Aetna®

HMO and ACO Plans

Network access plan

This manual will help you understand our health programs and policies. And we'll be right there with you, throughout all of life's stages.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies, including Aetna Life Insurance Company, Aetna Health Inc. and their affiliates (Aetna). Each insurer has sole financial responsibility for its own products.

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1. Introduction

This network access plan is for Aetna health maintenance organization (HMO) plans. The Louisiana Department of Insurance has licensed Aetna Health Inc. (Aetna) as an HMO.

The Aetna HMO network offers health plans in certain parishes in the state of Louisiana.

We are required as an issuer to create an access plan specific to each network. This access plan describes our strategy, policies, and procedures to create, maintain, and administer an adequate network.

The Aetna HMO network access plan is applicable to fully insured products.

Our main goal

We work every day to ensure the power of health is in your hands. We strive to see the world from your eyes. You can make confident choices and live a healthier life with our support and tools. And with us, you'll find convenient tools and resources that fit your life.

You pay less out of pocket when you use doctors and hospitals in our network. Our networks focus on quality and efficiency. This improves the health care experience for all. And members find it easy to get the care they need.

The network includes doctors, hospitals and other health care professionals and facilities in the Louisiana market. We negotiate discounted rates for covered health care services. In-network doctors and hospitals won't bill you for costs above our rates for covered services.

Our access plan provides a broad view of plan policies and procedures that cover participating providers and facilities.

This material is for information only. It is neither an offer of coverage nor medical advice. It's only a partial, general description of plan or program benefits. It isn't a contract. Consult your plan documents (such as the Schedule of Benefits or the Certificate of Coverage) to find governing contractual provisions, including procedures, exclusions and limitations relating to the health plan. If there's a conflict between the plan documents and this access plan, the plan documents will govern.

We don't provide health care services, so we can't guarantee any results or outcomes. We don't advise the self-management of health problems, nor do we promote any particular form of medical treatment. Consult your health care provider for the care that's right for your specific medical needs.

We've created certain policies and procedures to ensure our members get timely access to providers. You'll find a brief description in these sections of this access plan. Unless stated otherwise, this access plan also includes facilities.

Visit **Aetna.com** to get more information about the network.

If you're a member, to reach Aetna, use the toll-free phone number on your Aetna® member ID card. Not yet a member? Just call **1-888-98-Aetna (TTY: 711)** or **1-888-982-3862 (TTY: 711)**.

2. Network adequacy

Provider availability

We've created provider standards for access to care and service to ensure that our network has enough licensed health care providers available to meet members' needs. The Aetna National Quality Oversight Committee (NQOC) assesses these standards, which include:

- Adequate provider-to-enrollee ratio (examples of providers are primary care physicians (PCPs), obstetricians and gynecologists, and behavioral health care providers)
- Geographic distribution (participating providers are within a reasonable proximity to members)
- Appointment availability (service and wait times)
- An assessment of cultural needs, linguistic needs, and cultural and linguistic preferences of members

At least once every year, we check network adequacy based on member needs. We use the results to develop and implement market contracting plans.

Measurable process for access to care and service

The Aetna National Quality Oversight Committee creates standards for service and wait times to help ensure our members receive care within a reasonable time period.

- We monitor access to PCPs for routine care appointments, urgent care appointments, and after-hours care.
- We monitor access to specialty care, and prenatal care, and to high-volume and high-impact providers for routine care, and urgent care, and after-hours care.
- We check Member Services telephone access by reviewing call abandonment rates, average speed of answer, and total service factors. We also track member complaint data.

Each year, we measure behavioral health accessibility standards in these ways:

- We monitor access for routine behavioral health care, urgent care appointments, and after-hours care. We look at member complaints, behavioral health member experience and provider experience survey data, and/or phone surveys.
- We monitor access to behavioral health Member Services by reviewing call abandonment rates, average speed of answer, and total service factors. We also track member complaint data.

If we see opportunities for quality improvement, we prioritize and implement them.

Provider selection and criteria - how we build our networks

To build a robust provider network, we carefully review the providers available in each parish. We make sure there is a broad range of qualified providers so that access to care is safe and convenient.

Aetna pursues all available qualified providers. Providers must meet our high standards before we ask them to join our network.

Our network includes primary care providers, specialists, hospitals and other facilities. We want to ensure that members have access to the right medical services.

How we choose providers

Physicians

To be in our network, providers must:

- Pass our credentialing process
- Work with our medical benefits programs, including preventive care
- File claims on behalf of our members
- Accept our fees
- Agree to not bill the member for covered services charges that are over our fee
- Have active admitting privileges in at least one network hospital (depending on provider specialty)

Hospitals

To be in our network, hospitals must have a current license and be accredited by one of these entities:

- The Joint Commission (TJC)
- The American Osteopathic Association (AOA)
- Det Norske Veritas Healthcare, Inc. (DNVHC)
- An accrediting entity that meets Aetna policy and/or business participation requirements or state/ regulatory standards

These entities perform detailed reviews of hospitals, including onsite visits. Hospitals also need to show them their quality improvement activities.

If a hospital is not accredited from these entities, then they need to meet these alternative requirements:

- They must complete an onsite quality assessment.
- If the Centers for Medicare & Medicaid Services (CMS) or a state survey has a similar review process as Aetna, we may substitute the CMS or state survey for an onsite quality assessment.

Our contracts require hospitals to participate in our quality and patient management activities. Facilities must notify us of any material change of licensure or accreditation status. They must have adequate liability insurance or self-insurance. They must provide proof of insurance upon request.

Every three years, our credentialing team reviews the following for each hospital in our network. They make sure that the hospitals:

- Are in good standing with state and federal regulatory bodies
- Are accredited by an Aetna-recognized accrediting entity
- Have liability insurance limits
- Have a Medicare certification number, when applicable
- **More services**

  We also have participation standards for every type of provider service in our network, including:

  - Free-standing surgical centers
  - Urgent care centers
  - Skilled nursing facilities
  - Hospices
  - Ambulance services
  - Home health care agencies
  - Laboratories
  - X-ray facilities

Participation criteria may vary based on specialty, market, and applicable local, state, or federal laws.

Facilities must meet required:

- Licensing
- Certification
- Professional staffing standards
- Access standards
- Patient emergency standards

They must also:

- Have certain levels of liability insurance
- Follow patient confidentiality rules

All network providers must have:

- Proper licensing
- Appropriate education
- Appropriate training
- Applicable board certifications
- Certain levels of liability insurance

They must also not have:

- A history of professional liability claims
- A work history that would raise concerns for our members

Quality management program and scope

- Our quality management program checks and improves the quality and safety of clinical care and services to members. The quality management program includes but is not limited to:
- Evaluation of accessibility and availability of network providers
- Evaluation of member experience and practitioner satisfaction with case management and disease management programs
- Review and evaluation of preventive and behavioral health services; ambulatory, inpatient, primary and specialty care; high-volume and high-risk services; and continuity and coordination of care
- Development of written policies and procedures that reflect current standards of clinical practice
- Development, implementation and monitoring of patient safety initiatives, and preventive and clinical practice guidelines
- Monitoring of medical, behavioral health, case and disease management programs
- Establishing standards for and auditing of medical record documentation
- Performing credentialing and recredentialing activities
- Oversight of delegated activities
- Supporting initiatives to address racial and ethnic disparities in health care

Member experience

An important part of the quality management program is to check and improve the member experience. For this, we use surveys and aggregation, analysis, and trending of member complaints. And we encourage members to offer suggestions or express their concerns through our customer service phone lines and our member website.

We work hard to support providers and members and create a culture of better health - one that is connected, simpler, intuitive, convenient, affordable and powerful.

Providers influence the consumer experience. We help them with better tools, information and payment

models.
We contract with a certified vendor to administer the respective surveys.

- **Behavioral health member experience survey**

  We send this survey every year to the adult (age 18 and older) commercial behavioral health population who used behavioral health care. It measures members' experience of care in behavioral health services and administrative services.

- **Member experience surveys with care management services**

  Each year, we send this survey to a random sample of members in the case management and disease management programs. The aim is to check the member experience from those who have used these services. This process informs us how well the program meets our members' expectations. This in turn helps to find areas where the program performs well and areas where it needs to improve.

Corrective action process

We continue to monitor and improve availability and access to providers and facilities. Here are steps we routinely take:

- Every year, we measure and analyze:
  - Geographic distribution of providers
  - Member-to-practitioner ratios
  - Member complaints
  - Closed practice data - specifically against the goals and standards for availability
  - Tracking and trending of data relating to the network
- We review counties where enrollees don't have easy access to care. We try to determine availability of providers and, when possible, recruit them.

Accessing services outside the network

You can get a service or supply from an out-of-network provider at the same out-of-pocket cost share as a network provider, if you can't:

- Get a medically necessary service or supply through an in-network physician or hospital without unreasonable delay
- Find a participating physician who can provide the service or supply

You must get the service or supply pre-certified first. Then we'll cover it at the in-network benefits level. That means you'll pay your share of the costs (copayment, coinsurance, and/or deductible) at the in-network level. Medical emergencies don't require pre-certification. Your share of the costs for medical emergencies will also be at the in-network level.

- Members who receive inadvertent services from a nonparticipating provider at a participating facility will have no greater cost share than if the service or treatment was done by a participating provider.

Provider directories

To find a provider, use the printed provider directory or the online search tool.

- Printed provider directory
  - We publish a fully updated directory once a year.
  - We print quarterly addenda (these show providers that have been added and removed from the networks).
  - To get a directory and get on the list to receive the addenda, call the toll-free phone number on your Aetna member ID card or send us a written request.
- Online provider search tool
  - Go to **Aetna.com** and then visit your member website to use the tool.
  - It's usually updated six days a week

3. Network access plan procedures for referrals and prior authorizations

Choose a primary care physician (PCP)

Some HMO-based plans require you to select a PCP. You can change your PCP at any time by calling Customer Service at the number on your ID card.

Some cover your care at different levels, depending on whether you visit your chosen PCP, or if you go directly to any licensed doctor without seeing your PCP first and obtaining a referral. If you visit any licensed doctor without going to your PCP first, your out-of-pocket costs are often higher. Your PCP performs physical exams, orders tests and screenings, and will also refer you to a specialist, when needed.

Referrals within the provider network

Some health plans require you to get a referral from your PCP to get care from a specialist. Please refer to your plan documents to see:

- If you need to select a PCP
- Whether a PCP must refer you to a specialist before you can get access to a specialist's services

If you need a referral, contact your PCP before you get specialty care. You can find in-network specialists listed in our online provider search tool.

- Referral options may be restricted to fewer than all providers in the network who are qualified to provide covered specialty services

  While a member can be referred to any provider in the network, certain doctors may be affiliated with integrated delivery systems, independent practice associations or other provider groups. Members who select these doctors will generally be referred to specialists and hospitals within that system or group.

  Any plan that has a PCP referral requirement gives members direct access to benefits for medical emergency services, urgent care, or obstetric or gynecologic visits. Plans that don't require referrals permit members to go to any participating specialty care provider to receive network benefits.

Getting approval for some services

Sometimes, we will pay for care only if we have given an approval before you get it. We call that "precertification" or "prior authorization." Go to **Aetna.com/health-careprofessionals/precertification/precertificationlists.html** to see a list of services that require you to get prior authorization.

Participating providers will request prior authorization on your behalf. We make sure that the service is medically necessary for your condition. We also make sure that the service and place requested to perform the service are cost effective.

Our decisions are based solely on the existence of coverage and the appropriateness of care and service, using nationally recognized guidelines. We may suggest a different treatment or place of service that is just as effective as another one but costs less.

4. Network access plan disclosures and notices

Grievance and appeal

You can find grievance procedures in a number of documents. These include member disclosures and plan documents, including the Certificate of Coverage and the Summary of Benefits and Coverage (SBC). The grievance procedures are also on our website. The Explanation of Benefits (EOB) statement also provides information that addresses members' rights.

Specialty medical services

You can find information on available specialty medical services in the plan documents. These include the Certificate and the SBC. The Certificate describes the benefits and the SBC shows available services, cost-sharing amounts and visit limits. The SBC also shows some common medical events and the therapy services that may help to treat them.

Emergency and nonemergency medical care

You'll find information on our procedures for providing emergency and nonemergency medical care in the plan and member disclosure documents. Visit **Aetna.com** to read it online.

The documents and our website also define:

- What an emergency medical condition is
- What to do when an emergency occurs
- Where to go for treatment
- The differences between nonurgent care and an emergency
- The processes a member must follow

Access and accessibility of services of covered persons with limited English proficiency or illiteracy, with a particular cultural or ethnic background, or who have physical or behavioral health disabilities

Aetna uses Language Line Services, an interpretation service, to address the needs of enrollees with limited English proficiency. Language Line Services offers 24/7 over-the-phone interpretation in over 200 languages.

Explanation of benefits (EOB) statements and other correspondence generated through the claims and appeal process provide notice that translation services are available. And Aetna member disclosure information (available to members on our public website, as well as in enrollment packets) includes a notice that language services are available for members who speak another language or are hearing impaired.

For hearing-impaired or speech-disabled individuals, Aetna uses a relay service. The relay service acts as an intermediary for telecommunications between hearing individuals and individuals who are deaf, hard of hearing, deaf and blind, and/or have speech disabilities. We have specially trained communication assistants who complete the calls and stay on the line to relay messages, using any of the ways listed below.

- Electronically over a teletypewriter (TTY) or a telecommunications device for the deaf (TDD)
- Verbally, over the phone, to hearing parties

Aetna doesn't consider the member's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age or national origin when providing access to care. Aetna and participating providers must comply with these laws:

- Title VI of the Civil Rights Act of 1964
- The Age Discrimination Act of 1975
- The Americans with Disabilities Act
- Laws that apply to those who receive federal funds
- All other laws that protect your rights to receive health care

If a member chooses to provide certain information about race, ethnicity and languages spoken, it may help to improve access to health care. All information that a member provides is private. The member disclosure document addresses privacy and access to health care in more detail.

Assessing health care needs

Aetna is committed to providing members with quality health care. Through our quality management program and strategy, we assess, measure and monitor the care we provide.

The member disclosure form has online search instructions on how to find information about quality management programs. A printed copy of this information is also available. Just call Member Services at the number on your Aetna member ID card.

Program information includes goals, scope and outcome with clinical data and is publicly available on our website. Just go to **Aetna.com/individuals-families/ member-rights-resources/commitment-quality/ quality-management.html** to read the information.

5. Plans for coordination and continuity of care

Keeping the provider you go to now

You may have to find a new provider when you:

- Join our plan and the provider you have now is not in the network
- Are already a member and your provider stops being in our network

But in some cases, you may need to complete a treatment or have treatment that was already scheduled with a provider who is not in the Aetna network. You may ask to continue to go to your current provider. This is called "continuity of care" or "transition of care."

For example, if you join a plan and you're in an active course of treatment with a provider who is not in the network, we'll provide transition-of-care benefits. Transition of care gives you temporary coverage as we transfer services from an out-of-network specialty provider to an in-network specialty provider.

Transition-of-care requests do not apply to facilities. For transition-of-care coverage requests due to a provider becoming inactive, we provide continuity of care coverage:

- For an active course of treatment, as long as you have not been released from treatment
- For transition of care coverage requests for maternity care, we'll allow an active course of treatment from the second trimester through the postpartum period

Submission of requests for transitional benefits must occur within 90 days of the applicable provider or member status change. When approved, the effective date is the enrollment or renewal date of the member's plan orthe date of the provider's termination or network status change, as applicable. The care period is the is the earliest of the following time frames:

- The date of termination of the course of treatment by

the covered person or the treating provider

- 90 days after the effective date of your provider's departure or termination, unless the medical director determines that a longer period is necessary
- The date that care is successfully transitioned to the in-network provider
- The date when benefits limitations under the plan are met or exceeded
- The date when care is no longer necessary

Discharge planning

Proactive discharge planning is a process that anticipates your needs prior to discharge from an inpatient care setting. It provides the right transition plan from the inpatient setting to the next level of care and addresses your entire care.

The process begins at the time of notification and may include the hospital (or other alternate care provider, health plan, other health care providers, or the treating practitioner), you, and your family or caregiver. The staff finds and refers potential quality-of-care needs and patient safety events for more review during the discharge planning process.

The discharge plan considers your:

- Age
- Prior level of functioning
- Past medical history
- Anticipated discharge location
- Current medical condition, including diagnosis
- Current level of functioning
- Family and community support
- Psychosocial factors
- Potential barriers to discharge planning

The discharge plan may include:

- Identifying eligible members for referral to covered specialty programs
- Coordinating a variety of services or benefits to be used upon discharge (such as a transfer to an inpatient skilled nursing, sub-acute care, or rehabilitation facility, or arranging for home health care, community services, or durable medical equipment)

Provider termination

Our provider contracts with participating providers and facilities ensure a seamless transition in the event the contract ends. Our providers agree to continue services to our members for a limited time after termination.

When we terminate a PCP from the network, we send a letter to inform you. We also help members select a new PCP or practice site.

When a specialist no longer participates in our network, we inform members who see the specialist regularly by letter. The letter asks the member to have their PCP contact the Aetna Patient Management Department.

That way, they can coordinate continued care and issue a referral to a specialist, if necessary.

The hold-harmless provision

Our contracts contain a hold-harmless provision. This prevents network providers from balance billing members in the event of the insurer's insolvency or inability to continue operations.

Aetna complies with applicable federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, sexual orientation, age or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator, P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030 Fresno, CA 93779), **1-800-648-7817, TTY: 711, Fax: 859-425-3379** (CA HMO customers: **860-262-7705**), **CRCoordinator@aetna.com**.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at **1-800-368-1019, 1-800-537-7697 (TDD)**.