

MARKET CONDUCT EXAMINATION REPORT

ON

AETNA HEALTH INC.

as of

December 31, 2007

NAIC Code 95245
980 JOLLY ROAD
BLUE BELL, PA 19422-1904

I, Karen Weldin Stewart, Insurance Commissioner of the State of Delaware, do hereby certify that the attached REPORT ON EXAMINATION, made as of December 31, 2007 on

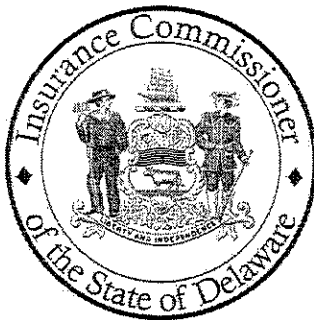
AETNA HEALTH INC.

is a true and correct copy of the document filed with this Department.

Attest By:



Date: 20 April 2011



In Witness Whereof, I have hereunto set my hand and affixed the official seal of this Department at the City of Dover, this 20th day of April 2011.



Karen Weldin Stewart, CIR-ML
Insurance Commissioner

REPORT ON EXAMINATION

OF THE

AETNA HEALTH INC.


AS OF

December 31, 2007

The above-captioned Report was completed by examiners of the Delaware Department of Insurance.

Consideration has been duly given to the comments, conclusions and recommendations of the examiners regarding the status of the Company as reflected in the Report.

This Report is hereby accepted, adopted and filed as an official record of this Department.



Karen Weldin Stewart, CIR-ML
Insurance Commissioner

Dated this 20th day of April 2011

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SALUTATION

March 1, 2010

Honorable Karen Weldin Stewart, CIR-ML
Insurance Commissioner
State of Delaware
841 Silver Lake Boulevard
Dover, Delaware 19904

Dear Commissioner Stewart:

In compliance with the instructions contained in the Certificate of Examination Authority Number 08-719 and pursuant to statutory provisions including 18 Del. C. §§318-322, a Market Conduct Examination has been conducted of the affairs and practices of:

Aetna Health Inc.

Aetna Health Inc., hereinafter referred to as the "Company," "Aetna," or as "AHI-DE" is incorporated under the laws of the State of Delaware. This examination consists of two phases, an on-site phase and an off-site phase. The on-site phase of the examination was conducted at the following Company location:

980 Jolly Road
Blue Bell, PA 19422-1904

The off-site examination phase was performed at the offices of the Delaware Department of Insurance, hereinafter referred to as the "Department" or "DDOI," and other appropriate locations.

The report of examination thereon is respectfully submitted.

FOREWORD

This Market Conduct Examination Report reflects the insurance activities of Aetna Health, Inc. in the State of Delaware. This report is, in general, a report by exception. As such, some of the information reviewed by the examiners will not be referenced in this written report, since reference to or comments about any practices, procedures, or files that did not result in any errors or irregularities is generally not made. However, since the examiners also reviewed the Company's general business practices as they pertain to Quality of Care, the examiners' observations about those portions of the Company's operations have been provided.

This report does not reflect a comprehensive review of all of the practices and activities of the Company.

Where used in the report:

“Company,” “Aetna” or “AHI-DE” refers to Aetna Health, Inc.

“Del. C.” refers to Delaware's Statutes

“DE Admin. Code” refers to Delaware's Regulations

“DDOI” refers to the Delaware Department of Insurance

“MCO” refers to a Managed Care Organization

“NAIC” refers to the National Association of Insurance Commissioners

“NAIC MRH” refers to the NAIC's *Market Regulation Handbook*

SCOPE OF EXAMINATION

The Delaware Department of Insurance has authority to perform this examination pursuant to, but not limited to, 18 Del. C. §§318-322. This examination began May 12, 2008. The examination period is generally the two (2) full calendar years preceding the commencement date of the examination, and the current year to date, unless otherwise stated. The examination period for this examination is January 1, 2006 through December 31, 2007.

The purpose of this examination is to determine the Company's compliance with 18 Del. C. §64, as amended effective July 6, 2006, which transferred regulatory authority over Managed Care Organizations from the Department of Health and Social Services to the Department of Insurance. This examination focused on a review of the Company's Managed Care coverages, with a concentration on Quality of Care issues. The relevant statutes and/or regulations are Chapter 64 - the “Delaware Managed Care Organization Act” or the “Delaware MCO Act” and DE Admin. Code 1403 - Health Maintenance Organizations.

This examination was performed in accordance with Market Regulation standards established by the Department and examination procedures established by the NAIC. While the examiners generally report on the errors found in individual files, this examination also reviewed general business practices of the Company and comments are provided thereon.

EXECUTIVE SUMMARY

This examination focused on a review of the Company's Managed Care coverages, with a concentration on Quality of Care issues, pursuant to 18 Del. C. §64 and DE Admin. Code 1403.

Aetna Health Inc. provides health insurance coverage for individuals and groups. The Company offers traditional and consumer-directed health insurance products and related services. These include medical, pharmacy, dental, behavioral health, group life, long-term care and disability plans and medical management capabilities.

The examiners completed a review of the MCO's procedures and found their internal processes are adequate for the satisfactory handling of the member's complaints, claim denials, credentialing oversight panels and providing information to enrollees.

The Company previously downsized its operations by withdrawing from the Small Employer Market, Medicare and Federal Employees Insurance Programs in the State of Delaware. The Company's commercial business declined considerably in 2006 and 2007. The decrease was offset by the Company re-entering the Medicare market in Delaware in 2007.

For any cited exceptions in the report, recommendations have been made to address the issues and concerns noted by the examiners.

EXPLANATION OF THE EXAMINATION PROCESS

FORMS and FILINGS

The examiners review the Company's policy forms, contracts and underwriting guidelines to determine compliance with filing approval and content requirements, to ensure that the contract language is not ambiguous and that the provisions of the policies adequately protect the consumer. For this examination, the examiners focused on the business areas of the Company that have an impact upon the Quality of Care provided to consumers.

AUTHORITY

Delaware law limits which companies may sell insurance, as well as the type of insurance that a company is allowed to market. The Department issues a Certificate of Authority to an insurer only after the insurer has completed an application process. The examiners review the Company's operations to ensure they are in compliance with their Certificate of Authority and the licensing requirements of Delaware.

COMPLAINTS

The examiners review the complaints the Company received directly from consumers and the complaints received by the Department. The purpose of the review is to determine any patterns of mistreatment, the accuracy of handling, the resolution of the complaint and the timeliness of the response.

COMPANY PROCEDURES

The examiners review the Company's procedures to determine if they are in compliance with the statutes and regulations. The purpose of the review is to determine if the procedures assist the Company in meeting its compliance obligations, its contractual obligations and business effectiveness. The examiners also look at the oversight utilized by the Company to ensure that the procedure is being followed and is performing as intended.

EXAMINATION FINDINGS

I. Company Overview

A. History

The principal executive offices for Aetna Health Inc. (AHI-DE) are located at 980 Jolly Road, Blue Bell, Pennsylvania, 19422. AHI-DE is incorporated and domiciled in Delaware and is licensed as a health maintenance organization (HMO) in Delaware, Maryland, New Jersey and Pennsylvania.

AHI-DE was incorporated on October 15, 1985 and is a wholly-owned subsidiary of Aetna Inc. Effective September 30, 2003 Aetna Inc. contributed all of the capital stock of AHI-DE to Aetna Health Holdings, LLC, whose ultimate parent is Aetna Inc.

B. Profile

Aetna Health Inc. is an HMO carrier licensed in the state of Delaware.

The Company has no employees. Aetna Health Management LLC ("AHM"), an affiliate and indirectly wholly-owned subsidiary of Aetna, makes available to the Company the services of Aetna's employees pursuant to its Administrative Services Agreement with the Company.

The Company is structured into geographical regions. Beginning in 2006, Aetna Regional Businesses was established to infuse a local geographic focus into its market segment operating model. Aetna then established a new business unit, Aetna Small & Middle Market Business (ASM). ASM aligns Small Group and Middle Market Accounts into one organization with one senior management team. This organization maintains staffing in areas of sales, sales support and customer service, including shared services such as actuarial and underwriting functions. The National Accounts division focuses on the plan sponsors with 3,000+ eligible employees.

C. Vendor Oversight

The Company maintains vendor contracts with the following entities:

- American Specialty Health Networks, Inc. (ASH) - chiropractic services, claims, credentialing and patient management
- National Imaging Associates (NIA) - patient management for high-tech radiology services
- Rehabilitation Alliance - claims delegation for capitated physical and occupational therapy
- Nemours Children's Clinic/Wilmington, of the Nemours Foundation and Alfred I. DuPont Hospital For Children of The Nemours Foundation - a non-profit health care institution that provides health care services to children and selected health services for the elderly of Delaware, regardless of their financial means. The foundation conducts nonprofit programs and provides health, education and research services.

The examiners reviewed the Credentialing Contracts for each of the above vendors and noted no areas of concern.

D. Internal Audits

- The Company was asked to provide all internal audit schedules and internal audit reports conducted by the Company or any entity within the last three (3) years, as well as a copy of the Company's Internal Audit Procedures.

AHI-DE performed annual oversight reviews for 2006 and 2007 of American Specialty Health Networks, Inc. (ASH). The oversight review in 2006 indicated that a provider satisfaction survey in 2005 resulted in a dissatisfaction with ASH's Utilization Management (UM) process due to the amount of paperwork required. ASH implemented an electronic request process in 2006 to address this issue. Another deficiency noted in the surveys was the denial explanations/rationales. There have been no changes noted in these practices to date. In the 2007 reviews provider information was missing from files. Also, two out of three cases regarding non-participating provider reviews included questions regarding the accuracy of the participation status of the two requesting providers.

Reviews of ASH's re-credentialing of providers practices were performed in 2006 and 2007 and the vendor was found to be in compliance.

National Imaging Associates (NIA) was reviewed in 2006 and 2007. In each of these years, the annual oversight resulted in the review of denied files randomly selected from other states. The NIA scored high due to its turnaround times and appropriate clinical information contained in each of the denied files. The annual oversight indicated that the majority of the files reviewed demonstrated a peer to peer discussion and/or documentation that no additional information was warranted prior to rendering a denial.

The Company had claim reviews performed in the eastern region for Rehabilitation Alliance on March 28, 2006 and March 1, 2007. Rehabilitation Alliance has two associates managing the

business and distributing the Aetna monthly capitation payment to the participating Physical Therapy Clinic. Rehabilitation Alliance does not utilize a claims system; instead it manually processes the payment of the monthly capitation distribution. Rehabilitation Alliance also maintains paper files of the claims received.

The audits revealed that Rehabilitation Alliance did not have a formal documented Quality Audit Program in place. This is a repeat audit finding. There was no corrective action or recommendation issued in 2006. However, in 2007 a corrective action was issued that policy and procedures outlining the Rehabilitation Alliance Quality Audit Program be submitted and the attendance roster for the 2006 Fraud Awareness Training also be submitted to the Company. In addition, corrective actions were also issued to Rehabilitation Alliance to implement the use of a column to calculate claim turn around time on the Aetna Capitation Distribution Excel file. Rehabilitation Alliance is maintaining the records on a monthly basis to facilitate monitoring and reporting compliance with the Delaware claim timeliness requirement. A reminder was made to complete all columns on the monthly report for each member submitted on the report including the date of the first visit.

RECOMMENDATION: It is recommended that Rehabilitation Alliance develop and adhere to a documented Quality Audit Program. Policies and procedures outlining the Rehabilitation Alliance Quality Audit Program for 2007 and the attendance roster for the 2006 Fraud Awareness Training should be submitted to the Company. The Rehabilitation Alliance should implement the use of a column to calculate claim turnaround time on the Aetna Capitation Distribution Excel file. Lastly, the Company should complete all columns on the monthly report for each member submitted on the report including the date of the first visit.

- In 2006 and 2007 a credentialing oversight review was performed on Nemours Foundation/A.I. Dupont. The 2006 oversight review found no program deficiencies. The examiners reviewed the audit reports and noted no concerns other than those addressed above.
- The Company was asked to provide a copy of Operational and IT audits conducted during the scope of the examination. AHI-DE provided twenty-one (21) audit reports prepared for and used by Management for Internal Audit procedures.

The examiners reviewed these reports and noted no areas of concern.

- The Company was asked to provide its Privacy and HIPAA Procedures.

Aetna has a written Disclosure Policy that is sent to their customers that outlines the Company's Privacy policy, states who the Company can and cannot disclose information to and presents the customer's rights regarding disclosure of their own information. The policy states that the Company is required by law to protect the privacy of the customer's health information. The notice explains how the Company uses the customer's information, when they disclose information to others, and the customer's rights regarding their health information disclosed in the notice.

The examiners noted no errors in this review.

NOTE: refer also to the section of this report pertaining to 18 Del. C. §6412 - Confidentiality of Health Information for related information.

COMPANY OPERATIONS AND MANAGEMENT

- AHI-DE provided a current organizational chart outlining the relationships of subsidiaries, branch offices and divisions/departments to the overall corporate management structure. The Company also provided a current organizational chart outlining the structure of Delaware operations with respect to management, marketing, customer service, complaints, underwriting and claims.

Information, data or records are stored in various media such as paper, electronically (*e.g.*, servers, magnetic tape, CD-ROM), microfilm, microfiche, audio, and video. Business areas at Aetna determine what medium is best for the records in which they have ownership responsibility. The complaint and appeals records are stored electronically on the computer network and include complaints received in writing, which are imaged and then uploaded to the system. These Procedures support Aetna's Records Retention and Management Policy. The Policy's Records Retention Schedule establishes the time periods for keeping specific categories of records. In addition, the Policy requires preservation of records related to lawsuits, government investigations and other proceedings (*e.g.*, tax audit) even when the Records Retention Schedule would otherwise no longer require the company to keep the record. The Policy and Records Retention Schedule are posted to the Company's intranet site for all-employee access.

The examiners reviewed the procedures provided as well as confirmed adherence thereto during the course of the examination. The procedures meet the requirements of 18 DE Reg. 1403 §12 - Recordkeeping and Reporting Requirements.

The examiners noted no errors in this review.

- AHI-DE provided copies of all Financial and Market Conduct Examination reports conducted during the last five (5) years. The Company also provided a description of all fines, penalties and recommendations from any state for the last five (5) years.

A DE Market Conduct Examination of Prompt Payment of Claims was conducted as of June 30, 2006 and one recommendation was made pertaining to the timeliness of claim payments.

The examiners reviewed these examination reports focusing on any repeat errors, errors that pertain to Quality of Care issues and/or directives from other states for the Company to implement any corrective actions.

The examiners noted no errors in this review.

A DE Financial Examination was conducted as of June 30, 2006 and seven (7) recommendations were made. None of the recommendations pertained to Quality of Care issues.

- AHI-DE is in compliance with 18 DE Reg. 1403 §5.0 which requires each MCO to have reinsurance protection in the event of catastrophic or unusual losses which would be in excess of the levels of loss which the MCO assumes in the basis of its calculation of premium charges.
- The Company provided the minutes from all committee meetings that occurred within the Company during the scope of this examination concerning the following areas: (a) Quality of Care, (b) Credentialing or Accreditation of Providers, (c) Claims, (d) Peer Review and (e) Grievances/Appeals.

The Review Committees for the above areas are comprised of medical professionals in various fields of specialty and expertise. The minutes of these meetings were recorded in accordance with the requirements of 18 DE Reg. 1403 §12 - Recordkeeping and Reporting Requirements.

The minutes are maintained in a confidential manner. The chairperson of the committee reviews the minutes for accuracy and completeness. The minutes use a standard format that includes a topic, discussion, recommendations and follow-up format. Follow-up items become topics for the next committee meeting.

The examiners reviewed the above minutes and noted no areas of concern.

COMPLAINT HANDLING

NOTE: As used in this report, the term complaint includes all DDOI Complaints and Grievances, all Complaints or Grievances submitted directly to the Company and all Quality Assurance issues.

- Aetna accepts written as well as verbal complaints. If during an initial call the complaint is resolved, the complaint resolution process ends and the concern is tracked and reported to the Quality Oversight Committee on a quarterly basis. If the complainant is not satisfied, the concern/issue is documented in the call system, routed to the Complaint and Appeal Tracking System (CATS) and then sent to the appropriate Resolution Team (RT). At that point an acknowledgement letter is sent to the member outlining the procedure and giving a timeframe for resolution. The complaint is then referred to the Subject Matter Experts (SME) per Aetna's Member Complaint and Appeal Policy for resolution. Once the complaint is resolved a letter is generated to the member and the case is closed in CATS.
- The Company provided 119 complaints for review; all of them pertained to claims. The examiners determined that AHI-DE follows its policies and that the policies comply with 18 Del. Admin. Code 1403 §8.1.
- AHI-DE has adequate procedures in place and adheres to strict timeframes in responding to its members. When the DDOI is involved in the complaint it is the goal of AHI-DE to send an acknowledgement letter the same day. The complaint is routed based on Aetna's internal process. The complaint file includes all documents received, a history of the complaint and the resolution. In cases where the DDOI is involved, Aetna sends response correspondence to both the member and the DDOI.

- AHI-DE tracks the total number of complaints by each State.
 - The Company's response to the complaints were found to be timely and in compliance with the MCO's internal procedures and policies. The responses addressed the issues raised by the members.
 - The resolution letter sent to the member outlines the process reasoning and actions taken to finalize the complaint. If the member is not satisfied with the Company's response, Aetna offers the appeal routes that can be taken and lists the address and phone number of the DDOI. The examiners found, however, that the DDOI contact number was outdated on the notices.
 - The files are complete and contained a copy of the written complaint or a written synopsis of a verbal complaint. The CATS notes describe what they did and the time frame, a copy of the acknowledgment letter and the resolution letter. The complaints were reviewed for timeliness and the examiners found that the procedures and tracking mechanisms utilized by the MCO complies with 18 Del. C §2304.

RECOMMENDATION: The Company should provide current DDOI contact information for complaints to its enrollees.

POLICY FORMS AND FILINGS

- Aetna provided an Excel spreadsheet summarizing the Policy forms {including policies, applications, riders, endorsements and amendments} filed with the DDOI, approved by the DDOI and/or filed with the DDOI but disapproved, or the Company amended, withdrew, or otherwise discontinued their use during the examination period.

The forms appear to be compliant with all relevant statutes and regulations.

QUALITY OF CARE REVIEW - Statutory Requirements

Chapter 64 - Regulation of Managed Care Organizations

- 18 Del. C. §6404 - Certificate of authority; when required; application and issuance; 18 DE Admin. Code 1403 §3.0 Certificate of Authority

FINDING: The Company provided its Delaware Certificate of Authority for the period under examination. The Certificate of Authority shows that AHI-DE is authorized to transact business as a Health Maintenance Organization within the State of Delaware. A review of the premium schedules was made to ensure the Company is licensed for the lines of business being written. The Company is operating in accordance with the requirements of its Certificate of Authority and the laws of Delaware.

- 18 Del. C. §6405 - Suspension or revocation of certificate of authority

FINDING: This statute is not applicable at this time.

- 18 Del. C. §6406 - Annual Report - Every MCO is required to annually file a report covering the preceding fiscal year with the Department.

FINDING: Aetna provided the following statement in response to the examiners' request for their annual report:

Aetna Health Inc. is not a publicly traded company, so there is not an annual report to the shareholders. The closest similarity to a report to shareholders that our non-publicly traded companies would have is the audited financial statement. The opinion letter from KPMG (our auditors) that is included in the audited financial statements is addressed to the "shareholders" of the respective company.

The Company provided a copy of its KPMG Report which covered the preceding years of 2006 and 2007. The report contained the Company's financial statements based on audits of pharmaceutical rebates receivables, hospital and medical costs and claims adjustment expenses and related reserves, aggregated health policy reserves and related expenses, aggregated health claim reserves, advances to non-related party hospitals and contractual arrangements with providers.

The examiners found the Company to be in compliance with this statute.

- 18 Del. C. §6407 - Prohibited practices; 18 DE Admin. Code 1403 §10.0 Prohibited Practices, 18 Del. C. §§2303 and 2304 – Unfair Trade Practices and Insurance Fraud

FINDING: Based upon a review of various Company documents, including procedures and complaint files, the examiners did not find evidence pertaining to any of the practices prohibited by these statutes and regulation (*e.g.*, questionable reimbursements, bonuses or incentives for physicians/providers based on a consumer's utilization of health care services, retribution or penalties for a provider reporting a questionable practice, advertising or solicitations which were untrue or misleading, cancellation or failure to renew the enrollment of an enrollee solely on the basis of the enrollee's health nor evidence of improper cancellations or nonrenewals).

No advertising complaints were found during the examiners' review.

- 18 Del. C. §6409 – Fees and 18 DE Admin. Code 1403 §4.0 Capital Funds Required

FINDING: The examiners noted no errors in this review.

- 18 Del. C. §6410 - Provision of professional services

To measure compliance with this statute the examiners reviewed a copy of the following items:

- a. the Medical Director's license, their job description and job responsibilities/duties
- b. a representative copy of all health care professional employment contracts
- c. one contract for each type of healthcare professional – *i.e.*, physician, surgeon, nurse, physical therapist, etc.

d. any contracts that address extenuating circumstances.
FINDING: The examiners noted no errors in this review.

Refer to the sections addressing 18 DE Admin. Code 1403 §7.0 Required Contractual Provisions and 18 DE Admin. Code 1403 §9.0 Provider Relations for additional information related to this review.

- 18 Del. C. §6412 - Confidentiality of health information

FINDING: The examiners reviewed the Company's written procedures as well as determined the Company's actual practices for maintaining confidential information. The statute contains specific instructions for the protection of any data or information pertaining to the diagnosis, treatment or health of any enrollee or applicant. The examiners reviewed how the Company develops and enforces its procedures, how employees are initially made aware of the procedures and subsequently updated about changes, and how employees are kept informed about HIPAA and DE's Privacy Regulation. [Reference 18 DE Admin. Code 904 and 905].

The Company has formal written procedures for Customer and Consumer Privacy Protection that are in compliance with this statute.

- 18 Del. C. §6413 - Freedom of choice

FINDING: The examiners did not conduct an underwriting review during this examination. This type of review would confirm compliance with this statute by reviewing declinations and the reason(s) for the Company's actions. The examiners did not, however, find any complaints pertaining to this issue and the procedures provided by the Company appear to properly address the requirements of the statute.

- 18 Del. C. §6414 - Nondisclosure clause

FINDING: An MCO contract cannot contain a provision or nondisclosure clause prohibiting physicians or other health care providers from giving patients information regarding diagnoses, prognoses and treatment options. The examiners reviewed the provider complaints and member handbooks and found no evidence of such a provision or nondisclosure clause.

- 18 Del. C. §6415 - Refusal to contract

FINDING: An MCO cannot refuse to contract with or compensate for covered services with an otherwise eligible healthcare provider solely because that provider has in good faith communicated with one or more of the provider's current, former or prospective patients regarding the provisions, terms or requirements of the health maintenance organization's products or services as they relate to the needs of that provider's patients.

The examiners reviewed provider complaints and consumer complaints being mindful of allegations of restricted information or restricted treatment options.

The examiners noted no errors in this review.

- 18 Del. C. §§6416 and 6417 - Independent health care appeals program and Appeal reviews; independent utilization review organizations

FINDING: The DDOI has jurisdiction over the Independent Utilization Review Organization (IURO). The procedures provided by the Company appear to be compliant with the requirements of these statutes. However, since the DDOI was only recently given jurisdiction over MCOs these procedures were not tested during this examination.

QUALITY OF CARE REVIEW - Regulatory Requirements

1403 - Health Maintenance Organizations

- 18 DE Admin. Code 1403 §1 and §2 are definitions; §3 – Certificate of Authority, §4 – Capital Funds Required, §5 – Reinsurance Requirement, §10 – Prohibited Practices and §12.0 Recordkeeping and Reporting Requirements are addressed above in the Statutory Review.

- 18 DE Admin. Code 1403 §6.0 Special Requirement in the Event of Financial Impairment/Insolvency

FINDING: This requirement was not applicable during the time period of this examination.

- 18 DE Admin. Code 1403 §7.0 Required Contractual Provisions

FINDING: Aetna provided copies of its Provider Contracts which include the Provider Agreement, the duties of the Provider, Provider participation in the Network, Payment Provisions, Liabilities of Parties, Confidentiality of Records, Resolution of Disputes and Terms & Termination. These contracts are in compliance with the requirements of this regulation.

Aetna has a Provider Contract that mandates that the Provider shall maintain in good standing all federal, state and local licenses; certifications and permits, without sanction, censure, probation or material restriction, which are required to provide health care services according to the laws of the jurisdiction in which Covered Services are provided; and shall comply with all applicable statutes and regulations. The Provider is also required to ensure that all healthcare professionals employed by or under contract with the Provider to render Covered Services to Members, including covering Providers, comply with this provision. The MCO and its Providers are required to comply with all applicable federal and state laws and regulations.

The examiners also confirmed that the contracts used by Aetna do not contain any language allowing for balance billing to the consumer and that the contract addresses coverage continuation in the case of an insolvency. Refer to 18 DE Admin. Code 1403 §7.1.1 and 7.1.2.

The examiners noted no errors in this review.

- 18 DE Admin. Code 1403 §8.0 Enrollee Rights and Responsibilities

FINDING: The Company provided copies of all information pertaining to an Enrollee's Rights and Responsibilities as detailed in this regulation. There are currently twenty (20) specific criteria that the MCO must address. In addition to providing information to show its compliance with these requirements, the Company has also established a Notice of Privacy Practices which outlines the member's rights as they pertain to restricting the disclosure of and the use of their personal health information. This notice also complies with the requirements of this regulation.

The examiners reviewed the Enrollee Information provided to all new enrollees and at the time of renewal. Results of the review indicate that the Company amended its policies and procedures to meet regulatory and legislative requirements specified in the Delaware insurance code that impact the Rights and Responsibilities Statement HMO, PPO and Medicare Members policy pursuant to health plans licensed in the State of Delaware.

Included in the Enrollee's Directory, page XIII, is a statement indicating that if there is a need for emergency care the enrollee is covered 24 hours a day, 7 days a week, anywhere in the world.

Member rights and responsibilities are found within the "Important Disclosure Information" document page 11 that is part of enrollment and re-enrollment packets and also available on Aetna.com.

Member Rights and Responsibilities were included in the member handbook, which was available through 2006, pages 17-19. Information about participating providers is:

- contained within the enrollment packets within the Important Disclosure Document
- found online at Aetna.com in DocFind (Aetna's on-line physician search tool) found at <http://www.aetna.com/docfind/home.do>
- listed in the 2006 Healthy Insights annual member mailing and in a 2007 post card annual member mailing.

The examiners noted no errors in this review.

- 18 DE Admin. Code 1403 §9.0 Provider Relations

FINDING: The MCO established Plan Summaries for each relevant Plan. The Provider is supplied with the applicable Plan Summary that relates to his/her program. The Plan Summary outlines the terms and conditions of the member's coverage, including copays and deductibles. The Plan requires the Provider to determine if an individual is a member.

The Provider can only provide covered services at credentialed locations and shall accept new patients without regard to race, religion, gender, national origin, age or physical or mental status. The Provider must also comply with all laws and requirements of all regulatory authorities.

The Plan Summary provides that the MCO and the Provider work together to resolve any disputes with their business relationship. If the dispute cannot be resolved and either party wishes to pursue the dispute, it is then submitted for arbitration.

The Provider contract addresses the termination of Providers. The agreement requires that the Provider cooperate with the MCO in notifying members of their pending termination and they must continue to provide services to the member until a new Provider can be established.

If the MCO determines that the health, safety or welfare of its members is in jeopardy, the Provider's termination will be immediate. If those factors do not apply then the agreement may be terminated by either party upon ninety (90) days prior written notice.

The examiners noted no errors in this review.

- 18 DE Admin. Code 1403 §9.0 Provider Relations

FINDING: Under the Provider Contracts the Company may at any time modify policies and will provide ninety (90) days prior notice by letter, newsletter, electronic mail or other media of material changes.

The Provider contract requires a "Dispute Resolution" clause whereby the Company shall provide an internal mechanism where the Physician may raise issues, concerns, controversies or claims regarding the obligations of the Parties under the agreement.

The contracts provide for a "Term and Termination" agreement and the contract addresses ongoing care to any Member who is an inpatient and addresses the transition of such Member's care to another provider.

The Company has other written policies in place for the termination of Providers. When a Primary Care Physician (PCP) is terminated from network participation, members assigned to the PCP or PCP group practice are notified by Aetna, in writing, of the termination. A notice letter is also sent to each affected member, providing information that the PCP will no longer participate in the Aetna network and instructions regarding new PCP selection or how to obtain assistance in applying for consideration for transition of care.

Members being seen regularly by a Specialist who terminates from Aetna network participation are notified by Aetna in writing of the termination. The Specialist termination letter is sent to members who have had claims/encounters for services from the Specialist Practitioner on two or more dates in the last twelve months.

- 18 DE Admin. Code 1403 §11.0 Quality Assurance and Operations

FINDING: AHI-DE has a written procedure designed to integrate the goals and objectives of its Quality Assurance into all of its health plan activities. The plan requires measuring performance against key factors; reviewing the quality and utilization of clinical care and service; and analyzing, identifying and addressing continuity and coordination of care, improvements to patient safety, customer and practitioner satisfaction and access and availability of care.

The Company provided copies of all information pertaining to its Quality Assurance and Operations, in particular, information detailing how the MCO met each of the requirements of this section of the Regulation.

The examiners noted no errors in this review.

The Company has a Chief Medical Officer in place to take care of the primary responsibility for the Quality Assessment activities.

The MCOs Medical Director is the designated senior physician who is responsible for the implementation of the Quality Improvement Program. The Director is responsible for providing management with information for strategic decision making and planning. This individual is also responsible for the oversight and maintenance of quality health care delivery programs, policies, procedures and measurements. In addition to other duties it is the Medical Director's responsibility to ensure compliance with state and federal requirements, accreditation standards and Company policies.

• Section 11.2 – Health Care Professional Credentialing

FINDING: AHI-DE has policies and procedures in place to establish requirements for entities participating in its network seeking authority to credential/re-credentialing practitioner and provider applicants for participation. AHI-DE's policies and procedures provide standards for evaluating potential delegates and for providing on-going oversight of delegated credentialing and provide consistency across the Company's markets in the roles, responsibilities and processes for pre-assessment and oversight of delegated credentialing.

The MCO requires twelve (12) criteria such as proof of licensure, liability coverage limits, DEA registration, status of hospital privileges, specialty board certification status, if applicable. All participating providers must notify AHI-DE of any change to the status of any of these twelve (12) items.

AHI-DE may delegate credentialing functions to entities that are participating providers in its network and that demonstrate compliance with the Company's credentialing standards and processes. Credentialing may be delegated for practitioners and/or for organizational providers. Practitioner credentialing functions considered for delegation includes:

- Acceptance of application along with reapplication and attestation
- Collection of credentialing/re-credentialing data
- Primary verification of credentialing/re-credentialing data
- Practitioner office assessments and medical record keeping review
- Peer review decisions
- Managing appeal of peer review decisions
- Ongoing monitoring of sanctions, and member complaints, and potential quality concerns against specific practitioners

AHI-DE has established a credentialing verification committee, consisting of licensed physicians to review credentialing verification information and supporting documents in order to make decisions regarding credentialing verification. The review of the Company's credentialing and performance committee minutes indicated that there were usually eighteen (18) members present which consisted of licensed physicians. The average meeting lasted approximately forty-five (45) minutes.

The Credentialing and Performance Committee minutes were reviewed by the examiners. During the period under examination, a review was made of the Company's performance committee meetings held January 12, 2006 through December 12, 2007. The meetings consisted of minutes of the Providers Initial Credentialing and Re-credentialing Participation in the Network meeting.

According to the minutes, in instances where a provider is either not approved to participate or has not been re-credentialed, an appropriate letter is sent to the Practitioners by the QM/Medical Director denying the application. The MCO's Quality Management procedures state that the Medical Director is responsible for sending appropriate letters to Practitioners regarding:

- Adverse actions taken by the State of Delaware
- Practitioners previous claim history with Company
- Adverse actions taken against clinical privileges by Aetna US Healthcare
- Adverse actions taken by State Department of Health, the Medical Board, Drug Enforcement Agency and Licensing Board, as well as license that are not in good standing
- Additional information obtained on malpractice history
- Conviction of a felony

FINDING: The Company provided Delaware amendment to QM Policy 54, "Practitioner Credentialing/Recredetialing" which notes that policies and procedures are available for review by the applying health care professional upon written request.

The examiners noted no areas of concern.

- Section 11.3 - Provider Network Adequacy

FINDING: The examiners reviewed AHI-DE's Provider Network Adequacy, both (1) Primary, Specialty and Ancillary Providers & Facility and (2) Ancillary Health Care Services to determine compliance with the requirements of this regulation. The examiners also reviewed the Company's related procedures and complaints to see if any raised concerns related to this issue. The regulation states that Providers must be geographically accessible and available within a reasonable period of time; if not, the MCO must cover non-network providers and shall prohibit balance billing.

AHI-DE stated that it meets or exceeds the goal of availability of primary care practitioners, practitioner specialists and hospitals. Goals are also met in the number of practitioners available geographically.

The examiners noted no areas of concerns.

- Section 11.3.3 - Emergency and Urgent Care Services

FINDING: The MCO's Open Emergency/Direct/Urgent Admission Process outlines the Member's Rights and Responsibilities Statement, Coverage for Services and Emergency &

Urgent Care Benefits. The Company has established written policies and procedures governing the provision of emergency and urgent care which meet the guidelines outlined in this regulation. AHI-DE's policies and procedures ensure that its membership and enrollees have access to physician care (including available and accessible services for urgent or emergency services) on a 24 hours/7 day a week basis.

The following standards are also required by this Regulation: the company's guidelines are distributed to each enrollee at the time of initial enrollment and after any revisions are made; the policies are easily understood; when emergency care services are performed by non-network providers the company attempts to make acceptable service arrangements with the provider and enrollee, and they do not allow balance billing; arbitration is recognized for instances where agreement cannot be reached; enrollees have access to emergency care 24 hours per day, seven days per week; and the company relies upon the prudent lay person standard for whether or not a condition merits emergency treatment.

All participating hospitals are required to notify the Company of an emergency admission within 24 hours, or the next business day, whichever comes first. For out-of-plan and out-of-area (within the United States) emergency admissions, the enrollee must notify the health plan of emergency admissions within 48 hours of the admission, if the enrollee is physically capable of so doing. Once notified, the responsible Aetna staff member will ascertain whether the clinical circumstances warrant additional hospitalization and at what point the enrollee's condition is such that the enrollee can be transferred to a participating facility.

The examiners noted no areas of concern.

- Section 11.4 - Utilization Management

FINDING: The Utilization Management (UM) Program is under the direction and oversight of the Medical Officer. The written UM Program Description is provided annually for review and approval to the Medical Advisory Committee which is a peer review committee. The 2006 version was reviewed and approved by the Medicine, Surgery and UM Peer Review Committee, which in 2007 became the Medical Advisory Committee.

The Company provides access to the Utilization Management staff for enrollees, physicians and practitioners via telephone, fax and e-mail. The Company states that their response time to inquiries is within one business day.

AHI-DE states they use nationally published written criteria whenever possible. A listing was provided to the examiners along with a listing of practitioners used in the review and approval of these criteria. When internal criteria are developed and subsequently revised, AHI-DE relies upon its practitioners input.

AHI-DE currently prohibits reimbursement, bonuses or incentives for physicians/providers based on consumer utilization of health care services, as per the requirements of this regulation. The staff is not compensated based on the outcome of individual certification decisions or the number or type of non-certification decisions. This policy and procedure pertains to all participating AHI-DE physicians/providers.

- Section 11.4.5 - Utilization Management Staff Availability.

This regulation requires that appropriately qualified staff be immediately available by telephone, during routine provider work hours, to render Utilization Management (UM) determinations.

FINDING: AHI-DE provides access to UM staff for enrollees/participants, physicians, health care practitioners and providers seeking information about the UM process and authorization of care via telephone, fax and e-mail. The UM Program Description addresses the hours of operation in the participant's handbook. AHI-DE's UM Department is available both during work hours and after hours via telephone. Both local and toll-free telephone numbers are provided to enrollees/participants on their membership cards; Members Services staff provide general information about the UM process and confirmation of approval or denial of coverage for a requested service. When adverse decisions are rendered, a toll-free telephone number is provided to the enrollees/participants within the notification letter that informs them to contact the Medical Director who rendered the decision or the Member Services Department to discuss any issues.

- Section 11.4.6 - Utilization Management Determinations

FINDING: AHI-DE's procedures require qualified health professionals to make preauthorization, precertification, concurrent and retrospective review decisions.

The Provider must request authorization for health services from the MCO by telephone prior to providing any services to a member, regardless of the time of day or day of the week, and they may not bill the member if this requirement is not followed.

A determination to deny or limit service must be rendered by qualified staff, must be made timely, may not retroactively deny reimbursement for a covered service provided to the enrollee by a provider who relied on written or verbal authorization from the MCO prior to performing the service, and the enrollee must receive written notice of all determinations to deny coverage.

The examiners noted no errors in this review.

- 11.5 Quality Assessment and Improvement

FINDING: AHI-DE's Quality Improvement policy and procedure (QIP) manual addresses the following processes: Promote and incorporate quality into the health plan's organizational structure and processes; Provide effective monitoring and evaluation of member care and services provided by contracted providers compared to the requirements of evidence based medicine to ensure the MCO is perceived by customers and professionals; Ensure prompt identification and analysis of opportunities for improvement with implementation of actions and follow-up; Coordinate quality improvement, risk management and patient safety activities, and Maintain compliance with local, state and federal regulatory requirements and accreditation standards.

In addition to the above materials the examiners also reviewed provider complaints. The examiners noted no errors in this review.

The examiners reviewed AHI-DE's Quality Improvement procedures to ensure that participating providers have the opportunity to participate in developing, implementing and evaluating the Quality Improvement (QI) system. AHI-DE's written policy states that practitioner surveys are to be conducted annually. The surveys are designed to assess which services are important to practitioners and providers and to determine practitioner satisfaction with AHI-DE's processes.

The examiners noted no errors in this review.

The MCO has a written procedure to establish communication of their QIP through the following: Board of Directors and Regional QI reports, Customer/Provider newsletters and internet portals, Customer/Provider handbooks, Regulatory body reports, surveys, staff meetings and employee communication material and internet portals. The MCOs QIP is integrated into all health plan activities.

Last, this Regulation requires an MCO to document and communicate information about its Quality Assessment program and its QIP in its marketing materials; that it include a statement of enrollee rights and responsibilities; and make available annually to participating providers and enrollees findings from its quality assessment and quality improvement programs and information about its progress in meeting internal goals and external standards, where available.

The examiners noted no errors in this review.

CONCLUSION

The following recommendations were noted throughout the body of this report, additional detail can be found within the referenced sections:

- It is recommended that Rehabilitation Alliance develop and adhere to a documented Quality Audit Program. Policies and procedures outlining the Rehabilitation Alliance Quality Audit Program for 2007 and the attendance roster for the 2006 Fraud Awareness Training should be submitted to the Company. The Rehabilitation Alliance should implement the use of a column to calculate claim turnaround time on the Aetna Capitation Distribution Excel file. Lastly, the Company should complete all columns on the monthly report for each member submitted on the report including the date of the first visit. (page 6)
- The Company should provide current DDOI contact information for complaints to its enrollees. (page 9)

No further recommendations were proposed. The examination was conducted by Roger Fournier and Gwen Douglas, supervised by Cynthia M. Amann and is respectfully submitted.



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Examiner in Charge