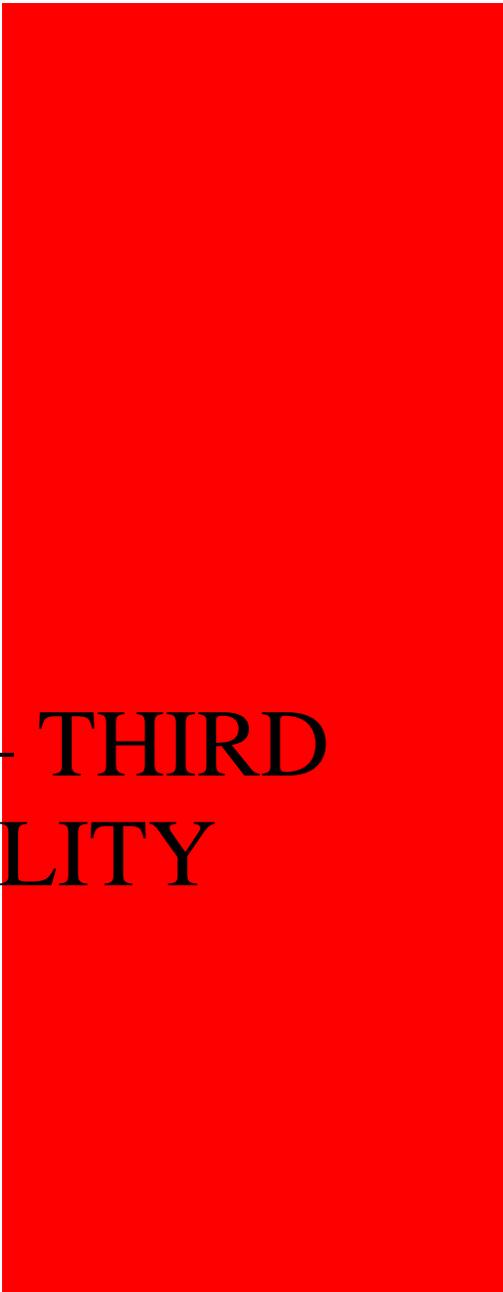
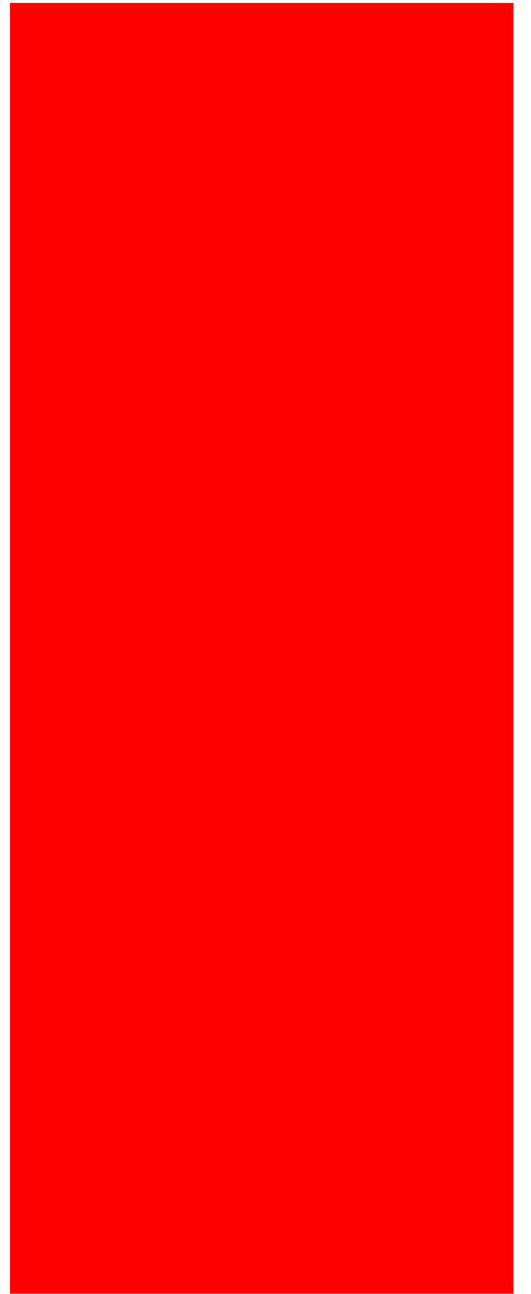


111 SECTION P – THIRD
PARTY LIABILITY



112 P.1



Section P: Third Party Liability (Section §5 of RFP)

P.1 Describe how you will coordinate with DHH and comply with the requirements for cost avoidance and the collection of third party liability (TPL), including:

- How you will conduct diagnosis and trauma edits, including frequency and follow-up action to determine if third party liability exists; (2) How you will educate providers to maximize cost avoidance;
- Collection process for pay and chase activity and how it will be accomplished;
- How subrogation activities will be conducted;
- How you handle coordination of benefits in your current operations and how you would adapt your current operations to meet contract requirements.
- Whether you will use a subcontractor and if so, the subcontractor's responsibilities; and
- What routine systems/business processes are employed to test, update and validate enrollment and TPL data.

In compliance with State and federal regulations, Aetna Better Health[®] has a standard operating procedure to identify and recover funds for which a third party is liable, in order to reduce Medicaid expenditures. These procedures see that costs for services otherwise payable by Aetna Better Health are either (1) cost avoided or (2) recovered from a liable party using post-payment recovery. Member educational materials, including the Member Handbook, remind members of their responsibility to report other health insurance, including employer sponsored insurance, as well as their involvement in any workers' compensation claim, pending personal injury or medical malpractice lawsuit, or involvement in an auto accident. Providers are also educated on third party liability policies, including notification to Aetna Better Health, as further explained below.

Primary Types of Third Party Liability (TPL)

- Private health insurance (handled by the Coordination of Benefits Unit, or COB)
- Employment related health insurance (handled by the COB Unit)
- Automobile insurance (including no-fault insurance)
- State Workers' Compensation
- Court judgments or settlements from a liability insurer
- Medical support from absent parents

The early identification of possible third party liability cases greatly increases Aetna Better Health's ability to effectively research and pursue recovery of medical expenses paid. The following mechanisms are utilized:

- **Internal referrals** - Personnel identify and refer possible TPL case specifics to the TPL Administration Department. All appropriate Aetna Better Health personnel are trained to be aware of TPL considerations and forward notification of possible TPL situations to the TPL Administration Department through a variety of mechanisms.

- Personnel include, but are not limited to: Prior Authorization, Medical Management, Claim Analysts, Finance, Provider Relations, COB unit, and Member Services.
- Referral mechanisms include QNXT™ call tracking, email, fax, phone calls, mail, and/or subpoenas.
- Information received ranges from notification that a member may have a TPL situation based on procedures/diagnoses reported to notification of specific TPL contacts (insurance companies and/or attorneys).
- **Diagnosis Code Report** - A weekly report of claims adjudicated in the prior week with diagnosis codes between 780 and E9999 is run and available every Monday.
- **State Provided TPL Reports/Notifications** – Correspondence and reports produced by state agencies is sent directly to or forwarded to the TPL Administration Department. The TPL Administration Department is located in Phoenix, and is the primary coordinator of TPL activities between the health plan, personnel, management, members, providers, insurance companies (liability), and attorneys.
- **Correspondence received directly from law firms and casualty insurance carrier** – TPL Administration receives lien and claim history inquires directly from attorneys and casualty insurance companies as they try to resolve their cases.

Coordinating TPL Activities with the Louisiana Department of Health and Hospitals (DHH)

Every reasonable effort to determine the legal liability of a third party to pay for services rendered to members shall be undertaken and DHH will be notified, including notification to any DHH third party liability vendors, of any third party creditable coverage discovered. The Enrollment/COB Department also maintains a database of all members with other insurance coverage to allow Aetna Better Health provide a report to DHH on the members who have been identified as having other insurance coverage. Although the Enrollment/COB Department would prefer to submit COB reports electronically via a COB/TPL file on a scheduled basis, the Enrollment/COB Department can also submit information regarding members with other primary insurance coverage via web forms, emails, or faxes. As contractually required, Aetna Better Health will prepare and submit TPL reports to DHH, such as the annual Third Party Liability Collections report, including copies of Form 1099s received from insurance companies for that same period. Other changes in TPL and coverage made known to Aetna Better Health will be forwarded to the DHH via the appropriate technical interface or reporting mechanism established by DHH.

Third Party Liability information will be provided to DHH in the format and medium prescribed by DHH. Aetna Better Health agrees to cooperate, in the manner requested by DHH, with DHH and/or its designated cost recovery vendor, as applicable, and within the established timeframes related to TPL reporting. Should DHH request information (e.g., individual medical records) not included in encounter data submissions, but necessary for the administration of Third Party Liability activity, said information will be provided by Aetna Better Health as contractually required, i.e., within thirty (30) calendar days of DHH's request. At DHH's request, we will demonstrate adherence to reasonable industry standards and practices sufficient to demonstrate

that reasonable effort is exercised in the pursuit, collecting and/or reporting of Third Party Liability and recoveries.

Diagnosis and Trauma Edits

Aetna Better Health maintains claims processing activities that include the application of comprehensive clinical and data related edits supporting the efficient, effective adjudication of claims. QNXT™, our core claims adjudication application, has data related edits configured within its software and is supplemented by two clinical claims editing solutions. The first of the two clinical claims editing solutions, iHealth Technologies' (iHT) Integrated Claims Management Services (ICM Services), applies select payment policies from a standard which provides comprehensive guidelines on correct coding and medical policy content libraries. The second, McKesson's ClaimCheck®, expands upon those capabilities by enabling our claims Management team to define and combine specific claims data criteria, such as provider or diagnosis, to set up unique edits that deliver enhanced auditing power.

The three applications utilize historic and "new day" claims information to detect questionable billing practices, identify fraudulent and abusive billing patterns and outliers of provider billing behavior. Furthermore, inbound claims are initially checked for items such as member eligibility, covered services, existence of other insurance, notations regarding third party liability, excessive or unusual services for gender or age (e.g. "medically unlikely"), duplication of services, prior authorization, invalid procedure codes, and duplicate claims. Claims billed in excess of \$50,000 are automatically pended for review, as are any requiring additional documentation (e.g. medical records) in order to determine the appropriateness of the service provided. Professional claims (CMS 1500s) that reach an adjudicated status of "Pay" are automatically reviewed against nationally recognized standards such as the Correct Coding Initiative (CCI), medical policy requirements [e.g., American Medical Association (AMA)], and maximum unit requirements in accordance with a member's covered services and benefits, with recommendations applied during an automatic re-adjudication process.

Claim Edits

Aetna Better Health uses the QNXT™ information management system, a product of Trizetto Inc., to process Medicaid claims. Over the past decade, Aetna Better Health has made enhancements to QNXT™ and the benefit of our investment is borne out in our claims processing performance and ability to hone in on specific aspects of the claim process. QNXT™ has over 400 business rules that Aetna Better Health's Business Application Management (BAM) Department configures to enforce claims-related Policies and Procedures (P&Ps). The application of specific conditions, customized reporting, call-tracking modalities, subpoena tracking, restrictions, and validation criteria promote the accuracy of claim processing against relevant state standards, such as the identification of and reporting of trauma/accident claims where payment is sought in excess of \$500.

Examples of data edits specific to QNXT™ include the following:

Benefits Package Variations

QNXT™ automatically analyzes CPT, REV, and HCPC codes to determine whether specific services are covered under the contract or benefit rules. If services are not covered, the system

will automatically deny the respective claim line. The claim line will deny with the appropriate HIPAA remittance remark on the EOB.

Data Accuracy

QNXT™ is continually updated based on the most current code sets available (HCPCS, REV, CPT codes) by year. As new codes are added, terminated, or changed, we update the codes in QNXT™ so the system is always in compliance with HIPAA standards. If a network provider bills a code that has been terminated, QNXT™ will deny the claim line and advise the provider the code is invalid via remittance advice.

Adherence to Prior Authorization Requirements

QNXT™ is configured to enforce the supporting documentation requirements of certain services. In addition, QNXT™ has the ability to configure Prior Authorization (PA) by code, provider type, and place of service. QNXT™ is configured to automatically identify certain types of authorizations for Medical Director review. Claim edit rules are set to validate the claim against the network provider, member, dates of service, services rendered, and units authorized.

Provider Qualifications

QNXT™ provider files are configured by specialty and category of service. This allows for the enforcement of categories of service and provider type on claims validation. Certain procedures can only be performed by select network provider types. For example, QNXT™ will not permit the processing of a claim for in-office heart surgery by a podiatrist. iHealth lends additional support in this regard, reviewing any claim line set to “Pay” for billing appropriateness by specialty. QNXT™ checks other provider-specific items as well, verifying, for example, that each provider has obtained the requisite National Provider Identifier (NPI) or its equivalent and included the identifier on all claims submissions.

Member Eligibility and Enrollment

QNXT™ validates the date of service against the member’s enrollment segment to determine if the member was eligible on the date of service. If the member was not eligible on the date of service, the system will automatically deny the claim using the appropriate HIPAA approved remittance comment.

Duplicate Billing Logic

QNXT™ uses a robust set of edits to determine duplication of services. Examples are same member, same date, same network provider, same service, or any combination of these criteria. In addition, claim lines set to “Pay” are subjected to iHealth’s duplicate logic.

ClaimCheck® Edits

ClaimCheck® is a comprehensive code auditing solution that supports QNXT™ by applying expert industry edits from a provider recognized knowledge base to analyze claims for accuracy and consistency. ClaimCheck® clinical editing software identifies coding errors in the following categories:

- Procedure unbundling
- Mutually exclusive procedures
- Incidental procedures

- Medical visits, same date of service
- Bilateral and duplicate procedures
- Pre- and post-operative care
- Assistant Surgeon
- Modifier Auditing
- Medically Unlikely

Examples of edits iHealth Technologies' (iHT) Integrated Claims

Management Services (ICM Services):

iHealth Edits

iHealth clinically edits claims to assist in promoting the proper and fair payment of professional durable medical equipment and outpatient claims.

Coding Accuracy

If the services are up-coded, or unbundled, iHealth will alert the Claims Department to deny the claim line along with the specific clinical editing policy justification for the denial. The claim line will deny with the appropriate HIPAA remittance remark on the Explanation of Benefits (EOB).

Duplicate Billing Logic

In addition, claim lines set to “Pay” are subjected to iHealth’s duplicate logic. This logic protects against Aetna Better Health paying for services rendered by the same physician or other physicians within the same provider group.

Durable Medical Equipment (DME) Editing

iHealth Technologies' (iHT) performs edits related to select DME payment policies that align with the applicable covered service policies of a given population. These DME edits include but are not limited to; DME rentals, oxygen and oxygen systems, hospital beds and accessories, external infusion pumps and anatomic/functional modifiers required for DME services.

Procedure Code Guidelines - iHealth

Aetna Better Health follows the AMA CPT-4 Book and CMS HCPCS Book, which both provide instructions regarding code usage. iHT has developed these guidelines into edits. For example, if a vaccine administration code is billed without the correct vaccine/toxoid codes, staff would then deny the code as inappropriate coding based on industry standards. According to the AMA CPT Book, this vaccination must be reported in addition to the vaccine and toxoid code(s).

Procedure Code Definition Policies - iHealth

iHT supports correct coding based on the definition or nature of a procedure code or combination of procedure codes. These editing policies will either bundle or re-code procedures based on the appropriateness of the code selection. For example, if a provider attempts to unbundle procedures, iHT will apply editing logic that will bundle all of the procedures billed into the most appropriate code. For example, if a provider bills an office visit and also bills separately for heart monitoring with a stethoscope at the same visit, iHT will rebundle the service into the appropriate E&M or office code.

Fraud & Abuse

Aetna Better Health's Fraud and Abuse Department, under the direction of the Chief Operating Officer (COO), utilizes claims payment tracking and trending reports, claims edits, audits, and provider billing patterns as indicators of potential fraud and abuse. The Fraud and Abuse Department uses this information to detect aberrant provider billing behavior, prompting additional analysis and investigation. Aetna Better Health's Compliance Officer works in conjunction with the Provider Services and Compliance Departments to address the questionable behavior(s) through provider education and outreach.

Trauma and Diagnosis Code Identification Functions

Aetna Better Health uses a suite of tools, including but not limited to, regularly scheduled and ad hoc reports to monitor claim receipts, automated claims processing, manual claims adjudication, TPL/COB activity, identify trauma/diagnosis and check and remittance advice production/distribution. Sample reports used to monitor claims include, but are not limited to, the following:

- ***Pended Claims Audit by Provider or Age***: Includes all claims that fail auto adjudication or are suspended for manual review.
- ***Pended Claims and Aging Report***: Allows Management to intervene and improve accurate and timely adjudication of claims.
- ***Unfinished Claims Report***: Identifies all claims by age and processing status category (e.g., open, pay, deny, pend, reverse).
- ***In-Process Claims Reports*** – Allows Management to track and manage claims in process so that needed interventions may be applied to improve the accuracy and timeliness of claim adjudication process.
- ***Diagnosis Code Report***: Identifies targeted diagnosis codes in support of various reporting and operational requirements.
- ***Denial Analysis***: Trends denied claims with corresponding reason for the denial.
- ***Claims Production***: Monitors daily, weekly, and monthly manual and auto adjudication production.
- ***Claims Performance Reporting***: Monitors turnaround time for clean claims over selected periods.
- ***Quality Review Statistics***: Reports by individual and plan as well as error frequency.

Aetna Better Health identifies trauma claims and related diagnosis through the “diagnosis Code Report. This report is reviewed and audited in fulfillment of contractual obligations related to trauma claims. Note that the Diagnosis Code Report is run on a weekly basis regarding all claims adjudicated in the prior week with diagnosis codes between 780 and E999.9. Trauma related cases are reported in accordance with the Department of Health and Hospital's requirements and for the established codes. Trauma code edits, applied during claims adjudication, utilize diagnostic codes 780 through 999.9 (excluding code 994.6) and other applicable trauma codes (including but not limited to E Codes) to identify additional instances of potential Third Party Liability. The flexibility of the reporting system accommodates updates to

the reporting layout to account for addition, deletions, or replacement of the pre-determined codes.

Provider Cost Avoidance Education

Aetna Better Health utilizes informational and educational tools to raise provider awareness of cost avoidance. These tools include, but are not limited to, the following:

- **Provider Manual** – The provider manual contains information and instructions explaining coordination of benefits, third party liability, subrogation and other cost-avoidance or coordination activities.
- **Provider Claim Reference Materials** – Claims reference materials include information about regarding cost avoidance.
- **Provider Newsletters** – Provider newsletters provide an on-going source of training on claims (and other) topics. Continuing throughout the term of this contract, newsletters will focus on the criticality of following established claims procedures.
- **Website** – The Aetna Better Health provider website offers other claim resources and contractual obligations.
- **Claim Personnel** - Provider claims personnel, through daily interaction with providers, including claims related provider inquiries, educate contracted and non-contracted providers on appropriate claims submission requirements, coding updates and available resources, such as provider manuals, websites, fee schedules, etc.

In addition to the resources named above, EDI vendors under contract with Aetna Better Health also offer support to providers that utilize these services.

Orientation and Ongoing Training

Our provider network orientation process, along with other provider educational materials (e.g., Provider Handbook), includes information about our claims handling process and procedures for third party liability, e.g. Coordination of Benefits and Third Party Liability. Provider education and training on these requirements are also available on our Internet website and in provider newsletters. Our Provider Services personnel also perform provider education and face-to-face training during new provider orientation and at regularly scheduled provider visits. Our general provider education and training addresses claims submission requirements, including requirements for CMS 1500, and UB04 claim forms. This education and training provides an overview of claim development requirements and includes the following elements:

- Mailing address and toll free telephone number of our Provider Service Center for submitting claims and receiving claim support
- Timeframes for participating and nonparticipating providers to submit clean claims
- Clean claim submission requirements – a clean claim is one that we can process to adjudication without obtaining additional information from the provider who provided the service or from another party
- Clean claims payment timeframes
- Modes of transmission for claims and transmission requirements (e.g. CMS1500 form or UB04 form as applicable, and use of standard industry codes such as ICD9, ICD10 transition, CPT, HCPCS, or NDC as applicable)

- Requirements for coordination of benefits and third party liability
- Providers are prohibited from balance billing members
 - Provider complaint process
 - Provider claim appeal process
 - How to report suspected fraud and abuse
 - How to report suspected abuse, neglect or exploitation of a member

Below is a sample matrix of the types of topics covered during a provider’s initial training, along with those training aspects which are specific to the claims process, including coordination of benefits and TPL related instruction:

Initial Training	Position Specific Training	Claims Specific Training
<ul style="list-style-type: none"> • Introduction and Overview of: <ul style="list-style-type: none"> - Medicaid program - Current health care legislation such as the Patient Protection and Affordable Care Act and Health Care Education and Reconciliation Act • Compliance and Fraud and Abuse (including HIPAA and False Claims Act Provisions) • Business Continuity and Recovery Plan (BCP)/Disaster Recovery Plan (DRP) • Aetna’s Business Conduct & Integrity • Medicaid Complaints/Grievance System • Medicare Complaints/Grievance System • Cultural Competency/Health Literacy and Diversity • Quality of Care – Identification of Issues and Referral to Quality Management • Introduction and Overview of Integrated Care 	<ul style="list-style-type: none"> • Duties, expectations, and code of conduct guidelines • Cultural competency • Responsive and courteous customer service • Provider Network Composition • All facets of the Aetna Better Health Provider website • All covered populations and brief description of covered services for each • CMS or State Medicaid guidelines, as applicable • QNXT™ - Aetna Better Health business application system <ul style="list-style-type: none"> - Proper caller verification and documentation procedures - Provider profile set up and changes - Contract validation • Claims policies, issues, reporting and submission requirements, EDI and research • Patient Centered Medical Home (PCMH) • Geographic Service Areas (GSAs) • Web resources such as Map Quest, Yahoo Maps, etc. 	<ul style="list-style-type: none"> • Clean Claim Submission Requirements • Timeliness of Claim Submissions • Payment Timeframes • Claim Inquiry Process • Subrogation • Coordination of Benefits • Notifying Aetna Better Health of Other Insurance or Third Parties Liable for Payment • Notifying Aetna Better Health upon Receipt of Funds from Third Parties or Other Insurance for Services Paid by Aetna Better Health • On-Line Provider Portal Support • EDI Requirements • Review of Contractual Obligations regarding Claim Submission, and related provisions, e.g., HIPAA, Fraud and Abuse

Initial Training	Position Specific Training	Claims Specific Training
Management (ICM) <ul style="list-style-type: none"> • Electronic Systems Navigation, e.g., EDI, prior authorizations, claim status • Risk Management 		

Aetna Better Health offers additional levels of training and education for those providers who request additional assistance. For example, a provider office with a change in billing staff may request supplemental trainings, and when Aetna Better Health identifies providers as needing assistance in order to support their timely, complete, and accurate claim submission. Our Claim Management personnel also trends claim information and provides recommendations to improve timeliness, completeness, and accuracy. Our Aetna Better Health Provider Services personnel deliver trainings at the provider’s office and upon request, may provide claims training through web-enabled mechanisms.

TPL Collection Recovery Process

Aetna Better Health understands that it is required to take all reasonable measures to identify third party resources which may have a legal, fiscal, or contractual liability as a result of medical assistance furnished to a Medicaid recipient. Where third party liability is known or reasonably expected, Aetna Better Health denies the claim and requires the provider to bill and collect from the liable third party. In cases where Aetna Better Health has made payment without taking reductions for third party benefits, Aetna Better Health undertakes measures to collect directly from third parties.

Note that certain claims are exempted from cost avoidance and will not be denied by Aetna Better Health due to available third party resources. Such claims will be paid and then submitted to the third party for payment recovery as stated herein. This process is commonly referred to as “Pay and Chase.” The Pay and Chase method is applied to Medicaid cases for EPSDT, preventive care, and pregnancy related services.

Post Payment Recovery

If the probable existence of TPL is not established at the time of service or during the claim mass adjudication process, Aetna Better Health adjudicates the claim and coordinates post-payment recovery afterwards. **Note**, as stated earlier, ESPDT and labor/delivery related expenses are always adjudicated and paid, with no concurrent coordination of benefits or third party liability activities taking place until after the claim is processed and paid. To initiate third party recoveries, Third Party Recovery (TPR) personnel query member records flagged for post-payment recovery as a result of state-provided TPL reports/notifications, internal referrals, system updates or related correspondence. Upon receipt of information or knowledge that TPL is involved, a notation is made in the member file advising users that a TPL case has been identified and providing known details. Then, member demographic information (i.e. name, member number, address, telephone number) and known details regarding each TPL case are assembled, with the entire documentation forwarded on a weekly basis to the Aetna Better Health TPR vendor for handling, via courier.

Aetna Better Health's TPR vendor pursues post-payment recovery on Aetna Better Health's behalf, following receipt of the assembled case documentation and through the weekly Diagnosis Code Report run by Aetna Better Health TPR personnel (the report is exported to Excel and submitted to the TPR vendor via secure SFTP), along with various other responsibilities and activities which the TPR undertakes, as summarized below:

- Send member TPL inquiry letters requesting additional non-medical information concerning the event, including details such as any pending legal activity or action.
- Investigate research and document TPL cases, responsible parties, availability of funds, and related matters
- Conduct weekly claim history reviews for open cases
- Correspond/communicate with attorneys, insurance representatives and other parties as necessary to communicate Aetna Better Health's subrogation rights and interest
- Pursue TPL cases to recovery
- Coordinate with Aetna Better Health regarding any third party recovery payment in excess of \$25,000, before any settlements are reached, in support of Aetna Better Health policy and related contractual obligations, i.e. DHH approval requirements
- Obtain maximum TPL recoveries in accordance with state requirements
- Provide Aetna Better Health TPR Management with a series of management reports, at the predetermined frequency and formats, concerning TPR activities for that month, e.g., open cases, closed cases, inquiry letters sent – along with any third party recovery

TPR Management at Aetna Better Health reviews and reconciles the TPR vendor report data, updates TPR Tracking Logs and makes notations in the member's record accordingly, and copies checks received for file documentation. TPR vendor performance reports, supporting documentation and data necessary to complete State-mandated TPL recovery reports are forwarded to Aetna Better Health's Finance Department in support of required DHH and other mandated reporting. Checks are deposited by Aetna Better Health and the recoveries treated as offsets to medical expenses for reporting purposes.

Aetna Better Health contracts with Recovery Management Services (RMS) to recover payments made by Aetna Better Health where non-medical third party liability has been determined to exist. RMS handles TPL investigation; file maintenance and recovery procedures as referenced in the above process summary.

Aetna Better Health will have all policies and procedures regarding recoupment of post-payments available for DHH's review during the Readiness Review process pertaining to those members determined to have other coverage or non-medical third party liability is involved. These policies will address specifics within the processes and will include, but are not limited to, addressing the following supportive activities:

- Voiding encounters for claims recouped in full
- Submitting replacement encounters for recoupment resulting in an adjusted claim value

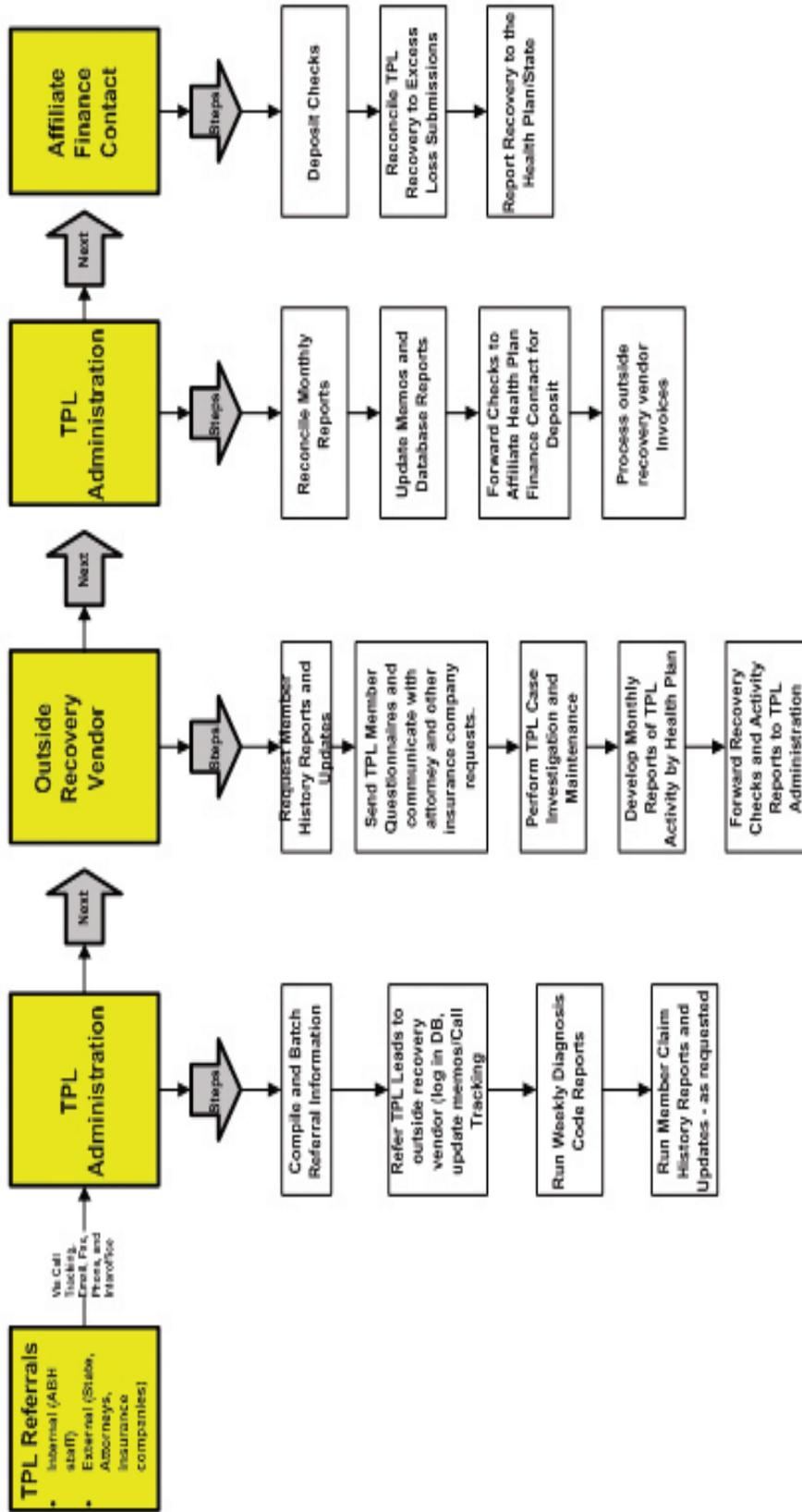
- Seeking, per the Louisiana Medicaid State Plan and federal Medicaid guidelines, reimbursement in accident/trauma related cases when aggregate claims equal or exceed \$500, as well as health plan mandated pursuit of claims below \$500.
- Obtaining DHH approval prior to accepting any Third Party Liability settlement on claims equal to or greater than \$25,000
- Transferring outstanding TPL to DHH's TPL vendor after 365 days in accordance with guidance provided by DHH post-award

Aetna Better Health is cognizant that 100% of TPL collections may be retained, in accordance with DHH policy, pursuant to the following considerations:

- Total collections received do not exceed the total amount of the financial liability for the member
- There are no payments made by DHH related to fee-for-service, reinsurance, or administrative costs (*i.e.*, lien filing, etc.)
- Such recovery is not prohibited by state or federal law
- Awareness that DHH will utilize the data in calculating future capitation rates

Please refer to the following flowchart for a process summary:

Aetna Better Health Third Party Liability (TPL) Pay & Chase Flowchart



Subrogation

Subrogation is the substitution of one party for another when the injured party has a legal claim against another party. Aetna Better Health is subrogated to the rights of a Medicaid member against any third party arising out of injury, disease, or sickness. This means that Aetna Better Health is allowed to recover from any other payer the cost of our providing health care benefits to a Medicaid member. In general, Aetna Better Health has the right to recover the cost of a member's medical care, to the extent of what Aetna Better Health has paid, from anyone the member has the right to recover from, or to substitute for the member and seek to recover our payment.

For example, if automobile or liability insurance is involved, Aetna Better Health will pay for the services rendered to a member as the primary payer (i.e., in those cases where Aetna Better Health, at the time of claim payment or service authorization, is unaware of the existence of the other insurance, or OI, or other TPL parties are unknown). If payment for the care rendered is subsequently made by the automobile or liability insurance carrier, directly to the physician, whom was also paid for the same services by Aetna Better Health, Aetna Better Health policy requires the provider to notify Aetna Better Health of the overpayment. Aetna Better Health then requests refund of the overpayment from the physician office, as applicable. At other times, payment to the physician may originate from another source but in any event, the provider is contractually obligated to notify Aetna Better Health of any such payments so that Aetna Better Health can decide whether or not to subrogate and to advise to whom any refunds should be sent.

Furthermore, the Medicaid member is required to assist and cooperate fully with Aetna Better Health in its effort to secure such rights, including the requirement to:

- Notify Aetna Better Health of filing suit against a third party
- Notify Aetna Better Health prior to entering any settlement with a third party
- Immediately pay Aetna Better Health all funds received from any third party to the extent necessary to satisfy the subrogation rights of Aetna Better Health
- Disclose information regarding health insurance or other third party resources upon enrolling in Aetna Better Health or upon being eligible for such benefits
- Notify providers of all medical care of any health and casualty coverage held and other third party resources at the moment medical care is rendered
- Notify Aetna Better Health of any health insurance obtained after becoming eligible for Medicaid
- Notify Aetna Better Health of any casualty/liability insurance which may cover medical treatment received due to an injury
- Execute and deliver all instruments and papers needed by Aetna Better Health in pursuit of its subrogation claim

Coordination of Benefits

In addition to identification of a third party liability as described above, during the claim adjudication process, Aetna Better Health also takes steps necessary to determine the existence of other insurance, such as Medicare HMO, commercial, or other third party resource, and determine the subsequent order of payment liability of other carriers. In essence, Aetna Better

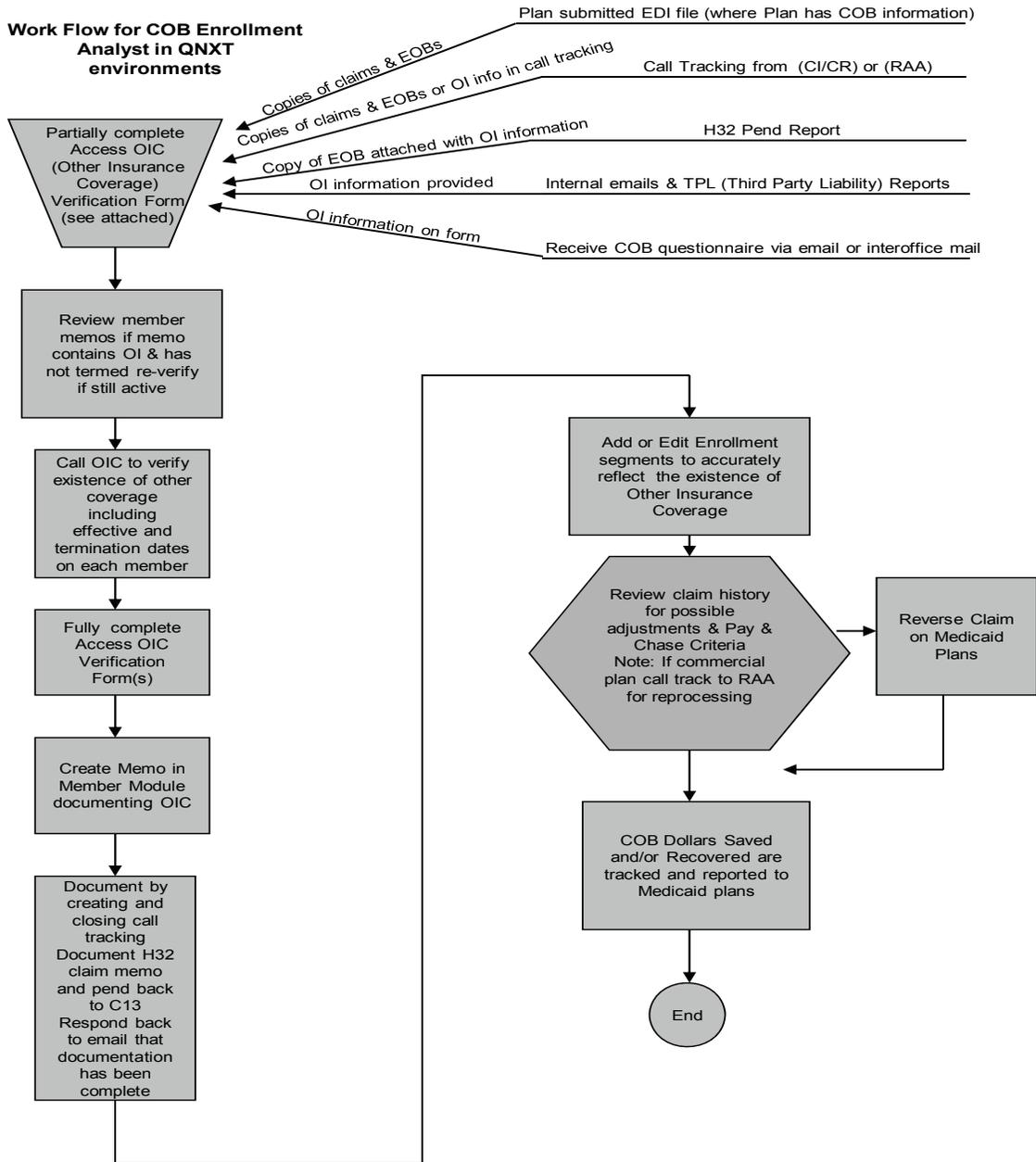
Health undertakes actions to coordinate benefits. First, Aetna Better Health will determine if Other Insurance (OI) coverage is available which may be primary to the member's Medicaid coverage, and where more than one party is identified as being possibly liable for payment of a member's claim, Aetna Better Health proceeds to determine the order of payment liability, e.g. does the member have other coverage, how many carriers exist, and if more than one carrier does exist, then determine which carrier pays first, which pays second and so forth, noting always that Medicaid payment is last. If Aetna Better Health is determined to be the primary payer, Coordination of Benefit guidelines do not apply and the claim is processed in the usual manner. If the claim services do qualify for Coordination of Benefits due to the existence of other coverage, and Aetna Better Health is determined to be the secondary (or tertiary) payer, Aetna Better Health will process the claim per COB guidelines, calculating the difference between the maximum allowable amount and the primary (and/or secondary as may be applicable) carrier's payment responsibility. **Note:** A procedural exception may occur in certain instances where a motor vehicle accident or workers' compensation claim is involved which require additional research and coordination among the liable parties.

The COB enrollment analyst receives information regarding other insurance coverage from a combination of sources. Aetna Better Health can receive COB notifications through copies of claims and accompanying Explanation Of Benefits (EOB) forms, and subsequently, enters this information into the eligibility system which feeds into the respective information systems, such as QNXT™ which is utilized during claims adjudication. Additionally, OI information may be obtained and documented through call tracking and other internal reporting mechanisms (e.g., electronic mail or dissemination of TPL reports which include members identified for COB). The COB enrollment analyst may also receive COB questionnaires or forms via interoffice mail or electronic mail. The COB enrollment analyst enters OI information into the member's record via a claim memo, after validating the reported coverage with the carrier(s).

During adjudication, if a memo concerning the existence of OI is identified, the COB enrollment analyst may have to re-verify the existence of OI (e.g., effective and termination dates may be re-verified and/or updated as may be applicable). Verifications of other insurance coverage are documented. Any updates which occur following re-verification of other insurance is entered into the claim memo and the COB enrollment analyst provides notification that documentation for OI, including data entry into the member record, is complete.

The Access OIC Verification form is circulated internally and results in adding or editing the enrollment segments/files to accurately reflect the existence of OI. During claim adjudication, claim history, along with pertinent memos, such as COB memos, is reviewed. If a Medicaid member's record indicates COB is necessary, the resulting claim is pending to allow staff to determine the order of payment liabilities, ensuring that Medicaid payment is the payer of last resort. Aetna Better Health completes the process through tracking COB related dollars saved (or avoided), including any recoveries of COB related monies from related collection activities (i.e., for those instances where COB was not determined at the time of claim adjudication.).

The flowchart which follows provides a COB workflow:



Aetna Better Health anticipates following a very similar procedure in adjudicating claims for the Louisiana Coordinated Care Network (CCN) program population. The differences in process are expected to occur as they relate to DHH required reporting, i.e., the mode, method, and frequency of COB/TPL reporting required by DHH will be different than those reporting requirements utilized by Aetna Better Health affiliates and the other Medicaid programs served.

Aetna Better Health is prepared to modify its existing processes in accordance with any DHH program specific requirements applicable to the covered population.

Once Aetna Better Health verifies the existence of Other Insurance (OI), we position ourselves as a secondary payer. As such, we will adjudicate the claim in accordance with our Coordination of Benefits (COB) protocols, which will involve making a notation in the member's record of the OI upon verification of OI, including billing the primary insurance within sixty days (60) from the date of OI coverage discovery. For instances where the OI is retroactive, the member's claims history is researched by a claims analyst to determine necessity of payment recovery activities on past paid claims. Additionally, claim edits are applied throughout the claim adjudication and member enrollment in Aetna Better Health, as described above, to maximize cost avoidance.

Routine Business Systems and Processes

The Aetna Better Health IT and Enrollment/COB Departments work together in establishing policies and processes regarding eligibility into the Aetna Better Health business systems, included related tests, updates, and maintenance of said eligibility and TPL related information. The Enrollment/COB Department jointly determine the business requirements, while the IT Department is responsible for developing, documenting, testing, implementing, and maintaining the EDI processes which support eligibility receipt and transmission to the Aetna Better Health systems, while adhering to standard or appropriate proprietary file specifications, such as those EDI and standardization requirements mandated by HIPAA.

Staff members from the IT Department retrieve daily, weekly, and/or monthly electronic member eligibility files from the designated State regulatory agency, e.g., DHH or its authorized enrollment broker. These eligibility files are loaded into the Aetna Better Health business application system in accordance with the HIPAA 834 Benefit Enrollment and Maintenance Transaction data import requirements and/or Aetna Better Health and/or state specific guidelines, as applicable and in manner such that eligibility information is up-to-date and able to support the timeliness of claims processes, including related eligibility determinations.

In general, inbound claims are uploaded to QNXT™, our claims processing system, where they are subjected to multiple header and line item edits. Among these are edits that compare service data to eligibility information provided by DHH or its designated enrollment broker, as may be applicable, in order to confirm members' eligibility during the period to which charges were incurred. In essence, QNXT™ validates the date of service against the member's enrollment segment to determine if the member was eligible on the date of service. If the member was not eligible on the date of service, the system will automatically deny the claim using the appropriate HIPAA approved remittance comment and reporting mandates, and in accordance with established notification timeframes.

Testing

The IT personnel produce pre- and post- processing exception reports through a series of automated and manual processes carried out by the IT team in order to test eligibility data received from the DHH. Thereafter, notification to the Aetna Better Health Enrollment Services Department of file and exception reports occurs which provide another mechanism for validating eligibility data and other supportive functions. The Enrollment Services Department reviews and

manually handles, i.e. manually updates the system with the correct eligibility information, any identified eligibility errors. Following manual corrections, the IT Department does a record reconciliation to verify that all records included in the 834 Eligibility File are processed. The Enrollment Services Department requires staff to sign off on the record reconciliation upon completion of the identified eligibility errors/exceptions as an added measure to promote accuracy.

Updates

Aetna Better Health can accept and process eligibility file updates, including updates specifically related to member TPL information, either on the 834 Eligibility File or on a separate TPL/COB file. In the latter scenario, the Aetna Better Health IT and Enrollment/COB Departments work together to identify file importing requirements, develop, test, and implement processes to import the TPL data for members into the Aetna Better Health processing system. Personnel from the Enrollment/COB Department manually work exception reports, where data could not be systematically loaded for whatever reason. Once the Aetna Better Health processing system is updated to reflect that a member has other insurance coverage, any Aetna Better Health staff member with access to the member record can see that the member has other primary insurance coverage. When the Claims Department is processing a claim for a member with other primary insurance coverage, an edit appears to alert the claims analyst that the member has primary coverage.

Validation

Routine systems/business processes used to test, update, and validate enrollment & TPL data:

- The Enrollment/COB Department also has a weekly quality monitoring process where a minimum of 10 random transactions are reviewed for accuracy. Staff members are expected to achieve a minimum of 98% quality.
- Email notifications when 834 files have been imported; TPL files imported or exported; etc.
- Enrollment and Capitation File reconciliation monthly to confirm membership accuracy in Aetna Better Health processing system
- Management monitoring of work functions to facilitate completion
- Use of Standardized Scripts for testing system upgrades and/or conversions for Enrollment/COB functions
- Make phone calls to other insurance companies to validate primary insurance coverage
- Audit reports to identify specific situations like members with address an address outside of the coverage area, Medicaid members with Medicare
- Claim edits to alert the Claims personnel of eligibility or COB situations (i.e., member has other insurance coverage)