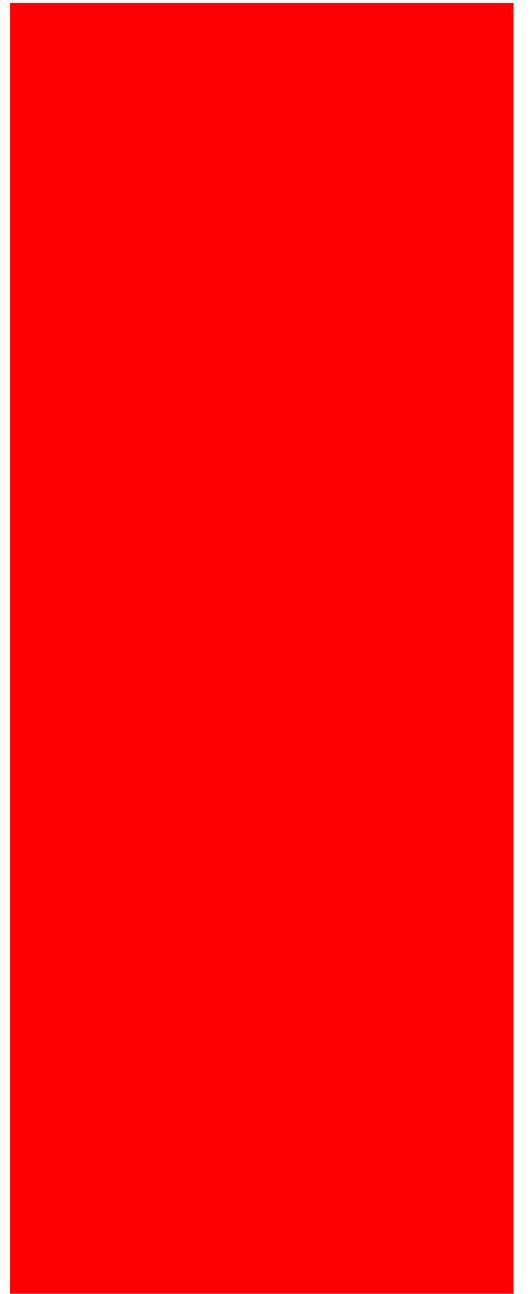


74 SECTION H –
UTILIZATION
MANAGEMENT

75 H.1



Section H: Utilization Management (UM) (Section §8 of RFP)

H.1 Describe how you will ensure that services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope as specified in the Louisiana Medicaid State Plan.

Aetna Better Health, together with its affiliates, has more than 25 years of experience in effectively and efficiently providing Utilization Management (UM) services for Medicaid populations. We serve over 1.3 million members in 10 states: Arizona, California, Connecticut, Delaware, Florida, Illinois, Maryland, Missouri, Pennsylvania, and Texas. Our experience working with populations that have complex health conditions includes providing UM programs and applying clinical guidelines for the full range of Medicaid members, including but not limited to: TANF; SCHIP, SSI, ABD, Members with Special Health Care Needs (MSHCN), Children with Special Health Care Needs (CSHCN) and waiver eligible members with complex health needs. Our UM program is member focused. We pride ourselves in making sound medical management decisions based on both nationally recognized guidelines and the best interest of the member and his/her medical condition.

Aetna Better Health's UM program has been established to center on the care and services that support the member's optimal health and integrate systems for managing, monitoring, evaluating, and improving the utilization of care and services each member receives. The design of our program is to assist each member and provider in the appropriate utilization of medically necessary and covered services, to identify opportunities to optimize a member's health outcome, improve quality of care, determine member and provider satisfaction with the process, and manage costs.

Aetna Better Health's UM process makes certain that we review service requests with minimal administrative barriers for providers. We provide an environment for consistent, collaborative, culturally competent, and optimal utilization of care that is responsive to our providers and members. When applying clinical criteria for prior authorization, concurrent review and retrospective review we consider the member and the member's support system, culture, diagnosis, disease stage, past medical history, including prescribed medicines and services we or a previous health plan have authorized in the past. Our written policies and procedures (P&Ps) include detailed standards, clinical practice guidelines, review criteria, turnaround timeframes, and other requirements relevant to making medically necessity determinations related to, but not limited to: level of care, place of service, scope of service, and duration of service.

We collect, monitor, analyze, assess, and report data from the UM program using our state-of-the-art IT system. We monitor that the results to confirm that:

- 1) Appropriate, services are provided by a participating provider
- 2) The member's medical history does not result in duplicated or inappropriate services
- 3) Services are medically necessary, delivered at an appropriate level of care, place of service and consistent with criteria and clinical practice guidelines
- 4) Under or over utilization of services is not occurring

- 5) Services are a covered benefit completed in a timely, quality manner, and cost-effective; and
- 6) We are collaborating with other Aetna Better Health and community programs and services to improve coordination of care.

Aetna Better Health views each service request as an opportunity to educate providers and to see that each member receives the right care, at the right time, in the right setting and with the right outcome. Over time, these interactions reshape provider behaviors, promote integration of care and guide treatment patterns towards the evidence-based practices that Aetna Better Health advocates.

Lines of Accountability

Aetna Better Health uses nationally recognized clinical criteria to guide our medical decision-making. We design, manage, and administer our process to adopt and disseminate clinical criteria to provide an environment for consistent, collaborative, culturally competent, and optimal utilization of care that is responsive to our members' needs and providers' expectations.

Our Board of Directors (the Board) is ultimately responsible for all aspects of our medical management program, including our utilization and quality management programs. This responsibility includes the evaluation and oversight of our quality and utilization management protocols including adoption of clinical practice guidelines and medical necessity criteria for utilization management decisions. The Board provides strategic management direction to our utilization management program and evaluates the degree that the philosophy and scope of the utilization management program is incorporated within each operational/management unit and across Aetna Better Health's operations. The Board delegates authority to Aetna Better Health chief executive officer (CEO) to develop and administer the medical management program (including quality management). The CEO delegates authority and responsibility to our chief medical officer (CMO) to execute all aspects of our medical management program. The CMO will have responsibility, accountability, and authority for the day-to-day operations of our utilization management program including the review of services for approval or denial. The CMO further delegates management responsibility to the Medical Management Coordinator. Our CMO will have the support of our Aetna Medicaid Business Unit corporate medical management personnel to continually strengthen and improve our ability to develop, implement, monitor/evaluate, and replicate successful interventions to improve health outcomes and quality of care.

Clinical Criteria for Decision Making

The Aetna Better Health CMO in conjunction with the Quality Management/Utilization Management (QM/UM) committee bases the integrity of utilization management decisions on the following clinical criteria standards:

- Clinical criteria are adopted only from nationally recognized professional organizations or through the involvement of clinical providers from the appropriate specialties when clinical criteria are internally developed
- Clinical criteria must be relevant to the disease-state and challenges of our members
- Clinical criteria are adopted in consultation with local community-based physicians with experience treating patients with those illnesses or diseases.

One of our goals is to reduce/eliminate health disparities and improve health outcomes of our members. Therefore, we consider the appropriate and responsive design, dissemination, and deployment of clinical criteria as a management, administrative and training priority. Aetna Better Health uses nationally recognized, evidence-based review criteria to improve the consistency of decisions made by our clinical utilization management personnel. These clinical criteria represent best practices and reflect national standards. They also support medical necessity determinations in conjunction with our utilization management processes. We use the following guidelines for medical necessity reviews:

- For physical health, Milliman Care Guidelines® are used as the primary decision support for most diagnoses and conditions. The guidelines are updated annually based on continuous research by Milliman’s physicians, nurses, and epidemiologists. The Milliman Care Guidelines® also provide Aetna Better Health with access to chronic care guidelines and patient educational materials to coach members as they move to self-care management.
- Aetna Better Health also utilizes its Clinical Policy Bulletins (CPBs). Our CPBs are developed based on evidence in the peer-reviewed published medical literature, technology assessments and structured evidence reviews, evidence-based consensus statements, expert opinions of healthcare providers, and evidence-based guidelines from nationally recognized professional healthcare organizations and public health agencies. Our CPBs are reviewed annually unless relevant new medical literature, guidelines, regulatory actions, or other relevant new information warrants review that is more frequent. Each time a CPB is updated, a comprehensive search of the peer-reviewed published medical literature is performed to determine if there is a change in the experimental and investigational status or medical necessity of the medical technologies addressed. Both new and revised CPB drafts undergo a comprehensive review process. This includes review by Aetna’s Clinical Policy Council and external practicing clinicians, and approval by Aetna’s CMO or his/her designee. Aetna’s Clinical Policy Council is comprised of Aetna pharmacists and medical directors from the Medical Policy & Operations unit, National Accounts Department, Behavioral Health Department, Clinical Pharmacy Department, and Health Care Delivery.

Our protocols for developing, reviewing, adopting and annually evaluating clinical criteria is based on a formal and systematic review of nationally recognized standards, and takes into consideration local/regional practice patterns. Aetna Better Health’s clinical criteria is supported by the following: a) Aetna Better Health’s written utilization management policies and procedures (P&Ps), b) Milliman Care Guidelines®, c) CMS regulations, d) Department of Health and Hospitals (DHH) requirements e) Aetna’s Clinical Policy Bulletins, and f) Clinical Pharmacology. Our process also includes using several evidence-based medicine sources to access and validate our clinical criteria. Examples of sources that may be surveyed or consulted during this process include, but are not limited to, 1) U.S. Food and Drug Administration; 2) ClinicalTrials.gov; 3) National Guideline Clearinghouse; 4) Centers for Medicare & Medicaid Services; 5) Centers for Disease Control and Prevention; 6) National Asthma Education Prevention Program Guidelines; 7) National Heart Lung and Blood Institute; 8) American Heart Association; 9) National Institutes of Health; 10) American Diabetes Association/Diabetes Care; 11) IAHP; and 12) IDSA.

Training

Newly-hired personnel who will administer, manage, communicate or process clinical criteria must attend, and successfully complete a mandatory and comprehensive training program. This skill-based training program lasts for a minimum of three weeks and includes training on Aetna Better Health clinical criteria: a) Aetna Better Health’s UM P&P, b) Milliman Care Guidelines[®], c) Aetna’s Clinical Policy Bulletins, and d) our Medical Management Plan. It is required that personnel from UM (e.g., prior authorization, utilization review and retrospective review), and medical directors attend and successfully complete the initial and annual training program. Utilization management personnel have continuous access to an online training application that provides a concise and readily available resource to help them accurately understand the application of Milliman Care Guidelines[®]. The application includes comprehensive care guideline training on Milliman Care Guidelines[®]; part of this application includes a process to test the employee’s ability to apply the criteria appropriately. These training modules are available “on-demand” and offer a self-pacing approach. In addition, personnel from provider services, member services, claims administration, and grievance and appeals receive initial and on-going training regarding clinical criteria.

For consistent application of clinical criteria by Aetna Better Health UM personnel, the medical management coordinator must have: 1) a valid State license as appropriate or required and in good standing with applicable board, and 2) a minimum of three years of experience and be a Louisiana licensed registered nurse or a physician or physician’s assistant. All other personnel who apply clinical criteria for medical management decision-making, including prior authorization, concurrent review and retrospective review personnel must have appropriate experience and Louisiana licensure as required by DHH regulations and Aetna Better Health P&Ps.

Dissemination of Clinical Criteria to Providers and Members

Aetna Better Health uses multiple resources and media for dissemination of clinical criteria to our providers and members. It is our standard operating procedure to maintain a complete inventory of all clinical criteria on our website. We also use the following communication, media, and resources for disseminating clinical criteria: a) provider manual; b) site visits and individual provider training; c) provider group meetings; d) blast faxes; and e) member and provider profiling. A provider may obtain an applicable, current, and valid copy of our clinical criteria from our website or by contacting the Provider Services Representative office. We also actively disseminate clinical criteria through our prior authorization, concurrent review, quality management, and case/disease managers when they interact with participating or non-participating providers. Clinical criteria are readily available to our members, and potential members through our website, member handbook, member newsletters or by contacting member services. Milliman Care Guidelines[®] are available to providers and members upon request. Aetna Better Health makes all clinical criteria utilized for clinical decision-making from public sources available to providers as described in the table below. There is never a cost charged to providers, members, or potential members when clinical criteria are requested. The table below lists the different methods by which we provide members and providers clinical criteria information.

Member Information	Provider Information
Member website	Provider web portal
Member Handbook	Provider Manual
Member Newsletters	Provider Newsletters
Case Management Team	Provider Services Representative
Care Plan	Care Plan
Member Call Center (Toll free call)	Provider Service Center
Notice of Action Letter	Service Approvals/Denials Determinations

Aetna Better Health’s CMO, working co-operatively with DHH, will attend State sponsored utilization management meetings for consideration of developing uniform clinical practice guidelines with other Coordinated Care Networks (CCNs).

Quality Management Oversight Committee (QMOC)

Aetna Better Health’s QMOC oversees the medical management program including quality and utilization management. QMOC is comprised of the Chief Executive Officer (CEO) director, Chief Medical Officer (CMO), Chief Operating Officer (COO), Chief Financial Officer (CFO), and directors and managers from various Aetna Better Health departments including, but not limited to:

- Provider relations
- Operations
- Member services
- Quality management
- Medical management
- Grievance and appeals

Aetna Better Health’s QMOC primary purpose is to integrate quality management and performance improvement projects and activities throughout the health plan and the provider network. QMOC is designated to provide executive oversight of the utilization and QAPI, reviews committee reports and recommendations (e.g., SIC, QM/UM Committee) and make recommendations to the governing body about Aetna Better Health’s quality management activities, including improvements to the health plan programs and processes. The QMOC also reviews quality of care concerns and investigations that have been reported to the complaint, grievance and appeals coordinator and required summaries of those reports and investigations are placed into the providers’ credentialing files.

Quality Management/Utilization Management (QM/UM) Committee

Our QM/UM Committee annually reviews, analyzes, and approves our clinical criteria. Chaired by the CMO or designee, the QM/UM Committee meets monthly. Membership in the QM/UM Committee includes Aetna Better Health’s medical directors; director of Medical Management; quality management coordinator; Maternal Child Health/EPSTD Coordinator; Director of Integrated Case Management; Provider Services Manager; Member Services Manager; local

community-based and network PCPs; specialists; representative of advocacy organization¹, and other personnel as needed. Prior to each meeting, participants and members of the QM/UM committee must execute a confidentiality and conflict interest agreement. The QM/UM Committee determines if actions are needed regarding: a) the process to design, develop or adopt clinical criteria; b) training of providers on applicable clinical criteria; c) Aetna Better Health personnel training how to administer or apply the clinical criteria; and/or d) the information available to providers or members regarding clinical criteria.

The QM/UM committee's annual review process consists of an evaluation of:

- Existing criteria
- New medical technologies
- New medical technologies, changes in covered services, practice patterns, or members' medical needs
- Determination of any recommendations or changes.

Through our QM/UM Committee, we receive recommendations from providers in the adoption, review, and dissemination of clinical criteria. The use of this multidisciplinary process allows for a wide range of local medical knowledge, including specific local community-base experience related to providing care to patients with similar characteristic as our members, to be considered and applied during the design, development, adoption, and re-evaluation of our clinical criteria. It is our experience that this process lays the foundation for continual improvement, understanding, and acceptance of our clinical criteria. Our CMO, QM/UM Committee manages and directs this process so that our clinical criteria encompasses local care standards and consistently results in appropriate decision-making, course-of-action and/or interventions necessary to improve: 1) health outcomes, and 2) quality of clinical care and or 3) maintain compliance with prudent practice measures. It is our experience that a multidisciplinary development process that includes local providers will encourage acceptance of clinical criteria by other community providers. We will notify DHH of any changes to clinical criteria, P&P in accordance with DHH policies, standards, or regulations.

Ensuring Consistent Application of Clinical Criteria

Aetna Better Health's UM Program P&P meet applicable NCQA standards and include clinical criteria and clinical practice guidelines that:

- Are adopted in consultation with a contracting healthcare professionals
- Are objective and based on valid and reliable clinical evidence or a consensus of healthcare professionals in the particular field
- Consider the needs of the members
- Are reviewed annually and updated periodically as appropriate.

Aetna Better Health has written P&P that govern the adoption and application of clinical criteria to support individualized clinical decision-making. Our P&P include detailed standards; clinical criteria protocols; review criteria; turnaround timeframes and other information relevant to making consistent; and responsive decisions including, but not limited to:

¹ This representation to be determined as part of our initial program design and communicated to DHH

- Level of care
- Place of service
- Scope of service
- Duration of service

Aetna Better Health's P&Ps require:

- 1) Only a medical director with appropriate clinical expertise in treating the member's condition or disease can deny a request for services; reduce the amount, duration, or scope of care; or excluded or limited services;
- 2) Individuals who conduct utilization management activities are not compensated nor is our compensation structured or designed to provide inappropriate incentives for selection, denial, limitation or discontinuation or authorization of services;
- 3) Prior authorization is unnecessary for emergency medical services.

Our CMO is responsible for the development, completeness, relevance and accuracy of our clinical criteria P&P. When applying clinical criteria, we consider the member, the member's support system, the member's diagnosis, the member's disease stage, co-occurring medical/behavioral health conditions and member's individual care plan (as applicable).

Furthermore, our P&P and clinical criteria and clinical practice guidelines are designed to:

- Improve clinical and functional status of members
- Provide the opportunity to review a member's response to treatment and progress toward recovery goals and to support member's access to the most appropriate level of care and treatment setting.
- Enhance our member's quality of life
- Provide services at an appropriate level of care and setting and are consistent with the member's disease state and medical needs
- Improve member safety through avoidance of medically unnecessary services and act as the member's advocate in "never-event" circumstances
- Support each member's right to treatment and provider choice and to exercise a strong voice in treatment planning and goal setting
- Control of fiscal growth and maximize savings by supporting member care being delivered at the most appropriate level of care while supporting each member's right to receive services in their community
- Facilitate the member navigating the healthcare system
- Educate providers regarding core concepts of effective utilization management and application of clinical practice and care guidelines.

Service Authorization Processes for Members with Special Health Care Needs

Aetna Better Health recognizes that Members with Special Health Care (MSCHN) and Children with Special Health Care Needs (CSCHN) often require multiple service authorizations and

complex discharge planning from an inpatient setting. Our medical management criteria are sensitive and responsive to the complex medical situations and conditions these members face each day. These members are “flagged” in our system for ease of identification to allow the application of our medically necessary criteria consistent with the member’s disease state and medical needs.

Internal Review of Medical Necessity Decision

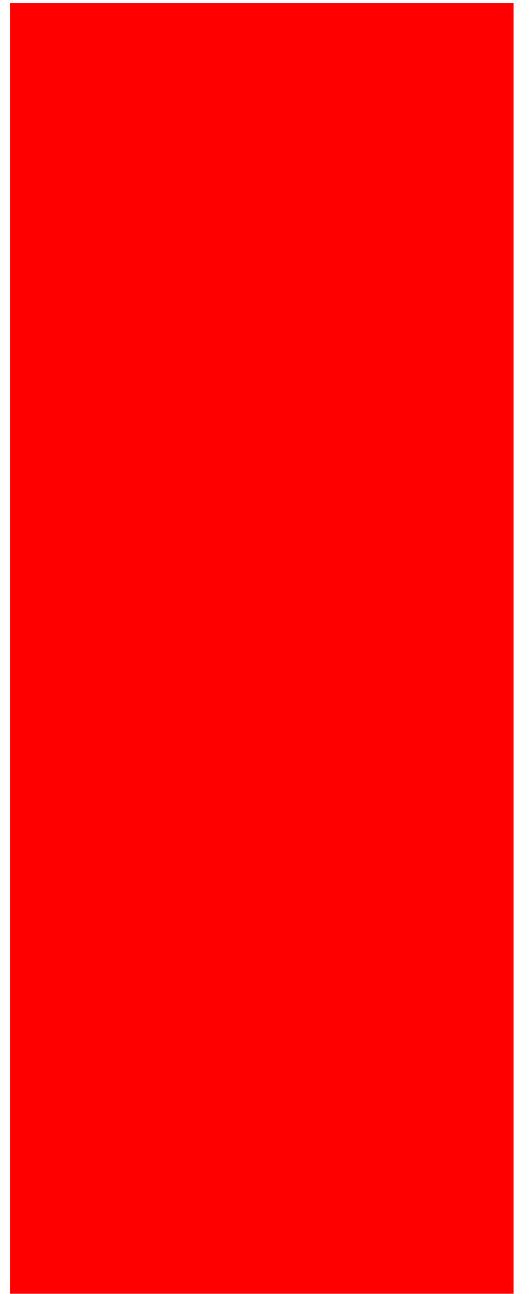
Our CMO, in conjunction with the Utilization Management Coordinator, administers an auditing tool to utilization management employees to validate that they are applying utilization management and medically necessary criteria and guidelines in accordance with established principles and processes. Utilization management personnel’s performance is monitored at least quarterly including a review of how decision-making related to the application of medical necessity criteria in a timely manner. Results of these audits are included in each individual’s performance review.

Inter-Rater Reliability Assessments

Aetna Better Health’s UM Department is responsible for compiling data, conducting and documenting reviews and inter-rater reliability (IRR) assessments, and reporting the results to our CMO. The CMO prepares a report for the QM/UM committee on the total number of utilization management personnel evaluated, the range of scores and the number of corrective education plans developed. The CMO reports to the Board in the annual UM evaluation report. Aetna Better Health uses IRR case studies to determine the consistent application of review criteria and confirm that consistent decisions are made by utilization management personnel, including medical directors, when applying Milliman Care Guidelines[®].

Aetna Better Health has written P&Ps that govern the IRR process. The CMO is responsible for the integrity of the IRR process. The UM assessment incorporates use of the correct guideline and process for clinical decision-making. We test IRR on a regular basis, but not less than annually to maintain uniform application of the clinical care criteria. In 2010, all employees who apply medically necessary criteria in all states (200 personnel) took the IRR assessment averaging an overall score of 94 percent; the score is well above the 85 percent P&P benchmark. Corrective education plans are instituted in the event that individual results fall below benchmarks.

76 H.2



H.2 If the UM guidelines were developed internally, describe the process by which they were developed and when they were developed or last revised.

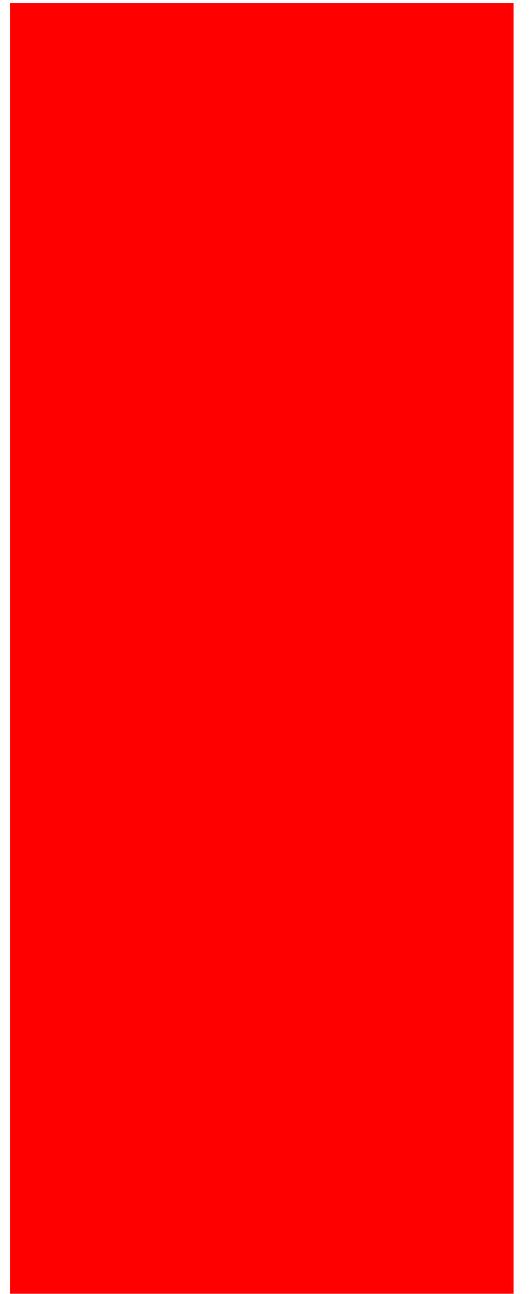
Aetna Better Health does not have internally developed UM guidelines. However, we do use Aetna's Clinical Policy Bulletins in cases where Milliman Care Guidelines[®] fail to address a member specific care needs. Aetna's Clinical Policy Bulletins, which are developed by Aetna's Clinical Policy Council, are policies on the experimental and investigational status and medical necessity of medical technologies and services.

Aetna's Clinical Policy Bulletins are accepted as clinical decision support tools within the healthcare industry, as evidenced by Amerigroup Corporation's adoption of Aetna's nationally recognized, peer-reviewed, evidence-based and publicly available Clinical Policy Bulletins. Amerigroup implemented use of Aetna's Clinical Policy Bulletins in August 2008 and continues to use these guidelines in addition to nationally approved criteria as the basis for Utilization Management decisions. A number of other healthcare organizations also utilize Aetna's Clinical Policy Bulletins.

Aetna's Clinical Policy Bulletins are detailed and technical documents that explain how we make coverage decisions for our members. Each of Aetna's Clinical Policy Bulletins describes medical services that may or may not be authorized for the specific condition that the Aetna's Clinical Policy Bulletin references. Aetna's Clinical Policy Bulletins are based on evidence from objective, credible sources including scientific literature, technology reviews, consensus statements, expert opinions, guidelines from national professional healthcare organizations and public health agencies. Each of Aetna's Clinical Policy Bulletin is based on clinical evidence provided in peer-reviewed literature and developed by Aetna's Medical Directors on Aetna's Clinical Policy Council, with input from practicing physicians. Sources of information include technology assessments and structured evidence reviews, evidence-based consensus statements, expert opinions of healthcare providers, and evidence-based guidelines from nationally recognized professional healthcare organizations and government public health agencies.

Aetna's Clinical Policy Bulletins are reviewed annually or more frequently when relevant new medical literature, guidelines, regulatory actions, or other relevant new information warrants review. Each time Aetna's Clinical Policy Bulletins are updated, a comprehensive search of the peer-reviewed published medical literature is performed to determine if there is a change in the experimental and investigational status or medical necessity of the medical technologies addressed. Both new and revised Aetna's Clinical Policy Bulletin drafts undergo a comprehensive review process. This includes review by Aetna's Clinical Policy Review Unit and external practicing clinicians, and approval by Aetna's Chief Medical Officer or designee. Aetna's Clinical Policy Council is comprised of Aetna Medical Directors and Pharmacists from the Medical Policy and Operations Unit, National Accounts Department, Behavioral Health Department, Clinical Pharmacy Department and Health Care Delivery Department. We use Aetna's Clinical Policy Review Unit when the requested service is not addressed by other criteria sets. The CMO submits a request for a position determination to the Aetna's Clinical Policy Review Unit. Aetna's Policy Review Unit will research literature applicable to the specific request and, when a determination is reached, will respond to the CMO or designee and post the determination with the Aetna's Clinical Policy Bulletins.

77 H.3



H.3 Regarding your utilization management (UM) staff:

- Provide a detailed description of the training you provide your UM staff;
- Describe any differences between your UM phone line and your provider services line;
- If your UM phone line will handle both Louisiana CCN and non-Louisiana CCN calls,
 - explain how you will track CCN calls separately; and
 - how you will ensure that applicable DHH timeframes for prior authorization decisions are met.

Aetna Better Health’s Utilization Management (UM) team, led by our Chief Medical Officer (CMO), will employ professionals with UM expertise, including those with experience in working with populations with complex physical and basic behavioral health care needs. Our UM team will use their clinical and/or customer service skills to support the coordination of our UM Program with members, PCPs and providers.

Aetna Better Health’s physicians and clinical personnel are responsible for each level of UM decision-making. Personnel involved in the utilization management process include:

- Chief Medical Officer
- Utilization Management Coordinator
- Quality Management Coordinator
- Prior Authorization Clinician
- Concurrent Review Clinician
- Care Coordinator Clinician
- Prior Authorization Representative
- Appeals Representative

It is Aetna Better Health, together with its affiliates, has more that 25 years experience providing Medicaid managed care services, that an effective orientation and training program is vital to the consistent application of our utilization management policies and procedures (P&P), clinical care guidelines and clinical practice guidelines. During the last two years, we have implemented three new health plans [Florida (April 2010), Pennsylvania (April 2010) and Illinois (May 2011)], successfully applying our two phase UM personnel training program in each implementation.

UM Employee Orientation

The first phase is our new employee orientation process. Orientation starts with “employee on boarding” that begins with the recruitment, interviewing and hiring process. The purpose of employee orientation is to assist employees in applying their experience, background, training and skills to the mission and operations of our organization. All new employees are required to complete the employee orientation process and to review critical policies that relate to specific contract and program requirements.

New employees participate in training outlining the CCN Program as part of the orientation process. Each employee will complete an assessment measuring their knowledge of the program following orientation. This evaluation will determine the need for additional training if necessary. After completion of the orientation program, employees will understand materials presented in the following areas:

- Louisiana CCN programs' background
- Aetna Better Health's mission and goals
- CCN Program services
 - Covered services
 - Excluded services
 - Carved-out services
- The importance of confidentiality, including the governing federal and state laws and regulations and members' rights
- The unique service needs of the populations served by Aetna Better Health
 - Louisiana has a high rate of poverty with poor access/poor utilization²
 - Overall poor health outcomes
 - ◇ High rate of sick newborns
 - ◇ Poor asthma outcomes
 - ◇ Poor diabetes outcomes
 - ◇ High cancer deathrate
 - Care coordination is often fragmented
 - Access is limited for specialists
 - Inappropriate utilization of services
 - ◇ High rate of Emergency Department (ED) utilization
 - ◇ High rate of hospitalizations
 - ◇ High rate of hospital readmissions
 - According to Louisiana Health First:
 - ◇ More people in Louisiana per 100,000 die of cancer each year than in every other state but two
 - ◇ More infants in Louisiana per 1,000 die each year than in every other state but one
 - ◇ More children in Louisiana per 100,000 die each year than in every other state but two
 - ◇ African Americans in Louisiana experience 54 percent more premature deaths than whites

² Reshaping Louisiana Medicaid's Service Delivery Systems – Coordinated Care Networks; Rodney Wise, MD, FACOG, Louisiana Medicaid Medical Director; June 29th, 2010

- ◇ Louisiana is ranked 51st for avoidable hospitalizations
- ◇ More than one in five of Louisiana citizens have no insurance
- Importance of community-based and advocacy organizations
- Aetna Better Health's organization and design
- Fraud and abuse standards and requirements
- Role of the member and the member's family/caregiver in our programs
- Design of the Care Management Program and member stratification process
- Reporting requirements
- Resources for staff development and assistance
- Disease management, and the Integrated Care Management (ICM) Program
- Compliance Program requirements
- Americans with Disabilities Act and its relevance and importance
- Keys for successful interactions with our members
- Comprehensive overview of Aetna Better Health's culture, including our values and ethics and dedication to providing an environment that is focused on our members and providers
- Cultural competency initiatives and training address member specific cultural and language needs that might challenge members' ability to access care or understand healthy practices. This includes an effective health literacy and cultural competency training program as a component of our employee orientation.
- Training to dispel the myths and stigmas related to Medicaid members
- Personnel are trained and tested and pass our mandatory compliance and ethics training including, but not limited to, topics such as the Health Insurance Portability and Accountability Act (HIPAA), Ethical Code of conduct, fraud, waste and abuse and diversity
- Job specific training includes education from experienced personnel in a hands-on environment, access to job specific policies, procedures and helpful resources, as well as job shadowing
- Extensive training on technology and systems tools that will support employees in performing their duties and enhance their ability to work efficiently

Upon completion of the orientation program, employees will have a sound overview of these key elements. Orientation sessions will be conducted in a classroom type setting and led by a member of the clinical training staff. A record of class attendance in the form of an employee sign-in sheet will be part of the official record for each session. The class record will also include electronic acknowledgements from each employee that they received and understand orientation materials on important concepts (e.g., confidentiality). Following the general orientation program, employees will join their units for applied and purposeful orientation specifically related to the requirements of their position, team, and unit.

UM Employee Training

Following the orientation sessions, Aetna Better Health will provide a comprehensive training program designed to prepare new utilization management personnel efficiently, with great care

and consideration for instilling the values and keys to successfully performing utilization management services for Medicaid members. Training program highlights include:

- Providing a comprehensive overview of our organization’s culture, including our corporate values and ethics, and our dedication to providing an environment focused on our members and providers
- Making sure that personnel are trained, tested and successfully pass our mandatory compliance and ethics training including, but not limited to, topics such as HIPAA, Ethical Code of Conduct, Fraud, Waste and Abuse, and Diversity, Reporting Abuse and Neglect
- Completing job specific training to include education on applying our Utilization Management clinical criteria (Milliman Care Guidelines[®] and Aetna’s Clinical Policy Bulletins) and clinical practice guidelines (e.g., asthma, diabetes, COPD and, CHF)
- Utilization management personnel have continuous access to an online training application that provides a concise and readily available resource to help them accurately understand the application of Milliman Care Guidelines[®]. The application includes comprehensive care guideline training on Milliman Care Guidelines[®]; part of this application includes a process to test the employee’s ability to apply the criteria appropriately. These training modules are available “on-demand” and offer a self-pacing approach.
- UM personnel are trained on CCN Program covered, excluded and carved-out services. This training includes any restrictions on services.

Our Utilization Management professionals will have expertise in acute care (e.g., maternity, preventive, EPSDT and, well-woman/well-man services). Our personnel will receive training to combine clinical skills with service techniques to support Aetna Better Health’s utilization management processes including prior authorization, concurrent review, and retrospective review of services. Aetna Better Health’s CMO has the ultimate responsibility, in collaboration with the Utilization Management Coordinator, for oversight of each level of utilization management including day-to-day program operations and activities. Aetna Better Health’s CMO and clinical prior authorization, concurrent review, care coordinator and appeals personnel are responsible for each level of utilization management decision-making. The table below highlights the role and responsibilities of each of our utilization management personnel.

Position	Clinical / Non Clinical	Responsibilities and Training Protocols	Decision Making Authority
<p>CMO</p>	<p>Clinical</p> <p>Louisiana board-certified licensed physician either in an appropriate behavioral or physical health area</p>	<p>The Aetna Better Health CMO will be a Louisiana board-certified licensed physician who oversees all clinical management programs. Our CMO is accountable for directing the development and implementation of the Utilization Management Program within Aetna Better Health. Our CMO is responsible for providing leadership in the following key functions: monitoring quality, continuity, and coordination of care and addressing over utilization and underutilization of services. The Aetna Better Health CMO is available to PCPs and/or other providers to discuss, clarify, or explain a utilization management policy, procedure, protocol or decision. With the assistance of the Utilization Management Coordinator and medical committees, the CMO oversees utilization management training activities to confirm that utilization management work plan activities are completed. In this capacity, the CMO oversees and participates in the orientation and training of personnel in prior authorization, concurrent review, care coordination, and retrospective claims review, and reviews of potential utilization management referrals. The CMO serves as the chairperson of the Quality Management/Utilization Management Committee.</p> <p>The CMO will have responsibility for prior authorization reviews and denials, original and standard reviews of claim determinations, appeals of claim and predetermination issues, and providing clinical, coding and reimbursement expertise. The CMO will apply and/or interpret policies, procedures, and regulatory standards while assessing the member needs to provide appropriate administration of benefits. Only the CMO or a delegated physician can deny a prior authorization request or approve a reduction, denial, or elimination of a service (e.g., medical, behavioral health, surgical, inpatient, outpatient, medications).</p>	<p>Yes</p>

Position	Clinical / Non Clinical	Responsibilities and Training Protocols	Decision Making Authority
Utilization Management Coordinator	Clinical The Utilization Management Coordinator will be a Louisiana licensed physician, Physician's Assistant or licensed Registered Nurse	The Utilization Management Coordinator will be a Louisiana licensed physician, physician's assistant or licensed registered nurse. The Aetna Better Health Utilization Management Coordinator oversees the utilization management programs and processes under the direction of the CMO. The Utilization Management Coordinator has the authority and responsibility to manage and administer the utilization management programs including prior authorization, concurrent review and retrospective review. This position works collaboratively with the Aetna Better Health training team for the orientation and training of the utilization management programs including prior authorization, concurrent review to provide a continuum of care for members. This position identifies, analyzes, plans, develops, organizes, implements and evaluates training needs and requirements within our utilization management areas: including, but not limited to the Inter-Rater Reliability Process. The Utilization Management Coordinator works with the utilization management staff to train and support the appropriate process, determination, interactions and competence of the staff.	Yes

Position	Clinical / Non Clinical	Responsibilities and Training Protocols	Decision Making Authority
Prior Authorization Nurse	Clinical Must be a Louisiana licensed physician, or licensed Registered Nurse, or other professional	The Prior Authorization (PA) Nurse utilizes clinical skills to support comprehensive coordination of medical services including making initial coverage determinations, screening, and referrals. The PA Nurse promotes quality effectiveness of healthcare services, collecting information prior to inpatient admissions and performance of selected ambulatory procedures and services. The process includes eligibility verification, determination if the service is a covered service, review of the service's medical necessity, contacting the requesting physician if additional information is needed, and notification of action (if the request is denied). These personnel receive training including, but not limited to: <ul style="list-style-type: none"> ● Covered, excluded and carved-out services ● Focused training on the unique medical needs and environment of CCN members ● Techniques to recognize potential under/over utilization, fraud and abuse, and physical abuse or neglect of members 	Yes
Prior Authorization Representative	Non Clinical Must be a high school graduate with experience in medical terminology or provider office experience	The Prior Authorization Representative is the first contact point for authorization requests. The Prior Authorization Representative works closely with the PA Nurses, CMO and Medical Directors to support the processing of authorization requests. Prior Authorization Representatives are trained in our technology systems that support the prior authorization process, and learn strong customer service skills. The Prior Authorization Representative supports the timely, correct and complete initiation of the authorization request whether it is received by telephone, fax or electronically.	No

Position	Clinical / Non Clinical	Responsibilities and Training Protocols	Decision Making Authority
Concurrent Review Clinician	Clinical Must be a Louisiana licensed RN or LPN	<ul style="list-style-type: none"> ● Utilizes clinical skills to support comprehensive coordination of medical services including making initial coverage determinations, screenings, and referrals ● Admissions are reviewed for medical necessity, and continuing services are reviewed for the appropriate use of inpatient medical resources (acute care, behavioral, substance abuse, rehab, skilled nursing) ● Applies the clinical criteria and clinical practice guidelines for concurrent review ● Applies medical policy, guidelines and decision-making criteria to make appropriate coverage decisions – for concurrent services ● Initiates discharge planning processes ● Identifies if a member may be subject to abuse, neglect or exploitation ● Works collaboratively with the Case Manager to confirm continuum of care for members during the discharge planning and post-discharge process (including home health care, DME, therapies and rehabilitative services) ● Identifies and escalates quality of care issues through established channels ● Consults with supervisors and/or Medical Directors when coverage criteria are not met ● Verifies accurate and complete documentation of required information to meet risk management, regulatory, and accreditation requirements ● Protects the confidentiality of member information and adheres to company policies regarding confidentiality 	Yes

Position	Clinical / Non Clinical	Responsibilities and Training Protocols	Decision Making Authority
		<p>These personnel receive training including, but not limited to:</p> <ul style="list-style-type: none"> ● Covered, excluded and carved-out services ● Focused training on the unique medical needs and environment of CCN members ● Techniques to recognize potential under/over utilization, fraud and abuse, and physical abuse or neglect of members ● Discharge planning and coordination with treating physician, hospital discharge planner and Aetna Better Health Case Manager 	
<p>Retrospective Review Clinician</p>	<p>Clinical Must be a Louisiana licensed RN or LPN</p>	<ul style="list-style-type: none"> ● Utilizes clinical skills to support review of claims to evaluate hospital inpatient, Emergency Department, outpatient services and certain ancillary claims to determine if: a) the service(s) were covered services; b) the services were medically necessary; c) the quality of care was provided according to evidence-based standards; and d) the appropriate level of resources was expended. ● Claims are reviewed for medical necessity, and continuing services are reviewed for the appropriate use of inpatient medical resources (acute care, behavioral, substance abuse, rehab, skilled nursing) ● Review of claims is based on applying clinical criteria and clinical practice guidelines for retrospective review as described below: ● For physical health, Milliman Care Guidelines® are used as the primary decision support for most diagnoses and conditions ● Aetna’s Clinical Policy Bulletins (CPBs) are used if Milliman Care Guidelines® and or State requirements are unclear on a process or procedure ● Applies medical policy guidelines and decision-making criteria to make appropriate coverage decisions 	<p>Yes</p>

Position	Clinical / Non Clinical	Responsibilities and Training Protocols	Decision Making Authority
		<ul style="list-style-type: none"> ● Identifies and escalates quality of care issues through established channels ● Consults with supervisors and/or Medical Directors when coverage criteria are not met ● Verifies accurate and complete documentation of required information to meet risk management, regulatory, and accreditation requirements ● Protects the confidentiality of member information and adheres to company policies regarding confidentiality <p>These personnel receive training including, but not limited to:</p> <ul style="list-style-type: none"> ● Covered, excluded and carved-out services ● Focused training on the unique medical needs and environment of CCN members ● Techniques to recognize potential under/over utilization, fraud and abuse, and physical abuse or neglect of members 	

Inter-Rater Reliability Assessments

Aetna Better Health's UM Department is responsible for compiling data, conducting and documenting reviews and inter-rater reliability (IRR) assessments, and reporting the results to our CMO. The CMO prepares a report for the QM/UM committee on the total number of utilization management personnel evaluated, the range of scores and the number of corrective education plans developed. The CMO reports to the Board in the annual UM evaluation report. Aetna Better Health uses IRR case studies to determine the consistent application of review criteria and confirm that consistent decisions are made by utilization management personnel, including medical directors, when applying Milliman Care Guidelines[®].

Aetna Better Health has written P&Ps that govern the IRR process. The CMO is responsible for the integrity of the IRR process. The UM assessment incorporates use of the correct guideline and process for clinical decision-making. We test IRR on a regular basis, but not less than annually to maintain uniform application of the clinical care criteria. In 2010, all employees who apply medically necessary criteria in all states (200 personnel) took the IRR assessment averaging an overall score of 94 percent; the score is well above the 85 percent P&P benchmark. Corrective education plans are instituted in the event that individual results fall below benchmarks.

Differences Between UM Phone Line and Provider Services Phone Line

Aetna Better Health has provider service operations in 10 states across the country. Aetna Better Health's provider services team and UM hotlines will be supported by an Avaya S8500 IP switch. We have centralized our Avaya Communications Manager Platform in Blue Bell, Pennsylvania. The Avaya switch maintains 20 percent extra capacity to cover any unforeseen spikes and growth spurts, handling up to 375,000 calls an hour if necessary. This server is one part of a cluster of Avaya PBXs that provide virtually unlimited growth potential. Data is shared between servers through distributed IP support, allowing real-time backup of data to the hot-site and dynamic distribution of calls. As a result, the system will be able to handle both Member Services and UM calls on the same switch.

Our Avaya PBXs are managed 24-hours-a-day, 7-days-a-week by on-site, dedicated personnel, with 24/7 Avaya technical support. Multiple levels of redundancy all but eliminate unscheduled downtime. In fact, it would take four separate points of failure to bring the system down.

Aetna Better Health will maintain a dedicated phone line for the Louisiana Medicaid CCN Program. Provider Services Representatives will be located in our Louisiana office. Below is a table delineating the similarities and differences between the Provider Services call center and UM call center.

Function/Responsibility	UM Call Center	Provider Services Call Center
<p>Training of Provider Services staff – both initial and ongoing</p>	<p>Prior authorization personnel receive training including, but not limited to:</p> <ul style="list-style-type: none"> • Covered, excluded and carved-out services • Focused training on the unique medical needs and environment of CCN members • Techniques to recognize potential under/over utilization, fraud and abuse, and physical abuse or neglect of members <p>Prior Authorization Representatives are trained in our technology systems that support the prior authorization process, and learn strong customer service skills. Prior Authorization Representatives support the timely, correct and complete initiation of the authorization request whether it is received by telephone, fax or electronically.</p> <p>Training also includes when and how to transfer calls to the Member Services, Provider Services, Quality Management, Care Management, Disease Management, Compliance or Fraud and Abuse Departments.</p>	<p>All personnel having contact with providers receive initial and ongoing training regarding the appropriate identification and handling of quality of care/service concerns. This training phase provides employees with tools, supports, and instructions that can be applied to successful performance in their specific positions.</p> <p>Training also includes when and how to transfer calls to the Member Services, Utilization Management, Quality Management, Care Management, Disease Management, Compliance or Fraud and Abuse Departments.</p>
<p>Process for routing calls to appropriate persons, including escalation; the type of information that is available to provider services staff and how this is provided (e.g., hard copy at the person’s desk or online search capacity)</p>	<p>All incoming provider calls are routed to the employee with the training, skills, and experience to resolve the issue. However, should the employee require additional assistance, the Avaya telephone system supports the seamless transfer of any incoming call elsewhere within the team or to a different area of the Aetna Better Health. Employees are trained on how to effectively transfer provider calls to the appropriate resource.</p>	<p>All incoming provider calls are routed to the employee with the training, skills and experience to resolve the issue. However, should the employee require additional assistance, the Avaya telephone system supports the seamless transfer of any incoming call elsewhere within the team or to a different area of Aetna Better Health. Employees are trained on how to effectively transfer provider calls to the appropriate resource.</p>
<p>Call Tracking Capability</p>	<p>Yes – All calls are tracked in the Avaya system, track UM call management metrics and provide all reports.</p>	<p>Yes – All calls are tracked in the Avaya system track UM call management metrics and provide all reports.</p>

Function/Responsibility	UM Call Center	Provider Services Call Center
Monitoring process for confirming the quality and accuracy of information provided to providers (and to providers for UM purposes)	<p>UM Managers monitor a random sample of calls per PA personnel each month. However, during initial launch in GSA A, GSA B and GSA C, monitoring will be more frequent. All calls are recorded through the Verint system, which allows managers to review of any call at anytime. After comparing the PA personnel work requirements against a carefully crafted performance tool, the results are shared with the individual to evaluate the need for additional training and/or other opportunities for improvement. Team coordinators continually walk the floor to provide accessibility and additional support and guidance.</p> <p>Should a workload pattern emerge indicating that either additional trunk lines or personnel will be needed, the Utilization Management Coordinator will facilitate the immediate training and deployment of temporary personnel (licensed in accordance with requirements for the position).</p>	<p>Member Services Managers monitor a random sample of calls per representative each month. However, during initial launch in GSA A, GSA B and GSA C, monitoring will be more frequent. All calls are recorded through the Verint system, which allows managers to review of any call at anytime. After comparing the Provider Services Representative's (PSR) work against a carefully crafted performance tool, the results are shared with the individual to evaluate the need for additional training and/or other opportunities for improvement.</p> <p>Should a workload pattern emerge indicating that either additional trunk lines or personnel will be needed, the Provider Services Manager will facilitate the immediate training and deployment of temporary personnel.</p>
Monitoring process for ensuring adherence to call management metrics	<p>Reports from our Avaya call management system enable our UM Coordinator to anticipate future call volume, supporting scheduling of UM personnel at levels sufficient to adequately address providers' needs and satisfy required performance metrics. See call management metrics below.</p>	<p>Reports from our Avaya call management system enable Supervisors to anticipate future call volume, supporting scheduling of PSRs at levels sufficient to adequately address providers' needs and satisfy required performance metrics. See call management metrics below.</p>
How your UM/provider service line will interact with other provider service lines maintained by state, parish, or city organizations (e.g., Partners for Healthy Babies, WIC, housing assistance, and homeless	<p>It is Aetna Better Health's standard operating procedure to work with state agencies, parish agencies, city agencies/organizations, community based organizations, and appropriate advocacy and support organizations to establish an intranet community and referral database for use by our utilization management teams. We will facilitate and support email</p>	<p>It is Aetna Better Health's standard operating procedure to work with state agencies, parish agencies, city agencies/organizations, community based organizations, and appropriate advocacy and support organizations to establish an intranet community and referral database for use by our provider service management team. We will facilitate and support email connectivity and a warm</p>

Function/Responsibility	UM Call Center	Provider Services Call Center
shelters)	connectivity and a warm transfer process to these organizations. Our Intranet database will serve as a resource list for organizations such as Partners for Healthy Babies, WIC, housing assistance, and local homeless shelters. Our UM personnel will make this information available to providers and other interested parties when they contact the Prior Authorization Department.	transfer process to these organizations. Our Intranet database will serve as a resource list for organizations such as Partners for Healthy Babies, WIC, housing assistance, and local homeless shelters. Our PSR personnel will make this information available to members and other interested parties when they contact the prior authorization department.
After-hours procedures	<p>P&Ps mandate that UM personnel, under the supervision of a UM Manager, retrieve messages from the department's voice mailbox every business morning and respond no later than the end of the business day.</p> <p>Providers seeking to verify enrollment for a member with an urgent or emergency medical condition are directed to a number of alternative enrollment verification sources. While there is no requirement that providers seek enrollment verification prior to providing emergency services, eligibility can be verified 24-hours-a-day, 7-days-a-week through Aetna Better Health's website (www.aetnamedicaid.com). In the event that a member inadvertently reaches the utilization management after hour's line, they will be instructed to either seek emergency medical care if necessary or contact the member service line to leave a message.</p>	<p>The provider message will include instructions for how to verify enrollment through AboveHealth® and that this service is available 24/7 for providers to verify eligibility.</p> <p>Providers who call the Provider Hotline after normal hours of operation are asked to leave a voicemail. A designated PSR will be responsible for returning calls from providers the next business day.</p> <p>Providers are also informed that there is no requirement that providers seek enrollment verification prior to providing emergency services.</p>
Providers submitting PA request and validating eligibility	Providers can enter PA request in AboveHealth®.	Providers can check member eligibility, PA status and send a secure email to Provider Services.

Louisiana CCN UM Phone Line

Aetna Better Health's Louisiana UM Department and its Provider Services phone line will only and exclusively serve Louisiana providers, DHH, and other interested Louisiana-based parties.

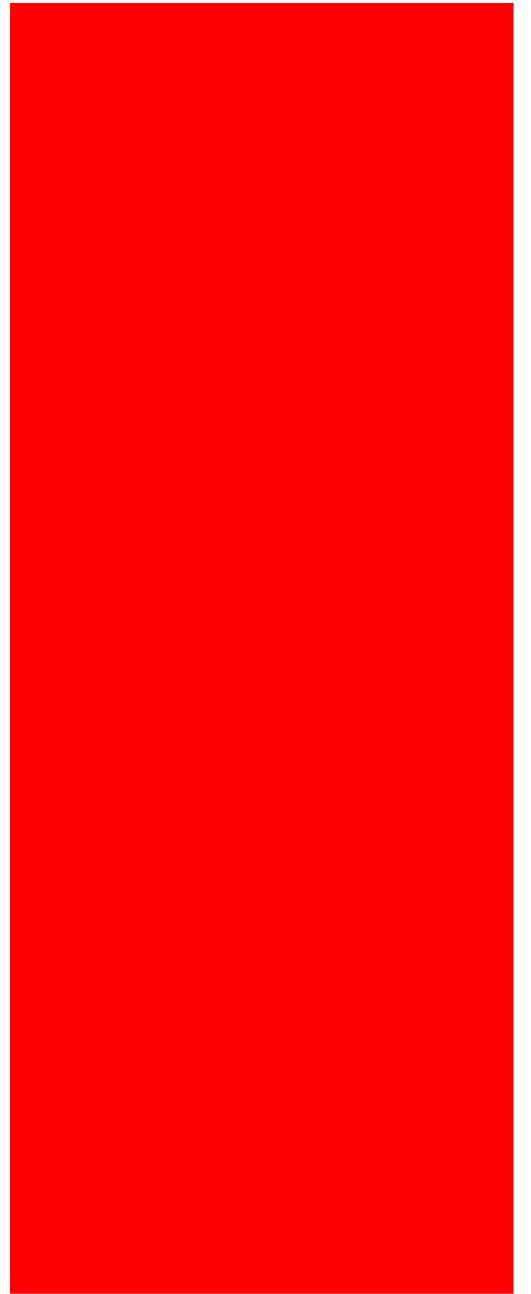
UM and Provider Performance Metrics

Our UM call center and Provider hotline service will meet DHH's performance metrics as defined be:

- Answer ninety (90) percent of calls will be answered within thirty (30) seconds
- No more than one percent (1%) of incoming calls will receive a busy signal
- Maintain an average hold time of three (3) minutes or less
- Maintain an abandoned rate of calls of not more than five (5) percent

The Medical Management Coordinator and the Provider Services Manager will conduct continuous quality assurance to measure and report performance. Based on performance we will implement corrective actions (hire and train additional personnel; train providers on the use of AboveHealth[®]; and isolate additional action steps). If DHH should determine that they need to conduct onsite monitoring or our UM, provider or member call center functions, Aetna Better Health shall be responsible for DDH's reasonable costs.

78 H.4



H.4 Describe how utilization data is gathered, analyzed, and reported. Include the process for monitoring and evaluating the utilization of services when a variance has been identified (both under- and over- utilization) in the utilization pattern of a provider and a member. Provide an example of how your analysis of data resulted in successful interventions to alter unfavorable utilization patterns in the system.

Aetna Better Health brings 25 years of experience and expertise in implementing, managing, and operating an efficient, effective and state-of-the-art data analytics program to the Department of Health and Hospitals (DHH) requirements. Aetna Better Health and its affiliates administer Medicaid plans in 10 states, requiring an integrated data analytics technology infrastructure that supports reliable, responsive, accurate, complete and timely actuarial and data analytics support.

Aetna Better Health's Board of Directors (the Board) is our governing body and is ultimately responsible for all aspects of our Medical Management Program. The Board delegates authority to our Chief Executive Officer (CEO) to develop and administer the Medical Management Program, including utilization management. The CEO delegates authority and responsibility to our Chief Medical Officer (CMO) to execute all aspects of our Medical Management Program. Under the leadership of our CMO, we have continually strengthened and improved our ability to gather, analyze, monitor/evaluate, and report utilization data to facilitate the delivery of appropriate care and services to our members. Throughout our process of collecting and managing utilization data, we make certain that the privacy of our members and the security of our members' protected health information (PHI) are protected.

Aetna Better Health's Quality Management and Utilization Management (QM/UM) Plan is our framework for gathering and analyzing over- and underutilization data. Aetna Better Health has written utilization management policies and procedures in place that are fully consistent with DHH requirements. Our comprehensive approach to continuous quality improvement and effective utilization management relies on the gathering and analysis of utilization data to identify opportunities for improvement (clinical or operational), determine the most effective interventions, and monitor the effectiveness of the intervention through pre-determined performance metrics. Our UM Department creates indicators for identifying potential over- and underutilization (including target and performance indicators) and presents them to the QM/UM Committee for review and approval.

The collection and analysis of UM data is a companywide effort, involving support from all functional areas. Our CMO is responsible for oversight of our UM Program and works collaboratively with other functional areas, including Medical Management, Quality Management, Finance, Provider Services, and Appeals to gather and trend a comprehensive set of utilization measures. The QM/UM Committee is responsible for overseeing data collection and analysis, reviewing the findings and their impact on service quality and member outcomes, and recommending opportunities or interventions to the CMO. This cross-functional committee is chaired by our CMO and includes representatives from our clinical areas, as well as local community providers. In addition, selected reports are regularly presented and reviewed at QM/UM Committee meetings and, if appropriate, the committee recommends intervention strategies to address identified opportunities for improvement to the QM/UM Committee. Our

QM/UM Program will operate in full compliance with DHH standards and will include established clinical functions and tools, such as practice guidelines and medical review criteria, to analyze the use of medical resources.

Processes for Gathering Utilization Data

The UM Department gathers utilization and utilization-related data for all services from multiple sources, including claims, clinical review data, and member and provider feedback. Our data warehouse and decision support system, the Actuarial Services Data Base (ASDB), houses eligibility, provider-generated member data, authorization, pharmacy, and medical claims data and is our utilization data repository. Our UM staff obtains regular management reports and creates ad hoc reports from ASDB. Our Finance Department generates Category of Expense reports that review utilization trends by categories. The outlier trends are reviewed in more detail to determine the root cause of the increase or decrease in that specific category.

Analysts from our Actuarial Services Department use the proprietary Actuarial Analytics Web Portal (AAWeb), an interactive interface, as a point-and-click query tool to access reports and drill down into data and export information from ASDB. For instance, AAWeb can generate customized analyses to identify favorable and unfavorable cost and utilization trends, measure performance against key benchmarks, and review summary information. It is a powerful tool that provides our leadership with access to member/provider cost and utilization trends.

Our UM nurses also gather concurrent review and prior authorization data through clinical reviews to identify occurrences of over- or underutilization and physician practice patterns, identify ways to improve the member's inpatient care outcomes, and monitor the cost effectiveness of the services by:

- Assessing the medical necessity of admissions and stays, the medical appropriateness and cost effectiveness of the setting, level of care, and services
- Monitoring services to see that they are appropriate and delivered in a timely manner
- Screening for potential quality, utilization, or risk issues
- Identifying and referring members who may benefit from our case management or disease management programs or a community health program
- Identifying clinical issues and referring them to the CMO or designee for discussion with the member's treating health care professionals

To further support and enhance our analysis of utilization trends and patterns, the Medical Management Department gathers additional utilization-related data. Examples include:

- Annual member and provider satisfaction surveys. These surveys provide us with feedback on how we are perceived by our key stakeholders, including member questions related to the availability, accessibility and utilization of services and providers' satisfaction with our UM procedures, claims processing and response to inquiries.
- Ambulatory medical record reviews conducted by the QM Department. These reviews provide us with information about the provision of recommended preventive services for adults, children, and pregnant members. We have found that preventive health screenings and

services are most frequently under-utilized and we closely track these services to identify low-performing providers.

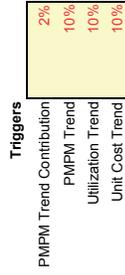
- Coordination of care, including:
 - Detecting inappropriate patterns of care (e.g., over- or underutilization of services, including pharmacy)
 - Identifying diagnoses or multiple comorbidities that place members at risk for serious consequences
 - Providing immediate support to members in need in order to reduce inappropriate care

This data is entered into our data warehouse for future member provider and system-level trend analysis. Selected examples of our utilization management reports include:

- *Category of Expense Report (COE)* – (Please see a sample copy of this report from our affiliate, Mercy Care Plan on the following page.) provides monthly summary reporting for unit cost and utilization trends. As part of basic COE reporting, additional details are available related to emergency room, inpatient hospital stays, laboratory, radiology, enrollment, and disenrollment trends, and provider specialty trends. COE reporting enables our CMO to spot unusual patterns and areas for focusing improvement initiatives.

MCP ACUTE
Rolling 12 Months Variance Report
By Category of Expense

PMPMs from Apr-11 financials
 Includes Most Recent Three (Noncredible) Months



Units	PMPM		Trend from 1 year ago		Trend Contribution		Util per 1,000		Trend from 1 year ago		Unit Cost		Trend from 1 year ago	
	12 Months Ending Apr-11	12 Months Ending Apr-10	%	Trend	PMPM	%	12 Months Ending Apr-11	12 Months Ending Apr-10	%	Trend	12 Months Ending Apr-11	12 Months Ending Apr-10	%	Trend
Inpatient Facility	60.45	62.90	-3.9%		-2.45	-1.2%	183.1	180.4	1.5%		3,961.80	4,183.88	-5.3%	
Mental Health Inpatient	0.05	0.09	-43.9%		-0.04	-0.04	0.5	1.0	-44.5%		1,140.36	1,126.92	1.2%	
Emergency	18.52	17.55	5.5%		0.97	0.5%	726.8	718.0	1.2%		305.78	293.32	4.2%	
Selected Ambulatory Facility	12.51	12.53	-0.1%		-0.02	0.0%	382.6	386.3	-1.0%		392.54	389.35	0.8%	
Mental Health Non-Inpatient	0.04	0.03	34.3%		0.01	0.0%	6.6	6.0	9.0%		71.44	57.97	23.2%	
Primary Physician	18.17	21.54	-15.6%		-3.36	-1.6%	2,996.2	3,435.0	-12.8%		72.78	75.24	-3.3%	
Specialist Physician	48.23	44.31	8.8%		3.92	1.9%	5,517.8	5,064.2	9.0%		104.88	104.99	-0.1%	
Home Health	2.49	2.74	-9.0%		-0.25	-0.1%	2,276.7	2,736.9	-16.8%		13.13	12.00	9.4%	
Laboratory	1.66	1.45	14.5%		0.21	0.1%	1,255.7	1,170.4	7.3%		15.83	14.83	6.7%	
Medical Pharmacy	2.32	1.96	18.5%		0.36	0.2%	7,593.4	7,746.6	-2.0%		3.67	3.03	20.9%	
Misc. Medical	8.92	8.50	5.0%		0.43	0.2%	23,574.9	19,900.1	18.5%		4.54	5.12	-11.3%	
Radiology	6.96	7.71	-9.7%		-0.75	-0.4%	1,198.2	2,047.7	-41.5%		69.74	45.19	54.3%	
Retail Rx	30.24	27.42	10.3%		2.82	1.4%	8,677.4	7,921.5	9.5%		41.81	41.53	0.7%	
Total	210.57	208.71	0.9%		1.86	0.9%								

Largest Effect PMPMs by COE

Units	PMPM		Trend from 1 year ago		Trend Contribution		Util per 1,000		Trend from 1 year ago		Unit Cost		Trend from 1 year ago	
	Current Year	Previous Year	%	Trend	PMPM	%	Current Year	Previous Year	%	Trend	Current Year	Previous Year	%	Trend
Top 5														
Retail Rx - Brand-SS	14.24	12.51	13.9%		1.74	93.5%	723.0	698.5	3.5%		236.41	214.83	10.0%	
Visits - Office - Prof Physician	5.12	3.81	34.5%		1.31	70.6%	1,127.0	850.9	32.4%		54.49	53.67	1.5%	
Retail Rx - Generic	13.11	12.07	8.5%		1.03	55.5%	7,417.0	6,706.5	10.6%		21.20	21.61	-1.9%	
Emergency Room - OP Facility	18.52	17.55	5.5%		0.97	52.3%	726.8	718.0	1.2%		305.78	293.32	4.2%	
Urgent Care - Prof Physician	3.34	2.77	20.3%		0.56	30.4%	437.7	386.9	13.1%		91.43	85.96	6.4%	
Total	54.32	48.71	11.5%		5.62	302.3%								
Bottom 5														
ICU/CCU - IP Facility	18.44	19.91	-7.4%		-1.47	-79.3%	34.8	32.7	6.7%		6,349.27	7,312.71	-13.2%	
PCP Other	2.69	4.03	-33.2%		-1.34	-72.1%	270.6	351.8	-23.1%		119.33	137.48	-13.2%	
Self-Performed Office Visits	9.01	10.25	-12.1%		-1.24	-66.8%	1,582.8	1,796.3	-11.9%		68.34	68.50	-0.2%	
NICU - IP Facility	6.72	7.88	-14.7%		-1.16	-62.3%	5.0	5.3	-4.0%		15,969.78	17,969.04	-11.1%	
Partner-Performed Office Visits	6.04	6.75	-10.6%		-0.72	-38.6%	1,071.7	1,206.4	-11.2%		67.57	67.16	0.6%	
Total	42.90	48.83	-12.1%		-5.93	-319.1%								

- *Quarterly Report of Physician Metrics* (Please see a sample copy of this report from our affiliate, Mercy Care Plan on the following page.) or the “provider profile” compares individual PCP performance to other providers in the areas of performance measures (e.g., EPSDT compliance rate), members’ use of the Emergency Department (ED), utilization measures, referral patterns, prescribing patterns, and other factors. These profiles enable us to identify individual providers with utilization patterns that fall outside the norms for their specialty. Additionally, by aggregating the data among provider types and for the entire provider network, we are able to identify health plan-wide opportunities for improvement.

MCP ACUTE
Quarterly Metrics

By Category of Expense
PMPiAs from Apr-11 financials
Includes Most Recent Three (Nonrenewable) Months

Per Member Per Month	Yr 0510-0411				Yr 0510-0411				Trend Impact	
	Jul-10	Oct-10	Jan-11	Apr-11	Jul-10	Oct-10	Jan-11	Apr-11		
Inpatient Facility	68.80	72.32	67.09	65.47	60.34	59.93	63.52	60.45	-3.9%	-1.2%
Mental Health Inpatient	0.10	0.10	0.09	0.11	0.08	0.07	0.04	0.01	-3.9%	0.0%
Emergency	16.28	17.05	16.71	18.39	17.54	18.02	19.21	18.52	-40.7%	-43.9%
Selected Ambulatory Facility	11.82	12.03	12.21	13.23	12.33	12.95	11.98	12.80	14.8%	8.8%
Mental Health Non-Inpatient	0.02	0.03	0.03	0.02	0.04	0.04	0.02	0.05	-1.5%	5.5%
Primary Physician	23.34	25.00	24.33	25.17	22.33	22.75	24.33	22.51	-28.8%	-34.3%
Specialist Physician	39.79	41.90	41.70	45.92	43.80	45.89	47.92	48.23	-10.4%	-15.6%
Home Health	2.29	2.56	2.88	3.04	2.41	2.41	2.57	2.49	-12.5%	-9.0%
Laboratory	1.63	1.56	1.51	1.66	1.56	1.60	1.59	1.88	-5.9%	-0.1%
Medical Pharmacy	9.40	9.79	8.94	9.20	8.47	8.86	8.85	9.53	11.5%	18.5%
Misc. Medical	7.15	7.47	6.83	7.47	7.30	7.43	6.35	6.77	8.5%	5.0%
Radiology	21.63	23.00	25.49	27.34	28.50	30.26	30.44	31.68	-10.9%	-7.4%
Retail Rx									10.6%	10.3%
Total	204.42	214.93	210.33	221.29	200.44	210.06	210.01	222.03	-0.5%	0.9%

Annual Utilization/1,000	Yr 0509-0410				Yr 0510-0411				Yr 0510-0411	
	Jul-10	Oct-10	Jan-11	Apr-11	Jul-10	Oct-10	Jan-11	Apr-11		
Inpatient Facility	201.2	206.2	197.2	185.0	169.7	183.5	186.6	193.9	-4.8%	8.2%
Mental Health Inpatient	0.1	0.1	0.1	0.1	0.0	0.0	0.0	0.0	-16.4%	-8.8%
Emergency	65.4	70.3	71.5	78.1	68.6	69.7	75.0	77.8	-3.2%	1.2%
Selected Ambulatory Facility	38.5	39.2	38.3	37.2	39.5	40.5	38.9	38.2	21.6%	9.0%
Mental Health Non-Inpatient	10.5	13.4	11.3	8.1	6.6	6.6	4.3	9.1	-3.5%	-12.8%
Primary Physician	3,156.3	3,466.2	3,408.0	3,615.4	3,041.5	3,375.2	3,037.7	2,522.0	1.1%	8.9%
Specialist Physician	4,437.0	4,755.0	4,661.6	5,088.5	4,857.2	5,157.0	5,526.4	6,554.0	-36.2%	-16.8%
Home Health	2,388.1	2,565.9	3,367.2	3,333.7	2,147.7	2,284.0	2,423.8	2,275.7	-3.2%	7.3%
Laboratory	1,497.3	1,422.4	1,479.4	1,235.5	1,210.3	1,143.5	1,232.2	1,449.1	15.2%	16.7%
Misc. Medical	7,189.1	8,135.2	6,398.2	7,969.4	7,764.2	8,284.9	7,006.6	7,307.0	-4.0%	-2.0%
Radiology	20,274.9	20,621.4	17,366.5	18,630.9	21,096.7	24,156.3	23,589.8	25,511.9	12.2%	18.5%
Retail Rx	1,181.2	1,228.1	1,122.4	1,305.3	1,190.9	1,244.5	1,159.7	1,197.4	-8.3%	-2.1%
Total	6,479.6	6,901.7	7,400.8	8,091.0	7,777.8	8,291.5	9,175.6	9,490.2	6.6%	9.5%

Unit Cost	Yr 0509-0410				Yr 0510-0411				Yr 0510-0411	
	Jul-10	Oct-10	Jan-11	Apr-11	Jul-10	Oct-10	Jan-11	Apr-11		
Inpatient Facility	4,103.60	4,209.24	4,082.29	4,247.51	4,132.43	3,944.65	3,853.05	3,931.66	-4.0%	-5.3%
Mental Health Inpatient	1,202.90	1,027.62	1,039.72	1,145.63	1,067.28	1,259.87	1,238.52	679.20	0.6%	1.2%
Emergency	298.41	292.26	280.35	279.70	306.62	314.69	304.86	297.92	4.2%	4.2%
Selected Ambulatory Facility	388.49	377.46	397.99	416.70	374.23	382.94	389.29	427.64	-12.7%	0.8%
Mental Health Non-Inpatient	25.25	28.53	34.42	35.90	25.34	25.34	25.34	25.34	64.5%	23.2%
Primary Physician	88.74	86.56	85.68	83.55	75.34	71.83	65.36	71.15	-9.9%	-3.3%
Specialist Physician	107.61	105.74	107.35	108.28	73.80	72.01	72.53	73.11	2.4%	-0.1%
Home Health	11.50	11.98	10.28	10.93	108.21	106.77	104.05	101.56	37.3%	9.4%
Laboratory	13.06	13.15	12.28	16.09	13.47	12.67	12.73	13.70	4.1%	6.7%
Medical Pharmacy	3.64	3.12	4.71	4.95	15.43	16.82	15.57	15.59	7.8%	20.9%
Misc. Medical	5.56	5.70	6.17	5.93	4.82	4.40	4.50	4.48	-12.2%	-11.3%
Radiology	72.60	72.87	72.99	77.82	73.52	71.65	65.73	67.80	-2.8%	54.3%
Retail Rx	40.07	39.89	41.34	40.54	44.12	43.80	39.81	40.06	6.2%	0.7%
Total									-1.7%	-0.4%

Process for Analyzing Utilization Data

Our comprehensive data collection system is used to generate reports that facilitate analysis of utilization data, allowing us to identify potential utilization issues at the individual provider/member level. They also enable us to assess the effectiveness of intervention strategies to improve clinical and operational performance and to annually evaluate our overall QM/UM program. Our data analysis strategies involve the use of quantitative performance indicators; evidence-based standards/benchmarks; data sorts by geographic area, provider type, or member age cohorts; statistical methodologies; and the trending of data over time. We have found that the comparison of our utilization performance measure results to targeted benchmarks (e.g., HEDIS^{®3} Medicaid 75th percentile) allows us to readily identify areas for improvement. We use other information management systems and data mining tools to support our data analysis including a *General Risk Model (GRM)* that transforms data into a series of markers measuring both risk and opportunity, and an interactive Graphical User Interface (GUI) that allows us to access reports and drill down into our data warehouse.

To help guide the analytical and report producing processes, we use personnel with clinical expertise, including the CMO as well as personnel with expertise in health care economics. UM management reports are reviewed monthly at UM staff meetings.

After data review, the CMO and the Director of Medical Management may decide to perform a more in-depth analysis; closely monitor the data to see if the trend continues or is simply a one time anomaly; take immediate action to remedy the situation; and/or refer the issue for further analysis and review.

Data Management and Information System

Aetna Better Health's data warehouse information system, which is robust, innovative, flexible, rules based, user-friendly and table driven, will support all DHH requirements. Aetna Better Health has extensive experience in integrating multiple data sources while taking full advantage of system functionality. The resulting data warehouse information system and data interfaces will:

- Be consistent with the DHH's information technology standards
- Comply with all system-related and security-related HIPAA requirements
- Present reliable, consistent and accurate information in a user-friendly format while still providing the flexibility to meet DHH's changing needs
- Include all data and information necessary to support reporting, comprehensive analyses and enterprise-wide business operations
- Provide information to other applications

The data warehouse is one component of our integrated application portfolio. Aetna Better Health has a proven record of success in these applications as they deliver a configurable solution with the options needed to accommodate DHH's reporting requirements.

Upon contract award, Aetna Better Health will work with the appropriate DHH personnel and other contractors (e.g., carve-out providers for pharmacy benefits management and behavioral

³ HEDIS is a registered trademark of the National Committee for Quality Assurance

health) to produce high-level process requirements and detailed process requirements documents. We will also create detailed file specifications for all data exchanges including: input/output, purpose, sender, receiver, secure transmission method, update or full file content, frequency, dependencies, business rules, file naming, file layouts, and the accounts and control system that will serve to systematically certify data and balances. These data exchange specifications will also include file transmission validation and verification.

How Utilization Data Is Gathered, Analyzed and Reported

Aetna Better Health gathers, analyzes, evaluates/monitors, and reports utilization data to effectively manage and deliver medically necessary and covered services in the amount, intensity, and duration necessary to achieve improved health outcomes for our members across the continuum of care (from prevention to the end of life). Our goal is that the members receive the right service, at the right time, and at the right level of care/setting. We consider the collection gathering, analyzing and reporting of accurate, timely, and complete utilization data to be pivotal to our success to facilitate the delivery of appropriate care and services to our members.

Claims and encounters data are one of our major sources of utilization data. These data are our most significant source of information for the evaluation, monitoring and reporting of utilization patterns. We augment claims data with prior authorization (PA) information, from both our PA Department and Case Managers (CMs).

Aetna Better Health has developed a utilization management (UM) suite of reports that provides our leadership with a comprehensive set of information to examine utilization patterns and trends. Data from these reports are analyzed by our CMO during a weekly inter-department UM work group to determine potential over- and underutilization. The UM work group is one of our medical management best practices. This UM work group is the forum for synthesizing information and data for inter-departmental coordination and activities necessary to identify and manage quality and utilization management activities. Of these reports, there are five key utilization reports that represent the core of the data we analyze. These reports are: 1) Category of Expense (COE); 2) Inpatient Cost Report; 3) Pharmacy Utilization Report; 4) Inpatient Census Report; and 5) ED Cost Report.

The CMO's weekly UM work group (including personnel from Finance, Operations, Medical Management, Case Management and other areas as necessary) is responsible for completing a comprehensive analysis of utilization data. This analysis identifies over- and underutilization and/or unexpected trends. Drilling down into these data is an iterative process that often results in identification of utilization variances. Our UM work group's knowledge, expertise, and experience are invaluable in identifying and analyzing these variances. Outcomes from the CMO's UM work group are shared with our QM/UM Committee, and ultimately with the Board. The UM work group is responsible for ascertaining root causes and developing recommended interventions to correct variances in unexpected or adverse utilization patterns that often impact our members' health outcomes and quality of care. The UM work group's recommendations are submitted to the QM/UM Committee for consideration and approval. Often there is discussion between the UM work group and the QM/UM Committee to finalize the intervention strategies to improve quality and cost effectiveness across the continuum of care.

Aetna Better Health reports utilization data internally - to communicate trends and identify member and/or provider utilization patterns - to QM/UM and all appropriate departments including, but not limited to: Member Services, Provider Services, Credentialing, Case Management, Quality Management, and Finance. Utilization data is also reported to our provider network and specifically to a provider or group of providers for specific problem-solving or developing corrective action plans.

Encounter Management System (EMS) and QNXT™

Aetna Better Health uses a combination of a custom, internally developed Encounter Management System (EMS) and highly-skilled, extensively-trained Encounter Unit (EU) employees to work with encounter data. The system functionality guides data through all stages of the submission process, including gathering, validating, analyzing, and reporting in a manner that is HIPAA-compliant, efficient, and easily adaptable to meet DHH requirements. Those sources include the QNXT™ system, which adjudicates most medical claims. Because the EMS is designed with the flexibility to accept data from disparate sources, it is able to act as the single repository for all encounter data.

Data Gathering

Throughout the encounter submissions process, data are continually validated for accuracy and completeness through the use of edits and checkpoints. Prior to submitting encounter data to DHH the following data validation steps occur:

- The QNXT™ system verifies that all necessary claims fields are populated with values of the appropriate range and type prior to the encounter information being loaded onto the EMS
- Encounter data files from vendor sources go through a staging process. The staging process consists of automated and manual verification, to validate that files have the proper layout and the appropriate fields populated. In this staging process, correct files are allowed to pass; pending files are corrected if there are correctable errors, or are rejected if the errors cannot be corrected. This staging process results in only the cleanest files being imported into the EMS.
- After data from QNXT™ and vendor sources are loaded into the EMS, they must pass the EMS Scrub Edits, which are customized based on DHH's requirements for clean encounters. Files that are unlikely to pass the State's edits are not submitted until they are corrected. Encounter Unit Analysts take responsibility for the correction. This proactive approach to identifying and correcting errors prior to the submission of data to the DHH expedites review and adjudication.

Data Analysis/Reporting

Aetna Better Health is able to streamline the reporting, analysis, and correction process because our EMS system contains all encounter data, regardless of the source. Reports are created and analyzed to meet the needs of DHH, Aetna Better Health and providers.

Examples of reports include:

- Encounter Aging Reports— These reports show the aging of existing encounters. Encounters approaching contracted submission deadlines can be identified and prioritized to substantiate on-time submission.

- Encounter Tracking Reports— These reports show the status of all encounter records in the EMS and can be aged by service date and/or QNXT™ paid date.

These reports and other analyses enable us to consistently identify inaccurate or incomplete encounter data and to identify over- and underutilization patterns at member and provider levels. It can also assist us with developing and implementing corrective action plans in a timely manner.

Monitoring Over- and Underutilization of Services

Aetna Better Health has a comprehensive process for monitoring and evaluating over- and underutilization of services. Based on outcomes from the process described above, we implemented the following interventions to address over- and underutilization variances. The goals of these interventions were to improve health outcomes, quality of care and cost effectiveness by promoting the availability of the right service, at the right time and the right level of care.

Aetna Better Health has several tools to assist in the identification of over- and underutilization of services. One of these tools is our propriety member utilization profile report. Extracted from claims data, the member utilization profile report is a summary of a member's health care utilization for a rolling 12 months. When a member is admitted to the hospital, the Concurrent Review Nurse analyzes the member's profile report to determine the history and pattern of medical service utilization. The member utilization profile report enables the Concurrent Review Nurse to easily click links to drill down into the member's information that includes past admission, ED/urgent care utilization patterns, outpatient PCP and specialty physician visits and pharmacy utilization. Based upon the review of past utilization patterns, the Concurrent Review Nurse is able to better identify the member's needs during the hospital stay; these needs are communicated to the admitting physician. Additionally, the Concurrent Review Nurse uses this information to identify and begin the process of gathering resources to support the member post discharge.

One area of overutilization we track relates to potential fraud and abuse by a provider. In these instances, a provider may be over utilizing a service or set of services and that pattern may represent poor medical practice management and potential fraud and abuse. As a result we may review a provider's claims history to identify potential overpayments, potential fraud/abuse, or claims adjudication systems issues. This review often considers medical necessity and quality of care factors. When a provider/member is identified by UM personnel, they will forward this information to Aetna Better Health's Compliance Department. These cases and any other suspected fraud or abuse cases are immediately referred to DHH's Program Integrity Unit in accordance with 42 CFR §455.1(a)(1).

Process for Monitoring and Evaluating Identified Over-Underutilization Patterns

Following is a case example of the process used for monitoring and evaluating the utilization of services when a variance has been identified for over- or underutilization in the utilization patterns of a member.

Member Overutilization Example 1: Internal research at an Aetna Better Health affiliate, Missouri Care Plan indicated that the costliest five percent of our membership accounts for about 65 percent of costs, but for the sub-group with at least one co-morbid behavioral health

diagnosis, the top five percent accounts for almost 80 percent of costs. For individuals with at least one chronic physical health condition, the presence of a behavioral condition like depression or severe anxiety nearly doubles the per member per month (PMPM) costs. For example, we found that PMPM costs for members with a specific chronic disease combined with at least one behavioral health condition are as follows:

- Diabetes: 130 percent higher PMPM
- AIDS/HIV: 150 percent higher PMPM
- Asthma: 150 percent higher PMPM
- Congestive heart failure: 50 percent higher PMPM
- Chronic obstructive pulmonary disease: 80 percent higher PMPM
- End-stage renal disease: 40 percent higher PMPM

Members with two behavioral health conditions have triple the PMPM costs and members with three or more behavioral health conditions have almost quadruple the PMPM costs. ED visits and inpatient admits reflect the same trend. Moreover, only nine percent of these members are enrolled in case management. This analysis demonstrates that addressing these members' behavioral health problems is a critical component in managing and treating their physical health conditions.

Missouri Care analyzed its entire membership and targeted those with more than three inpatient admits who had comorbid physical and behavioral health conditions, excluding members with HIV/AIDS, cancer, ESRD, transplants and senility. The overall number of members who met this description was minimal, so we additionally included the top 1,000 members with substance-related behavioral disorders and a physical health diagnosis that had 10 or more ED visits during the previous 12 months.

Interventions of Biopsychosocial Project included:

- Researching members' pharmacy, inpatient, outpatient and ED utilization through predictive modeling, QNXT™ and the Express Scripts utilization database
- Attempting to contact the members by phone and/or mail
- Completing an assessment specific to project members
- Developing an individualized care plan with the member
- Communicating with PCPs or the appropriate provider after obtaining members' permission
- Educating the member and making appropriate referrals
- Researching members utilization every two weeks
- Contacting the member every two weeks or more as clinically appropriate
- Enhanced training for our case managers

In addition, Missouri Care implemented a routine of conducting weekly grand rounds staffed by a multi-disciplinary team (chief medical officers for medical and behavioral health, case managers and managers of medical management and behavioral health) in order to discuss members who have complex or comorbid conditions, are of high acuity, have high ED usage and are difficult to engage.

The goal for the Biopsychosocial Project was for the targeted population to achieve a 2.5 percent reduction in any of the following metrics: inpatient admits, inpatient bed days, ED visits and PMPM costs. The initial results indicated that the actual reduction exceeded the goal.

Member Underutilization Example 2: In 2001, an Aetna Better Health affiliate, Missouri Care conducted a multivariate analysis of premature births and found that members who had been hit, kicked or slapped during pregnancy tended to be at increased risk. Our internal review of results from the pregnancy risk assessment and notification form, which is completed by the member’s OB provider, reflected that slightly more than two percent of members gave responses indicating they are or had been victims of domestic violence.

In response, to address the low percentage of positive responses to the domestic violence question among our members, the affiliated health plan implemented a provider training program to increase awareness and notification of pregnant members facing domestic violence. As a result Missouri Care offered an outreach and education to our OB/GYN network to identify, assist, and provide services to victims of domestic violence. The plan used information from American College of Obstetrics and Gynecology (ACOG) to develop a one-page, easy-access reference guide that offers instructions on how to assess abuse, ask the appropriate questions, document findings, and conduct screenings. The reference guide included locations, phone numbers, and a summary of services available at local shelters and advocacy centers. Missouri Care also created a resource directory containing screening tools, provider materials, and ACOG resources. Missouri Care also equipped provider offices with brochures and cards regarding domestic abuse to place in waiting rooms and bathrooms for easy access by members in need.

As a result of the training programs, rates of provider reporting of domestic violence increased monthly to over 10 percent by 2004. This afforded appropriate referral for case management intervention and provided opportunities to impact low birth weight outcomes and gestational periods beyond 28 weeks. Birth outcomes pre- and post-education are noted in the following table:

Birth Outcomes

Time Period	Number of Newborns	Number of Deliveries	# of Newborns Born ≤ 28 Weeks	Expected Births	% of Total Live Births	% Reduction of Newborns ≤ 28 Weeks
Jan 01- Mar 03	2898	2862	21	N/A	0.72%	N/A
Apr 03-Dec 04	3306	3067	16	24	0.48%	33%
	Number of VLBW* Newborns	% VLBW* Number	% Reduction of VLBW Newborns	# of LBW** Newborns	% LBW** Newborns	% Reduction of LBW Newborns
Jan 01- Mar 03	37	1.28%	N/A	264	9.11%	N/A
Apr 03- Dec 04	28	0.85%	34%	205	6.20%	32%

*VLBW – Very Low Birth Rate

**LBW – Low Birth Rate

Missouri Care received national recognition from the Centers for Health Care Strategies for this innovative program.

Provider Over- and Underutilization Examples:

Following is a case example of the process we would use for monitoring and evaluating the utilization of services when a variance has been identified for over- or underutilization in the utilization patterns of a provider.

Provider Underutilization Example 1: The QM/UM Committee of our Arizona affiliate, Mercy Care Plan, identified that providers were failing to adhere to evidence based clinical practice guidelines for certain diseases. Mercy Care Plan analyzed historical medical and pharmacy claims experience, laboratory test results (when available) and determined we had an under utilization of statins in members at high risk for cardiovascular disease. The outcome of this analysis was the generation of a Care Consideration recommendation, mailed to the provider, member or the member's family/care giver, and at the same time is made available to members' assigned case manager in the web based care management business application. The value of Care Considerations in improving PCP adherence to evidence based clinical practice guidelines was that PCP acceptance of the Care Consideration recommendation and the increase in statin utilization for members from 47 scripts/thousand to 62 scripts/thousand. Mercy Care performed a provider satisfaction survey and the results indicated that over 61% of PCPs agreed with the member specific Care Considerations. These data indicate that PCP compliance with Care Considerations has increased from 29% to 42% (from 2009-2010). This experience indicates improved adherence to evidence based clinical practice guidelines through appropriate utilization of statins and increased optimized care for our members at risk for cardiovascular disease.

Provider Over Utilization Example 2: The QM/UM Committee of our Arizona affiliate, Mercy Care Plan recognized an increase utilization pattern of radiology services in all settings (inpatient, radiology centers and physician offices). Mercy Care Plan recognized increased utilization of radiology service from providers, especially in physician practice sites, and developed intervention strategies to address these trends. Through analysis of claims data identified the adverse utilization trends and developed a comprehensive intervention strategy to address aberrant utilization patterns. The CMO, working with the Service Improvement Committee and QM/UM Committee identified high performing radiology providers that had a center of excellence approach to radiology management and would work cooperatively with Mercy Care Plan and had sufficient capacity to deliver accessibility and availability of services. Furthermore, Mercy Care Plan amended the existing contracts with hospital providers and those physician practices that offered radiology services in the office setting by reducing the fee schedule for covered radiology services to reduce utilization trends at these sites. The CMO and designated medical directors identified and visited physician practices with a history of ordering radiology services that failed to adhere to evidence based clinical practice guidelines. The purpose of these visits was to educate providers regarding evidence based clinical practice guidelines in an attempt to change practice patterns. The intent of these multi-faceted interventions was to target utilization that exceeded evidence based clinical practice guidelines without reducing access to medically necessary radiology services. The QM/UM Committee approved these interventions to assess best practices in 1) reduce unnecessary utilization; 2) control cost and 3) provide a geographically convenient flow of members among network

providers. The chart below shows there has been a reduction in radiology claims in the past two quarters. Data for this chart was extracted from our February 2011 COE report.

