AETNA

2003 PATIENT MANAGEMENT PROGRAM DESCRIPTION

Patient Management Program Approval

The Patient Management Program was:

Drafted: July 17, 1996 (as Aetna U.S. Healthcare)
Revision Approved:

William Popik, MD Chief Medical Officer.	March 7, 2003 Date
____________________________ Regional Medical Director	____________________ Date
____________________________ Chairperson Regional Behavioral Health Oversight And Advisory Committee	____________________ Date
____________________________ Chairperson Regional Quality Oversight Committee	____________________ Date

While this Patient Management Program is believed to be accurate as of Aetna's print date, it is subject to change without notice. This material contains only a partial, general description of our plans and programs. In case of a conflict between a member's plan documents and this information, the plan documents will govern. For a complete description of the benefits available to a particular member, including procedures, exclusions and limitations, refer to the member's specific plan documents, which may include the Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Group Insurance Policy and any applicable riders. All the terms and conditions of a member's plan and special programs are subject to and governed by applicable contracts, laws, regulations and policies. The availability of a plan or program may vary by geographic service area, and not all plans or programs are available to all members. Certain services, including but not limited to non-emergency inpatient hospital care, require precertification. All benefits are subject to coordination of benefits. All member care and related decisions are the sole responsibility of participating providers and their patients. Aetna does not recommend the self-management of health problems, nor do we promote any particular form of medical treatment. Members should be instructed to consult with their physicians for the advice and care appropriate for their individual needs.

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I. INTRODUCTION

Aetna coordinates care and encourages members to be informed participants in decision making. In addition, Aetna evaluates and determines the appropriate level of coverage for medical services provided to our members. To accomplish this, Aetna has developed a comprehensive Patient Management Program.

II. PATIENT MANAGEMENT PHILOSOPHY

Patient Management is based upon the premise that dedicated staff, performing integrated activities, can contribute to improving the coordination of care delivered to members by independent health care providers within a managed care system in such a manner that an opportunity for an improvement in the quality of care occurs. An integrated managed care system should offer provider contracting based on quality of care and cost effectiveness, a Patient Management program that address the entire continuum of clinical needs, and data analytical capabilities which support a continual improvement in the quality of care and services. Further, this integration should successfully affect all aspects of the coordination of health care benefits, inclusive of, medical/surgical, obstetrical, pediatric and behavioral health needs.

The Aetna Patient Management Program is accomplished through the combined efforts of nurses, Medical Directors and other staff in multiple Aetna departments and locations.

Aetna's Patient Management philosophy includes the following:

- Putting quality care first;
- Building collaborative relationships with physicians and hospitals;
- Using medical information and technology to its full affect; and,
- Bringing quality service to members and value to plan sponsors.

The program emphasizes early case identification based on predictive tools as well as other medical management approaches. The Patient Management Program operates at regional and national levels. However, oversight is generally consolidated in the regional office structure to promote consistency through health plans and products. This regional structure enhances efficient resource utilization and is designed to maximize administrative efficiency. Since each region has unique needs based on the maturity of its markets and the demographics of the members, their Patient Management program is tailored to fit these needs as appropriate. The Patient Management program integrates and complements the Regional Quality Management program.

The focus of the Patient Management Program is on providing members with access to quality care and service while coordinating benefits based on clinical need. The Patient Management Program defines quality care as treatment that:

- Improves the member's physical and emotional status;
- Promotes health and healthy lifestyles and behaviors;
- Encourages early treatment;

- Involves members in informed decision making;
- Is provided by independent practitioners sensitive to illness-related issues;
- Is based on accepted medical principles;
- Uses technology and other resources effectively;
- Is accessible to members in a timely fashion; and,
- Is sufficiently documented in medical records.

The goals of the Patient Management Program are to:

- Improve the overall health and productivity of members;
- Promote the efficient utilization of medical resources throughout the care continuum;
- Provide consistent administration of benefits, processes and decision making; and,
- Identify and refer potential quality of care concerns to Quality Management for review.

III. MECHANISM FOR UPDATING PROGRAM

The Patient Management Program is reviewed annually. At the time of annual review, Patient Management staff, Quality Management staff, Medical Directors, including the Regional Medical Directors, and the Chief Medical Officer suggest revisions. The Chief Medical Officer approves the National Patient Management Program Description. The revised, approved national document is then submitted to the Regional Quality Advisory Committee (QAC) for review and recommendations, including applicable state-specific requirements, to the Regional Behavioral Health Oversight and Advisory Committee (RBHOAC) or its equivalent and the Regional Quality Oversight Committee (QOC) for review and adoption.

IV. COMMITTEES

Responsibility for development, implementation and evaluation of the Patient Management and Quality Management programs rests with the **Quality Oversight Committee (QOC)**, a multidisciplinary group composed of the following members:

- Regional Manager or Designee (Chair)
- Medical Director
- Quality Management Manager
- Patient Management Representative
- Provider Relations/Network Manager
- Provider Contracting Manager
- Marketing/Sales Manager
- Member Services Manager
- Pharmacy Representative
- Behavioral Health Representative
- Claims/Operations Manager

The QOC establishes priorities for the region Patient Management Program and evaluates clinical and operational quality and integrates quality improvement activities among all departments. The QOC monitors Patient Management activities for consistency with both national and regional program goals. The QOC reviews and approves Patient Management

policies and procedures, clinical and service indicator/monitors, and quality improvement studies and interventions. The QOC approves the Patient Management Program Description, Annual Patient Management Workplan and Annual Program Evaluation, and approves and oversees delegated activities. The QOC receives periodic reports from the National Patient Safety Work Group and the national pharmacy committees for discussion. In addition, the QOC acts as the designated internal committee to create and review confidentiality policies and to review practices regarding the collection, use and disclosure of medical information. The QOC meets at least 8-10 times a year and is chaired by the Regional Manager or designee.

To monitor and facilitate quality of care and services to members, the QOC has established additional regional committees that report to the QOC. These committees are outlined below.

Quality Advisory Committee (QAC): is delegated by the QOC to manage and provide direction on clinical quality improvement initiatives, and to review and make recommendations on: quality improvement studies and surveys, clinical indicators, member and provider interventions, member and provider communications, policies and procedures, *Program Description, Annual Patient Management Workplan and Annual Patient Management Program Evaluation*. The QAC reviews clinical criteria and protocols, and clinical practice guidelines, for adoption by the QOC; provides feedback regarding clinical practice guidelines, coverage policy bulletins and formulary; refers provider-specific performance issues to the Regional Credentialing and Performance Committee (CPC).

Through its sub-committee, the Regional Practitioner Appeals Committee (PAC), the QAC conducts professional review hearings for appeals of Credentialing and Performance Committee determinations.

The QAC meets at least 8-10 times a year and membership includes:

- Medical Director, Chairperson
- Psychiatrist/psychologist
- Eight to ten participating practitioners with representation chosen from the following practice areas: family practice, internal medicine, pediatrics, OB/GYN, general surgery, orthopedics. Other specialty providers may be included as necessary for peer review and clinical input.

The Medical Director chairs the meetings.

The National Pharmacy & Therapeutics Committee (P & T): makes determinations regarding whether a drug represents an important therapeutic advance, is therapeutically similar to other available products, or has significant disadvantages in safety or efficacy when compared to other similar products in the same therapeutic class.

The P & T's determinations are based on consideration of FDA, manufacturer and peer-reviewed medical literature, qualitative input of the Aetna National Pharmacy Quality Advisory Committee, and do not include any consideration of information regarding drug costs. This committee also reviews and considers qualitative comments of the National Pharmacy Quality Advisory Committee regarding certain proposed drug precertification and exception criteria.

The National P & T Committee meets no less than six times a year, with ad hoc meetings as necessary. The committee may invite to its meetings persons outside or within Aetna who can contribute specialized or unique knowledge, skills, and judgment.

The composition of the National P & T Committee is as follows

- Director of Core Clinical Pharmacy, Co-Chair (1)
- Core Clinical Policy Medical Director, Co-Chair (1)
- Core Clinical Pharmacists (3)
- Medical Director, Coordinator of National Pharmacy Quality Advisory Committee (1)
- Medical Director from each region (6)
- Regional Pharmacy Directors (2)

The National Pharmacy Quality Advisory Committee (PQAC): a subcommittee of the National Pharmacy & Therapeutics Committee (P & T), reviews literature and other clinical information regarding specific drugs, and provides qualitative comments regarding such drugs to the National Pharmacy and Therapeutics Committee. The PQAC also reviews and provides qualitative comments upon certain proposed drug precertification and exception criteria.

This Committee meets no less than six times a year, with ad hoc meetings as necessary. The National PQAC committee may invite to its meetings persons outside or within Aetna who can contribute specialized or unique knowledge, skills, and judgment.

The composition of the Aetna National Pharmacy Quality Advisory Committee is as follows:

- Medical Director, Coordinator
- Twelve participating practitioners in active clinical practice representative of such specialties as:
  - ⇒ Family Practice
  - ⇒ Internal Medicine
  - ⇒ Pediatrics
  - ⇒ Cardiology
  - ⇒ OB/GYN
  - ⇒ Psychiatry
  - ⇒ Gastroenterology
  - ⇒ Oncology
  - ⇒ Ophthalmology
  - ⇒ Practicing Pharmacists
  - ⇒ Other specialties will be invited to all meetings, but attendance may be optional if agenda items are not in areas of specialty.

Regional Behavioral Health Oversight and Advisory Committee (RBHOAC): is delegated authority by the QOC to provide guidance and direction on administrative, clinical and quality issues pertaining to behavioral health (mental health and chemical dependency), as well as approval and oversight of delegated behavioral health activities, such as quality management, credentialing, and/or patient management. It provides an environment for collaborative initiatives between the Health Plans and the behavioral health contractor(s), as well as facilitates the integration of behavioral health with primary care. The RBHOAC reports to the QOC, provides analyses of reports and makes recommendations for level of oversight activities and quality and service initiatives. The RBHOAC meets at minimum ten (10) times per year and membership includes, but is not limited to:

Company Representatives

– Regional Behavioral Health Manager (Chair)

– Regional Patient Management Medical Director

– Regional Quality Management Director

– Regional Patient Management Representative

– Quality Managers

– Member Services Representative

– Network Representative

– Regional Medicare Compliance Officer

Behavioral Health Contractor Liaisons

– Medical Director

– Quality Representative

– Patient Management Representative

– Network Representative

The Regional Behavioral Health Manager chairs the meetings.

Behavioral Health PPO-Based Products Oversight Workgroup: This workgroup, led by National Behavioral Health, oversees the clinical and administrative behavioral health aspects of the delegation of Aetna's PPO-based products. Committee members include Medical Directors from both Aetna and the behavioral health contractor, as well as clinical, operational and network staff from both organizations. Meetings are generally held at least 10 times per year.

Specialty Committees: Ad hoc committees may be called to meet specific Patient Management Program needs. Additional national and regional staff are asked to participate on specific ad hoc task forces, as indicated. These task forces may also include external consultants, hospitals, and practitioners.

External Review Oversight Committee: Chaired by the National QM Medical Director, this committee meets quarterly to facilitate and improve the appeals and external review process by:

- Reviewing potential revisions to the Aetna coverage policies;
- Formulating and operationalizing process improvements;
- Evaluating the coverage decision making processes;
- Identifying training needs;
- Providing feedback on external review outcomes to regional and national management; and
- Developing policy and procedures for compliance with all external regulatory agencies, and to suggest action steps to achieve national consistencies and regulatory compliance.

The membership of the External Review Oversight (ERO) Committee is as follows:

- Claims Medical Management Representatives
- Government Programs Representatives
- National Behavioral Health Representatives
- Regional Grievance Unit Representatives
- Regional and Local Medical Directors
- Law Department Representative
- ERO Unit Representatives

Corporate Appeals Committee: is responsible for handling all second and/or final level appeals of denials regarding the National Medical Excellence (NME) programs and other second level appeals identified as appropriate by the Regional Medical Directors.

The Corporate Appeals Committee (CAC) consists of the following representatives:

- Chief Medical Officer - Chairman
- National Medical Director, Medical Policy & National Transplant - Vice-Chairman
- National Accounts Medical Director
- National Medical Director, Quality Management
- National Medical Director, Patient Management
- Regional Medical Directors - 2 (Rotating Position)
- Clinical Policy Medical Director
- National Medical Services Law Support (non-voting)
- Regional Counsel (when appropriate)

- NME Medical Director

The Aetna Chief Medical Officer serves as the chairperson for the CAC. The National Medical Director for Medical Policy and National Transplant serves in his absence. Medical Policy and National Transplant provides coordination and functional support for all CAC activity.

The CAC meets weekly with emergency meetings held as necessary for expedited cases. Decisions rendered by the CAC are communicated by the Committee Chairperson within the timeframes set forth by regulatory and corporate policies.

Applicable external review activity is offered when the CAC maintains denial of the treatment/services.

National Risk and Delegation Oversight Committee: is co-chaired by the head of Network Contracting and Strategy or designee and the segment head of Key and Select Accounts or designee.

The National Risk and Delegation Oversight Committee has oversight of:

- National risk and delegation agreements, policies, procedures and processes
- Overall monitoring and reporting of risk entity and delegate performance
- Performance metrics and accountability

This is a multidisciplinary group composed of members from the following areas:

- National Medical Director, National Patient Management
- Head of Credentialing
- Head of National Quality Management
- Chief Compliance Officer
- Head of Internal Audit
- Head of Quality Assurance and Management, National Customer Operations
- Head Field Network Services, Network Contracting and Strategy
- Chief Financial Officer, Key and Select Accounts
- Legal Advisor, Deputy Chief Counsel, Health Delivery
- Business Advisor(s): Head of National Risk Contracting Strategy, and Head of National Delegation Oversight

The purpose of the National Risk and Delegation Oversight Committee (NRDOC) is to establish benchmarks for national policies and processes to evaluate the performance of risk and/or delegated provider relationships, including the use of due diligence, contracting, and reporting tools designed to identify acceptable partners, identify our risks, monitor the entities' actual results, and help monitor provider corrective actions when needed. The NRDOC will monitor periodic reports regarding risk and delegated provider relationships.

Delegation Oversight and Management: As part of the Patient Management Program, a comprehensive set of policies and procedures is in place to manage the delegation of

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responsibility for any program function that may be delegated. Prior to making a decision to delegate, Aetna assesses:

- The business need for delegation;
- The cost/benefit and the delegate's readiness to assume the delegation (includes financial integrity, management expertise, and Information Technology (IT) capabilities of the delegate); and
- The potential impact on clinical care and service to members.

A delegation pre-assessment questionnaire is used to assist the health plan in the decision-making process.

Aetna's delegation process also includes a review of the contractor's program for adherence to Aetna's standards, standards of applicable accreditation entities (the National Committee for Quality Assurance [NCQA] and American Healthcare Commission [URAC]), as well as compliance with applicable federal and state laws and regulations. The regional Quality Oversight Committee is responsible for the oversight of delegated functions. Oversight of behavioral health activities is performed and reported to the QOC by the Regional Behavioral Health Oversight and Advisory Committee. Relevant documentation should be reviewed by the appropriate staff prior to an on-site assessment. The on-site assessment of the contractor's program is evaluated and documented through the use of standardized Aetna audit tools. The completed report serves as documentation of the strengths and opportunities for improvement of the contractor's program, and is utilized by the committee responsible for approval of delegated relationships. An on-site assessment of each delegated entity is performed at least annually with results reported to the QOC. Between annual on-site assessments, ongoing monitoring and oversight activities are conducted.

Aetna policies require all delegation arrangements to be supported by a written, signed delegation agreement which outlines the responsibilities of the parties, defines their relationship, specifies how the delegate's performance will be monitored and sets forth remedies if either party is not meeting contractual obligations. The written agreement also outlines on-going monitoring activities, including the provision of quarterly reports that include information appropriate to the scope of delegated functions.

When a contractor in turn subcontracts with another entity to perform a delegated function, it is considered sub-delegation and requires oversight on the part of the region, as well as reports of oversight from the delegated entity. Sub-delegated arrangements must be approved by the region, who retains ultimate accountability, and all parties must enter into a three-way sub-delegation agreement.

Regional Patient Management Quality Management Committee: The Patient Management and Quality Management (PMQM) Program Descriptions outline the quality management process and initiatives within the Patient Management department. They define a PM/QM committee that provides oversight of Patient Management policy and program development, review of Patient Management quality measurements and indicators, quality of care complaints, and Patient Management quality initiatives. This multi-disciplinary group may be comprised of, but not limited to the following members:

- Senior Patient Management Medical Director or Patient Management Medical Director designee (Chairman)
- Quality Manager or designee
- Patient Management Auditor/Trainer
- Patient Management Manager or designee
- Regional Behavioral Health Manager
- Member Services Representative
- Claims Representative
- Director of Network Management/Provider Relations or designee
- Appeals Manager or designee
- Inbound Queue Associate or Care Management Associate Supervisor/Team Leader

The Regional PMQM Committee meets at minimum bi-monthly, guided by a formal agenda with written documentation of the proceedings. Each member is responsible for informing the team of current quality issues or concerns relative to his/her own area of operation. The PMQM Committee facilitates barrier analysis, corrective action plans, and monitors follow-up activities for identified issues. Additionally the PMQM Committee is responsible for the oversight of policies and procedures governing complaints and appeals, and the review of all quality of care complaints.

The development and maintenance of the Patient Management and Quality Management Program Descriptions, Annual Work Plans and Annual Quality Program Evaluation are the responsibilities of the Regional Senior Patient Management Medical Director and the Regional Patient Management Director.

V. CLINICAL REVIEW POLICIES

A. Review Protocols

Aetna Patient Management staff use evidence-based clinical guidelines from nationally recognized authorities to guide utilization management decisions involving precertification, inpatient review, discharge planning, and retrospective review. Aetna Patient Management staff consult guidelines from the following sources: Milliman Care Guidelines (Seattle, WA: Milliman USA)©; InterQual® Intensity, Severity and Discharge (InterQual ISD) criteria (San Francisco, CA: McKesson Health Solutions); and HCIA-Sachs LOS by Diagnosis and Operation (Western Region) (Baltimore, MD: HCIA-Sachs, L.L.C.). These guidelines may also be applied to utilization management decisions affecting Aetna Medicare members unless these guidelines are inconsistent with Centers for Medicare & Medicaid Services (CMS) coverage determinations and regulations. Aetna's Oral and Maxillofacial Surgery (OMS) Unit uses the American Association of Oral and Maxillofacial Surgeons (AAOMS) Parameters and Pathways 2000: Clinical Practice Guidelines for Oral

and Maxillofacial Surgery (ParPath 2000) version 3.0 to guide utilization management decisions for oral and maxillofacial surgery services. The relevant guidelines used in making coverage decisions are made available upon request to Aetna members and their treating physicians if they receive an adverse utilization management determination.

Aetna's delegated behavioral health contractors consult Aetna's Level of Care Assessment Tool (LOCAT) in making decisions about the medically necessary level of care for behavioral health services. Aetna's Level of Care Assessment Tool (LOCAT) is a set of internally developed and validated evidence-based clinical guidelines for behavioral health services. American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC) (Chevy Chase, MD: American Society of Addiction Medicine) are considered in decisions regarding the medically necessary level of care for chemical dependency services. Aetna's Mixed Services Guidelines are used to clarify responsibilities and facilitate care coordination of members with comorbid medical and mental health conditions.

Aetna's Patient Management utilization management criteria are reviewed annually by Aetna's regional Quality Advisory Committees for recommendations, and reviewed by the regional Quality Oversight Committees and Regional Behavioral Health Oversight and Advisory Committees for adoption.

Aetna medical benefit plans exclude from coverage medical technologies that are considered experimental and investigational and/or not medically necessary. Aetna's Coverage Policy Bulletins ("CPBs") are used as a guide in determining whether a specific medical technology is considered established and medically necessary for Aetna members. Aetna's Coverage Policy Bulletins state Aetna's general coverage policy with respect to selected medical technologies, including pharmaceuticals, medical devices, clinical procedures, and healthcare settings.

Requests for creation or revision of CPBs may be made by Aetna's internal staff, members, or providers. Coverage Policy Bulletins are created and revised by the staff of Aetna's Clinical Policy Unit, based on a comprehensive review of credible, peer-reviewed published medical literature. In drafting CPBs, Aetna's Clinical Policy Unit also considers the regulatory status of the technology (e.g., Food and Drug Administration [FDA] approval, Centers for Medicare & Medicaid Services [CMS] national coverage determinations, etc.), evidence-based guidelines of federal public health and health research agencies (e.g., Centers for Disease Control and Prevention [CDC], Agency for Health Care Research and Quality [AHQR], National Institutes of Health [NIH], U.S. Preventive Services Task Force [USPSTF], and evidence-based guidelines and positions of leading national health professional organizations (e.g., American College of Physicians – American Society of Internal Medicine [ACP-ASIM], American Academy of Pediatrics [AAP], American College of Obstetricians and Gynecologists [ACOG], American Academy of Family Physicians [AAFP], etc.). External experts on the medical technology are also consulted when necessary. New and revised draft Coverage Policy Bulletins are presented to Aetna's Clinical Policy Council for review. Aetna's Clinical Policy Council is primarily

composed of Aetna Medical and Pharmacy Directors. Aetna's Patient Management, Claims, Coding, and Reimbursement areas are also represented on the Council. New and revised draft CPBs that have been presented to the Clinical Policy Council are reviewed by the Senior Medical Director for Aetna's Medical Policy and Transplant Department. All CPBs are approved by Aetna's Chief Medical Officer, or his/her physician designee. Once approved, the new or revised CPB is implemented at the time it is published on Aetna's Internet website. Coverage Policy Bulletins are also reviewed by Aetna's regional Quality Advisory Committees (QAC). QAC members' comments or questions are summarized and forwarded to Aetna's Clinical Policy Unit for consideration. Aetna's Clinical Policy Unit responds to these comments or questions, and revises the CPBs where appropriate. Coverage Policy Bulletins are reviewed and updated at least annually or more frequently if necessary based upon current evidence-based guidelines and findings from recent peer-reviewed published medical literature.

Aetna's Pharmacy Coverage Policy Bulletins (PCPBs) are used to guide coverage determinations of the experimental/investigational status and medical necessity of outpatient prescription medications for Aetna's pharmacy benefit plans. Coverage of outpatient prescription medications may also be subject to formulary restrictions. For information regarding the process by which outpatient prescription medications are selected for inclusion on Aetna's formulary and the factors that are considered in formulary selection, please see the Aetna® Medication Formulary Guide. Copies of Aetna's Medication Formulary Guide are distributed to Aetna members upon enrollment and updated information is made available annually thereafter. Aetna's participating providers also receive copies of Aetna's Medication Formulary Guide when they join Aetna and annually thereafter.

Aetna Pharmacy Coverage Policy Bulletins (PCPBs) also provide coverage criteria to be considered in decisions involving step-therapy requirements, injectible medications, and coverage exceptions for drugs included on Aetna's Formulary Exclusion List.

An Aetna Pharmacy Management core clinical pharmacist develops Pharmacy Coverage Policy Bulletins for medical exception, precertification, and step therapy coverage criteria. All PCPBs are developed in consultation with physicians specializing in a particular field of practice. Coverage criteria are developed based on nationally recognized evidence-based guidelines and evidence in nationally recognized peer-reviewed published medical literature. A literature search is performed to document clinical medical evidence from a number of sources, including but not limited to: Medline and other databases, including relevant findings of federal government agencies (e.g., National Institutes of Health, Agency for Healthcare Research and Quality, Centers for Disease Control and Prevention), medical professional associations (e.g., American Medical Association, American Academy of Pediatrics, American College of Cardiology), national commissions (e.g., Institute of Medicine, Expert Panel on Detection, Evaluation and Treatment of High Blood Cholesterol in Adults), and peer-reviewed journals (e.g., Journal of the American Medical

Association, New England Journal of Medicine, Annals of Internal Medicine, Drugs, and Annals of Pharmacotherapy).

Pharmacy Coverage Policy Bulletins are reviewed by Aetna Pharmacy Management, Aetna Medical Directors, and practicing physicians and pharmacists. The National Pharmacy Quality Advisory Committee (PQAC) provides qualitative comments to the National Pharmacy and Therapeutics Committee (P&T) regarding certain precertification and step therapy criteria. The National Pharmacy and Therapeutics Committee reviews the qualitative comments from the National Pharmacy Quality Advisory Committee and the proposed criteria. After review by the National Pharmacy and Therapeutics Committee, the criteria are presented to Aetna Pharmacy Management for adoption. The criteria are re-reviewed periodically, as new clinical information becomes available.

B. Determinations and Review Time Frames

Patient Management coverage decisions are made within applicable Department of Labor, National Committee for Quality Assurance (NCQA), American Accreditation Healthcare Commission (URAC), Centers for Medicare & Medicaid Services (CMS), and state mandated time frames whether Patient Management activities are delegated or not.

Medical Directors make all final decisions resulting in a denial of coverage for services on the basis of medical necessity. The Medical Directors conducting reviews have the education, training and experience commensurate with Patient Management or Utilization Management reviews. Medical Directors are available twenty-four hours per day, seven days per week for consultation on coverage decisions. Administrative denials based on the absence of any clinical information as well as plan benefit limitations or exclusions may be issued without Medical Director review.

Behavioral health medical necessity denial decisions are rendered by a licensed psychiatrist. Pharmacy denial decisions are rendered by a licensed pharmacist or physician reviewer.

Neither Aetna nor the delegated behavioral health contractor compensates employees conducting Patient Management/Utilization Management reviews based on denials of coverage. There are no financial incentives to Patient Management/Utilization Management decision-makers for encouraging denials of coverage or service. In addition, Patient Management staff is also trained to focus on the potential risks of under-utilization or over-utilization of services.

C. Program Evaluation

Aetna evaluates the effectiveness of the Patient Management Program through:

- Analysis of outcome data;

- Tracking and trending utilization activities in all components of medical care;
- Monitoring patterns of care for potential over- and under-utilization;
- Surveying member and provider satisfaction;
- Tracking and trending member complaints and appeals;
- Evaluating consistency of inter-reviewer reliability in applying criteria in making coverage decisions; and,
- Providing oversight of delegated Patient Management Programs.

The Patient Management Program monitors and evaluates licensed and non-licensed Patient Management personnel activities on a regular basis. Assessment tools are used to evaluate compliance with the Patient Management policies and procedures, NCQA and URAC standards, as well as state or federal laws and regulations. A process is in place to evaluate inter-reviewer reliability.

The Patient Management Program is evaluated annually and on an ongoing basis by the Quality Advisory Committee, Quality Oversight Committee and Regional Behavioral Health Oversight and Advisory Committee or the equivalent.

VI. ORGANIZATIONAL STRUCTURE, STAFFING AND STAFF PERFORMANCE

Aetna's Patient Management professional staff is composed of registered nurses, licensed practical nurses, social workers, and physicians. In general, these professionals have a minimum of three to five years of clinical experience. Clerical staff supports all functions.

The Aetna Regional Medical Director has ultimate responsibility for oversight and implementation of the Patient Management Program for the region. Reporting to the Regional Medical Directors, the Regional Patient Management Medical Directors are responsible for the daily activities of Patient Management (PM) operations.

Board certified specialists of all types and training are available to assist in making coverage determinations.

The Aetna Behavioral Health Program is overseen nationally by a Behavioral Health Medical Director who has ultimate responsibility for the implementation of the behavioral health care aspects of the Patient Management Program.

A. Roles and Responsibilities

Regional Medical Director

- Oversees the Utilization Management activities for the region and sets strategic direction for the development of regional Patient Management activities;

- Tracks and assesses the delivery, by independent healthcare providers, of quality, cost effective medical care;
- Oversees Regional Patient Management Medical Directors;
- Maintains interdepartmental communications; and,
- Protects the confidentiality of member information and adheres to company policies regarding confidentiality.

Regional Patient Management Medical Director

- Directs and oversees daily operational activities of the Patient Management Department;
- Develops and maintains consistent Patient Management policies within the region;
- Provides appropriate, cost effective medical management through the oversight of precertification, inpatient review, Case Management, and discharge planning;
- Interacts with other regional Patient Management Medical Directors and with providers and practitioners regarding case specific clinical issues and Patient Management Program processes;
- Analyzes utilization data to identify trends and track medical management;
- Participates in Quality Committees;
- Oversees investigations of potential quality of care concerns;
- Maintains consistent medical benefit interpretation; and,
- Protects the confidentiality of member information and adheres to company policies regarding confidentiality.

Patient Management Director

- Responsible for implementation and evaluation of Utilization Management activities and programs;
- Directs all Continuous Quality Improvement activities throughout the Patient Management Department;
- Develops annual Patient Management Work Plan and Patient Management Plan;
- Develops and updates policies and procedures;
- Manages the oversight for delegated utilization activities;
- Communicates and supports all Patient Management linkage partners (e.g., Case Management, Women's Health Program, Moms to Babies™, National Medical Excellence, Disease Management);

- Facilitates all Patient Management activities to meet or exceed the standards set by NCQA, URAC and CMS; and,
- Protects the confidentiality of member information and adheres to company policies regarding confidentiality.

Care Management Manager/Supervisor

- Performs direct management, implementation, and maintenance of all Patient Management activities;
- Identifies utilization issues and develops strategies and performance measures for improved management;
- Directs the Patient Management Continuous Quality Improvement activities throughout the Patient Management Department;
- Serves as a content model expert and mentor to the team regarding practice standards, quality of interventions, problem resolution and critical thinking;
- Manages resources responsible for identification of members, development and implementation of case management plans, enhancement of medical appropriateness and quality of care, and the monitoring, evaluation and documentation of care;
- Communicates productivity expectations, balances workload (e.g., daily team meetings to discuss new referrals), monitors efficiency and initiates control measures to minimize variances in workload over time; and,
- Protects the confidentiality of member information and adheres to company policies regarding confidentiality.

Precertification Nurse

- Performs precertification of services through the receipt of calls from providers or members regarding proposed services/procedures which are on the Precertification List; application of appropriate clinical criteria; and referrals to appropriate patient management services and Medical Directors. Coordinates the precertification request for proposed services/procedures in accordance with the benefit plan;
- Identifies recommendations for referrals to alternative programs e.g., Disease Management and Case Management proactively and appropriately;
- Evaluates and identifies health care service delivery using clinical knowledge in determining the most appropriate and cost effective setting by identifying opportunities for members to utilize participating providers and services;

- Promotes communication, both internally and externally, to enhance effectiveness of medical management services (e.g., physicians, claim administrators, plan sponsors, third party payors as well as members, family members, and health care team members respectively);
- Applies and/or interprets appropriate clinical criteria and guidelines, standardized Case Management plans, and policies, procedures and regulatory standards, while assessing member needs for appropriate administration of benefits;
- Interprets relevant medical policy/benefits for an identified case;
- Provides the appropriate level of intervention to facilitate coordination of care;
- Identifies members that may have other co-morbidities and may benefit from intervention at the individual or population based level;
- Advocates for members to the full extent of existing health benefits coverage and programs;
- Interprets medical policy and guidelines to make appropriate coverage decisions;
- Identifies and escalates potential quality of care concerns through established channels;
- Administers the hospital care and Case Management precertification processes in compliance with applicable laws and regulations, URAC and NCQA standards, and Case Management Society of America (CMSA) standards (as applicable), while adhering to company policy and procedures;
- Consults with supervisors and/or Medical Directors to overcome barriers to meeting PM goals and objectives; presents cases at Medical Director rounds when coverage criteria are not met and presents cases at case conferences to obtain multidisciplinary review;
- Ensures accurate and complete documentation of required information that meets risk management, regulatory, and accreditation requirements; and,
- Protects the confidentiality of member information and adheres to company policies regarding confidentiality.

Inpatient Care Coordinator

- Performs concurrent review and discharge planning on hospitalized members;
- Monitors all emergency or unplanned admissions;

- Assesses members' clinical condition and ongoing medical services and treatments to determine medical appropriateness;
- Refers cases, as appropriate, to the Medical Director for determination when not meeting inpatient guidelines for admission or continued stay;
- Identifies continuing care needs to facilitate hospital discharge;
- Coordinates discharge plans for inpatient admissions;
- Collaborates with Case Management and other Special Program departments;
- Identifies and communicates potential quality of care concerns to the Quality Management Department;
- Collaborates with delegated behavioral health contractors on mixed services guidelines; and,
- Protects the confidentiality of member information and adheres to company policies regarding confidentiality.

Care Management Associate

- Performs initial review and triage of Care Management Team tasks;
- Identifies the principal reason for admission, the facility, and the type of coverage to apply intervention assessment tools;
- Screens members using targeted intervention business rules and processes to identify needed medical services, makes appropriate referrals to medical services staff and coordinates the required services in accordance with the benefit plan;
- Monitors non-targeted cases for entry of appropriate discharge date and disposition;
- Identifies and refers outlier cases (e.g., length of stay) to clinical staff;
- Identifies triggers for referral into Case Management, Disease Management, Mixed Services, and other Specialty Programs;
- Utilizes eTUMS and other Aetna systems to build, research and enter member information, as needed;
- Supports the development and implementation of case management plans;
- Coordinates and arranges for health care service delivery under the direction of a nurse or Medical Director in the most appropriate and cost-effective setting by identifying opportunities for the member to utilize participating providers and services;

- Promotes communication, both internally and externally, to enhance effectiveness of medical management services (e.g., health care providers, and Care Management Team members respectively);
- Performs non-medical research pertinent to the establishment, maintenance and closure of open cases;
- Provides support services to team members by answering telephone calls, taking messages, researching information and assisting in solving problems;
- Adheres to compliance with Patient Management policies and regulatory standards;
- Maintains accurate and complete documentation of required information that meets risk management, regulatory, and accreditation requirements;
- Protects the confidentiality of member information and adheres to company policies regarding confidentiality;
- Assists in the research and resolution of claims payment issues through referred inquiries; and,
- Supports the administration of Case Management and Quality Management processes in compliance with applicable laws and regulations, URAC and NCQA standards, Case Management Society of America (CMSA) standards (as applicable), while adhering to company policy and procedures.

Inbound Queue Associate

- Performs intake and triage for appropriate healthcare benefit management including eligibility, demographics, and data collection:
- Performs registration of activities for services not designated for precertification review;
- Approves services that do not require a medical review in accordance with the benefit plan;
- Performs non-medical research including eligibility verification, COB, and benefits verification;
- Refers cases for precertification review to nurse consultant;
- Conducts initial screening of cases referred to Case Management; and,
- Protects the confidentiality of member information and adheres to company policies regarding confidentiality.

Nurse Consultant/Retrospective Reviewer

- Reviews pended claims for coverage;

- Identifies potential quality of care or utilization compliance concerns;
- Provides instructions to claims staff for appropriate claim adjudication;
- Forwards potential quality of care or utilization compliance concerns to the appropriate area within Patient Management for further review or investigation;
- Refers cases, as appropriate, to the Medical Director when not meeting inpatient admission or continued stay guidelines;
- Refers cases to Case Managers based on guidelines; and,
- Protects the confidentiality of member information and adheres to company policies regarding confidentiality.

Regional Disease Management Manager

- Designs regional infrastructure to support Disease Management Programs;
- Oversees regional program implementation and maintenance;
- Manages and reviews clinical information to coordinate management of internal and external ad hoc referrals;
- Communicates with, and receives member health status information from the vendor (such as alerts, and Case Management referrals);
- Participates on weekly calls with regional specific vendor to discuss referrals and develop plans to address specific member needs;
- Attends QOC, QAC, Patient Management, Quality Management, and other interactive departmental meetings to provide consistent information and data circulation;
- Coordinates and participates in the preparation for Regional Disease Management NCQA, URAC and CMS audits and assists in the development and monitoring of corrective action plans from the above audits;
- Establishes regional distribution list to facilitate communication of Regional Disease Management updates to cross functional areas;
- Assists National Disease Management in development of new initiatives, and enhancement of current programs;
- Monitors vendor performance measures to maintain program quality and service to members;
- Documents in appropriate systems, as necessary; and.,
- Protects the confidentiality of member information and adheres to company policies regarding confidentiality.

Case Manager

- Completes assessment of member's healthcare needs and determines appropriateness of member for Case Management;
- Provides Case Management for members who have complex or catastrophic medical conditions;
- Monitors the quality of care and effectiveness of services;
- Identifies opportunities to positively impact member outcomes and/or healthcare costs through Case Management intervention; and,
- Protects the confidentiality of member information and adheres to company policies regarding confidentiality.

Regional Behavioral Health Quality Manager/Consultant

- Performs oversight of delegated Patient Management activities performed by behavioral health contractors, including annual oversight visits/audits, monitoring adherence to the standards in the Behavioral Health Contractor's Standards manual, reviews reports submitted by the behavioral health contractor(s);
- Develops regional strategies in program design and development for behavioral health to support the integration of primary care with behavioral health in collaboration with Regional/National Quality Management and the Medical Directors for behavioral health and Patient Management; and,
- Protects the confidentiality of member information and adheres to company policies regarding confidentiality.

Patient Management Administrative Assistant

- Performs all secretarial functions, e.g., typing, filing and phone support for the Patient Management Department; and,
- Protects the confidentiality of member information and adheres to company policies regarding confidentiality.

B. Training and Auditing

A comprehensive orientation is provided for all Patient Management staff. This includes several weeks of structured classroom training as well as on-the-job training, using experienced preceptors. There is also dedicated regional staff to assist in the training. A standardized schedule and list of functions is provided to each employee at the start of their employment. Staff is encouraged to participate in external educational programs and conferences to maintain their competency in the subject matter. A formal Medical Director Training Program is provided to new Medical Directors. In addition, on an as needed basis, Medical Directors receive one-on-one training sessions with other experienced

Medical Directors. Medical Directors are encouraged to participate in regular Continuing Medical Education programs.

Aetna monitors all professionals for inter reviewer reliability on an annual basis to maintain consistent application of the criteria. Consistency in the application of criteria and policy is verified by a number of methods, including random Utilization Management file audits, as described in the Patient Management Policy and Procedure Manual. The inter-reviewer reliability audit tool is one method utilized to evaluate staff performance. When opportunities for improvement are identified, a re-training program is developed for Patient Management staff. Patient Management staff who do not meet Aetna's performance benchmarks are reevaluated and provided individual coaching to assist in performance improvement.

C. Accessibility

Patient Management personnel are accessible via a toll free number during normal business hours (7a.m. – 7 p.m. Monday through Friday). On weekends, holidays, and after 7 p.m. on weekdays, all HMO calls are managed by a precertification unit in Blue Bell PA via the same toll free number. This unit handles routine precertification requests and member inquires concerning specific authorization requests. Traditional product (provider only) calls after normal business hours are handled in the Patient Management region in which the member is assigned. The toll free number to access any of these Patient Management Units is printed on the member ID card.

Requests with respect to urgent or emergent issues related to discharge planning, transportation, or services by non-participating providers are forwarded to the on-call Medical Director for immediate handling. A Medical Director is on call via beeper during all non-business hours. Therefore, Patient Management staff personnel are available 24 hours/day, seven days/week.

VII. COMPONENTS OF THE PATIENT MANAGEMENT PROGRAM

Aetna offers various combinations of the Patient Management Program to plan sponsors. Not all programs are available to all members. Depending on the specifics of each unique health benefit plan the following components may be included:

A. Inpatient Services

- Precertification
    a. Inpatient Services Notification
    b. Inpatient Medical Review
- Inpatient Review

- Discharge Planning
- Retrospective Review

B. Outpatient Services

- Precertification - Notification and Medical Review
- Home HealthCare/Durable Medical Equipment (DME)
- Emergency Services

C. Case Management

D. Other Patient Management Program Components

- Adverse Determination and Appeal Process
    a. Initial Adverse Determination Process
    b. Peer to Peer Review Process
    c. Appeal Process
    d. External Review
- Non-Participating Provider Referral Authorization Process
- Transition of Care

E. Quality Management Indicators

- Quality of Care Indicators
- Service Indicators
- Utilization Management
- Evaluation of Member and Practitioner Satisfaction with Patient Management Process

F. Special Programs

- Healthy Outlook Programs® (Disease Management)
- National Medical Excellence Program®
- Women's Health Programs
    1. Women's Diabetes Care Program
    2. Moms to Babies Maternity Management Program™
    3. Infertility Case Management Program
    4. Genetic Testing for Hereditary Breast and Ovarian Cancer
    5. Breast Cancer Case Management Program
- Government Programs

A. Inpatient Services

1. *Precertification*

Precertification is the process of collecting information prior to inpatient admissions and performance of selected ambulatory procedures and services.

A precertification list, which identifies services, supplies and procedures that require precertification, has been established and is reevaluated and adjusted periodically with a Patient Management core team of Medical Directors and Patient Management department directors.

The precertification process permits advance eligibility verification, determination of coverage, and communication with the physician and/or member (precertification). It also allows Aetna to coordinate the member's transition from the inpatient setting to the next level of care (discharge planning), or to refer members for specialized programs such as Disease Management, Case Management, or the Maternity Management program. Precertification may either be done telephonically or electronically, through an Electronic Data Interchange (EDI) or Internet solution. There are two components of precertification, notification and medical review.

a. *Inpatient Services Notification*

Notification is the process of gathering basic information about an inpatient service before services are rendered (notification). This information allows proactive management of the case or can trigger referral to programs such as Case Management for high-risk maternity care. Notification is a data entry precertification process and does not require any judgment or interpretation of medical necessity. Notification may either be done telephonically or electronically through an Electronic Data Interchange (EDI) and Internet solution. The electronic solutions are available 24 hours/day six and one-half days a week.

The purpose of notification is to:

- Determine member eligibility for services and benefits;
- Facilitate accurate and timely claim adjudication;
- Identify opportunities for referral to Case Management, National Medical Excellence or other special programs after determining that benefits are available;
- Assess provider utilization patterns;
- Investigate potential alternative benefit opportunities (e.g. Coordination of Benefits, Worker's Compensation, Medicare fee for service as primary carrier, subrogation);
- Identify utilization issues that may adversely impact care to members (i.e. over or under utilization);

- Initiate pre-admission discharge planning when feasible; and,
- Assign length of stay for tracking purposes.

b. *Inpatient Medical Review*

Inpatient medical review requires that the treating physician or hospital utilization staff provide information regarding the patient's medical condition and proposed treatment or service. Once this information is obtained, Utilization Review/Patient Management staff uses nationally recognized guidelines and resources, such as Milliman Care Guidelines©, and InterQual® ISD criteria, to guide the precertification, inpatient review, discharge planning and retrospective review processes. To the extent certain Utilization Review/Patient Management functions are delegated to integrated delivery systems, independent practice associations or other provider groups ("Delegates"), such Delegates utilize criteria that are scientifically based.

Decisions are made based on criteria discussed above as well as the individual needs of the member, taking into account the make up of the local network.

2. *Inpatient Review*

Inpatient review encompasses those aspects of Patient Management that take place during the provision of services at an inpatient level of care. Inpatient review is conducted on-site or telephonically. The inpatient review process includes:

- The obtaining of necessary information from providers and facilities concerning the care being provided to members;
- The assessment of a member's clinical condition and ongoing medical services and treatments to determine medical appropriateness;
- The early identification of continuing care needs to facilitate discharge to the appropriate setting; and,
- Discharge planning and coordination.

The goals of inpatient review include:

- Determination of appropriate levels of coverage for continued inpatient stay;
- Determination of coverage for appropriateness of admission and level of care;
- Verification of member benefits and coordination of covered services and supplies;

- Determination of payment to providers commensurate with the services being rendered and according to applicable contracts and agreements;
- Identification of potential quality of care concerns involving network providers;
- Early discharge planning assessment and coordination;
- Working closely with hospitalists (as applicable) to eliminate redundancies in functions;
- Identification of cases for referral to the Case Management Program, Disease Management Programs, National Medical Excellence Program, Moms to Babies Maternity Management Program™, other Women's Health Programs, and behavioral health contractors;
- Identification of potential alternative benefits (e.g. Coordination of Benefits, Worker's Compensation, Medicare fee for service as Primary carrier, subrogation) not noted during precertification;
- Identification of cases requiring Medical Director intervention; and,
- Identification of individual needs of the member, taking into account the local healthcare delivery system.

When the Inpatient Care Coordinator or Case Manager identifies a potential issue, they may review the issue with the attending physician or other physicians participating in the care of the member.

A member's treating physician may decide to revise the treatment plan to reflect more appropriate utilization. When an agreement on coverage cannot be reached, the member's case is reviewed by a Patient Management Medical Director. The attending or primary care physician (PCP) may be contacted by the Patient Management Medical Director to discuss the issue further before making a final coverage determination. If information needed to make a determination is not available from either the physician or hospital, coverage of the day(s) in question may be denied. When the information available is insufficient to render a determination, a decision may also be made to request the pertinent portions of the medical record in order to perform a retrospective review.

It is intended that, through the Patient Management Program, all coverage decisions be made concurrently unless appropriate information is not available from physicians and/or hospital utilization management staff.

3. Discharge Planning

Discharge planning for the confined member is defined as a collaborative, prospective planning process that includes the hospital or other alternate care provider, Aetna, other healthcare providers, the treating physician and a member and his/her family to facilitate transitioning the member to a setting appropriate to his/her clinical needs in as timely and efficient a fashion as possible.

Discharge planning may be initiated at any stage of the Patient Management process. Assessment of potential discharge planning need begins at the time of notification, and coordination of discharge plans commences upon identification of post discharge needs during precertification or inpatient review. The discharge plan considers the age/social status, prior history, prior admissions, home safety issues and psychosocial issues. The discharge plan may include initiation of a variety of services or benefits to be utilized by the member upon discharge from an inpatient stay. Referral to internal resources may include Case Management, Disease Management Programs and vendors, Women's Health and National Medical Excellence. External referrals and services may include transfer to inpatient skilled nursing, sub-acute care or rehabilitation facilities, home health care, durable medical equipment and supplies, social work services, community resources, and support groups.

Discharge planning goals include:

- Determination of benefits according to applicable contracts and agreements;
- Prevention of readmission through the promotion of optimal recovery;
- Delivery of care in the appropriate setting;
- Continuity of care;
- Cost-effective utilization of appropriate resources;
- Identification of cases for referral to Case Management Program, Disease Management Programs, National Medical Excellence Program, Moms to Babies Maternity Management Program™, other Women's Health Programs, and behavioral health contractors.

4. *Retrospective Review*

Retrospective review is the process of obtaining necessary information from providers and facilities concerning care which has already been provided to members. Retrospective review includes making coverage determinations for the appropriate level of service consistent with the member's needs at the time of service after confirming the member's eligibility and benefit plan.

The purpose of retrospective review is:

- To analyze retrospectively, any potential quality and/or utilization issues;
- To initiate appropriate follow-up action, based on quality or utilization issues;
- To review initial requests for certification, in anticipation of claim adjudication, made after discharge or the provision of service; and,
- To analyze submitted documentation to determine coverage and rationale behind failure to follow Patient Management utilization guidelines.

Aetna's effort to monitor the services provided to members by independent health care providers includes the retrospective review of claims submitted for payment, and a review of a given case for potential quality and utilization concerns. These concerns are identified through three main sources:

- Patient Management Department review (nurse reviewers identify a potential quality assessment/utilization review concern during precertification, inpatient review, or Case Management activities);
- The routine selection of claims based upon predetermined criteria; and,
- Special requests (grievances, complaints, chart review, confirmation of administrative data sets, etc.).

B. Outpatient Services

1. *Outpatient Services Precertification/Notification* *(not available for all Aetna Traditional products)*

The outpatient service precertification process, and the development and evaluation of the Precertification List for outpatient services follow the same processes observed for inpatient services for those members who have coverage for this benefit under their health benefit plan. As with inpatient services, some outpatient services require only notification. Notification and precertification may either be done telephonically or electronically through an Electronic Data Interchange (EDI) or Internet solution.

Referrals to participating specialists, most diagnostic services and outpatient surgical procedures using participating network providers generally do not require prospective review by Aetna. However, the terms of a member's particular coverage may require prospective review for such services.

Specialists participating with Aetna may typically perform "automatic studies," as a part of their initial evaluation, without receiving specific authorization to do so. In addition, several "Direct Access" programs and the Specialist as Principal Physician Program exist. Members may seek

routine care through these specialists without PCP referral, within the limits of their benefit plan.

Requests for referrals to non-participating specialists are reviewed through the precertification process by the Patient Management Department staff, under a Patient Management Medical Director's direct supervision. All requests for coverage for behavioral health services by non-participating providers are reviewed by the delegated behavioral health contractors.

2. *Outpatient Services-Home Health Care/DME*

Managing, coordinating and tracking certain outpatient services or supplies not connected with an inpatient stay are also functions performed by the Patient Management staff. Home health care, electric beds, motorized wheelchairs and scooter, limb and torso prosthetics and customized braces are examples of services and equipment that may require coverage approval by the Patient Management or Case Management staff in order for benefits to be available. Behavioral health contractors perform authorizations for psychiatric outpatient services, including homecare.

Requests for these services may be received from the attending or Primary Care Physician, specialist physicians or other providers for members in the home or outpatient setting. Since most services are of an on-going nature, initial certification is followed by a period of care coordination and utilization monitoring. Goals of this process are:

- Assessment of the level and quality of the services provided;
- Determination of the coverage for the proposed treatment;
- Identification of care and treatment alternatives, when appropriate;
- Identification of members for referral to Case Management; and,
- Identification of members for referral to Healthy Outlook Programs®, for members who have coverage for this benefit under their health plan benefits and other special programs.

3. *Emergency Services*

Aetna's definition of "Emergency Services" includes the "prudent lay person" standard definition in compliance with the Balanced Budget Act of 1997. Accordingly, an emergency medical condition is "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the

woman and her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part."

C. Case Management

Case Management is defined as a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes. [1]

Case Managers review and coordinate services for members with multiple and complex needs, (e.g. cardiac care, complex pediatric care, oncology, transplantation, etc.) and for members who are at risk for high cost or high utilization. Case Management staff strive to enhance the member's quality of life, support continuity of care, facilitate provision of services in the appropriate setting and manage costs and resource allocation to promote quality, cost-effective outcomes. Case Managers collaborate with the member, family, caregiver, physician and healthcare provider community to coordinate care, with a focus on member education and maximizing quality outcomes.

Case Managers provide the member with information about alternative coverage or continuing care opportunities, as appropriate, and inform the member of ways to obtain that coverage or care in the event the member's benefits end and the member requires additional care. Alternative options for coverage or care may include local, state, or federally funded agencies or non-profit organizations.

The objectives of Case Management are to provide early identification and intervention for members who would benefit from:

- Improved skill in self management;
- Improved transition and coordination among multiple providers and/or levels of care;
- Coordination of end of life care needs;
- Assistance to maximize the effective use of a limited health plan benefit;
- Reduction of acute exacerbation of a chronic illness; and,
- Reduction of avoidable costs.

Members may be identified for Case Management through various internal sources including Claims, Member Services, Hospital Services, and PULSE, Aetna's Predictive Modeling tool. External referrals are also accepted from sources such as the Primary Care Physician and family members.

Members referred to Case Management are screened and assessed prior to acceptance into the program. Only those members likely to benefit from Case Management are accepted into Case Management.

[1] Case Management Society of America

Once accepted into Case Management, Case Managers will, in coordination with the attending physician, member, or member designee, develop a Case Management plan. The Case Manager's plan will have identified short and long-term goals. The Case Manager's interventions are targeted to facilitate the achievement of the Case Management goals. Progress toward the achievement of the expected outcome will be monitored and tracked. For each member in active Case Management, progress in meeting Case Management plan goals and objectives will be reviewed on a regular basis. The Medical Director and Supervisor will assess potential barriers to quality and efficient care and will be available to the Case Management staff as a resource. Cases are closed when the Case Management objectives have been met, if the member requests closure or when the member's functional abilities have reached baseline or chronic custodial level of care.

Delegated behavioral health contractors perform high-risk Case Management activities and report these activities to the Regional Behavioral Health Quality Manager/Consultant.

D. Other Patient Management Program Components

1. Adverse Determination and Appeal Process

a. Initial Adverse Determination Process

Denials are non-certifications or decisions of non-coverage for requested services or supplies, based on either administrative or clinical reasons. Clinical denials are denials of coverage for proposed or provided medical services or supplies that, based on available information, do not meet accepted criteria for coverage. Administrative denials are denials of coverage based upon a contractual or benefit exclusion, limitation, or exhaustion or the absence of any clinical information.

Only licensed physician Medical Directors make clinical coverage denial decisions for reasons related to medical necessity. Coverage denial letters describe the rationale for the denial, delineate any unmet criteria, standards and guidelines, include the availability of the specific coverage criteria or policy provisions used in the benefit determination and inform the provider and member of the applicable appeal process. Clinical coverage denial letters also inform the provider(s) of the Medical Director's availability to discuss the denial decision.

b. Peer to Peer Review Process

The Patient Management peer-to-peer review process is defined as the process through which a treating provider, who has not spoken with the Medical Director prior to a clinical coverage denial, questions the determination and may request to speak with the Medical Director. The treating physician has the option of speaking to either the Medical Director who made the initial determination to deny coverage or to another physician reviewer, such as a second Medical Director, if the Medical Director who made the initial determination is not available. The peer-to- peer process is not an additional level of review or an appeal, but rather serves to facilitate an interim discussion between the treating physician and Medical Director that may resolve the coverage issue prior to appeal.

c. Appeal Process

Aetna has written policies and procedures in place that permit members or their authorized representatives to appeal coverage decisions. Written correspondence informing the providers and members about the coverage determination describes the appeal process and how to access it. The member, member representative or the provider on behalf of the member, may request an expedited appeal when a delay in decision-making might seriously jeopardize the life or health of the member. Aetna and the delegated behavioral health contractor follow applicable state and federal requirements when informing members of their appeal rights and in processing appeals. Once a member has exhausted the plan's appeal

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process, eligible members are offered the option of an independent external review of a denial of coverage based on a lack of medical necessity, a proposed treatment that is considered experimental or investigational, or as required by applicable law or regulation.

d. *External Review*

Aetna provides an external review process for all commercial fully insured plans and self-funded HMO-based plans. Traditional self-insured plan sponsors must elect the external review program for their members to be eligible to participate in this process. Certain states mandate separate review processes that may differ from the Aetna process. The information below addresses the Aetna sponsored external review program, which is available in the absence of a state mandated process.

Eligible members may request external review for certain denials of coverage decisions based upon lack of medical necessity or the experimental or investigational nature of the proposed or rendered service or treatment. The cost of the service (including pharmacy cases, dental issues and appeals for specialist as primary physician) or treatment, at issue, for which the member would be financially responsible, must be at least $500 (or as required by applicable state mandate). External review is available after the member has exhausted the applicable appeal process.

Members are given information regarding external review in the final level appeal letters which notify the member of a coverage denial. Members will not be charged a professional fee for external review (except where applicable state law or regulation requires members to pay a filing fee as part of a state-mandated program).

The Aetna External Review unit facilitates the external review process, but the reviews are conducted by independent physician reviewers selected by the independent review organizations. State Certified Independent Review Organizations ("IRO") or similar organizations are used where appropriate and/or required by applicable law or regulation. The decision of the independent external review expert is binding on Aetna and when applicable, the plan sponsor.

2. *Non-Participating Provider Referral Authorization Process*

The nurses who review non-participating provider referrals, which are requests for approval of coverage for the use of out-of-network services at the in network referred level of benefits, are under the direction of the Patient Management Medical Director. All requests for non-participating behavioral health referrals are reviewed by the delegated behavioral health contractor(s). In general, coverage for the use of a non-participating provider is approved for elective care only if the member requires a unique, highly specialized service which is not otherwise available from a provider

within the Aetna participating provider network. The Patient Management Medical Directors and the nurses in this unit consider continuity of care issues for members with complex medical problems when reviewing such requests. The Aetna Medical Director is responsible for all coverage denial decisions. If the request for the coverage of services provided by the non-participating provider is denied, the decision is communicated in writing to the member, to the non-participating provider and to the Primary Care Physician. The Primary Care Physician is also informed of participating providers within the network who are qualified to render the services.

The purpose of the non-participating provider referral review is to:

- Review coverage of member and physician requests for the use of non-participating providers if the member in question: (1) does not have an out-of-network benefit option; or (2) has an out-of-network benefit option, but has requested that the service be covered as an "in-network" referred benefit;
- Monitor and facilitate the coordination of the quality of care delivered to members who are out of the Aetna service area and under the care of non-participating providers; and,
- Promote access to quality treatment centers and physicians.

3. *Transition of Care*

The Transition of Care process provides guidelines for the transition of care of members who are enrolling in an Aetna plan, are moving from one network plan to another, or are receiving care from a physician or therapist whose contract has been discontinued within the last 90 calendar days for reasons other than quality deficiencies (e.g., business reasons or practitioner choice)[an inactive provider]. These guidelines are used when a member is in an "Active Course of Treatment" and the member's treating provider is not participating in the network of the member's plan. Aetna may provide coverage for a member who has met certain requirements to continue an "Active Course of Treatment" with a non-participating provider for a transitional period of time without penalty, at the new/preferred plan benefit level.

E. Quality Management Indicators

Clinical and service indicators of quality are established and monitored on a regular basis in order to assess health plan performance in the management of clinical care and service. Clinical and service indicators are approved by and reported to the Quality Oversight Committee (QOC); clinical indicators are approved by the Quality Advisory Committee (QAC). All indicators are trended for change over time. Indicators, which are outside target ranges established for the indicator, provide the basis for quality improvement projects.

1. *Quality of Care Indicators*

Potential quality of care concerns identified are referred to Quality Management for investigation, tracking and trending and are reported to the Quality Advisory Committee and Regional Behavioral Health Oversight and Advisory Committee. Potential quality of care concerns are identified according to the following indicators:

- Unexpected outcomes, for example:
  - ⇒ Unexpected death by medical cause;
  - ⇒ Cardiac arrest/pulmonary emboli that was not part of admission diagnosis;
  - ⇒ Unexpected admission post out-patient procedure;
  - ⇒ Diagnosis related events, e.g. delay of care, misdiagnosis; and,
  - ⇒ Medication related events.
- Mental Health/Substance Abuse issues:
  - ⇒ Unexpected death, suicide, homicide;
  - ⇒ Violent assaultive behavior on others or self (requiring MD care, ER or medical admission);
  - ⇒ Significant property damage;
- Member reported events; and,
- Potential legal issues.

Review staff communicate directly and concurrently with the actively involved independent physicians in an effort to prevent or minimize the occurrence and consequence(s) of adverse events. The Patient Management Medical Director will intervene by obtaining additional information, when appropriate, to attempt to resolve the quality of care concern. Behavioral Health delegated contractors report adverse events to the Regional Behavioral Health Quality Manager/Consultant.

2. *Service Indicators*

Aetna monitors Patient Management's telephone responsiveness and decision making and notification time frames. Average Speed of Answer (ASA), Telephone Abandonment Rate, and Turn Around Times for decisions and notifications are monitored, trended, and reported to the QOC on a quarterly basis. Indicators which do not meet target ranges established for the indicator provide the basis for quality improvement projects.

3. *Utilization Management*

Patient Management has mechanisms in place to monitor its Patient Management Program to detect potential under or over-utilization of services and monitor against their thresholds. The Plan identifies relevant utilization data, establishes thresholds and monitors against these thresholds to detect potential under or over utilization. At a minimum, monitoring and analysis is performed on an annual basis. The monitors may include data to manage utilization, HEDIS data, Use of Service measures, tracking/trending member complaints, member/provider satisfaction with the Patient Management process, and costs for each product line. For HMO, at least one monitor will be related to behavioral health. If qualitative analysis of cause and consequences identifies potential over or under utilization, the Plan will perform the same type of monitoring and analysis at the level of the practitioner and provider site as relevant. If indicated, interventions are identified and implemented. The intervention(s) must be related specifically to the barrier(s) or specific circumstances that were identified from the causal analysis to achieve improvement when performance is measured again. In addition, at specified intervals, the Plan will measure the effectiveness of the interventions to determine if there was measurable improvement.

4. *Evaluation of Member and Practitioner Satisfaction with Patient Management Process*

Aetna has mechanisms in place to evaluate member and practitioner satisfaction with the Patient Management process. Member complaint tracking and trending is one measure that may be utilized. In addition, Aetna conducts the annual CAHPS® 3.0H Member Satisfaction Survey version for the commercially insured, and uses the results of the Medicare version of the CAHPS® 3.0H Member Satisfaction Survey conducted by CMS's contractor for Medicare +Choice members.

Practitioner satisfaction is surveyed using the Aetna Physician Survey. This survey is conducted in two parts. Primary Care Physicians (PCPs) receive one version of the survey. It is sent to a sample of PCPs contracted for all products and a sample of physicians contracted for Traditional products only. Only one physician in an office receives a survey. There is a different version of the survey for practice managers. Practice managers in the same office as the physicians are sent a survey, regardless of type of contract (all products or Traditional products only).

The results of both the Member and Physician Satisfaction Surveys are reviewed to determine areas of dissatisfaction. Barrier analysis is performed to determine the reasons and consequences of the results and is an important step to identifying effective interventions, if indicated.

VIII. SPECIAL PROGRAMS

A. Healthy Outlook Programs® (Disease Management)

Disease Management is the member-centered multi-disciplinary management of chronic disease, across the health care continuum, with the goal of improving quality health outcomes and controlling costs. This program is available for all HMO-based members and for Traditional members depending on the benefits selected by the employer. In addition to internally developed and managed Disease Management programs, the Aetna Healthy Outlook (Disease Management) Programs utilize expert vendors, to educate members about their condition and how modifying their lifestyle, including diet, exercise, and medication compliance may help improve their health status or overall well being.

In addition, Aetna supports goals, such as:

- Providing high service value for members and plan sponsors;
- Improving care for common and high cost chronic diseases;
- Encouraging management of chronic conditions consistent with evidence-based clinical practice guidelines; and,
- Meeting NCQA, URAC and HEDIS standards and compliance with all federal and state mandates.

Depending on the severity of their condition, members may also receive individualized Case Management, Disease Management teaching, outpatient education and home health monitoring technology such as a biometric scale. Since depression may accompany chronic disease, members are offered information about depression and its relationship to chronic physical conditions.

The Aetna approach to Disease Management is characterized by:

Patient Identification Process

Members are identified in a variety of ways including member self-referral, physician referral, internal staff identification and identification using administrative data by US Quality Algorithms® (USQA), our performance measurement subsidiary. In addition, real-time member identification using pharmacy prescription and Utilization Management (UM) hospital discharge data have been added to further enhance the identification process.

Members are stratified, when possible, to assess the level of program services appropriate. Stratification levels are assigned as follows:

- USQA assigns stratification levels 1 through 5, 5 being at highest risk;

- Members identified using Utilization Management and pharmacy data are unassigned but considered moderate or high risk due to an exacerbation or hospitalization;
- Regional Disease Management staff assigns a risk level as low, moderate, or high using the risk assessment tool in eTUMS.

Member and Physician Communication

Upon identification, members and physicians receive introductory information explaining the educational opportunities available and encouraging participation.

The Healthy Outlook Programs are an opt-out type of program. This means identified members are considered enrolled. Enrollment status is characterized as logged, active, or closed. The member may opt-out at any time since participation is voluntary. In addition, the member's physician may opt the member out at any time. An active enrollment status means the member is actively engaged with a disease management nurse. That engagement may include one or more of the following: assessment, teaching, monitoring, provision of educational materials and communicating with the member and their treating physician.

Program features vary, but generally target clinical and educational tools for internal staff, physicians, and members.

The Healthy Outlook Programs currently address asthma, congestive heart failure (CHF), coronary artery disease (CAD), diabetes, low back pain (LBP), and end stage renal disease (ESRD). In 2003, enhancements were added to the asthma and CAD programs. The Low Back Pain program is being reviewed and redesigned and the new program is expected to be introduced during the second quarter of 2003.

The Aetna Healthy Outlook (Disease Management) CHF, Diabetes and ESRD Programs utilize expert vendors to:

- Educate members about chronic conditions and enhance partnership with physicians;
- Coach members;
- Perform biometric monitoring; and
- Provide individual Case Management, when appropriate; and,

The services provided by the vendors meet NCQA, URAC, and HEDIS standards and comply with relevant federal and state mandates.

B. National Medical Excellence Program®

Aetna's National Medical Excellence (NME) Program® was created to focus on the evaluation and management of transplants and certain other rare or complex conditions. The team, including a Senior Medical Director and dedicated clinical and administrative staff, assist eligible members to access appropriate,

covered treatment at facilities with demonstrated expertise. The program includes the following components:

- The National Transplantation Program focuses on evaluating and managing all members in need of solid organ and tissue (bone marrow and stem cell) transplants. To ensure continuity of care and member satisfaction, the Transplant Manager will manage all of the member's needs from evaluation through the post transplant period.
- The National Special Case Program assists members with rare or complex conditions requiring specialized treatment in evaluating their treatment options and obtaining appropriate care.
- The Out-of-Country Care Program evaluates and coordinates care to the nearest facility that can effectively treat the member emergently admitted while traveling out of country.

The National Medical Excellence Program utilizes The Institutes of Excellence (IOE) Network of facilities that have demonstrated expertise in their field and have met Aetna's credentialing requirements for transplant and transplant related care. This unit works closely with the National Transplant Claim Unit to coordinate customer service and claim payment, including transportation and lodging.

C. Women's Health Programs

Aetna has designed a variety of benefits and programs to promote women's health and is committed to educating female members about the lifelong benefits of preventive health care. Aetna also makes accessing gynecological care easy for Aetna members; for members in HMO and HMO-based plans, no referrals are needed for routine ob/gyn office visits and routine obstetrical care, well-woman exams, Pap smears, and office visits for gynecologic problems and follow-up care. The Aetna Women's Health Programs offers the following:

1. *Women's Diabetes Care Program*

Aetna's Women's Diabetes Care Program applies to members in Aetna's HMO, QPOS, USAccess, Open Access HMO and Golden Medicare Plan. It was designed for diabetic women in their childbearing years, and provides nurse Case Management and education to reduce the risk of diabetes-related pregnancy complications.

2. *Moms-to-Babies Maternity Management Program™*

Formerly the L'il Appleseed program, the Moms-to-Babies Maternity Management Program is available to most female members in Aetna's HMO-based plans (HMO, QPOS, USAccess, Aetna Open Access HMO and Golden Medicare Plan). It is also available to other members depending on the benefits selected by the employer. To determine whether a member is

eligible to participate in this program, call the toll-free Member Services telephone number on the member's ID card. This program features:

- Assistance in accessing prenatal care benefits;
- Care coordination by experienced obstetric nurse Case Managers who assist in arranging covered services, coordinate covered specialty care, review the program's features and answer general pregnancy-related questions;
- A pregnancy risk survey, which helps identify potential risk factors and pregnancy complications;
- Nurse Case Management and targeted education relating to any risk factor(s) identified on the survey;
- Smoke-free Moms-to-be™, a personalized smoking-cessation program designed specifically for pregnant women;
- A comprehensive pregnancy handbook, including detailed information on prenatal care, labor and delivery, newborn care, breastfeeding, postpartum depression and other pregnancy-related health issues;
- Focused, educational information "For Dad or Partner";
- Translation services, including up to 150 different languages, to assist members in communicating with program staff; and,
- Program materials in Spanish.

Program Enrollment

Participating OB care providers are encouraged to notify Aetna following the first prenatal care visit to activate enrollment for eligible members in the Moms-to-Babies program. Members can also register for the program through the Aetna Navigator or by directly contacting the Moms-to-Babies Maternity Management Program at 1-800-272-3531.

Pregnancy Risk Survey

Each maternity management program registrant is asked to complete a pregnancy risk survey, which helps identify whether she may be at risk for certain pregnancy-related complications. If a member identifies a risk factor on the survey, relevant educational materials are sent and an obstetric nurse Case Manager is available to coordinate specialty care with the member's participating obstetrical care provider and, as appropriate, to help arrange for the member to see a high-risk pregnancy specialist (perinatologist). The perinatologist can coordinate delivery in a participating facility with the expertise, staffing and equipment to handle a complication if it arises.

Authorizations for OB Care

For members enrolled in Aetna's Moms-to-Babies Maternity Management Program, any necessary authorizations for care not provided in the OB care

provider's office must be coordinated by the Moms-to-Babies program at (1-800-272-3531). Members not enrolled in the maternity management program must have any necessary authorizations coordinated through the Aetna Precertification Unit. The toll-free number for this unit is on the member's ID card.

3. *Infertility Case Management Program*

The Aetna Infertility Case Management Program is a rich education and information resource for members who are experiencing infertility. The program provides clinical education regarding covered infertility benefits and may guide members to a select network of infertility providers for services which may or may not be covered. To verify a member's infertility benefits, call the toll-free Member Services telephone number on the member's ID card.

Once covered infertility benefits have been identified, the Infertility Case Management Program provides any appropriate authorizations required under the plan for eligible members. Some benefits may vary due to group size, state mandates or employer choice.

4. *Genetic Testing for Hereditary Breast and Ovarian Cancer*

Available to Aetna members in all plans who have never had breast or ovarian cancer, but who have a high risk for developing the disease(s). Participants must meet specific criteria.

Aetna's Genetic Testing promotes early risk identification by providing confidential genetic testing to members at risk for developing inheritable breast and ovarian cancer. Individuals at high risk include those with a family history of breast and/or ovarian cancer and those with a relative who is known to have a mutation in the BRCA1 or BRCA2 genes (specific criteria developed by the American College of Medical Genetics are detailed in Coverage Policy Bulletin #227 available at (www.aetna.com).

5. *Breast Cancer Case Management Program*

This program is available to Aetna members in HMO plans (HMO, QPOS, USAccess, Aetna Open Access HMO and Golden Medicare Plan), and assists female members who have been diagnosed with breast cancer in making informed choices for their care.

Features of this program include:

- Second opinions at breast cancer Centers of Excellence;
- Member education about breast cancer and Aetna benefits; and,
- Daily access to a registered nurse, who can help coordinate care with the member and her doctor, hospital and specialists. The

nurse is also trained to provide telephone support for members and their families.

D. Government Programs

Aetna recognizes the special needs of Medicare beneficiaries and, in some regions; we have developed specialized Patient Management units to:

- Provide Health Risk Assessments to new Medicare members;
- Oversee access to quality health care services for Medicare members; and,
- Support Case Management services rendered to Medicare members.

IX. Delegated Patient Management

Delegation is a process by which Aetna agrees to grant an outside entity (the "Delegated Entity") the ability to perform specified functions or activities on its behalf. Each Delegated Entity must demonstrate conformance to Aetna's program requirements for all delegated activities. Performance of these activities by the Delegated Entity is documented in an agreement between the parties.

Aetna may delegate Utilization Management responsibilities to entities that are certified by the National Committee for Quality Assurance (NCQA) or American Healthcare Commission (URAC) or which demonstrate capability to Aetna's satisfaction. All entities considered for Utilization Management delegation, but not holding current NCQA or URAC certification for Utilization Management, will be evaluated pre-contractually for their Utilization Management capability. Aetna remains responsible for oversight of all delegated activities, whether they are fully or partially delegated. Aetna has developed a structured oversight process, in accordance with the relevant standards of the National Committee for Quality Assurance (NCQA), Joint Commissions on Accreditation of Healthcare Organizations (JCAHO), American Healthcare Commission (URAC), and Centers for Medicare & Medicaid Services (CMS), which include initial, periodic, and interim reviews and reports to evaluate programs of entities which have requested delegation and to which Aetna has delegated Patient Management activities. When Patient Management is delegated, Aetna remains responsible to verify that Patient Management functions are performed in accordance with these standards, as well as applicable laws and regulations**.**

A. Purpose/Goals

The goals of delegated Patient Management activities include all of the goals previously outlined for non-delegated Patient Management in addition to:

- Delivery of the most appropriate covered level of care;
- Increased member satisfaction;
- Ease of administration and determination of responsibility;

- Support and training to providers;
- Establishment of guidelines for providers;
- Management of provider performance using data collection, analysis and reporting;
- Flexibility to target specific markets/conditions;
- Improved efficiencies; and,
- Net expense reduction.

B. Reports/Audits

Reports include an annual written evaluation of the Patient Management Program provided by the Delegated Entity to the health plan's Patient Management Department. This evaluation must include, but is not limited to:

- An aggregation and analysis of the performance measures submitted on a quarterly basis;
- A description of any updates or modifications to the delegated entity's Patient Management policies and procedures; and
- A description of any updates or modifications to the criteria used in Patient Management services.
- A determination of the delegated entity's compliance with the health plan policy; and,
- The adherence to NCQA and URAC standards.

The health plan will perform an annual on-site audit to determine the delegated entity's compliance with the health plan standards and policies. This audit includes, but is not limited to:

- Evaluating the Patient Management Program description plan;
- Evaluating the Patient Management Program's policies and procedures; and,
- Evaluating the existence of the following:
  - ⇒ Confidentiality policy;
  - ⇒ Patient Management Committee that oversees Patient Management processes;
  - ⇒ Patient Management Policy and Procedure Manual;
  - ⇒ Behavioral Health Contractor's Standards Manual;
  - ⇒ Written Patient Management protocols or criteria;
  - ⇒ Authorization policy and procedure;

⇒ Denial procedure;

⇒ Periodic, at least semi-annually, substantive evaluation of regular specified reports; and,

⇒ Mechanism for notifying the Health Plan of updates and reports.

There are three levels of compliance determined by the audit: full compliance, partial compliance, and non-compliance. The Delegated Entity's program is evaluated by the Regional Quality Oversight Committee (QOC) or the Regional Behavioral Health Oversight and Advisory Committee for Behavioral Health (RBHOAC) for HMO, or the Behavioral Health PPO Based Products Oversight Workgroup or other equivalent committee to determine if the program meets the minimum Patient Management standards to maintain a delegated status. The QOC or appropriate oversight committee may alter the delegation determination at any time if they determine that the delegate's activities do not meet the plan's requirements.

C. Appeals

The review of complaints, grievances and appeals is generally not delegated, but may be delegated for behavioral health. Regardless, both Aetna and the delegate follow the Aetna Member Complaint and Appeal Resolution Process.

X. COMPONENTS OF THE DELEGATED BEHAVIORAL HEALTH PATIENT MANAGEMENT PROGRAM

Patient Management of behavioral health is delegated to a behavioral health contractor(s) who provides varying utilization review activities in this specialty area.

A. Program Overview

1. Philosophy

Aetna is committed to quality-based managed behavioral health (BH) care. In keeping with that commitment, Aetna has developed the following philosophy regarding behavioral health services:

- The integration of services for the mind, and body is important. Behavioral health contractor(s) should, when appropriate, and subject to privacy laws. work collaboratively with other providers of care. Behavioral health services are based on a biopsychosocial (mind, body and social environment) model.
- Members should have easy access to medically necessary covered behavioral health services so that treatment, when possible, may begin relatively early in the disease process. A complete and

accurate clinical evaluation performed by a qualified practitioner is important to successful treatment.

- Coverage for certain medically-acceptable treatment modalities, based on medical necessity, should be available to members. Having a range of services available promotes quality, cost effective care.
- Network development, Quality Management and Patient Management should be consistent with National, Regional, and local Health Plan needs.

Behavioral health contractor(s) agree to adhere to all standards outlined in the two (2) manuals provided to the behavioral health delegated contractor(s) by Aetna that describes the key elements of Aetna's HMO and PPO Behavioral Health Programs and the accountability for each activity. Behavioral health contractor(s) are required to meet all standards set forth in these manuals by Aetna. Compliance with these standards and criteria is monitored by Aetna on a continuing basis.

2. *Objectives*

The primary objectives of the Behavioral Health Patient Management program are:

- To provide access to the appropriate level of care, which is geographically accessible and delivered by an appropriate practitioner for persons with mental health/chemical dependency conditions;
- To provide guidelines for determining the appropriate level of care;
- To facilitate continuity and coordination of care for members;
- To utilize participating providers whenever appropriate;
- To facilitate, as appropriate, the coordination and integration of mental health and chemical dependency treatment services with other medical/surgical care;
- To educate providers about behavioral health issues (mental health and chemical dependency); and,
- To evaluate provider performance.

Subject to Aetna oversight, and in compliance with Aetna, NCQA and URAC standards, and federal and state law requirements, the behavioral health contractor(s) is required to provide the following Patient Management activities as required by plan/product design, including, but not limited to:

- Precertification;
- Inpatient review and, when applicable, concurrent outpatient review;

- Case Management (including high-risk behavioral health and medical co-morbidity cases);
- Discharge planning;
- Level one appeals (in limited areas);
- Evaluation of requests for coverage for the use of non-participating providers, especially for transition of care;
- Collaboration with, at times, primary care physicians, activities and staff from Aetna's medical Patient Management programs, and with Aetna's Disease Management Programs and other health programs including Moms-to-Babies™ to provide continuity and collaboration of care; and,
- Benefit administration and tracking (as applicable).

3. *Accountability and Monitoring*

In delegated arrangements, Aetna delegates certain Patient Management functions, but remains accountable for these services to its members. Consequently, a structured oversight process has been implemented to evaluate the behavioral health contractor(s) adherence to policies, procedures, standards and criteria that comprise Aetna's Behavioral Health Patient Management Program. Aetna oversees performance of the behavioral health contractor(s) through review of regular reports, periodic meeting summaries, committee minutes, clinical and service monitoring reports, annual on-site review, workgroups, and other audits or activities deemed appropriate by Aetna. The Aetna Behavioral Health Program is overseen nationally by a Behavioral Health Medical Director who has ultimate responsibility for the implementation of the behavioral health care aspects of the Patient Management Program.

The behavioral health contractor(s) program is evaluated by the Regional Behavioral Health Oversight and Advisory Committee (RBHOAC) or its equivalent for HMO products and Behavioral Health PPO Based Products Oversight Workgroup for PPO based products to determine if the program meets the minimum Patient Management standards to maintain a delegated status. The behavioral health oversight committee may request Aetna investigate altering the delegation determination at any time if they determine that the delegate's activities do not meet the plan's requirements.

A board certified psychiatrist, as Aetna's Behavioral Health Medical Director, is expected to provide overall clinical leadership and implementation of the Patient Management program. In addition, the psychiatrist is expected to assume case specific responsibility for all levels and types of behavioral health contractor Patient Management recommendations and decisions.

The behavioral health contractor must have a psychiatrist on-call at all times, 24 hours a day, 365 days a year, to provide behavioral health consultation

and to supervise and make Patient Management decisions, where applicable, on a case-specific basis for those products providing 24 hour access. The behavioral health contractor must have access to specialty specific psychiatrists for consultation for utilization reviews.

Aetna requires that the behavioral health contractor(s) comply with Aetna's standards and policies that are consistent with industry standards, NCQA, URAC, and all applicable state and federal law requirements. Aetna requirements include, but are not limited to:

- Promoting integration of behavioral health with medical/surgical care through collaboration of activities;
- Maintaining consistent standards for members on both the behavioral health and the medical/surgical side of Patient and Quality Management; and,
- Responding to employer and regulatory requirements.

B. Guidelines for Behavioral Health Contractor(s)

1. *Contractor Policy and Procedure Guidelines*

At a minimum, there must be compliance with the following standards:

- Use of Aetna-approved behavioral health guidelines for making coverage decisions including Level of Care Assessment Tool (LOCAT) and, Mixed Services Policy, in addition to American Society of Addiction Medicine (ASAM) guidelines, and/or any specific state-mandated criteria such as the Texas Alcohol and Drug Addiction criteria (TCADA) (28 TAC §§3.8001-3.8022);
- Documentation of Patient Management decisions and protocols utilized in the Patient Management record;
- Dissemination, at least annually, of clinical guideline information and significant changes, as necessary, to network practitioners;
- Implementation of a mechanism for checking the consistency of the application of LOCAT, ASAM and TCADA criteria among Patient Management Medical Directors and other reviewers (inter-rater/reviewer reliability); and,
- For HMO-based products, a description of the contractor plan, capacity and methodology for producing an Annual Patient Management Program Evaluation Report that includes the contractor's evaluation of performance against the annual Patient Management Work Plan for the year under review.

With regard to denial of coverage decisions, policies and procedures must include, at minimum:

- A Medical Director (a doctoral level clinical psychologist, or certified addiction medicine specialist may review for a potential denial of coverage), a licensed psychiatrist, renders decisions for denial of coverage;
- Denial reasons must be clearly described and made available to members, providers and practitioners in accordance with applicable law, NCQA and URAC requirements;
- Denial letters must be approved by Aetna, include all appropriate state-mandated or ERISA language (as appropriate), and information regarding the appeals process;
- Denial decisions, both verbal and written, must meet NCQA and URAC requirements, and all applicable laws;
- For Aetna Golden Medicare Plan™ or Aetna Golden Choice™ Plan members, all denial letters must meet Medicare (CMS) guidelines and protocols. These letters must be sent to Members and providers immediately following telephone notification to members, practitioners or families; and,
- Appeals of behavioral health contractor(s)'s Patient Management denials must be immediately directed to the Plan for review (except level one appeals for PPO-Based Products or in certain limited areas where level one appeals are delegated for the HMO) through the Plan's behavioral health appeal protocol.

All denials are rendered by a board-certified, licensed psychiatrist employed and/or directly contracted by the behavioral health contractor, either as a Medical Director or as a physician advisor. Where state mandated, the denial must be rendered by a psychiatrist licensed to practice in that state.

All clinical appeal determinations must be rendered by a psychiatrist. Where state law mandates, all re-considerations and appeals of utilization review non-certifications are evaluated by a medical doctor licensed to practice in that state.

2. Reports

Reports include an annual written evaluation of the HMO Patient Management Program, Work Plan, and revised Patient Management Program description provided by the behavioral health contractor(s) for presentation to the Regional Behavioral Health Oversight and Advisory Committee (RBHOAC), or its equivalent, which has approval authority for oversight activities from the Quality Oversight Committee. The results of the behavioral health contractor(s)'s annual evaluation should parallel the work plan for the year. It should assess the overall effectiveness of the Patient Management Program and include, but not be limited to:

- Analysis of utilization data, including inter-reviewer reliability statistics and turn around times for Patient Management decisions;
- Trending of service and quality indicators (e.g., provider satisfaction, adverse events, over/under utilization, etc.);
- Quantitative and qualitative analyses, including barrier analysis;
- Action plans and/or changes of protocols as a result of ongoing analysis approved by Aetna;
- Summary of data from all required reporting for the calendar year; and,
- Evidence that the behavioral health contractor(s)'s Patient Management Program, policies and procedures have been reviewed, updated, revised (if appropriate), have involved network practitioners in development, and have been dated and signed by the behavioral health contractor(s)'s Medical Director and Patient Management Committee.

Behavioral health contractor(s) reports to the Regional Behavioral Health Quality Manager and/or RBHOAC are standardized as described in the Behavioral Health Contractor Standards Manual for HMO and the Behavioral Health Contractor Standards Manual for PPO-Based Products, and should include but may not be limited to:

- Case Management activities;
- Denial data;
- Status of reported adverse events;
- Statistics of Patient Management decisions for:
  - ⇒ Inpatient admission;
  - ⇒ Partial hospital stays;
  - ⇒ Intensive outpatient treatment; and,
  - ⇒ Outpatient treatment.
- Quarterly reports;
- Annual documents;
- Patient Management audit results for:
  - ⇒ Inter-rater reliability; and,
  - ⇒ Timeliness of Patient Management decisions.

Other reports may include: Practitioner Satisfaction Survey Reports, action plans for improvement and Patient Management Committee Minutes.

3. *Clinical Guidelines*

Unless otherwise required by applicable law, three sets of clinical practice guidelines serve to assist the behavioral health contractor(s) and Aetna Patient Management personnel in overseeing decisions regarding level, type and duration of care. The LOCAT, ASAM or TCADA, and Mixed Services Guidelines presented in the Aetna Behavioral Health Contractor Standards Manual for HMO and the Behavioral Health Contractor Standards Manual for PPO-Based Products are only guidelines. They are not intended to replace the professional judgment exercised by properly trained, licensed, and experienced behavioral health clinicians and professionals with regard to the provision of care in accordance with accepted standards of care. Other guidelines will be used in states that mandate their use.

Level of Care Assessment Tool

The Aetna **"LOCAT**" instrument, with its attached scoring guidelines, helps determine appropriate levels and types of care for members in need of evaluation and treatment for mental health and psychiatric conditions and diagnoses, and for members in need of placement in specialized psychiatric or mental health facilities or units.

The Level of Care Assessment Tool (LOCAT) is a tool which Aetna has been utilizing and updating since 1990. Aetna 's Behavioral Health Department, along with panels of experts, developed the Level of Care Assessment Tool.

Over the years, the LOCAT has been modified to address the treatment needs of children, adolescents, adults and the geriatric population. Behavioral health contractor(s) are required to utilize the LOCAT with regard to the collection of information and the provision of care, in accordance with accepted standards, to members.

The American Society of Addiction Medicine Guidelines

The American Society of Addiction Medicine Criteria and Guidelines (**"ASAM")** is a nationally recognized criteria set that helps determine appropriate levels and types of care for members in need of evaluation and treatment for chemical dependency conditions and diagnoses, and for members in need of placement in specialized chemical dependency detoxification or rehabilitation facilities or units. Note: For Texas insured members, the Texas Alcohol and Drug Addiction Criteria (28 TAC §§3.8001-3.8022) is utilized in place of ASAM.

The Aetna Mixed Services Guidelines

The Aetna Mixed Services Policy helps outline appropriate levels and types of care, and the types of collaboration necessary between Aetna Patient Management staff and the designated behavioral health contractor staff, for members with combinations of medical/surgical and behavioral health – (mental health/chemical dependency) conditions and diagnoses.

C. Activities

1. Triage and Referral

The initial intake is conducted by a non-clinical telephonic intake/customer service worker for verification of membership and benefits. Non-licensed staff does not provide clinical referral and triage. Callers seeking clinical services that are not for routine appointments are directed to the Care Management Department for an initial telephonic assessment to obtain information that forms the basis for:

- Determining the level of urgency for treatment services (life threatening emergency, non life threatening emergency, urgent or routine care);
- The level of care needed to promote the effectiveness of behavioral health; and,
- The provider characteristics suited to meet the individual needs or preferences of each member.

The assessment data are used to arrange for care with regard to a member's needs, preferences, and a network provider's expertise.

Written triage and referral protocols are in place to facilitate appropriate access according to the following levels of care:

- Life threatening emergency is a condition that requires immediate intervention to prevent death or serious harm to the member or others. An emergency medical condition may also be defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in death or serious harm to the individual;
- Non-life threatening emergency is a condition that requires rapid intervention to prevent acute deterioration of the member's clinical state or condition;
- Urgent is a situation that is less clinically compelling than an emergency situation. A referral for urgent level of care services is made when the clinical situation would likely deteriorate if the member were not seen in a timely fashion; and,
- Routine is a clinical situation that is considered to be sufficiently stable. A referral for routine care is one in which it is considered to not have a negative impact on the member's condition by offering a face-to-face assessment within ten (10) calendar days following the request of service.

2. *Precertification*

Note: These remarks apply to only those products that require precertification for that specific level of care.

Precertification is defined as the process of determining the eligibility and appropriateness of the proposed level of care and place of service. Collection of complete and accurate clinical data is an important element in the successful completion of the precertification process. The purpose of precertification is:

- To assess medical necessity and appropriateness of care for coverage purposes;
- To determine member eligibility for services and benefits;
- To establish that care is being rendered at an appropriate site by an appropriate provider;
- To identify members who will benefit from Case Management;
- To investigate potential coordination of benefits with other health benefits coverage;
- To identify if members are appropriate for mixed services guidelines; Disease Management services; and
- To initiate pre-admission discharge planning.

3. *Inpatient Review/Concurrent Review*

Concurrent review is the process of determining utilization and quality issues at the time the particular service is being rendered for a member, including:

- Evaluating a member's current status for continued stay and level of care;
- Identifying potential utilization review and quality concerns; and,
- Identifying members who will benefit from Case Management services, Mixed Services Guidelines, and Disease Management Programs.

4. *Discharge Planning*

Behavioral health contractor(s) is responsible for initiating discharge planning at the time of admission and for facilitating transition to lower levels of care on the day of discharge or the next business day. Upon discharge, members are triaged to the next level of care for follow-up. A written discharge plan should exist for all Aetna members discharged from a

hospital or residential facility where they received mental health or chemical dependency treatment.

5. *Retrospective Record Review*

Retrospective review is the process of reviewing medical services or treatments after the service or treatment has been provided in order to make a determination of coverage and member eligibility. This includes:

- Verification of member eligibility and benefits in accordance with the applicable plan documents;
- Determination of coverage for inpatient admissions, including but not limited to, acute hospital, non-acute facility and skilled nursing facility admissions;
- Identification and referral to the Case Management program when appropriate; and,
- Identification of any quality of care issues and referral, as appropriate, for review.

In compliance with state and federal mandates and confidentiality laws, the behavioral health contractor(s) will request relevant medical records from the practitioners and/or hospitals. Records must be directed to the appropriate parties for utilization and quality reviews.

6. *Coordination of a Member's Care and Transition of Care when Benefits End*

The behavioral health contractor(s) is responsible for providing appropriate Case Management services where required in the delegation agreement and in accordance with plan design. The behavioral health contractor's Care/Case Managers work closely with network providers and Aetna Patient Management staff in order to be prepared for a situation where benefit limits have been maximized and hence, coverage is no longer available. In accordance with accepted professional guidelines and standards for clinical practice, members in active treatment are not abandoned. Rather, appropriate policies are in place to support the safe transition of each member from one provider to another under a different benefit plan, private pay or publicly-funded arrangement. The behavioral health contractor(s) provide, in part:

- **Exchange of benefits:** Aetna recognizes that continued treatment with the same practitioner may be beneficial. Accordingly, when defined in plan documents and state regulations allow, an exchange of inpatient benefits for outpatient benefits may occur. When this benefit is available, it will be exercised in accordance with the applicable state law;

- **Positive practices by contractor: In accordance with acceptable standards of medical care,** offer the option of lower cost services such as support groups and group therapy; and,
- **Alternative financial arrangements:**
  - ⇒ Discussion of fees with Member well in advance of the exhaustion of benefits;
  - ⇒ Identification of practitioners who are willing to accept a lower compensation rate; and,
  - ⇒ Payment plans.

In the event the member's benefits end and the member still needs care, the case manager will attempt to provide the member with information about alternative coverage or continuing care opportunities, as appropriate, and inform the member of ways to obtain that coverage or care. Alternative options for coverage or care may include local, state or federally-funded agencies or non-profit organizations.

7. *High Risk Case Management*

Case Management is a collaborative process, which assesses, plans, implements, coordinates, monitors, and evaluates services to meet an individual member's needs.

Standard, non-high risk, Case Management is expected to be provided by behavioral health contractor(s) for any member in treatment where provided for in plan design. Two kinds of special high-risk Case Management programs are an integral part of the behavioral health contractor(s)'s provision of behavioral health services to Aetna's membership:

- High risk behavioral health Case Management; and
- High risk medical/behavioral health Case Management (members with behavioral health conditions and medical co-morbidities). This includes members appropriate for Aetna Medical Healthy Outlook Programs (e.g., asthma, diabetes, low back pain, and heart failure).

High-risk Case Management criteria and policies and procedures are outlined in Aetna's Behavioral Health Contractor Standards Manual-HMO and the Behavioral Health Contractor Standards Manual for PPO-Based Products.

8. *Non-Participating Provider Review*

For plans requiring a PCP referral, a written referral from the member's Primary Care Physician requesting coverage for routine outpatient

behavioral health services by a practitioner who is not contracted with the behavioral health contractor(s)'s network is considered a "non-par" request.

As with any "non-par" request, a determination of coverage must be individually evaluated by the behavioral health contractor(s) based on medical necessity, appropriate level of care, and plan benefit availability.

9. *Appeals*

The review of level one appeals, except for Aetna Golden Medicare Plan™ or Aetna Golden Choice™ Plan, may be delegated to the behavioral health contractor. Level two appeals are handled by Aetna. Regardless, both Aetna and the delegate follow the Aetna Member Complaint and Appeal Resolution Policy.

XI. CONFIDENTIALITY

Aetna considers nonpublic personal member information private and confidential and has policies and procedures in place to protect the information against unlawful use and disclosure. Participating network providers, vendors, and consultants who help administer the health plan are required by contract to keep member information confidential, as required by applicable law. Aetna and health care providers must also give members access to their medical records within a reasonable time after any request. When necessary or appropriate for the care or treatment of members, the operation of the health plan, or to conduct related activities, we disclose nonpublic member information to health care providers (doctors, dentists, pharmacies, hospitals and other providers and facilities), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits members receive under the plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents.

We also use the information internally for the foregoing purposes. Some of the ways in which nonpublic member information is used include claims payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, Disease and Case Management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health claims and analysis and reporting; health services research; data and information systems management; compliance with legal and regulatory requirements; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider the foregoing activities key for the operation of our health plans. To the extent permitted by law, we use and disclose nonpublic member information as provided above without member authorization. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health benefits. We do not disclose nonpublic member information for these marketing purposes unless the member

authorizes. We also have policies addressing circumstances for release of member information when members are unable to give authorization.

Members can obtain a copy of the notice describing in greater detail the policies concerning use and disclosure of personal member information, and how they can access information about themselves, by calling the toll-free Member Services number on the member's ID card or visiting our Internet site at www.aetna.com (the Internet site is not applicable in Arizona).