2. Discontinue prophylactic penicillin in children with HbSS at age 5 unless they have had a splenectomy or invasive pneumococcal infection. When discontinuing penicillin prophylaxis at age 5, it is important to assure that the child has completed the recommended pneumococcal vaccination series, and if not, complete the series immediately.
    (Weak Recommendation, Moderate-Quality Evidence)

3. Consider withholding penicillin prophylaxis from children with HbSC disease and HbSβ+-thalassemia unless they have had a splenectomy.
    (Weak Recommendation, Low-Quality Evidence)

4. Assure that people of all ages with SCD have been vaccinated against Streptococcus pneumoniae.*
    (Strong Recommendation, Moderate-Quality Evidence)

5. Remind people with SCD, their families, and caregivers to seek immediate medical attention whenever fever (temperature greater than 101.3°F or 38.5°C) occurs, due to the risk for severe bacterial infections.
    (Consensus–Panel Expertise)

* Refer to the "Immunization" section of this chapter for comprehensive information on immunizations.

Screening for Renal Disease

1. Screen all individuals with SCD, beginning by age 10, for proteinuria. If the result is negative, repeat screening annually. If the result is positive, perform a first morning void urine albumin-creatinine ratio and if abnormal, consult with or refer to a renal specialist. **(Consensus–Panel Expertise)**

Screening for Pulmonary Hypertension

Based on the insufficient evidence, the expert panel was unable to make a recommendation for or against screening for PH. However, this does not diminish the importance of evaluating individuals who have symptoms or who have had abnormal echo testing.

Electrocardiogram Screening

1. Routine ECG screening is not recommended in children and adults with SCD. **(Weak Recommendation, Low-Quality Evidence)**

Screening for Hypertension

1. In adults with SCD, screen for hypertension and treat to lower systolic blood pressure ≤140 and diastolic blood pressure ≤90 according to "The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure" (JNC 7).
    (Consensus–Adapted)

2. In children with SCD, measure blood pressure, and evaluate and treat hypertension following recommendations from the NHLBI's "Fourth Report on the Diagnosis, Evaluation, and Treatment of High Blood Pressure in Children and Adolescents."
    (Consensus–Adapted)

Screening for Retinopathy

1. In people with SCD, refer to an ophthalmologist for a dilated eye examination to evaluate for retinopathy beginning at age 10.
(Strong Recommendation, Low-Quality Evidence)

2. For people having a normal dilated retinal examination, re-screen at 1–2 year intervals.
(Consensus–Panel Expertise)

3. Refer people with suspected retinopathy to a retinal specialist.
(Consensus–Panel Expertise)

Screening for Risk of Stroke Using Neuroimaging

1. In children with Sickle Cell Anemia (SCA), screen annually with transcranial Doppler ultrasound (TCD) according to methods employed in the STOP studies, beginning at age 2 and continuing until at least age 16.
(Strong Recommendation, Moderate-Quality Evidence)

2. In children with conditional (170–199 cm/sec) or elevated (>200 cm/sec) TCD results, refer to a specialist with expertise in chronic transfusion therapy aimed at preventing stroke.
(Strong Recommendation, High-Quality Evidence)

3. In children with genotypes other than SCA (e.g., HbSβ+-thalassemia or HbSC), do not perform screening with TCD.
(Strong Recommendation, Low-Quality Evidence)

4. In asymptomatic children with SCD, do not perform screening with MRI or CT.
(Moderate Recommendation, Low-Quality Evidence)

5. In asymptomatic adults with SCD, do not perform screening with neuroimaging (TCD, MRI, or CT).
(Moderate Recommendation, Very Low-Quality Evidence)

Screening for Pulmonary Disease

1. In children and adults with SCD, assess for signs and symptoms of respiratory problems (such as asthma, COPD, restrictive lung disease, or obstructive sleep apnea) by history and physical examination.
    (Consensus–Panel Expertise)

2. In children and adults with SCD found to have signs or symptoms of respiratory problems by history and/or physical examination, further assessment, which includes pulmonary function tests, is recommended to determine the cause and develop a plan to address the problem.
    (Consensus–Panel Expertise)

3. Do not screen asymptomatic children and adults with pulmonary function tests.
    (Moderate Recommendation, Low-Quality Evidence)

Reproductive Counseling

Evidence reviews on this topic were not performed by the methodology team. The expert panel based its recommendations on a review of the literature and consensus opinion.

Specific Recommendations for Women or Men With SCD

1. Encourage each woman, man, and couple affected by SCD to have a reproductive life plan.
    (Consensus–Panel Expertise)

2. As a part of primary care visits, provide risk assessment and educational and health promotion counseling (or refer to individuals with expertise in these disciplines) to all women and men of childbearing age to reduce reproductive risk and improve pregnancy outcomes. Provide contraceptive counseling, if desired, to prevent unintended pregnancy, and if pregnancy is desired, provide preconception counseling.
    (Consensus–Panel Expertise)

3.   If the partner of a man or woman with SCD has unknown SCD or thalassemia status, refer the partner for hemoglobinopathy screening.
(Consensus–Panel Expertise)

4.   After testing, refer couples who are at risk for having a potentially affected fetus and neonate for genetic counseling.
(Consensus–Panel Expertise)

Specific Recommendations for Women With SCD

1.   Test women with SCD who have been transfused and are anticipating pregnancy for red cell alloantibodies.
(Consensus–Panel Expertise)

2.   If a woman has red cell alloantibodies, test her partner for the corresponding red cell antigen(s).
(Consensus–Panel Expertise)

3.   If the partner tests positive for the corresponding red cell antigen(s), counsel the woman and her partner about the risks of hemolytic disease in the fetus and neonate, how it is monitored, and how it is treated, or refer them to a maternal-fetal specialist who can provide this education.
(Consensus–Panel Expertise)

4.   Counsel women with SCD and their partners or refer for counseling about the following:
(Consensus–Panel Expertise)

   a.   Pregnancy in women with SCD is considered high risk, and there is an increased risk of adverse pregnancy outcomes including fetal (intrauterine) growth restriction, preterm delivery, and stillbirth.

   b.   Additional fetal surveillance is required during a pregnancy.

c. There are increased risks to a woman's health during pregnancy. These risks include an increased frequency of pain crises and an increased risk of thrombosis, infections, preeclampsia, and death relative to women who do not have SCD.

For women who require chronic opioid therapy during pregnancy, there is an increased risk of neonatal withdrawal in their newborns.

Contraception

Evidence reviews on this topic were not performed by the methodology team. Therefore, the expert panel based its recommendations on those developed by the WHO and the CDC.

1. Progestin-only contraceptives (pills, injections, and implants), levonorgestrel IUDs, and barrier methods have no restrictions or concerns for use in women with SCD. **(Consensus–Adapted)**

2. If the benefits are considered to outweigh the risks, combined hormonal contraceptives (pills, patches, and rings) may be used in women with SCD. **(Consensus–Adapted)**

Clinical Preventive Services

People with existing chronic diseases such as SCD may fail to receive some of the recommended clinical preventive services because they and their health care physicians are focused on controlling and preventing problems from SCD and its related complications or other comorbid chronic diseases. Unfortunately, this primary focus on SCD may result in people developing other health problems that could have been prevented or treated at an earlier stage, when complications are less frequent. With this situation in mind, the expert panel has identified important recommendations from the U.S. Preventive Services Task Force (USPSTF) that should be followed in the care of newborns, children, adolescents, and adults with SCD.

The USPSTF is an independent panel of non-Federal experts in prevention and evidence-based medicine and is composed of primary care clinicians (such as internists, pediatricians, family physicians, gynecologists/obstetricians, nurses, and health behavior specialists). The USPSTF conducts scientific evidence reviews of a broad range of clinical preventive health care services and develops recommendations for the general population in the United States. These recommendations are published in the form of "Recommendation Statements." The recommendations are aimed at the prevention and early recognition of chronic disease.

We have included only the strong recommendations with high-level evidence from the USPSTF and therefore will not address the strength of recommendation or evidence for each of the recommendations listed in exhibit 5. (Please note that these include grade A and B recommendations from the USPSTF. For more information, see http://USPreventiveServicesTaskForce.org.) These general clinical preventive services should be provided to the person with SCD within the patient's principal health care site. This could be a primary care provider, a sickle cell specialist, or, in many instances, both working together and communicating with one another.

Recommendations of the USPSTF are updated on an ongoing basis. Health care professionals are encouraged to view the most up-to-date recommendations at any time by visiting either http://USPreventiveServicesTaskForce.org or by utilizing the searchable and downloadable electronic Preventive Services Selector (ePSS) available at http://www.ePSS.ahrq.gov.

Immunizations

Evidence reviews on this topic were not performed by the methodology team. Therefore, the expert panel based its recommendations on those developed by the Advisory Committee on Immunization Practices (ACIP).

1. All individuals with SCD should receive immunizations according to the ACIP harmonized immunization schedule unless they have a personal contraindication as noted in the ACIP schedule.
    (Consensus–Adapted)

2. Because of their increased susceptibility to invasive pneumococcal disease, all infants with SCD should receive the complete series of the 13-valent conjugate pneumococcal vaccine series beginning shortly after birth and the 23-valent pneumococcal polysaccharide vaccine at age 2 years, with a second dose at age 5 years.*
    (Consensus–Panel Expertise)

* There is strong and clear evidence that pediatric patients should discontinue prophylactic penicillin at age 5 years provided that their immunizations are up to date. However, this would mean they would be at potential risk of infection by invasive pneumococcus if they would have to wait for additional coverage until age 7. The Expert Panel's experience dictates that giving the second dose at age 5 years ensures adequate coverage.

Chapter 3: Managing Acute Complications of Sickle Cell Disease

Vaso-Occlusive Crisis (VOC)

The recommendations labeled "consensus" in this section were based on recommendations developed by the American Pain Society (APS) or on panel expertise. The remaining recommendations are based on the evidence review conducted by the methodology team. These recommendations are intended to be for all settings where patients present with VOC.

1. In adults and children with SCD and pain,
   - When indicated, initiate diagnostic evaluation of causes of pain other than a VOC while beginning to treat pain.
   (Consensus–Adapted)

2. In adults and children with SCD and a VOC,
   - Determine characteristics, associated symptoms, location, and intensity of pain based on patient self-report and observation. If the VOC pain is atypical, investigate other possible etiologies of pain.
   (Consensus–Adapted)

   - Rapidly assess the patient's recent analgesic use (opioid and nonopioid).
   (Consensus–Adapted)

   - Rapidly initiate analgesic therapy within 30 minutes of triage or within 60 minutes of registration.
   (Consensus–Panel Expertise)

- Base analgesic selection on pain assessment, associated symptoms, outpatient analgesic use, patient knowledge of effective agents and doses, and past experience with side effects.
  (Consensus–Adapted)

3. In adults and children with SCD and a VOC,
   - Use an individualized prescribing and monitoring protocol (written by the patient's SCD provider) or an SCD-specific protocol whenever possible to promote rapid, effective, and safe analgesic management and resolution of the VOC.
     (Consensus–Panel Expertise)

4. In adults and children with SCD and a VOC associated with mild to moderate pain who report relief with NSAIDS in the absence of contraindications to the use of NSAIDS, continue treatment with NSAIDS.
   (Moderate Recommendation, Low-Quality Evidence)

5. In adults and children with SCD and a VOC associated with severe pain, rapidly initiate treatment with parenteral opioids.
   (Strong Recommendation, High-Quality Evidence)

6. In adults and children with SCD and a VOC associated with severe pain,
   - Calculate the parenteral (IV or subcutaneous) opioid dose based on total daily short-acting opioid dose currently being taken at home to manage the VOC.
     (Consensus–Panel Expertise)

   - Administer parenteral opioids using the subcutaneous route when intravenous access is difficult.
     (Consensus–Panel Expertise)

   - Reassess pain and re-administer opioids if necessary for continued severe pain every 15–30 minutes until pain is under control per patient report.
     (Consensus–Adapted)

- – Maintain or consider escalation of the dose by 25 percent until pain is controlled. **(Consensus–Panel Expertise)**

- – Reassess after each dose for pain relief and side effects. **(Consensus–Panel Expertise)**

- – Initiate around-the-clock opioid administration by patient-controlled analgesia (PCA) or frequently scheduled doses versus "as requested" (PRN) administration. **(Moderate Recommendation, Low-Quality Evidence)**

7. If ordering around-the-clock, continuous infusion of opioids via the PCA, carefully consider whether there is a need to withhold long-acting oral opioids to prevent over-sedation. **(Consensus–Panel Expertise)**

- – If demand dosing only is ordered via the PCA, continue use of long-acting oral opioids. **(Consensus–Panel Expertise)**

- – At discharge, evaluate inpatient analgesic requirements, wean parenteral opioids prior to conversion to oral opioids, and adjust home dose of long- and short-acting opioid prescriptions to prevent opioid withdrawal after discharge. **(Consensus–Panel Expertise)**

8. In adults and children with SCD and a VOC, do not use meperidine unless it is the only effective opioid for an individual patient. **(Consensus–Adapted)**

9. In adults and children with a VOC, administer oral NSAIDS as an adjuvant analgesic in the absence of contraindications. **(Consensus–Adapted)**

10. In adults and children with a VOC who require antihistamines for itching secondary to opioid administration, prescribe agents orally, and do not re-administer with each dose of opioid in the acute VOC management phase. Re-administer every 4 to 6 hours if needed. **(Consensus–Panel Expertise)**

11. To reduce the risk of acute chest syndrome in adults and children hospitalized for a VOC,
    – Encourage use of incentive spirometry while awake.
       (Strong Recommendation, Moderate-Quality Evidence)

    – Encourage ambulation and activity as soon as possible.
       (Consensus–Panel Expertise)

12. In adults and children with VOC, use adjunctive nonpharmacologic approaches to treat pain such as local heat application and distraction.
    (Consensus–Adapted)

13. In euvolemic adults and children with SCD and a VOC who are unable to drink fluids, provide intravenous hydration at no more than maintenance rate to avoid over-hydration.
    (Consensus–Adapted)

14. In adults and children with SCD and a VOC being treated with opioids, monitor for excessive sedation by measuring sedation with an objective measurement sedation scale and oxygenation levels.
    (Consensus–Panel Expertise)

15. Gradually titrate down parenteral opioids as VOC resolves.
    (Consensus–Panel Expertise)

16. In adults and children with SCD and a VOC, do not administer a blood transfusion unless there are other indications for transfusion (see the chapter "Blood Transfusion in the Management of Sickle Cell Disease" in this report).
    (Moderate Recommendation, Low-Quality Evidence)

17. In adults and children with SCD and a VOC with an oxygen saturation <95 percent on room air, administer oxygen.
    (Consensus–Panel Expertise)

Fever

1. In people with SCD and a temperature ≥101.3°F (38.5°C), immediately evaluate with history and physical examination, complete blood count (CBC) with differential, reticulocyte count, blood culture, and urine culture when urinary tract infection is suspected.
    (Consensus–Panel Expertise)

2. In children with SCD and a temperature ≥101.3 °F (38.5 °C), promptly administer ongoing empiric parenteral antibiotics that provide coverage against Streptococcus pneumoniae and gram-negative enteric organisms. Subsequent outpatient management using an oral antibiotic is feasible in people who do not appear ill.
    (Consensus–Panel Expertise)

3. Hospitalize people with SCD and a temperature ≥103.1 °F (39.5 °C) and who appear ill for close observation and intravenous antibiotic therapy.
    (Consensus–Panel Expertise)

4. In people with SCD whose febrile illness is accompanied by shortness of breath, tachypnea, cough, and/or rales, manage according to the preceding recommendations and obtain an immediate chest x ray to investigate for ACS.
    (Consensus–Panel Expertise)

5. In febrile people with SCD who have localized or multifocal bone tenderness, especially when accompanied by erythema and swelling, include bacterial osteomyelitis in the differential diagnosis and manage accordingly.
    (Consensus–Panel Expertise)

Acute Renal Failure (ARF)

1. In the setting of an acute rise in serum creatinine of ≥0.3 mg/dL,
   – Monitor renal function daily, including serum creatinine and fluid intake/output.
     (Consensus–Panel Expertise)

   – Avoid potential nephrotoxic drugs and imaging agents.
     (Consensus–Panel Expertise)

   – Evaluate the patient thoroughly for all potential etiologies in consultation with a nephrologist as needed.
     (Consensus–Panel Expertise)

2. Do not give blood transfusions to treat ARF unless there are other indications for transfusion.
   (Consensus–Panel Expertise)

3. Use renal replacement therapy (e.g., hemodialysis) when needed for acute renal failure.
   (Consensus–Panel Expertise)

Priapism

1. For an episode of priapism lasting 4 hours or longer, initiate interventions to include
   – vigorous oral or intravenous hydration and oral or intravenous analgesia
     (Strong Recommendation, Low-Quality Evidence); and
   – consultation with a urologist who can perform further evaluation and intervention for symptoms which do not remit with initial conservative medical management.
     (Consensus–Panel Expertise)

2. Do not use transfusion therapy for immediate treatment of priapism associated with SCD.
   (Moderate Recommendation, Low-Quality Evidence)

3. Consult with a hematologist for possible preoperative transfusion if surgical intervention is required.
    (Consensus–Panel Expertise)

Hepatobiliary Complications

1. Treat acute cholecystitis in children and adults with SCD with antibiotics and surgical consultation.
    (Consensus–Panel Expertise)

2. Treat asymptomatic gallstones with watchful waiting in children and adults with SCD. In those who develop symptoms specific to gallstones, treat with cholecystectomy. The laparoscopic approach is preferred if surgically feasible and available.
    (Strong Recommendation, Moderate-Quality Evidence)

3. Consult with a hematologist or sickle cell expert for possible preoperative transfusion if surgical intervention is required.
    (Consensus–Panel Expertise)

4. In children and adults with SCD and signs and symptoms of AHS or AIC, provide hydration, rest, close observation, and consult a sickle cell expert for further management.
    (Consensus–Panel Expertise)

5. In children and adults with SCD and signs and symptoms of possible AHS or severe AIC, obtain urgent consultation with a sickle cell disease expert for diagnosis confirmation.
    (Consensus–Panel Expertise)

6. In children and adults with SCD with confirmed AHS or severe AIC, perform simple or exchange transfusion.
    (Consensus–Panel Expertise)

Acute Anemia

1. During all acute illnesses in people with SCD, obtain a CBC and reticulocyte count, repeat daily in all hospitalized patients, and compare the results with the patient's prior measurements. **(Consensus–Panel Expertise)**

2. Assess people with SCD whose hemoglobin concentration is 2 g/dL or more below their baseline (or less than 6 g/dL when the baseline is unknown) for acute splenic sequestration, an aplastic episode, a delayed hemolytic transfusion reaction, ACS, and infection. **(Consensus–Panel Expertise)**

3. Use simple transfusion in people with SCD and acute anemia whose symptoms are due to anemia. **(Consensus–Panel Expertise)**

4. Perform a CBC and reticulocyte count promptly and again 7 to 10 days later in siblings and others with SCD who are exposed to a person with an aplastic episode. **(Consensus–Panel Expertise)**

5. Manage aplastic events with immediate red blood cell transfusion aimed at restoring the hemoglobin to a safe (not necessarily baseline) value. Isolation of hospitalized patients (droplet precautions) is required to prevent spread of the parvovirus B19 to pregnant women and others with SCD or compromised immunity. **(Consensus–Panel Expertise)**

Splenic Sequestration

1. In people with hypovolemia due to severe acute splenic sequestration, immediately provide IV fluid resuscitation. **(Strong Recommendation, Low-Quality Evidence)**

2.   In consultation with a sickle cell expert, transfuse people who have acute splenic sequestration and severe anemia to raise the hemoglobin to a stable level, while avoiding over-transfusion.
(Strong Recommendation, Low Quality Evidence)

3.   In consultation with a sickle cell expert, address the performance and timing of splenectomy in people with recurrent acute splenic sequestration or symptomatic hypersplenism.
(Moderate Recommendation, Low-Quality Evidence)

Acute Chest Syndrome

1.   Evaluate people with SCD who develop acute onset of lower respiratory tract disease signs and/or symptoms (cough, shortness of breath, tachypnea, retractions, or wheezing) with or without fever for ACS. This should include a chest x ray and measurement of oxygen saturation by pulse oximetry.
(Consensus–Panel Expertise)

2.   Hospitalize people with ACS.
(Consensus–Panel Expertise)

3.   Treat people with SCD who have ACS with an intravenous cephalosporin, an oral macrolide antibiotic, supplemental oxygen (to maintain oxygen saturation of greater than 95 percent), and close monitoring for bronchospasm, acute anemia, and hypoxemia.
(Strong Recommendation, Low-Quality Evidence)

4.   In people with SCA, give simple blood transfusion (10 mL/kg red blood cells) to improve oxygen carrying capacity to people with symptomatic ACS whose hemoglobin concentration is >1.0 g/dL below baseline. If baseline hemoglobin is 9 g/dL or higher, simple blood transfusion may not be required.
(Weak Recommendation, Low-Quality Evidence)

5. In people with HbSC disease or HbSβ+-thalassemia with ACS, decisions about transfusion should be made in consultation with an SCD expert.
(Strong Recommendation, Low-Quality Evidence)

6. In all persons with SCD, perform urgent exchange transfusion—with consultation from hematology, critical care, and/or apheresis specialists—when there is rapid progression of ACS as manifested by oxygen saturation below 90 percent despite supplemental oxygen, increasing respiratory distress, progressive pulmonary infiltrates, and/or decline in hemoglobin concentration despite simple transfusion.
(Strong Recommendation, Low-Quality Evidence)

7. Encourage use of incentive spirometry while awake.
(Strong Recommendation, Moderate-Quality Evidence)

Acute Stroke

1. In people with SCD who present with severe headache, altered level of consciousness, seizures, speech problems, and/or paralysis, evaluate for acute stroke by seeking neurologic consultation and performing an urgent head computerized tomography (CT) scan followed by magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA) if available.
(Consensus–Panel Expertise)

2. In consultation with a sickle cell expert, perform exchange transfusion in people with SCD who develop acute stroke confirmed by neuroimaging.
(Consensus–Panel Expertise)

3. Initiate prompt evaluation, including neurologic consultation and neuroimaging studies, in people with SCD who have mild, subtle, or recent history of signs or symptoms consistent with transient ischemic attack.
(Consensus–Panel Expertise)

4. In children and adults who have had a stroke, initiate a program of monthly simple or exchange transfusions.
(Moderate Strength, Low-Quality Evidence)

5. In children and adults who have had a stroke, if it is not possible to implement a transfusion program, initiate hydroxyurea therapy.
(Moderate Strength, Low-Quality Evidence)

Multisystem Organ Failure

1. In people with SCD who exhibit severe deterioration during a VOC, immediately evaluate for potential MSOF.
(Consensus–Panel Expertise)

2. In people with SCD and respiratory failure, support respiratory status with supplemental oxygenation and mechanical ventilation when needed.
(Consensus–Panel Expertise)

3. Use renal replacement therapy (e.g., hemodialysis) when needed for acute renal failure.
(Consensus–Panel Expertise)

4. In people with SCD and MSOF, immediately initiate either simple or exchange transfusion in consultation with a sickle cell expert or hematologist.
(Consensus–Panel Expertise)

Acute Ocular Conditions

1. Immediately examine for hyphema anyone with SCD who presents with eye trauma. If hyphema is present, immediately refer to an ophthalmologist for further management. **(Consensus–Panel Expertise)**

2. Promptly refer anyone with SCD exhibiting signs and symptoms such as protrusion of the eye, changes in visual acuity (flashers or floaters), and unilateral or bilateral loss of vision to an eye specialist capable of performing a dilated eye exam to assess visual acuity, intraocular pressure, and the peripheral retina. **(Consensus–Panel Expertise)**

3. Manage acute ocular complications in consultation with an ophthalmologist, hematologist, and other specialists with expertise in SCD. **(Consensus–Panel Expertise)**

Chapter 4: Managing Chronic Complications of Sickle Cell Disease

Chronic Pain

1. Determine the cause and type of SCD-related chronic pain. This includes chronic pain with objective signs such as avascular necrosis (AVN) and leg ulcers, and chronic pain without objective signs due to neuroplasticity of the peripheral or central nervous system.
   (Consensus–Adapted)

2. Use a combination of the patient's response to treatment—including pain relief, side effects, and functional outcomes—to guide the long-term use of opioids.
   (Consensus–Adapted)

3. Encourage people to use deep tissue/deep pressure massage therapy, muscle relaxation therapy, and self-hypnosis as indicated.
   (Weak Recommendation, Low-Quality Evidence)

4. Use long- and short-acting opioids to manage chronic pain that is not relieved by nonopioids.
   (Consensus–Adapted)

5. Assess all people with SCD for chronic pain annually or more often as needed. This assessment should include descriptors of the pain; its severity on a numerical scale; its location; factors that precipitate or relieve it, including biopsychosocial factors; and its effect on the patient's mood, activity, employment, quality of life, and vital signs.
   (Consensus–Adapted)

6. Use a partnership agreement leading to a written, individualized treatment plan (to include risks, benefits, and side effects) with the patient if long-term opioids are indicated. The partnership agreement should list the patient's rights and responsibilities, and the treatment plan should list the type, amount, and route of administration of the opioid in question, including random drug urine testing.
(Consensus–Adapted)

7. Appoint one physician or other clinician to write the biweekly to monthly prescriptions for long-term opioids. Refills without seeing the patient should be kept to a minimum, and people on chronic opioid therapy must be evaluated in person every 2–3 months.
(Consensus–Adapted)

8. Document all encounters with a patient, including medical history, physical exam, diagnosis, plan of management, type and amount of opioids prescribed and their side effects, if any, and lab data as needed.
(Consensus–Adapted)

9. Encourage people receiving opioids to increase their fluid intake, maintain dietary fiber intake per the current dietary fiber recommendations, and to use stool softeners and bowel stimulant laxatives such as senna and/or docusate as needed.
(Consensus–Adapted)

10. Believe the patient's report of pain and optimize therapeutic outcomes to achieve adequate pain relief and improve the patient's quality of life.
(Consensus–Adapted)

11. Refer patients for evaluation by a mental health professional such as a psychiatrist, social worker, or addiction specialist as needed.
(Consensus–Adapted)

12. Assess all people for other types of non-SCD related chronic pain including postoperative pain, pain due to trauma, pain due to therapy, iatrogenic pain, and pain due to comorbid conditions.
(Consensus–Adapted)

Avascular Necrosis

1. Evaluate all children and adults with SCD and intermittent or chronic hip pain for AVN by history, physical exam, radiography, and MRI as needed.
   (Strong Recommendation, Low-Quality Evidence)

2. Treat AVN with analgesics and consult physical therapy and orthopedics for assessment and followup.
   (Strong Recommendation, High-Quality Evidence)

3. Refer symptomatic patients with advanced stages of AVN to an orthopedic surgeon and SCD specialist for evaluation and possible hip arthroplasty.
   (Consensus–Panel Expertise)

Leg Ulcers

1. Inspect the lower extremities during physical examination for active or healed ulcers, record their number, and measure their depth.
   (Weak Recommendation, Low-Quality Evidence)

2. Treat leg ulcers in patients with SCD with initial standard therapy (i.e., debridement, wet to dry dressings, and topical agents).
   (Moderate Recommendation, Low-Quality Evidence)

3. Evaluate people with chronic recalcitrant deep leg ulcers for osteomyelitis.
   (Moderate Recommendation, Low-Quality Evidence)

4. Evaluate possible etiologies of leg ulcers to include venous insufficiency and perform wound culture if infection is suspected or if the ulcers deteriorate.
   (Moderate Recommendation, Low-Quality Evidence)

5. Treat with systemic or local antibiotics if leg ulcer site is suspicious for infection and wound culture is positive and organism susceptible.
    (Moderate Recommendation, Low-Quality Evidence)

6. Consult or refer to a wound care specialist or multidisciplinary wound team for persistent or recalcitrant leg ulcers.
    (Consensus–Panel Expertise)

Pulmonary Hypertension

1. If people with SCD have symptoms or signs suggestive of PH, refer them for echocardiography.
    (Strong Recommendation; Moderate-Quality Evidence)

2. For people with an elevated TRV ≥2.5 m/sec by echocardiography, consult a provider with expertise in pulmonary hypertension to guide further assessment and management, including right heart catheterization, and consideration of PH therapy.
    (Consensus–Panel Expertise)

Renal Complications

1. If microalbuminuria or macroalbuminuria is identified, order a 24-hour urine test for protein.
    (Consensus–Panel Expertise)

2. Refer people with proteinuria (>300 mg/24 hours) to a nephrologist for further evaluation.
    (Strong Recommendation, Low-Quality Evidence)

3. For adults with microalbuminuria without other apparent cause, initiate ACE inhibitor therapy.
    (Moderate Recommendation, Moderate-Quality Evidence)

4. For adults with proteinuria without other apparent cause, initiate ACE inhibitor therapy.
    (Moderate Recommendation, Low-Quality Evidence)

5. For children with microalbuminuria or proteinuria, consult a nephrologist.
    (Consensus–Panel Expertise)

6. Consider patients with SCD with modest elevations of serum creatinine (>0.7 mg/dL in children, >1.0 mg/dL in adults) to have renal impairment and refer to a nephrologist for further evaluation.
    (Consensus–Panel Expertise)

7. Give ACE inhibitor therapy for renal complications when indicated even in the presence of normal blood pressure.
    (Moderate Recommendation, Low-Quality Evidence)

8. Renal replacement therapy (e.g. hemodialysis, peritoneal dialysis, and renal transplantation) should be used in people with SCD if needed.
    (Strong Recommendation, Low-Quality Evidence)

Stuttering/Recurrent Priapism

1. In men and boys with SCD and recurrent or stuttering priapism, offer evaluation and treatment in consultation with a sickle cell disease specialist and a urologist, especially when episodes increase in severity or frequency.
    (Weak Recommendation, Low-Quality Evidence)

Ophthalmologic Complications

1. Refer persons of all ages with Proliferative Sickle Retinopathy (PSR) to an ophthalmologist for evaluation and possible laser photocoagulation therapy.
    (Strong Recommendation, Moderate-Quality Evidence)

2. Refer children and adults with vitreoretinal complications of PSR refractory to medical treatment for evaluation and possible vitrectomy.
    (Strong Recommendation, Low-Quality Evidence)

Chapter 5: Hydroxyurea Therapy in the Management of Sickle Cell Disease

1. Educate all patients with SCA and their family members about hydroxyurea therapy. **(Consensus–Panel Expertise)**

2. In adults with SCA who have three or more sickle cell-associated moderate to severe pain crises in a 12-month period, treat with hydroxyurea. **(Strong Recommendation, High-Quality Evidence)**

3. In adults with SCA who have sickle cell-associated pain that interferes with daily activities and quality of life, treat with hydroxyurea. **(Strong Recommendation, Moderate-Quality Evidence)**

4. In adults with SCA who have a history of severe and/or recurrent ACS, treat with hydroxyurea.* **(Strong Recommendation, Moderate-Quality Evidence)**

5. In adults with SCA who have severe symptomatic chronic anemia that interferes with daily activities or quality of life, treat with hydroxyurea. **(Strong Recommendation, Moderate-Quality Evidence)**

6. In infants 9 months of age and older, children, and adolescents with SCA, offer treatment with hydroxyurea regardless of clinical severity to reduce SCD-related complications (e.g., pain, dactylitis, ACS, anemia). **(Strong Recommendation, High-Quality Evidence for ages 9–42 months; Moderate Recommendation, Moderate-Quality Evidence for children >42 months and adolescents).**
    Note: The panel intentionally used the term "offer" realizing that patients' values and preferences may differ particularly considering treatment burden (e.g., laboratory monitoring, office visits), availability of drug in a liquid form, and cost. Therefore, the panel strongly encourages shared decisionmaking and discussion of hydroxyurea therapy with all patients.

7. In adults and children with SCD who have chronic kidney disease and are taking erythropoietin, hydroxyurea therapy can be added to improve anemia.
    (Weak Recommendation, Low-Quality Evidence)

8. In females who are pregnant or breastfeeding, discontinue hydroxyurea therapy.
    (Moderate Recommendation, Very Low-Quality Evidence)

9. To ensure proper use of hydroxyurea and maximize benefits and safety, use an established prescribing and monitoring protocol.
    (Strong Recommendation, High-Quality Evidence)

10. In people with HbS β+-thalassemia or HbSC who have recurrent sickle cell-associated pain that interferes with daily activities or quality of life, consult a sickle cell expert for consideration of hydroxyurea therapy.
    (Moderate Recommendation, Low-Quality Evidence)

11. In people not demonstrating a clinical response to appropriate doses and duration of hydroxyurea therapy, consult a sickle cell expert.
    (Moderate Recommendation, Very Low-Quality Evidence)

* For more information, see the ACS section of the "Managing Acute Complications of Sickle Cell Disease" chapter.

Consensus Treatment Protocol and Technical Remarks for the Implementation of Hydroxyurea Therapy

The following laboratory tests are recommended before starting hydroxyurea:
*   Complete blood count (CBC) with white blood cell (WBC) differential, reticulocyte count, platelet count, and RBC MCV

*   Quantitative measurement of HbF if available (e.g., hemoglobin electrophoresis, high-performance liquid chromatography (HPLC))

- Comprehensive metabolic profile, including renal and liver function tests

- Pregnancy test for women

Initiating and Monitoring Therapy

- Baseline elevation of HbF should not affect the decision to initiate hydroxyurea therapy.

- Both males and females of reproductive age should be counseled regarding the need for contraception while taking hydroxyurea.

- Starting dosage for adults (500 mg capsules): 15 mg/kg/day (round up to the nearest 500 mg); 5–10 mg/kg/day if patient has chronic kidney disease

- Starting dosage for infants and children: 20 mg/kg/day

- Monitor CBC with WBC differential and reticulocyte count at least every 4 weeks when adjusting dosage.

- Aim for a target absolute neutrophil count ≥2,000/uL; however, younger patients with lower baseline counts may safely tolerate absolute neutrophil counts down to 1,250/uL.

- Maintain platelet count ≥80,000/uL

- If neutropenia or thrombocytopenia occurs:
  - Hold hydroxyurea dosing

  - Monitor CBC with WBC differential weekly

  - When blood counts have recovered, reinstitute hydroxyurea at a dose 5 mg/kg/day lower than the dose given before onset of cytopenias

- If dose escalation is warranted based on clinical and laboratory findings, proceed as follows:
    - Increase by 5 mg/kg/day increments every 8 weeks

    - Give until mild myelosuppression (absolute neutrophil count 2,000/uL to 4,000/uL) is achieved, up to a maximum of 35 mg/kg/day.

- Once a stable dose is established, laboratory safety monitoring should include:
    - CBC with WBC differential, reticulocyte count, and platelet count every 2–3 months

- People should be reminded that the effectiveness of hydroxyurea depends on their adherence to daily dosing. They should be counseled not to double up doses if a dose is missed.

- A clinical response to treatment with hydroxyurea may take 3–6 months. Therefore, a 6-month trial on the maximum tolerated dose is required prior to considering discontinuation due to treatment failure, whether due to lack of adherence or failure to respond to therapy.
    - Monitor RBC MCV and HbF levels for evidence of consistent or progressive laboratory response.

- A lack of increase in MCV and/or HbF is not an indication to discontinue therapy.

- For the patient who has a clinical response, long-term hydroxyurea therapy is indicated.

- Hydroxyurea therapy should be continued during hospitalizations or illness.

Chapter 6: Blood Transfusion in the Management of Sickle Cell Disease

Indications for Transfusion
Prophylactic Perioperative Transfusion

1. In adults and children with SCA, transfuse RBCs to bring the hemoglobin level to 10 g/dL prior to undergoing a surgical procedure involving general anesthesia.
    (Strong Recommendation, Moderate-Quality Evidence)

2. In patients with HbSS disease who require surgery and who already have a hemoglobin level higher than 8.5 g/dL without transfusion, are on chronic hydroxyurea therapy, or who require high-risk surgery (e.g., neurosurgery, prolonged anesthesia, cardiac bypass), consult a sickle cell expert for guidance as to the appropriate transfusion method.
    (Strong Recommendation, Low-Quality Evidence)

3. In adults and children with HbSC or HbSβ+-thalassemia, consult a sickle cell expert to determine if full or partial exchange transfusion is indicated before a surgical procedure involving general anesthesia.
    (Moderate Recommendation, Low-Quality Evidence)

Recommendations for Acute and Chronic Transfusion Therapy

Exhibit 14. Acute Complications—Graded Recommendations To Transfuse

Indication	How To Transfuse	Quality of Evidence	Strength of Recommendation
Symptomatic acute chest syndrome (ACS) combined with a decreased Hb of 1 g/dL below baseline	Simple transfusion	Low	Weak
Symptomatic severe ACS (as defined by an oxygen saturation less than 90% despite supplemental oxygen)	Exchange transfusion	Low	Strong
Acute splenic sequestration plus severe anemia	Simple transfusion	Low	Strong
Stroke	Simple or exchange transfusion	Low	Moderate

Exhibit 15. Acute Complications—Consensus Recommendations To Transfuse

Indication	How To Transfuse
Hepatic sequestration	Exchange or simple transfusion
Intrahepatic cholestasis	Exchange or simple transfusion
Multisystem organ failure (MSOF)	Exchange or simple transfusion
Aplastic crisis	Simple transfusion
Symptomatic anemia	Simple transfusion

Exhibit 16. Acute Complications—Graded Recommendations When Transfusion Is Not Indicated

Indication	Quality of Evidence	Strength of Recommendation
Uncomplicated painful crisis	Low	Moderate
Priapism	Low	Moderate

Exhibit 17. Acute Complications—Consensus Recommendations When Transfusion Is Not Indicated

Indication
Asymptomatic anemia
Acute kidney injury, unless multisystem organ failure (MSOF)

Exhibit 18. Chronic Complications—Graded Recommendations for When To Initiate a Chronic Transfusion Program

Indication	How To Transfuse	Quality of Evidence	Strength of Recommendation
Child with transcranial Doppler (TCD) reading* >200 cm/sec	Exchange or simple transfusion	High	Strong
Adults and children with previous clinically overt stroke	Exchange or simple transfusion	Low	Moderate

TCD reading is the time averaged mean maximal cerebral blood flow velocity. See section about Screening for Risk of Stroke Using Neuroimaging in the "Health Maintenance for People With Sickle Cell Disease" chapter.

Exhibit 19. Chronic Complications—Graded Recommendations for When Transfusion is Not Indicated

Indication	Quality of Evidence	Strength of Recommendation
Recurrent splenic sequestration	Low	Weak

Appropriate Management/Monitoring

1. RBC units that are to be transfused to individuals with SCD should include matching for C, E, and K antigens.
    (Moderate Recommendation, Low-Quality Evidence)

2. In patients with SCA, who are not chronically transfused and who are therefore at risk for hyperviscosity due to high percentages of circulating HbS-containing erythrocytes, avoid transfusing to a target hemoglobin above 10 g/dL.
    (Moderate Recommendation, Low-Quality Evidence)

3. In chronically transfused children with SCA, the goal of transfusion should be to maintain a HbS level of below 30 percent immediately prior to the next transfusion.
    (Moderate Recommendation, Moderate-Quality Evidence)

4. The expert panel recommends that clinicians prescribing chronic transfusion therapy follow an established monitoring protocol.
    (Moderate Recommendation, Low-Quality Evidence)

Chapter 6: Blood Transfusion in the Management of Sickle Cell Disease

Consensus Protocol for Monitoring Individuals on Chronic Transfusion Therapy

The following is a consensus protocol for the initiation and monitoring of patients on chronic transfusion therapy. It is understood that the recommended testing schedule may not be available to patients everywhere; therefore, this protocol should serve only as a helpful guide for transfusion management.

At Initiation
- Obtain patient treatment history to include locations where prior transfusions were received and any adverse effects.

- Notify the blood bank that the patient being initiated on chronic transfusion therapy has SCD. Ask the blood bank to contact hospitals where the patient reported receiving previous transfusion therapy to obtain transfusion information.

- Obtain a RBC phenotype, type and screen, quantitative measurement of percent HbA and percent HbS, complete blood count (CBC), and reticulocyte count.

- Inform the patient if he or she is alloimmunized, so that this information can be communicated as part of the patient's self-reported medical history.

Suggested Evaluation Before Each Transfusion
- CBC and reticulocyte count—This procedure is done to help guide the frequency and volume of transfusions. It is expected that, with effective chronic transfusion therapy, the patient's bone marrow will be suppressed and the reticulocyte count should decrease, but the value may rise by the time of the next transfusion.

- Quantitative measurement of percent HbA and percent HbS—This procedure is done to confirm the success of chronic transfusion therapy with achieving the target percent of HbS.

- Type and screen—This is done to assess whether the patient has developed any new RBC antibodies from the prior transfusion.

Suggested Periodic Evaluations
- Liver function tests annually or semiannually—These tests are done to follow liver function in individuals with iron overload.

- Serum ferritin (SF) quarterly—This test is done to follow iron stores in individuals with iron overload; it can be helpful in evaluating compliance with chelation.

- Screening for hepatitis C, hepatitis B, and HIV annually.

- Evaluation for iron overload every 1–2 years by validated liver iron quantification methods such as liver biopsy, MRI R2 or MRI T2* or R2 techniques.

Recommendations for the Management and Prevention of Transfusion Complications
Recommendations for Both Children and Adults

1. Obtain patient transfusion history to include locations of prior transfusions and adverse effects.
   (Consensus–Panel Expertise)

2. Ask the blood bank to contact hospitals where patient reported receiving previous transfusion therapy to obtain transfusion information.
   (Consensus–Panel Expertise)

3. RBC units that are to be transfused to individuals with SCD should include matching for C, E, and K antigens.
   (Moderate Recommendation, Low-Quality Evidence)

4. Consult the blood bank for a workup of a possible DHTR in a patient with any of the following signs or symptoms: acute anemia, pain, or jaundice within 3 weeks after a blood transfusion.
   (Strong Recommendation, Moderate-Quality Evidence)

5. In patients with SCA who are not chronically transfused and who are therefore at risk for hyperviscosity, avoid transfusing to a target hemoglobin above 10 g/dL (unless the patients are already on chronic transfusions or have low percent HbS levels). **(Moderate Recommendation, Low-Quality Evidence)**

6. In patients who receive chronic transfusion therapy, perform serial assessment of iron overload to include validated liver iron quantification methods such as liver biopsy, or MRI R2 or MRI T2* and R2* techniques. The optimal frequency of assessment has not been established and will be based in part on the individual patient's characteristics. **(Strong Recommendation, Moderate-Quality Evidence)**

7. Administer iron chelation therapy, in consultation with a hematologist, to patients with SCD and with documented transfusion-acquired iron overload. **(Moderate Recommendation, Moderate-Quality Evidence)**

Quality Response Template
NCQA Ratings
(refer to electronic version)

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NCQA Certificate of Accreditation

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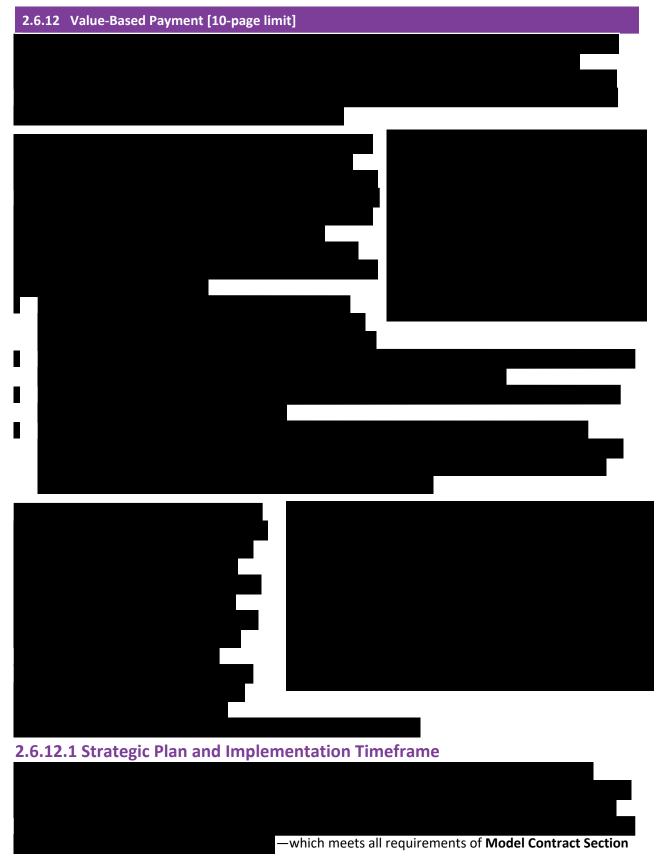## 2.6.12 Value-Based Payment

As an avid supporter of afterschool activities for children of all ages, **ABHLA routinely partners with the Boys & Girls Clubs of Metro Louisiana** to celebrate and recognize all of the hard work the Clubs do throughout the school year. ABHLA CEO Rick Born is a board member of the Baton Rouge Boys & Girls Club and supports several programs for school-aged youth focused on academics, health, and character.
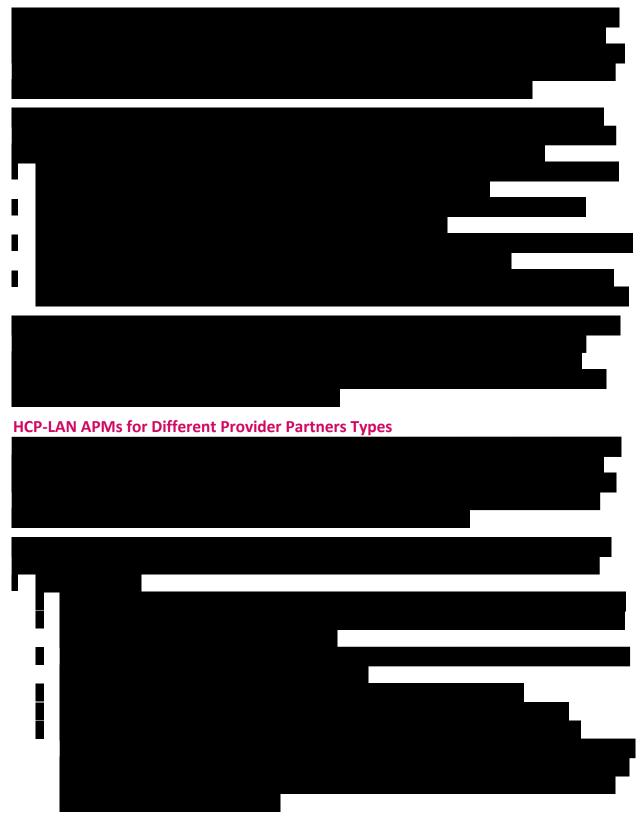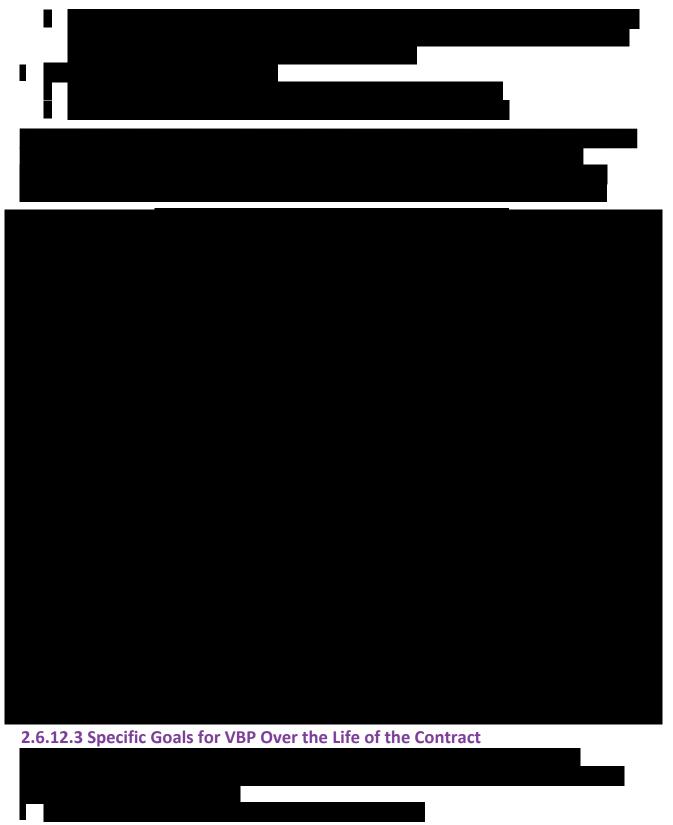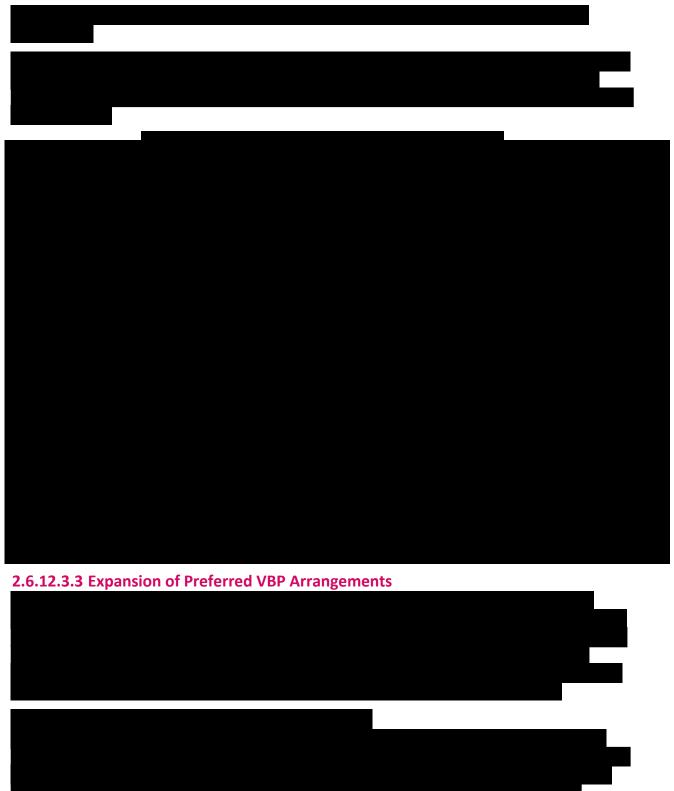
2.6.12   Value-Based Payment [10-page limit]

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2.6.12.1 Strategic Plan and Implementation Timeframe

[REDACTED] —which meets all requirements of **Model Contract Section**

2.17.1 and Louisiana's **MCO Manual and Attachment E—** ████████████████████████
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HCP-LAN APM Models and Implementation Timeframe

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2.6.12.2 Expanding and Enhancing Initial VBP Efforts

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motivation, and feasibility, and (7) Accounting for consumer behavior. Our model builds skills and

Evolution of Provider Partners along the APM Model Continuum

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HCP-LAN APMs for Different Provider Partners Types

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2.6.12.3 Specific Goals for VBP Over the Life of the Contract

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2.6.12.3.1 Specific VBP Models and Arrangements for 2023

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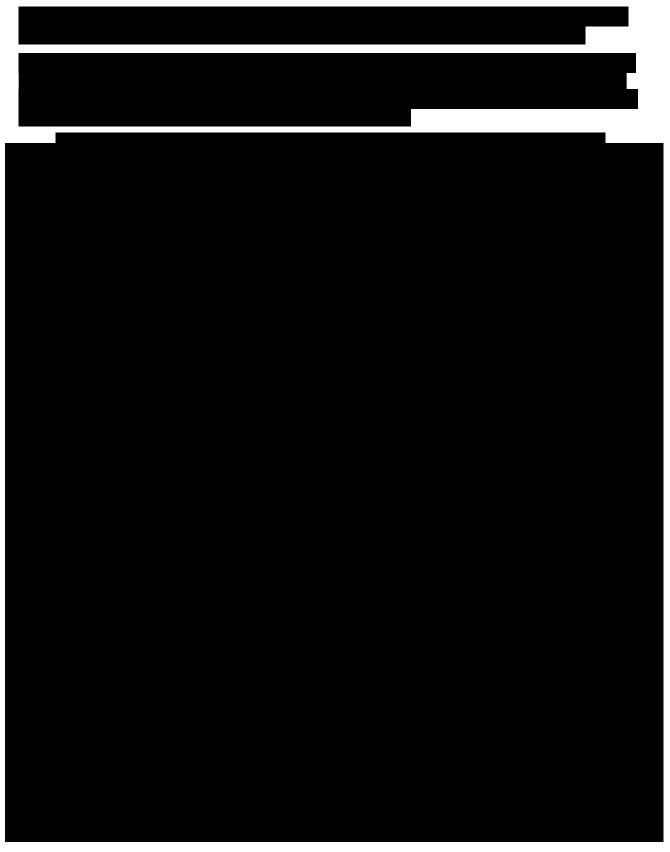
2.6.12.3.2 Improving Clinical Outcomes through VBP Implementation

[redacted]

2.6.12.3.3 Expansion of Preferred VBP Arrangements

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2.6.12.3.4 Supporting Provider Partners in Delivery System Reform

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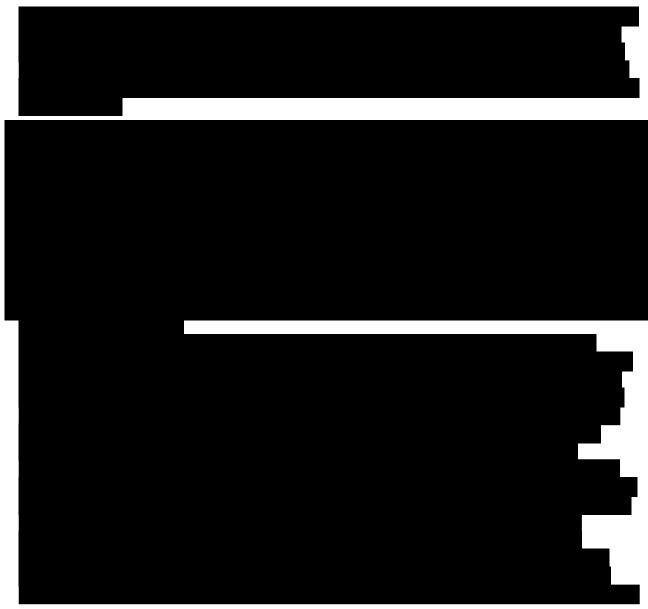
2.6.13 Claims Management and Technical Requirements

ABHLA employees help the members of our community with housing needs through the health plan's collaboration with Habitat for Humanity.

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2.6.13 Claims Management and Systems and Technical Requirements [10-page limit; data flows…

Aetna Better Health® of Louisiana (ABHLA) has been a trusted partner to the Louisiana Department of Health (LDH) since 2015, meeting the requirements of the Louisiana Medicaid program and applicable State regulations and statutes. Our established management information systems (MIS) are customized for Louisiana and positioned to meet the new contractual requirements set forth in this **Request for Proposal (RFP) and Model Contract.** Our flexible systems adjudicate claims timely and accurately, simplify enrollee and provider engagement, and provide seamless external interfaces.

ABHLA will meet or exceed all program requirements, including but not limited to **Section 2.6.13 of the RFP, Model Contract Sections 2.11, 2.18, and 2.19, Part 4 of the MCO Manual,** and all other applicable State policies, statutes, and systems companion guides.

In addition to our system capabilities**, our ABHLA team maintains strong relationships** with LDH and actively engages in State workgroups for administrative simplification, new initiatives, and ongoing Medicaid Management Information System (MMIS) requirements, and stands willing to continue providing thought leadership throughout the duration of this contract. Our fully integrated operational teams have proven to be responsive to LDH's needs and requirements as they evolve over time, providing consistency in trusted points of contact who have a breadth of Louisiana Medicaid experience and knowledge. ABHLA ensures best practice capabilities are customized and integrated to support the Louisiana program while being supported by an organization with national scale. The combined strength of the organization **ensures quality care is delivered efficiently with reduced administrative burden** through our customized Louisiana State-specific systems that meet the needs of LDH, providers, and enrollees.

2.6.13.1. The Proposer should describe how it will customize a Louisiana…

ABHLA operates a customized and standalone system for adjudicating claims to meet the requirements of the Healthy Louisiana Medicaid Program, including Sections 2.18 and 2.19 of the Model Contract, Parts 7 and 8 of the MCO Manual, MCO System Companion Guide, LDH Managed Care Entity Interoperability Compliance Plan, Centers for Medicare & Medicaid Services (CMS) State Medicaid Manual, LDH's Information Security Policy, and State administrative rules and statutes. It is designed to enhance provider administrative simplification while maintaining the integrity of our systems. We maintain our claims processing system in alignment with State requirements through continuous monitoring of our claims payment performance, review of new requirements, and adjusting our highly configurable system accordingly.

In addition to meeting State requirements, we prioritize a seamless experience for providers by configuring our systems in accordance with Louisiana fee schedules, covered services, and MCO and provider manual requirements. Our claims processing system has the flexibility to respond quickly to the needs of LDH when updates occur off-cycle through the MCO Companion Guide, information bulletins, and ad hoc requests. Our claims processing system also contain provider-specific claims payment

requirements included in certain provider contracts. ABHLA's Operations and Systems team documents all policy updates, State communications, and the resulting claims processing system changes in a searchable, interactive software system, which allows us to track historical policy and leverage information across multiple departments and functionalities or other systems and databases.

In 2019, we conducted an in-depth audit of all Medicaid program documentation to ensure alignment to provider manuals, statutes, informational bulletins, system companion guides, fee schedules, and encounter edits. The audit was the first step in our ongoing efforts to enhance alignment across the claims processing system, ensuring ABHLA can accept all new requirements in the **Model Contract** and any initiatives forthcoming from LDH. The audit revealed opportunities to strengthen our claims processing system configuration around Medicaid policy and reduce post-payment audits across the program. For example, we strengthened our editing on behavioral health provider types, specialties, levels of care, and education requirements—which improved our claims payment accuracy and network reporting and reduced our largest driver of encounter denials.

When we receive policy changes from the State, or when ABHLA processes otherwise identify needed changes, we immediately act on them. Our Louisiana-dedicated support staff translate those policy changes into new system configuration requirements and adjust ABHLA's claims processing system. Our team meets daily to ensure ongoing compliance with contractual obligations and change completion times. Every system change project receives a post-production internal audit by the team conducting the change to validate expected outcomes and confirm alignment to policy. ABHLA's Operations and Systems team conducts a post-production review to ensure LDH intent and policy wording are addressed by the changes. In addition, the national Quality Review team conducts an end-to-end audit. Our post-validation concludes once encounters are confirmed and accepted.

Maintaining claims payment policies highly aligned with State requirements supports our business operations to run smoothly. Other business processes such as UM, CM, Customer Service, Grievance and Appeals (G&A), Enrollment, and Encounter reporting benefit from a claims payment system properly configured to meet State requirements on the front end.

We will achieve the requirement (**Model Contract Section 2.18.2.1.3**) to pay or deny 100 percent of clean claims within 30 days with a campaign to increase provider submission of electronic claims
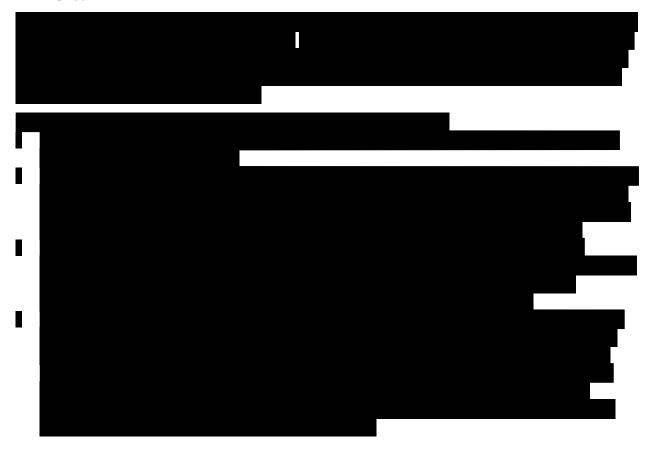
ABHLA understands the importance of our providers receiving timely, accurate payments. Our Claim Quality team conducts monthly prepayment and post-payment audits. These audits do not focus on specific providers or services but are devised to deliver an unbiased view of provider/claims processing activities for a specified time period.

The application of the quality assessment program identifies quality improvement, trending, and training opportunities.

Encounters

(content redacted)

2.6.13.2. The Proposer should describe in detail the Management Information …
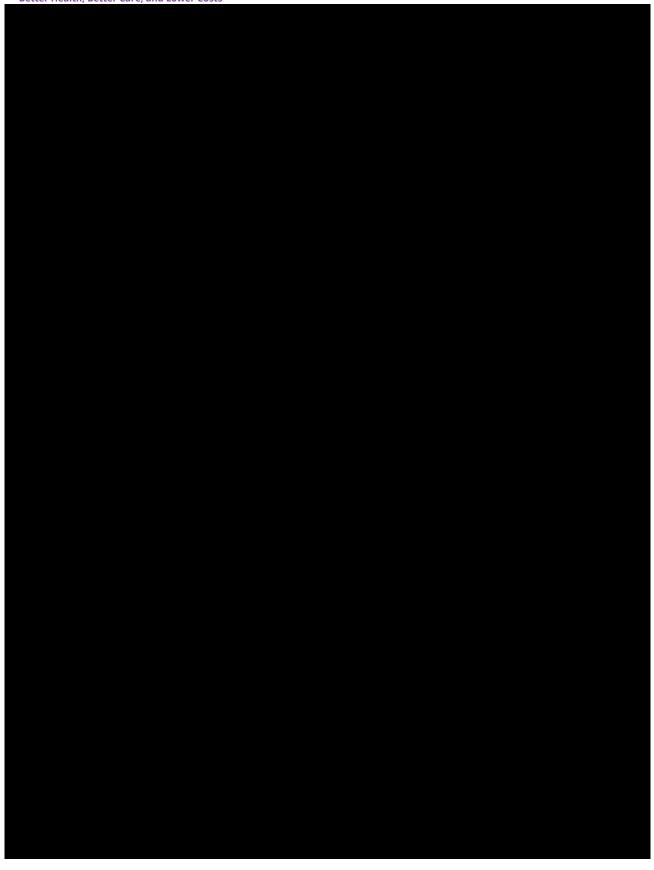
Our information technology solution is a customized, Louisiana-specific solution that supports ABHLA operations. All our systems are designed, maintained, enhanced, or changed in alignment with requirements of the **Model Contract, the MCO Manual, the Louisiana System Companion Guide,** and all State and federal statutes and rules.

2.6.13.2.1 The length of time the Proposer has been utilizing the MIS proposed for…, 2.6.13.2.2 Hardware and system architecture specifications for all systems that…, and 2.6.13.2.3 All proposed functions and data interfaces;

ABHLA has successfully administered our MIS in compliance with **Section 2.19 of the Model Contract** since February 2015. We routinely review the manufacturer's software versioning to be as current as possible. **Table 45** captures our responses to **Sections 2.6.13.2.1 and 2.6.13.2.3**. **Table 46** of the RFP provides a description of our MIS hardware, software, and overall system architecture in response to **Section 2.6.13.2.2** of the RFP.

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2.6.13.2.4 Data and process flows for all key business processes; and

ABHLA supports the integrated, interdependent flow of data within and across systems. The process flows are designed to illustrate how the MIS applications, systems, and platforms directly support the health plan's administrative and clinical operations. Also noted on the process flows are all the touchpoints for the LDH constituents through our platforms and systems of engagement. The following diagrams provide detail regarding data and process flows:

- Enrollee enrollment **(Figure 36)**
- Provider enrollment **(Figure 37)**
- Claims adjudication **(Figure 38)**
- Enrollee customer service **(Figure 39)**
- Provider customer service **(Figure 40)**
- UM **(Figure 41)**
- CM **(Figure 42)**
- Financial processes **(Figure 43)**
- LDH data interfaces **(Figure 44)**

Please note that the colors used through the graphics hold no relational value; they are intended to simply create visual distinction between the platforms.

2.6.13.2.5 Proposed resources dedicated to Medicaid Management Information…

ABHLA handles MMIS exchanges to ensure timely, fully compliant processing of all inbound and outbound files. The team is organized around specific business functions (enrollment, claims and encounters, clinical management, finance and reporting, provider experience, and digital innovations),

which allow our systems to be agile and responsive to the needs of the program. We also have dedicated teams responsible for **each component of our MIS.**

Our managers and support staff work to ensure that MIS processes such as file transfers, enrollment, and claims processing, reporting, and all auxiliary systems are functioning properly and within State guidelines. Our IT staff work closely with the State's subject matter experts to deliver solutions and translate the State's requirements into specific system or process designs for leading-edge solutions. The team coordinates the integration of all infrastructure support areas to ensure required IT resources are appropriately allocated to meet Louisiana's business objectives. As a national organization, we leverage our expertise and scale to ensure world-class system performance, particularly in areas like information security, data integrity, data monitoring, and disaster recovery.

As an example of our direct engagement with LDH MMIS staff, our IT staff participate in a Healthy Louisiana data call every other Thursday to discuss issues that the plans are having with claims and encounters submission. The plans identify categories of claims or encounters that appear to be rejecting inappropriately. State MMIS staff conduct research to determine if there might be a misconfiguration on their end and then report back to the group at a later meeting.

2.6.13.3 The Proposer should describe in detail any system changes or…

Louisiana Department of Health
Louisiana Medicaid Managed Care Organizations
RFP #3000017417

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2.6.13.4 The Proposer should describe the capability and capacity of the Proposer's…

ABHLA follows a secure, proven process for establishing and maintaining all electronic data interchange (EDI) interfaces. Our industry-standard secure File Transfer Protocol servers handle inbound and outbound file exchanges. When establishing a new EDI interface, we collaborate with the State and trading partners to exchange the key information required to establish a secure file exchange connection for both sides. These connections enable the implementation of a wide range of data sharing, including all HIPAA X12 file exchanges. Examples include enrollment (CMS 834), claim payment/advice (835), health care claim and encounter (837I/P/D), prior authorization (278), and capitation premium financial reconciliation (820). In addition, ABHLA supports the exchange of custom file interfaces whenever required by LDH or other subcontractor systems. Aetna is further prepared to bring its national experience interfacing in a single pharmacy benefit manager model to advance the efficiency of the pharmacy program and ensure appropriate enrollee care to benefit the entire Louisiana Medicaid Managed Care Program **(Model Contract Section 2.18.17.5).**

ABHLA accepts and processes daily and weekly (and others as scheduled) enrollment files provided by LDH. We maintain a proprietary rules-processing engine for loading 834 files and reconciling the data with our business application. Our rules-based engine is fully customizable to meet the specific requirements of LDH's enrollment file processing and produces comprehensive statistics reports allowing extensive reporting and monitoring by our Enrollment team.
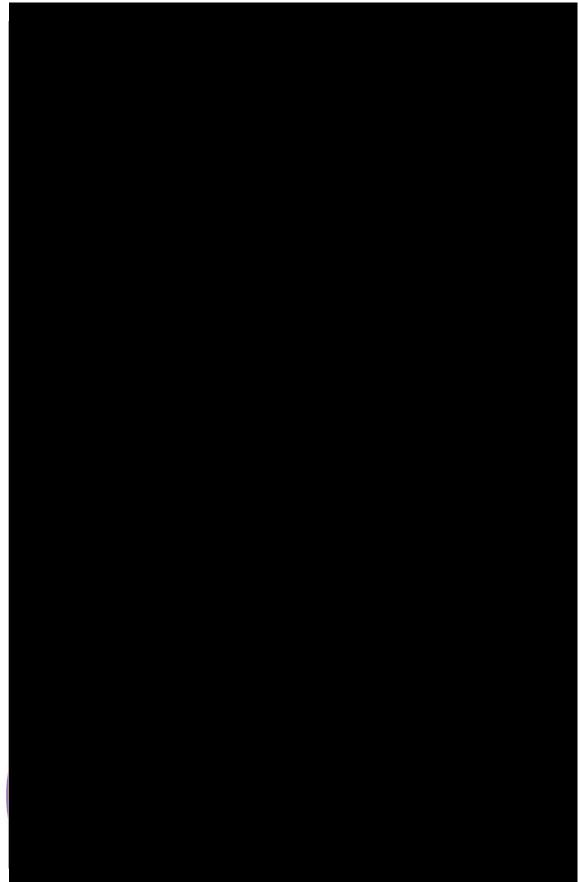
Upon request, authorized LDH users have access to near real-time replicated copies of our production databases (2.19.12) using table level views available through Microsoft SQL Server Management Studio accessible using Structured Query Language. LDH personnel also have access to our extensive API library, which supports the review of specific, granular data sets from the Medicaid Data Hub. Our SSO methodology provides easy and secure access to these systems. For providers, ABHLA supports real-time HIPAA transactions, including eligibility inquiry and response (270/271) and claim inquiry and response (276/277). Additionally, ABHLA continually promotes and adopts different transaction formats and protocols, including HL7, the messaging standard that enables clinical applications to exchange data. For subcontractors, ABHLA accepts weekly encounter files.

We have also recently completed integration with the Louisiana Health Information Network Encounter Notification Service® and are using that data for CM purposes.
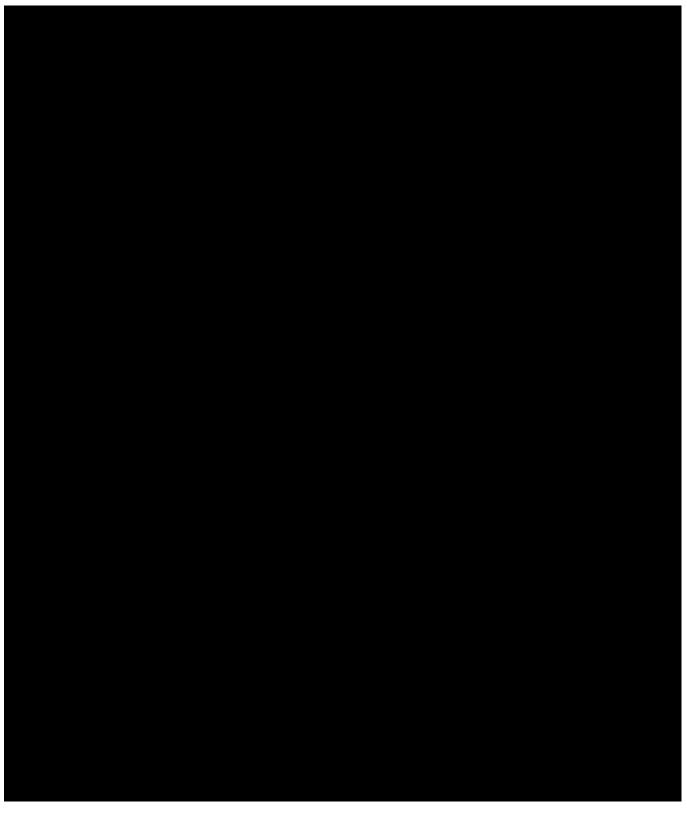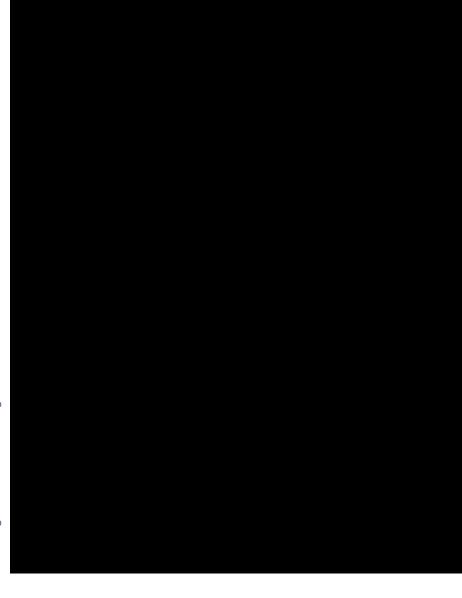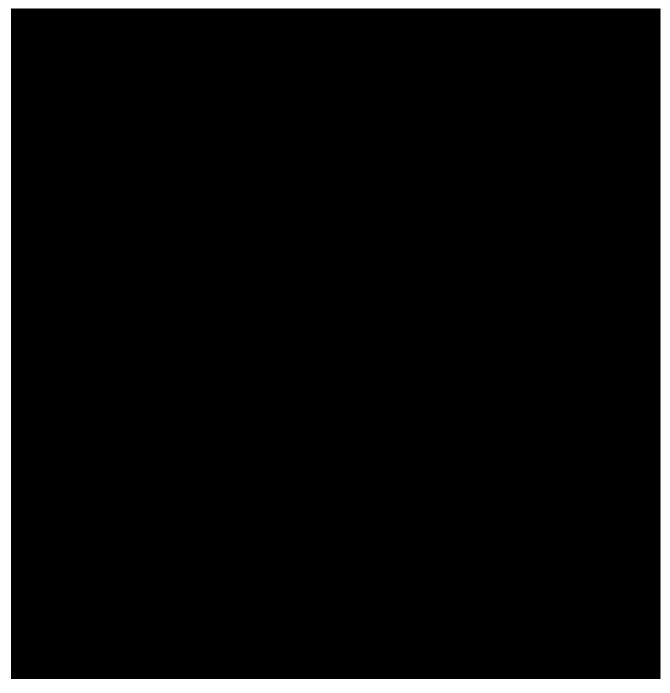
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2.6.14 Program Integrity

Louisiana's breast cancer mortality rate is statistically significantly higher than the rest of the country. ABHLA has promised to bring solutions to our communities and members **by providing resources including access to screenings and treatment, meeting our members where they live, work, and worship.** Through grant funding, the Louisiana Breast & Cervical Health Program will extend its mobile screenings units to uninsured, lower-income women in Louisiana.

2.6.14   Program Integrity [10-page limit]

The Aetna Better Health® of Louisiana (ABHLA) Program Integrity (PI) program ensures we are good stewards of Louisiana Medicaid funds.

2.6.14.1 ABHLA's Proven Program Integrity Program Delivers Results

We work collaboratively with our provider partners.

Figure 46 shows ABHLA's PI program delivers strong results for the Louisiana Department of Health (LDH) and Healthy Louisiana. We have an outstanding local ABHLA team supported by our Aetna national team to successfully lead, staff, and oversee our PI activities.

Leadership, Staffing, Oversight

Chief Compliance Officer (CCO) Emily Byrd and PI Manager (PIM) Garry Williams oversee our PI efforts and both report to Richard C. Born, ABHLA chief executive officer (CEO). Emily Byrd is a lawyer with health care compliance experience, who served with the Honorable Ivan L. R. Lemelle, U.S. District Court Eastern District of Louisiana. Mr. Williams is a seasoned investigator and 38-year law enforcement veteran who is still active part-time with the New Orleans Police Department. He is supported by three Louisiana-based special investigators, Aetna's National Medicaid Special Investigations Unit, Fraud Analytics team, and Medical Economic team. **Figure 47** shows the current PI team. Per **Model Contract Section 2.20.1.10**, we will hire additional full-time investigators located in Louisiana for every 50,000 enrollees, or as needed to support the PI program.

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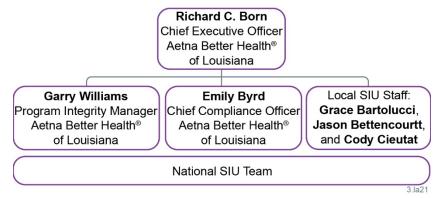
Figure 47: ABHLA's PI Team
Experienced local Louisiana team supported by national infrastructure

ABHLA's SIU is supervised by Riley Varnado, previously a criminal investigator with the Louisiana Medicaid Fraud Unit (MFCU) who was born and raised in Louisiana. Our CCO and PIM oversee monitoring and enforcement of our FWA compliance program according to State and federal rules and regulations. ABHLA's CCO develops and implements policies, procedures, and practices per **Model Contract Section 2.20.2.2.2** and reports directly to the ABHLA CEO and the Board of Directors. Although our CCO will continue to serve as the primary point of contact and meet in person with the LDH to discuss FWA, neglect, and overpayment issues, the CEO, COO, and PIM will continue to attend any LDH PI and the Louisiana Office of the Inspector General's (OIG) MFCU, or other requested LDH meetings per **Model Contract Section 2.20.1.2.**

██ The national SIU team monitors all Aetna lines of business, giving us access to corporate-wide data that includes current FWA trends and schemes discovered in any one of our programs, so we can remain abreast of new trends and have the ability to respond quickly. **Figure 47** shows active engagement from Aetna's national and local senior leaders in the PI oversight.

ABHLA's Fraud, Waste and Abuse Program

Per **Model Contract Section 2.20.1.8,** ABHLA programs and procedures prevent, detect, and report known or suspected FWA activities to safeguard Louisiana Medicaid program funds against unnecessary or inappropriate and improper payments pursuant to 42 CFR 438.60 8 (a)(1). Our prevention, detection, and deterrence of FWA activities adhere to all Louisiana requirements, the U.S. Department of Health and Human Services OIG's Seven Elements of an Effective Compliance Program, as they appear in 42 CFR 438.608(a), and the Model Contract requirements. ABHLA and its subcontractors will comply with these requirements and all applicable federal and State laws, regulations, policies, procedures, and manuals relating to Fraud, Abuse, and Waste, including but not limited to 42 CFR 438.1-438.608; LaRS 46:437.1-437.14; 42 CFR 455.12–455.23; LAC 50:I.4101-4235; and Sections 28,1156, and 1902(a)(68) of the Social Security Act. We execute all Model Contract Part 2 PI requirements including *prevention*—**prepayment claim review** and routing to avoid fraudulent payments; **effective training** of ABHLA staff, enrollees, providers, and subcontractors; **collaboration** with other Aetna health plans, Louisiana managed care organizations (MCOs), LDH, and State and other law enforcement agencies to identify/mitigate FWA risks; ensuring

> Aetna is a founding member of the **National Healthcare Anti-Fraud Association (NHCAA)**, and our SIU staff have access to the NHCAA's Special Investigation Resource Information System (SIRIS) portal. The SIRIS portal allows investigators to review and share information on specific FWA cases.

service authorization processes **uphold standards of conduct**; detection—using proactive **data analysis** and other **risk assessment** techniques to identify providers of interest based on behaviors within their peer groups; **investigation** thoroughly exploring historical/current provider billing/practice behavior; completing investigations of allegations from internal/external sources; **collaborating** with other investigative entities; recovery—working with providers to understand, educate, and pursue recovery **referring cases** to government agencies/law enforcement/legal counsel for civil/criminal prosecution or civil remedies; **responding promptly** to detected offenses and **implementing corrective action**; and reporting and compliance—completing mandated State and federal fraud reports**; maintaining a tracking database to preserve evidence and business records. Figure 48** illustrates ABHLA's PI oversight structure.

Monthly Regulatory Compliance Committee	The CCO chairs the Regulatory Compliance Committee (RCC) required by Model Contract Section 2.20.2.2.4. The RCC comprises senior executive leadership from Medical Management, Quality Management, Health Services, Provider Services, Enrollee Services, the SIU, Operations, Grievance and Appeals, Pharmacy, and Provider Network. Per Model Contract Section 2.20.2.2.5, this committee ensures effective communications between the CCO and the organization's employees so they understand any impacts to their areas and any mitigation or prevention efforts for which they will have a role or function.
Monthly Executive Medicaid Compliance Steering Committee	The Executive Medicaid Compliance Steering Committee (EMCSC) is chaired by ABHLA's CEO and includes senior leadership from all ABHLA business units. The committee oversees Aetna's Medicaid program and ensures, among other things, a 'top down' commitment to compliance to ensure ABHLA meets contractual requirements and federal regulations. ABHLA executives know and understand general and urgent current industry trends and ABHLA's countermeasures.
Monthly ABHLA Fraud, Waste, and Abuse Workgroup	ABHLA holds monthly FWA meetings to address issues and trends, including developing processes and solutions for proactive implementation. Our CEO, CFO, COO, CCO, CMO, PI, pharmacy director, and Aetna's national SIU CMO, director, supervisor, data analyst, SIU investigators, and other staff participate in the FWA monthly meetings.
Monthly Quality Management Oversight Committee	ABHLA's CCO identifies and reports program integrity and FWA issues to the Quality Management Oversight Committee monthly to inform and identify new PI policies and opportunities to identify investigative leads.
Quarterly ABHLA's Board of Directors	ABHLA's CCO identifies and reports program integrity and FWA issues to the board of directors quarterly per Model Contract Section 2.20.2.2.3. The board of directors discusses these issues to identify opportunities to strengthen ABHLA's program integrity.
Weekly PI and SIU Meetings	ABHLA's PI and three local investigators meet a minimum of once a week or more often as needed to exchange ideas and come up with innovative approaches to resolve investigations, schemes, and operations. Louisiana and other regional SIU staff in all of Aetna's Medicaid plans meet weekly with their ABHLA SIU colleagues. Our teams regularly discuss and collaborate on current and potential cases and ways to improve PI and reduce FWA.
Annual (or on request) LDH Readiness Review	ABHLA will submit to LDH or its designee the FWA Compliance Plan as part of readiness review, annually after that, and upon updates or modifications for written approval at least 30 calendar days in advance of making them effective per Model Contract Section 2.20.2.4.

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Figure 48: ABHLA's PI Oversight
Strong local and national leadership oversight of ABHLA

ABHLA submits an annual FWA Plan to the LDH for review and approval 30 days before we make any updates or modifications effective, including any updates requested by LDH per **Model Contract**

Sections 2.20.2.4 and 3.1.9.1.8.25. Our FWA Plan includes staffing, policies and procedures, training and education, auditing and monitoring, controls, comprehensive monitoring, and tools to report FWA. ABHLA and its subcontractors fully cooperate and assist the State and any State or federal agency with identifying, investigating, or prosecuting suspected FWA, including: reporting FWA, giving Louisiana's MFCU access to their place of business, program, and service delivery sites; providing timely, accurate and free access to all program and financial records; and making employees, consultants, subcontractors, and their employees available for interviews, grand jury proceedings, pre-trial conferences, hearings, trials, and other investigative processes. Per **Model Contract Sections 2.20.1.1, 2.20.1.3 through 2.20.1.7, and 2.20.1.9,** our provider enrollment and credentialing process ensure that ABHLA, its subcontractors and providers comply with all federal exclusion and debarment screening requirements (42 CFR Part 1002). Our PI staff participates in all LDH training, activities, and quarterly meetings. ABHLA's FWA policies are designed ensure employees conduct business legally and ethically and prevent, detect, and investigate embezzlement, internal theft, and other forms of employee, provider, subcontractor, or enrollee fraud.

2.6.14.1.1 Employee Training and Awareness Activities

All ABHLA employees complete training that includes content outlined on **Table 47** within 30 days of being hired and annually thereafter. Employees must obtain a passing grade to complete the training. All employees sign ABHLA's Code of Conduct Attestation. **ABHLA publishes our Code of Conduct training on the intranet and on the Compliance and Regulatory Affairs home page.** We provide training and printed manuals, recorded webinars, in-person and virtual town hall meetings, departmental meetings, which are accessible on the Compliance and Regulatory Affairs home page. ABHLA's CCO, PIM, and SIU investigators also develop information to share in employee newsletters, alerts, and FWA activities and trends. We keep track of all employee training by capturing employee names and titles, regulation policies reviewed, and date and time of completion for their annual training, including annual attestation.

Program Integrity and Special Investigations Unit Training

Our CCO, PIM, SIU investigators, and other essential PI staff receive mandatory trainings for all federal and State laws related to Medicaid PI and prevention of FWA per **Model Contract Sections 2.20.1.11, 2.20.1.11.2.3 and 2.20.1.11.2.4**, **2.20.2.2.8 through 2.20.2.2.12, 2.20.2.2.14, 2.20.2.2.15.** PI and SIU must achieve a passing score of 100 percent and if they do not, they are retrained until they successfully meet this standard. ABHLA's specific PI staff training curriculum is listed in **Table 47**. Additionally, ABHLA's PI staff complete both in-person and web-based National Health Care Anti-Fraud Association (NHCAA) industry-specific trainings, including coding clinics, fraud schemes, medical record review strategies, prescription drug fraud schemes, and related FWA prevention topics.
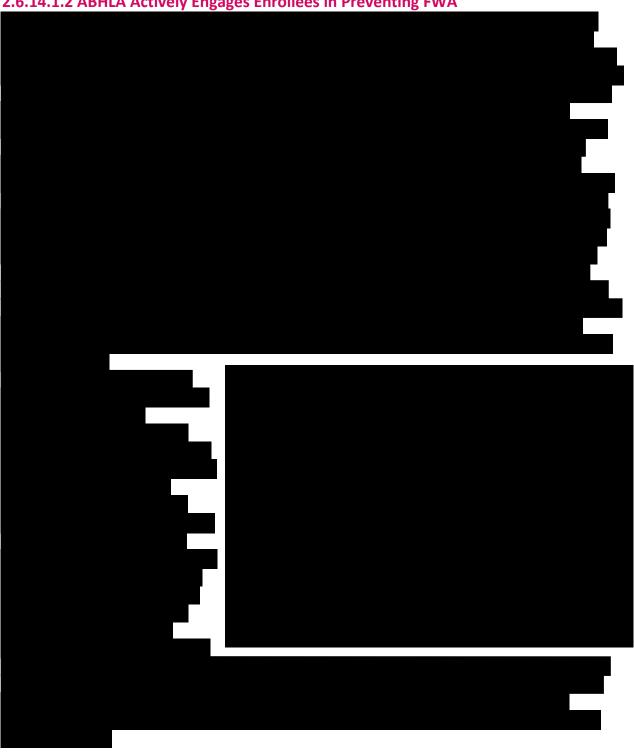
Subcontractor Training and Awareness

All ABHLA subcontractors and their employees are required to receive the same annual training and testing as ABHLA's staff and includes **Table 47**. If a passing grade is not achieved, they are retrained until they successfully meet or exceed this standard. We provide subcontractors training and information in printed manuals, recorded webinars, in-person and virtual meetings, subcontractor reviews, and on the intranet Compliance and Regulatory Affairs home page. We include the required language in **Model Contract Section 2.20.1.12** in all subcontractor contracts and monitor any reporting to identify patterns of FWA. ABHLA's subcontractor oversight process includes a review of the subcontractor's FWA program and verification of their employee FWA training. Documentation on completed subcontractor training includes subcontractor's employee name, title, regulation policies reviewed, date, and education time.
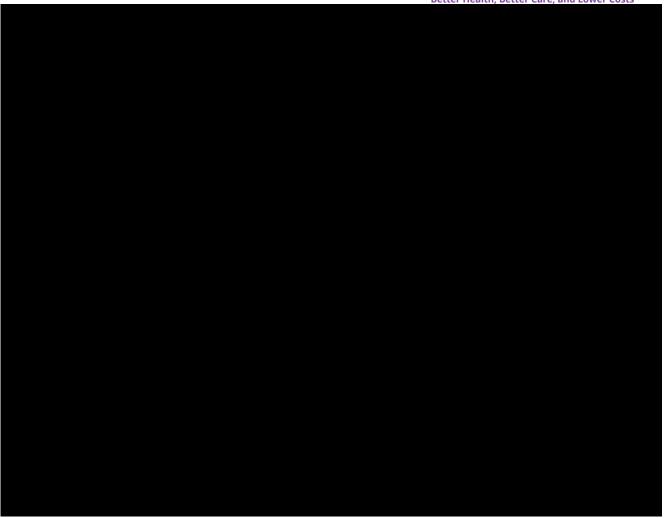
Provider Partner Training and Awareness

2.6.14.1.2 ABHLA Actively Engages Enrollees in Preventing FWA

2.6.14.1.3 Data Analytic Algorithms ABHLA Uses to Detect and Prevent Fraud

2.6.14.1.4 Methods ABHLA Uses to Identify High Risk Claims
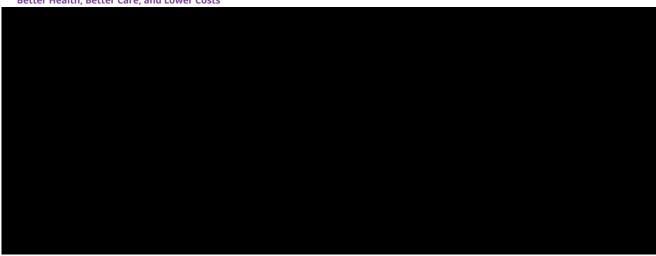
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2.6.14.1.5 ABHLA Provider Recovery Collection Experience

ABHLA monitors claims payment to detect issues with overpayments. When we identify an issue such as an unusual billing pattern, we outreach to our providers in a collaborative and respectful manner requesting documentation of services provided to our enrollee. We value our provider partners and proactively engage and deliver education and training when an overpayment is identified, including the process to rebut findings. ABHLA actively manages and issues prompt reporting of all overpayments identified or recovered due to potential fraud to the State as required by **42 CFR 438.608(a).** We use the LDH MCO enrollee fraud referral template to evaluate an enrollee case to determine if an LDH referral is warranted. Once overpayments are finalized, State notification is made, and approval is received. Payment options are discussed with the provider including direct refund, offset from future claims payment, and a payment plan.

When providers are monitored, next steps like audit, education, or investigation are conducted. In an instance where an investigator cannot validate an allegation, but details of the allegation are substantial, we refer to the LDH Eligibility Fraud Unit and MFCU. Once potential FWA is detected, our CCO oversees the investigative process and report to LDH. After the investigation is complete, we present a final report including any recovery figure to the CCO and Monthly FWA workgroup. The Monthly FWA workgroup reviews the case, approves SIU recommendations, or makes alternate recommendations. If we find a credible fraud allegation at any point in the process, we promptly report to the Louisiana Office of the Attorney General MFCU and LDH as soon as practical, but no later than three business days per **Model Contract Section 2.20.5.1.** For each complaint that warrants full investigation is conducted following **42 CFR 455.15 and 455.16,** ABHLA provides LDH at a minimum the reporting requirements in Model Contract section 2.20.5.4.3 and all its subsections.
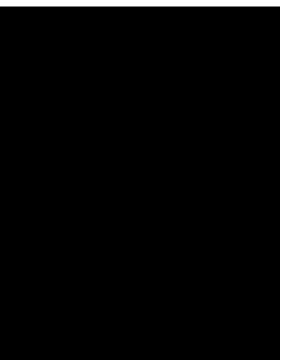
2.6.14.2 Producing Required Reporting and Proposed Innovations for Reporting Data

ABHLA will continue to submit timely reporting to the LDH PI team required in **Model Contract Sections 2.20.5.2 and 2.20.5.3.** We store and query data and generate reports using our proprietary Case Tracker System, which is updated daily. We can generate real-time reports, with detailed information on impacted enrollees, service types, and amounts billed or owed. Reports are produced in a standard State-defined format in an Excel spreadsheet. Our robust data warehouse gives us the ability to query our system using SQL, ODBC, linking, and embedding. ABHLA certifies all statements, reports, and claims, financial and otherwise, as true, accurate, and complete, per **Model Contract Section 2.20.1.7**, applicable federal and State laws, regulations, rules, policies, procedures, and manuals, the State Plan, waivers, contract, and MCO Manual. ABHLA will issue monthly reporting outlined in **Model Contract Section 2.20.5.4**, including the following: number of complaints of fraud, abuse, waste neglect, and overpayments made to the contractor that warrant preliminary investigation (under 42 CFR 455.14); total audits performed, and overpayments identified and recovered by the contractor and all its subcontractors. [See 42 CFR 438.608(d)(3)]; number of complaints reported to the CCO; and, per **Model Contract Section 2.20.5.7**, ABHLA will report overpayments made by LDH to the contractor within 60 calendar days from the date the overpayment was identified; and all unsolicited provider refunds, including any payments submitted to the contractor and its subcontractors by providers for overpayments identified through self-audit.
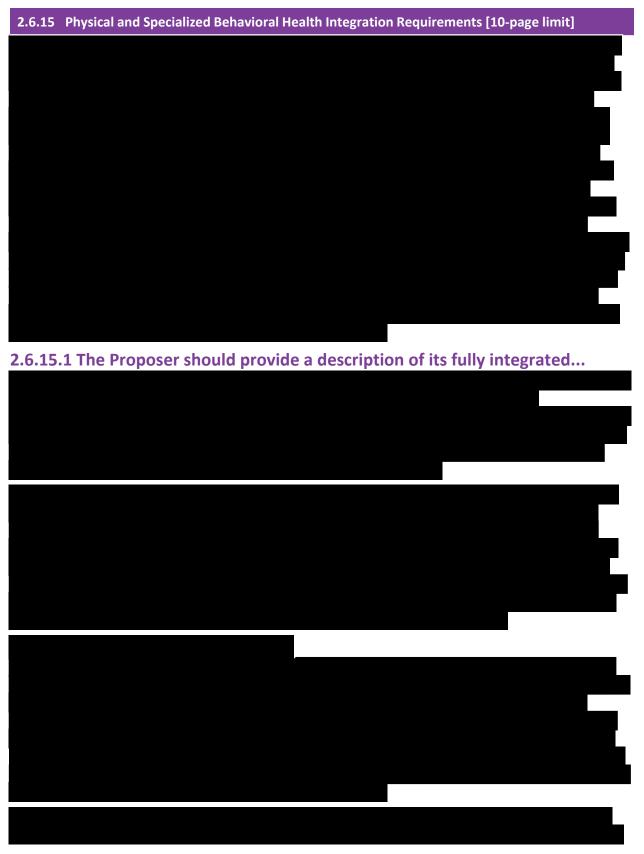
2.6.15 Physical and Specialized Behavioral Health Integration Requirements

ABHLA staff members are Louisianans who are engaged in our communities. The ABHLA Community Development Outreach team participates in events to bring educational and support resources directly to the community.
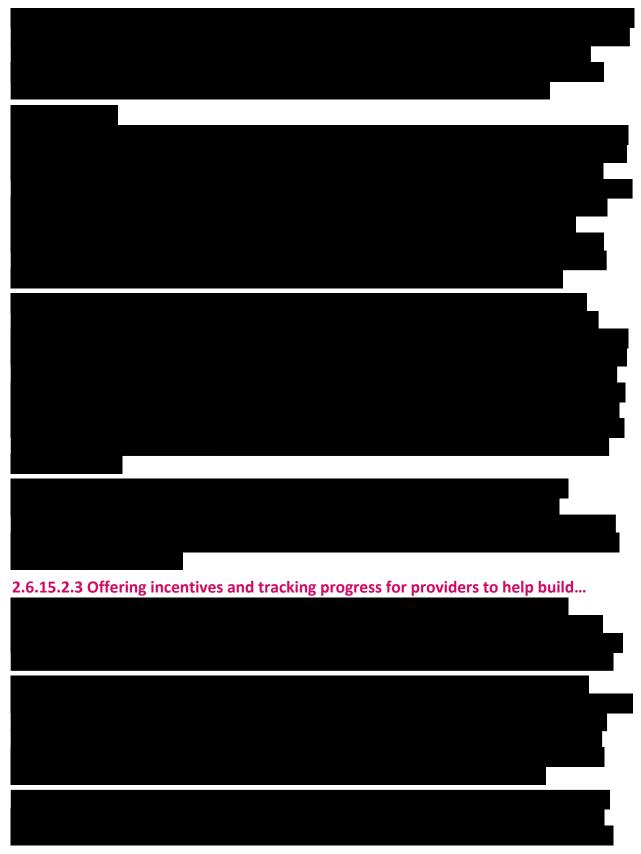
2.6.15   Physical and Specialized Behavioral Health Integration Requirements [10-page limit]

2.6.15.1 The Proposer should provide a description of its fully integrated...

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2.6.15.2.1 Enhancing detection and treatment of behavioral health disorders…

2.6.15.2.2 Coordination of care for enrollees with both medical and behavioral…

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

2.6.15.2.3 Offering incentives and tracking progress for providers to help build…

[REDACTED]

[REDACTED]

[REDACTED]

[black redaction bars]

2.6.15.2.4 Offering tools, guidance and financial incentives to help improve...

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2.6.15.2.6 Ensuring continuity and coordination of care for enrollees who have been…

Appendix E

Louisiana │ Transforming Health Care │ **Aetna**

Appendix E

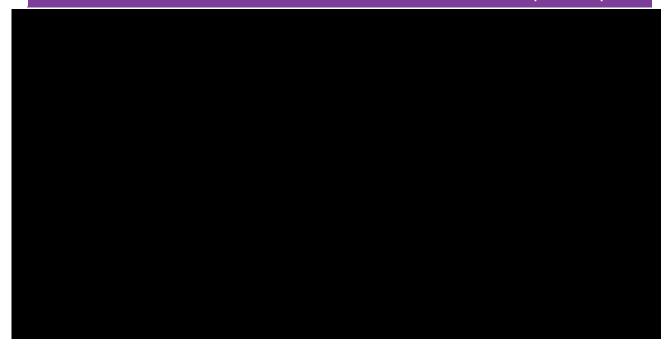# Louisiana Housing Investments

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4.4 Veteran and Hudson Initiatives Response

Working with local community partners and organizations, **ABHLA has allocated philanthropic funds to several initiatives** including outreach to communities of color, support to frontline workers, and local support grants.

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Better Health, Better Care, and Lower Costs

Hudson and Veterans Initiative Response Template
(refer to electronic version)

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