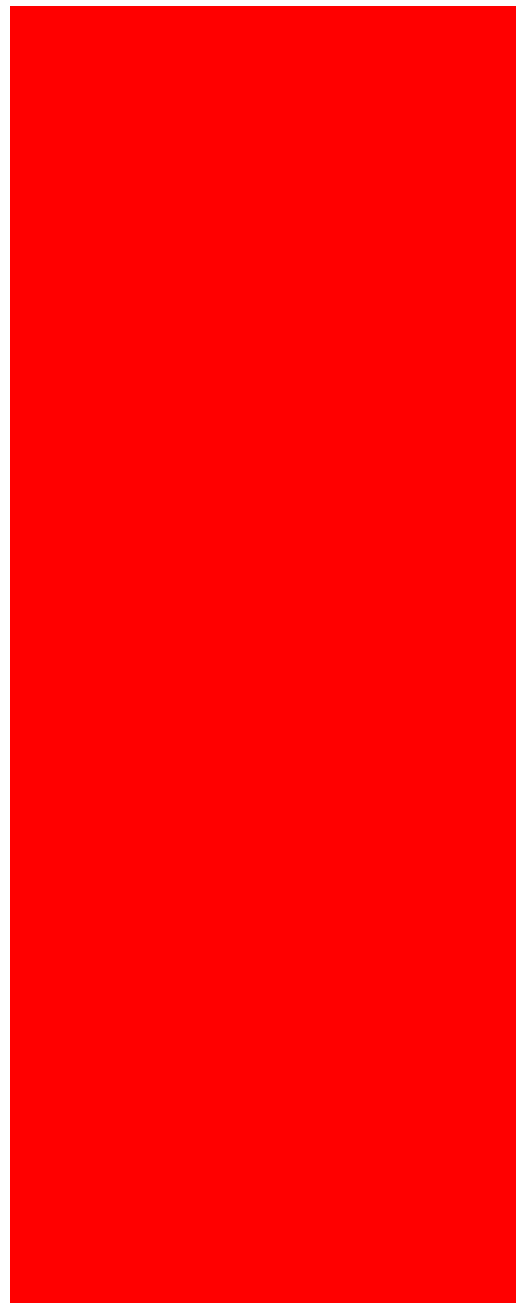




46 SECTION E – CHRONIC  
CARE/DISEASE  
MANAGEMENT

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## Section E: Chronic Care/Disease Management (Section §6 of RFP)

**E.1 Describe existing (other state Medicaid or CHIP contracts) and planned Chronic Care/Disease Management programs for the Louisiana CCN Program that are designed to improve health care outcomes for members with one or more chronic illnesses. Describe how the Chronic Care/Disease Management programs' data are analyzed and the results utilized by your organization to improve member outcomes.**

### Chronic Care/Disease Management Experience

Aetna Better Health, together with our affiliates, has more than 25 years of experience providing disease-specific outreach, education and care management to Medicaid eligible members with chronic conditions. Aetna Better Health has been successfully operating disease management programs in our Medicaid managed care health plans throughout the country since 1993 and has, through our affiliate, Schaller Anderson, L.L.C. (Schaller Anderson) operated an NCQA certified Disease Management Program for four targeted chronic diseases (i.e. asthma, Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD) and diabetes) since 2006. Our experience has shown that disease management programs can be an effective strategy for improving the management of care for members with chronic conditions, resulting in improved health outcomes and cost savings.

Schaller Anderson's Disease Management Program is currently offered in seven states: Arizona, Connecticut, Delaware, Florida, Missouri, Pennsylvania and Texas. Following is a table that lists Schaller Anderson's cumulative DM enrollment for a recent six months period.

**DM enrollment for a recent six months period**

	Nov-10	Dec-10	Jan-11	Feb-10	Mar-11	Apr-11	Average
Total Members Managed - High Risk (Open Cases)	720	638	710	727	745	622	694
New High Risk Cases Opened (New Cases Opened)	154	184	183	168	194	103	164
Total - Low Risk	26,051	26,608	26,379	26,517	26,544	27,278	26,563
Total Cases Closed	243	118	157	183	211	167	180
Outbound Calls	5,718	5,412	5,373	4,774	6,049	4,040	5,228

### General Member and Provider Outreach and Engagement

It is Aetna Better Health's experience that Chronic Care/DM Programs increase their effectiveness when members and Primary Care Providers (PCPs) and Patient-Centered Medical Homes (PCMHs) receive information and education about the value, scope, and depth of the programs. While enrollment into the program is voluntary, members receive information about our Chronic Care/DM at time of enrollment and continually through other sources (e.g., website, member newsletters). Providers receive information during new provider orientation and through other sources (e.g., web portal, provider newsletters). We use the following communication tools to inform our members and providers about our Chronic Care/DM Program:

Member Communication	Provider Communication
Member Website	Provider Web Portal
Member Handbook	Provider Manual
Member Newsletters	Provider Newsletters
Case Management Team	Provider Services Representative
Care Plan	Care Plan
Member Call Center (Toll-free call)	Provider Service Center
Member Profile	Member Profile

Additionally, quarterly member profiles are used to promote provider education concerning gaps in members' evidence based care, new diagnoses, and/or medication. The profiles provide a window on provider practice patterns, as reflected in individual utilization, and include comparisons to the overall provider network. These profiles enable our DM team to closely monitor each provider's specific members who are not compliant with medical standards and, if necessary, take corrective interventions. When the Health Coach Consultant (Disease Manager) identifies a concern related to provider practice, our CMO is notified and provider education and outreach are offered to provide proper follow up.

### **Disease Management Programs' Goals**

Schaller Anderson's Chronic Care/DM Programs emphasize self-management support and member and family/caregiver education to improve healthcare outcomes for members. The program goals are:

- Increase the number of members using their medications correctly
- Reduce morbidity and mortality of the disease
- Decrease the incidence of Emergency Department (ED) visits and hospital admissions/length of stay
- Engage the member and the member's family/caregiver in maintaining a member's wellness in the most integrated setting
- Based on the member's functional level, teach self-management skills
- To support both the member and the PCP/PCMH/provider in establishing a consistent relationship that improves adherence to the members' care plan

Another focus of Schaller Anderson's DM Programs is the member's PCPs/PCMHs and other appropriate providers and includes specific program elements for:

- 1) Education of PCPs/PCMHs/providers regarding evidence-based clinical practice guidelines and that adherence to these guidelines improves members' health outcomes
- 2) Monitoring PCPs/PCMHs/providers compliance with approved evidence-based clinical practice guidelines
- 3) Methods to improve PCPs/PCMHs/providers' compliance with evidence-based clinical practice guidelines, including but not limited to, corrective action plans or individualized training with Quality Management personnel, CMO, or designee

- 4) Provide each PCP/PCMH with a profile of their members enrolled in the DM Programs that the PCP/PCMH can use to support member education and treatment planning

We encourage providers to evaluate and make suggestions to improve our DM Programs through our provider surveys or our QM/UM Committee. In addition, a provider may also contact the CMO to suggest improvements to our DM Programs.

Schaller Anderson's Chronic Care/DM Programs are also comprised of the following:

- 1) Reviewing the member's care plan in our web-based care management business application (Dynamo™) to identify the results of the member assessment, including the member's bio-psycho-social needs
- 2) Collaborating with the member and the member's family/caregiver to identify the member's goals for management of their disease/condition, quality of life expectations, and interventions founded on evidence-based guidelines to support those goals
- 3) Teaming with the member, and member's family/caregiver, assigned Case Manager, and key providers (e.g., PCP, carved-out Behavioral Health (BH) provider) to identify the member's needs and strengths to implement successful interventions founded on evidence-based clinical guidelines, eliminating any barriers to care
- 4) Developing a care plan to address the member's critical physical, behavioral and social needs to promote resiliency, recovery and optimal self-management with specific member outcomes
- 5) Educating members about their chronic disease and effective tools for self- management and evaluating the effectiveness of this member education as it relates to the members' self-management of their disease
- 6) Promoting access to a continuum of services, including community services, based on the intensity and complexity of the member's needs
- 7) Monitoring member outcomes to assess the program's effectiveness
- 8) Keeping the member's PCP/PCMH informed about the member's enrollment in DM program and the disease management activities and outcomes

### **Disease Management Organization**

Schaller Anderson's DM personnel include:

- *Senior Medical Director and other Medical Directors:* responsible for consulting with DM personnel and healthcare professionals to confirm that sound medical decisions are being made
- *Disease Management Director:* a licensed registered nurse with experience in disease management, responsible for guidance of program activities, including planning, directing, managing and evaluating DM department operations and supervising and overseeing clinical and non-clinical personnel
- *Disease Management Supervisor:* a licensed registered nurse with experience in disease management and program management, responsible for the day-to-day operations and guidance of many program activities, including tracking, supporting, planning, and

evaluating Disease Management Department operations and overseeing clinical and non-clinical activities

- *Health Coach Consultant, RN*: coordinates DM services and interventions to assigned members identified as high risk that require medical/social outreach, education, coaching, motivation and monitoring
- *Health Coach Associate, LPN*: coordinates DM services to assigned members identified as high risk who require medical/social outreach, education, coaching, motivation and monitoring
- *Care Coordinators*: responsible for conducting member outreach activities and member education regarding disease-specific care and the importance of adhering to scheduled preventive, ancillary and specialty care visits as outlined on the member's care plan

### **Outreach and Engagement**

DM personnel conduct outreach to each high-risk member at least monthly, but more often if indicated by the needs identified during the outreach and assessment process. During the outreach and assessment process, DM personnel help members to identify needs and agree upon goals and care plan interventions.

### **Interpretive Services for All Key Oral Contacts**

Aetna Better Health is sensitive to communicating with our members and has standard operation procedures that include, but are not limited to:

- Access to a certified interpretation service through Language Line® Services
- Louisiana Relay Services to accommodate the hearing impaired
- Special assistance for cognitively impaired members or their caregivers as needed

Our goal is to recruit Disease Management personnel who are bilingual.

### **Cultural Competency**

Aetna Better Health makes certain that the member outreach and education components of the Chronic Care/DM Programs are readily accessible to the diverse membership we serve. Our clinical and non-clinical personnel, as well as our providers, are subject to our cultural competency measures, which include efforts to:

- Identify opportunities to remove linguistic/cultural barriers to availability and accessibility to care
- Increase internal awareness of activities that will increase the plan's cultural competence

Specific activities include:

- Training personnel about the need for understanding of and respect for cultural differences when interacting with members and developing services that better meet the needs of minority populations
- Promoting development of a staff of qualified, diverse, and culturally competent employees

Assessing applicable feedback from members about programs, quality initiatives, member materials, and other education and outreach tools

## Program Descriptions

Aetna Better Health will utilize for the Coordinated Care Network (CCN) program, four of Schaller Anderson's NCQA certified Chronic Care/DM Programs: asthma, diabetes, CHF, and COPD. The objectives of the Chronic Care/DM Programs are to:

- Promote appropriate medication adherence/compliance when appropriate
- Improvement in disease appropriate HEDIS<sup>®1</sup> measures
- Decrease risk of adverse outcomes, when such outcomes may be modifiable
- Encourage reduction and/or elimination of smoking and other complicating factors (e.g., poor diets, obesity, self-damaging behaviors)
- Identify and facilitate treatment of problems early, before they become catastrophic or more complex
- Educate members on the signs and symptoms of:
  - Their primary disease state
- Co-morbid states which complicate the primary state

## Analysis of Chronic Care/Disease Management and Results used to Improve Outcomes

Aetna Better Health's goal is to positively impact the health status of our members through an integrated and coordinated Chronic Care/DM program. Aetna Better Health, working with its affiliate Schaller has continuously improved and enhanced our programs to: 1) positively impact our members' health outcomes and quality of care; 2) support the member's quality of life; and 3) improve our providers' practice patterns and compliance with evidence based clinical practice guidelines.

The QM/UM Committee continually evaluates, reviews, and makes modifications to the chronic care/disease management program. For instance, our Arizona affiliate – Mercy Care Plan conducted an outcome analysis of Schaller's DM programs for CHF, COPD and Diabetes and the impact of these Chronic Care/DM programs on PCP and ED utilization. Mercy Care Plan, in its analysis compared pre- and post-enrollment for members who were enrolled in the disease management programs between 1/1/2007 and 9/30/2009. They found that ED and PCP visits along with per member per month expenditures, were consistently lower for all three measurement years after members enrolled in our disease management program.

Asthma		
	<u>Pre DM</u> (n = 77)	<u>Post DM</u> (n = 77)
Member Months	882.2	891.64
Medical Paid	\$227,193	\$173,407
Emergency Department Visits	179	102
Inpatient Admits	15	6

<sup>1</sup> HEDIS<sup>®</sup> is a registered trademark of the National Committee for Quality Assurance.

Cost & Utilization for Members Enrolled in Disease Management		
Medical Cost Per Member Per Month	\$257.53	\$194.48
Emergency Department Visits Per Member Per Year	2.43	1.37
Inpatient Admits Per Member Per Year	0.20	0.08

Aetna Better Health assesses programmatic performance, as well as provider performance, using evidence based clinical practice guidelines. Our experience has shown that when we implement a new program in a new state, we need to perform more frequent monitoring in order to refine the program to meet the standards of care for both members and providers. We firmly believe that our evaluation approach and follow through lead to enhanced member health outcomes and provider support for Chronic Care/DM programs.

### Quarterly Data Analysis on Clinical Indicators

The CMO evaluates compliance with clinical practice guidelines on a quarterly basis using claims analysis through the General Risk Model (GRM)<sup>2</sup>, provider profiles and reports that identify the following:

- Cholesterol management with members who have cardiovascular disease
- Inpatient admission rates for members enrolled in a disease management program
- Compliance with medication for members related to their specific disease

The CMO orders reports through GRM on a quarterly basis and focus on key HEDIS and other indicators such as:

- For those enrolled in the asthma DM program:
  - Use of asthma controller medications in children
  - Adult inpatient admission rates
  - Use of Peak Flow meters
- For those enrolled in the diabetes DM program:
  - Monitoring compliance with HgbA1C tests
  - Monitoring compliance with diabetic retinal exams
  - Monitoring compliance with LDL level
- For those enrolled in the CHF
  - Monitoring compliance with cardiovascular medications

<sup>2</sup> The *General Risk Model (GRM)* has been developed to identify Aetna Better Health's members who would benefit from enrollment in our DM Programs. The application prospectively identifies members who are at risk of becoming high utilizers of services and who have actionable gaps in care, or who present opportunities for more efficient medical management consistent with evidence-based guidelines.

- Monitoring compliance of members obtaining LDL screening.
- For those enrolled in the COPD DM program:
  - Inpatient admission rates
  - Monitoring compliance of members obtaining spirometry testing
- Comparisons of member utilization across all DM programs:
  - Utilization of services
  - ED visits
  - Hospital admission and readmission rates in members who have quarterly PCP visits

The CMO communicates these findings to the QM/UM committee for review. The QM/UM committee then sends the findings to the QMOC which, after it is reviewed, will be sent to Aetna Better Health's Board of Directors (Board). After the Board reviews the report, they will grant the CMO the authority to act upon recommendations.

#### ***Annual DM Program Evaluation***

Aetna Better Health utilizes Schaller to perform Chronic Care/DM activities. This arrangement is outlined in the Intercompany Master Agreement. Since the DM programs are provided by Schaller, Aetna Better Health's CMO has responsibility for oversight of the functions performed on behalf of the health plan. Our CMO evaluates the overall effectiveness of Schaller's Chronic Care/DM Program annually. The program evaluation assesses the year's completed and ongoing activities. It includes analyses of results of program initiatives (including barriers to goal attainment) and reports progress made in our efforts to evaluate and improve Chronic Care/DM related outcomes. It also includes member and provider satisfaction results and ROI analysis and results with respect to the Chronic Care/DM program.

Our state-of-the-art information technology system provides the data collection, storage, integration, validation and retrieval resources, and support for identifying, selecting, tracking, and analyzing data/information to facilitate our DM evaluation efforts. In utilizing the Plan-Do-Study-Act (PDSA) model, we establish baseline measures using performance measures, study indicators, and targeted benchmarks.

After the program evaluation is completed, the CMO prepares a report with findings and recommendations, if applicable. The CMO sends the report to the QM/UM committee for review. The QM/UM committee then sends the report to the QMOC which, after it is reviewed, will be sent to Aetna Better Health's Board of Directors (Board). After the Board reviews the report, they will grant the CMO the authority to act upon the recommendations.

#### **Analytical Tools and Systems**

The ASDB also supports Aetna Better Health's reporting and analytical capabilities, such as our multidimensional GRM and statistical outlier analysis. The application houses eligibility, provider, prior authorization and claims data and serves as a key data source for a diverse user base, including Medical Management, Finance and Operations.

Analysts can use the proprietary Actuarial Analytics Web Portal (AAWeb), an interactive interface, as a point-and-click query tool to access reports, drill down into data and export information from ASDB. For instance, AAWeb can generate customized analyses to identify

favorable and unfavorable cost and utilization trends, measure performance against key benchmarks, and review summary information. It is a powerful tool that affords Aetna Better Health's DM personnel access to member and provider profiles, as well as current cost and utilization trends. This gives us the ability to disseminate analysis results on treatment best practices to providers, who can then identify and prevent unnecessary migrations to higher levels of care and the development of chronic health conditions.

Based on claims received for each member during the month, the GRM performs a rule-based analysis of indicators, markers, and other data to determine if a member's risk level classification should be reassessed. The GRM's state-of-the-art protocols evaluates the member claims data against clinical practice guidelines embedded as edits within the system to determine this reassessment. The monthly reassessment/re-stratification report is provided to each Health Coach Consultant (Disease Manager) for analysis, member contact, or consultation with the DM supervisor as appropriate. In any instance where a member's risk level is adjusted by GRM from either high-risk to low-risk or low-risk to high-risk requires outreach to the member or the member's family/caregiver to validate the change.

***Disease Management Reporting Requirements***

Aetna Better Health will submit DM reports quarterly with an annual summary to the Department of Health and Hospitals (DHH). We understand and agree that DHH reserves the right to request additional reports as deemed necessary. DHH will notify Aetna Better Health of additional required reports no less than sixty (60) days prior to due date of those reports. The reports will include at a minimum:

- Number of members identified with potential special healthcare needs utilizing historical claims data
- Number of members with special healthcare needs identified by the member's PCP
- Number of members with assessments
- Number of treatment plans completed, and
- Number of members with assessments resulting in a referral for DM

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**E.2 Describe how recipients will be identified for inclusion into the Chronic Care/Disease Management program. Identify which disease states/ recipient types will be targeted for the Chronic Care/Disease Management program. Describe how the Chronic Care/Disease Management program will coordinate information and services with the PCP.**

### **Disease Management Program Overview**

Aetna Better Health, together with our affiliates, has more than 25 years of experience providing disease-specific outreach, education and care management to Medicaid eligible members with chronic conditions. Aetna Better Health has been successfully operating disease management programs in our Medicaid managed care health plans throughout the country since 1993 and has, through our affiliate, Schaller Anderson, L.L.C. (Schaller Anderson) operated an NCQA certified Disease Management Program for four targeted chronic diseases (i.e. asthma, Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD) and diabetes) since 2006. Our experience has shown that disease management programs can be an effective strategy for improving the management of care for members with chronic conditions, resulting in improved health outcomes and cost savings.

The DM Programs are developed based on disease prevalence, our ability to intervene effectively to improve patient outcomes for the chronically ill, those with physical and behavioral health conditions, and children and adults with special healthcare needs.

Schaller structures DM Programs on principles of evidence-based practice guidelines and standards of care and includes written policies and procedures (P&Ps) to improve member engagement. We have observed improved patterns of care for members engaged in DM, including reductions in the frequency and severity of exacerbations for members with target conditions.

### **Identifying Louisiana CCN Members for Disease Management**

#### ***Historical Claims Data***

Aetna Better Health, after receipt and analysis of the two years of historic claims data for members enrolled in Aetna Better Health effective the start date of operations will employ a stratification process that will facilitate participants' assignment to the appropriate risk level; allowing DM personnel information to appropriately target members who, based on their claims history, have a chronic condition covered by our DM Program. A member who has more than one chronic condition, has a chronic condition that is unmanaged or has a chronic condition with contributing factors (e.g., homelessness, lack of support structure) will be referred to our Integrated Care Management (ICM) model. The Medical Management Coordinator and the Disease Management Coordinator in collaboration with the Chief Medical Officer (CMO) will be responsible for overseeing the stratification process

Key to our stratification process is our General Risk Model (GRM). We successfully use GRM in each of our Medicaid care management programs and it is a standard tool for our care management system solution. Through the utilization of GRM will be able to assign a Total Risk Score to each participant and determine the appropriate risk level into which the participant falls. Unlike some identification methods which are solely dependent on retrospective claims

review or referrals, this tool uses innovative data-driven identification and stratification methods that includes looking at gaps in medical care and problematic participant behavior. GRM is an effective tool to accurately identify a member's future high-cost utilization and/or those at risk of developing a serious chronic condition for whom enrollment in care management programs would result in improvements in both clinical and financial outcomes.

The analysis of the two years of historic claims data will also facilitate the identification of providers the member has frequently had encounters. We will use this data to determine:

- 1) The member's PCP/PCMH
- 2) The specialists the member frequently visits
- 3) If the member's PCP/PCMH or specialists participate with Aetna Better Health

We will use the results of this analysis to identify providers that we currently have under contract and begin outreaching to those providers. This analysis will be a key tool for our network expansion efforts and we will fine tune our network to meet the needs of our members. If we are unable to reach a contractual agreement with a provider we will use our single case agreement process so that the member may continue in the provider's care. We will be especially sensitive to providers used by MSHCN and CSHCN to secure continuity of care for these members. A report of any gaps in providers will be provided to the Chief Operating Officer (COO) and the Provider Services Manager as a planning tool. The Quality Management Coordinator and Grievance System Manager will also be copied on this report and be involved in any planning sessions.

#### ***Determination of Total Risk Score***

In order to assign each participant a Total Risk Score, GRM will utilize two years of historic claims data from the Department of Health and Hospitals (DHH) – including physical, behavioral and pharmacy claims data. This predictive modeling tool will transform the data into a series of markers (i.e., risk scoring elements) that show both the level of risk and opportunity for care improvement for each participant and include the following:

- *Medicaid Rx.* This pharmacy claims-based risk assessment tool uses the timeliest pharmacy data available for identification of a participant's risk or health status identification. Medicaid Rx was designed and developed specifically for Medicaid populations
- *Compliance.* A participant's overall compliance with certain evidence-based treatment activities (HbA1c test for diabetics, flu vaccination) is assessed
- *Comorbidity.* A participant's comorbidity burden based on the chronic condition identification and categorization methodology employed by GRM
- *Impactability.* A participant's primary is assessed (using clinical input) as to the level of impact care management can have on the participant's financial and clinical outcomes
- *Recent Claims Cost.* A rolling 12 months of claims cost (excluding trauma and maternity) is calculated for each participant.

GRM combines the scoring elements described above to calculate a participant's Total Risk Score and population rank for stratification purposes.

***Determination of Member DM Risk Level***

Utilizing the results from GRM, members will be assessed to determine if the pattern of claims indicates the presence of a covered DM chronic disease. Members with a claims history that indicates a covered DM chronic disease will be stratified into one of two risk levels – *high-risk* or *low-risk*. A brief description of the two risk levels is provided below, along with a case example for each one. These case examples are included to show generally the type of member that may fall into each of the risk levels and the member's increased need for intervention.

- *Disease Management Low Risk* – Members in this group have a specific chronic medical condition (e.g., asthma, diabetes, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD)).
- *Low Risk Case Example* – A representative case example of a member who may likely be assigned to disease management services is a 53-year old woman who the data indicated was diagnosed with diabetes about a one and a one-half years earlier and analysis of test results indicate that this condition is currently controlled relatively well on two oral medications.
- *Disease Management High-Risk* – Members in this group have a specific chronic medical condition [e.g., asthma, diabetes, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD)] that are either not controlled or controlled with extenuating circumstances such as homelessness or complicating social/medical factors.
- *High Risk Case Example* – A representative case example of a participant who may be assigned to high-risk DM might be an 18-year old woman with a claims history of asthma. She has been to the ED three (3) times in the last two (2) months with uncontrolled asthma. Claims data indicates appropriate visits to her PCP. However, analysis of claims data indicates she is not adhering to evidence based practice guidelines for asthma.

Aetna Better Health will continually evaluate the appropriateness of a member's DM assigned risk level and will reassign members to higher or lower risk levels depending on the their care needs. Because of our sophisticated predictive modeling tool, the General Risk Model (GRM) and our in-depth experience providing DM services to Medicaid populations, Aetna Better Health will be able to effectively perform risk assessment using the State's claims data.

Aetna Better Health will use the results from GRM to assign each member to one of the two risk levels described above. Based on the member's Total Risk Score, Aetna Better Health will rank each member from lowest to highest (with a higher score representing higher risk). The members with the highest Total Risk Scores will more than likely be assigned to the high-risk DM group.

After initial program implementation in each GSA, Aetna Better Health will further evaluate the member's initial DM risk level through:

- A review of the Health Risk Questionnaire (HRQ) that each member completes when entering the DM Program
- An assessment by DM personnel of high or low-risk, including discussions with member's family/caregiver, PCP and administration of standardized assessment tools

These processes will allow us to validate that each member has been placed into the appropriate level of care prior to the development of a care plan.

During the ongoing operational phase, Aetna Better Health will conduct a monthly stratification of all members and use GRM results to: 1) determine if the member's assigned risk level needs to be changed and 2) monitor the success of interventions as reflected by improvements in participant risk scores.

### **Stratification Report**

Our stratification report will show how the member population has been stratified into the two risk groups. It will also provide detail breakdowns of the overall member population by rate code and of members by Parish and by disease states.

Aetna Better Health will use the stratification report as an internal monitoring tool both at the individual member and program level.

- *Individual member level:* Health Coach Consultants (Disease Manager) will use the stratification report to assist in determining if the implemented DM services have been effective in improving a member's outcomes and if a member may need a higher or lower or higher level of care.
- *Program level:* Aetna Better Health will use the stratification report to assess the overall success of our DM services in improving clinical outcomes (i.e., member's health status) and reducing inappropriate costs. The report will be reviewed by Aetna Better Health's QM/UM Committee each quarter to: 1) determine if there are opportunities for improvement and 2) as appropriate facilitate the implementation of any needed interventions.

### **Initial Contact with Eligible Members**

Aetna Better Health recognizes the initial contact process as a key first step in DM services leading to successful clinical and financial outcomes. Through the initial contact we will be able to:

- Educate the member about the benefits of the Coordinated Care Network (CCN) and DM program
- Encourage and facilitate member enrollment in the DM program
- Establish the foundation for a working partnership between Aetna Better Health and the member
- Facilitate the selection of PCP/PCMH by the member
- Collect basic health information (i.e., HRQ) from the member that can be used to further assess the member's level of risk and healthcare needs

The Medical Management Coordinator, with supervision by the CMO, will oversee the initial contact process and will be supported in this effort by the DM Team, Maternal Child Health/EPSTD Coordinator, Prior Authorization, Concurrent Review, Member Services and Grievance and Appeals. Schaller Anderson has policies and procedures (P&P) that govern its Disease Management programs and will submit these P&P to DHH for review and approval.

Aetna Better Health will mail each member a Welcome Packet. We will be able to distribute 10,000 new member packets per day and therefore, we do not foresee any problems in meeting DHH's distribution standards. The Welcome Packet will contain:

- Welcome letter highlighting major program features, providing CCN contact information and advising members that a CCN-specific card will be sent in the mail under separate cover
- Welcome member newsletter
- Member Handbook containing all the information the member will need to access covered services appropriately and highlighting preventive care, DM and other services available to members
- Information regarding direct access to providers for members with special healthcare needs
- CCN member identification card
- Provider Directory (which will also be available in a searchable format online)
- The HIPAA Notice of Privacy Practices – Explanation of Members’ rights to access, amend, and request confidential communication of, request privacy protection of, restrict use and disclosure of, and receive an accounting of disclosures of Protected Health Information (PHI)

These materials will include:

- A description of the disease management program including the benefits it offers to members and the role Aetna Better Health plays in delivering these services
- A description of a PCP/PCMH, including a discussion on the importance of their role in assisting in the management of a member’s care and instructions on how to select an appropriate PCP/PCMH. Participants will be asked to either submit the name of the PCP/PCMH they would like to use (and/or may be already using for regular care).
- Instructions on the appropriate use of the Emergency Department (in the Welcome Newsletter and the Member Handbook)
- The toll-free phone number for Aetna Better Health and a description of the information that is available on our Website
- Information on linguistic access, including the availability of Language Line for phone calls and other alternative formats such as large print for the visually impaired or Telecommunications Device for the Deaf (TDD)

The materials in the Welcome Packet will all be written at a 6th grade level in a manner that is easily understood and culturally sensitive. The materials will be available in English and Spanish and Vietnamese or additional languages if requested by the member, as well as in alternative formats and media (e.g., large print, TDD).

### ***Welcome Call***

For all new members, we will make a Welcome Call. Aetna Better Health places a high priority on outreach to and support for our members, beginning with the transition process. Our goal is to contact these members as soon as possible following enrollment to assist them in making a seamless transition into the CCN Program. Our Member Services and Disease Management personnel will work to make sure that there are no interruptions in service, no gaps in care and no concerns on the part of the member during the critical transition period. Our Welcome Call is an important part of the new member’s introduction to all of the services and support available to them through Aetna Better Health.

Our Welcome Call: 1) welcomes each new member to our program and informs the member of the availability of oral interpretation and written translation services and how to obtain them free of charge; 2) identifies members who are pregnant or members with a chronic condition, or any special care needs and expedites transition to care that supports the individualized needs of each member; 3) identifies the member's current primary care provider relationship; 4) identifies the member's current and ongoing services needs; 5) educates members about healthcare benefits coverage and instructions on how to utilize services; 6) educates members about the important role of the PCP/PCMH in centralizing and coordinating care; 7) the importance of the member making a first appointment with his or her PCP/PCMH for preventive care before the member requires care due to illness or condition and instructions about changing the PCP/PCMH, 8) provides emergency numbers; 9) assists members with obtaining services, as needed, and 10) a statement of confidentiality.

During implementation for each GSA area and beginning with the first daily enrollment files received following the initial member transition period to the CCN Program, we will initiate new member welcome calls within twenty-one (21) business days of receipt of the enrollment file during the phase-in implementation and fourteen (14) business days thereafter. We will contact new members using our interactive voice recognition (IVR) system that has proven to be successful with Medicaid populations in other states. In fact, data indicates that the response rate to the IVR supports its use for this situation. We selected the IVR approach because of its high response rate and cost efficiency. As described below, the member always has the option of requesting to speak with an individual any time during the call. We will ask new members if they are pregnant, have a chronic condition or have a special healthcare need early in the call. The member responses will be documented in our web-based care management business application (Dynamo™). Each night record of these responses will be transmitted to Aetna Better Health's team for call back and intake processing. This Welcome Call is the beginning of a transition process that supports the member every step of the way in obtaining care.

The information obtained through the Welcome Call is another way that we identify and immediately support our members. We will take the opportunity during this initial call to educate members and/or the member's family/caregiver, as appropriate, about benefits, the importance of finding a Patient-Centered Medical Home (PCMH) and how to select their primary care provider if they have not already done so. Depending upon the members responses to the IVR, the member or the member's family/caregiver will be contacted by an Aetna Better Health Case Manager or a Health Coach Consultant (Disease Manager).

Members stratified into high-risk Disease Management will receive a call from a DM Care Coordinator. The DM Care Coordinator will administer the initial intake questionnaire and welcome the member into the Disease Management Program. At a mutually agreed upon time, the Health Coach Consultant (Disease Manager) will contact the member and administer a condition specific clinical assessment.

We will make three telephone attempts on different days and at different times of day. If these attempts are unsuccessful, Disease Management personnel will mail the member a request to contact letter. If we discover the member's telephone number has been disconnected or is no longer working our personnel will reach out to the PCP/PCMH identified based on our analysis of the two years of historical claims data provided by DHH. Information on non-working

telephone numbers and returned mail will be researched for alternate avenues to contact the member as part of the DM team's work process.

### **Ongoing Member Identification**

The purpose of outreach is to educate our members and promote the value of our DM Programs. Aetna Better Health will use the following three methods to identify CCN members who would benefit from DM services:

- **The General Risk Model (GRM)** – We successfully use GRM in each of our Disease Management programs and it is a standard tool for our care management system solution. Utilization of *GRM* will assign a Total Risk Score to each participant and determine the appropriate risk level into which the participant falls. The proprietary, evidence-based GRM process analyzes claims data to prospectively identify members who are at high medical risk.
- **Surveillance methods** – These include, but are not limited to: inpatient daily census, readmissions and other “traditional” case finding methods, including referrals from the member, provider, family and/or caregiver
- **Member and Stakeholder Referral** – Member and stakeholder referrals are a valued and important way to access the DM programs. We support and encourage member and stakeholder referrals as an avenue to identify potential members for the DM programs. In many instances, these referrals assist in getting a member into a disease management program before there is sufficient data to support stratification and identification.

#### **General Risk Model**

The General Risk Model (GRM) has been developed to identify Aetna Better Health's members who would benefit from enrollment in our DM Programs. The application prospectively identifies members who are at risk of becoming high utilizers of services and who have actionable gaps in care, or who present opportunities for more efficient medical management consistent with evidence-based guidelines.

The GRM processes information from a variety of sources and transforms it into a series of markers that measure both risk and opportunity. It then scores these markers and assigns a rank to every member, reflecting both the level of risk and potential opportunity for improvement. In addition to its risk algorithms, GRM identifies members who meet specific rules-based criteria for individual treatment interventions.

The GRM provides our Disease Managers with the ability to review a member's entire administrative history (claims, prescriptions, authorizations, diagnosed conditions, laboratory results when available, enrollment history, and contact information), along with key data gathered through our web-based case management system. This is a powerful tool for integrating health data and facilitating the flow of information between all of the member's caregivers. Finally, GRM supports outcomes reporting and the measurement of Return on Investment (ROI) for DM Programs.

Aetna Better Health's GRM program is proven technology for identifying members who have or are at risk of developing complex and/or chronic healthcare needs. GRM accomplishes this task through an internal diagnostic grouping process that evaluates over 15,000 ICD-9 codes and identifies specific chronic and acute conditions, including asthma, diabetes, Chronic Obstructive

Pulmonary Disease (COPD), and Congestive Heart Failure (CHF). The goal is to accurately identify a primary chronic care condition for each member if indicated in the claims data. The application funnels information from various sources into a member profile that allows our DM personnel to access a concise 12-month summary of activity. The information is stored in a database that has key linkages to our Actuarial Service Data Base (ASDB), making outcome reporting related to specific members available literally “on demand.” ASDB has the capacity to accept pharmacy utilization data from external systems and then distribute this vital information internally through GRM.

Aetna Better Health uses GRM to assist in identifying potential candidates for disease management. To accomplish this, GRM sorts, analyzes and interprets the following information:

- Claims history
- Pharmacy data
- Demographic information
- Identified gaps in care based on evidence-based guidelines
- Impact levels of the member’s primary condition

GRM provides an empirically sound database that identifies members based on the following indicators:

- Predicted future cost/utilization of services
- Complicating co-morbid conditions
- Inappropriate patterns of care for chronic conditions (over-, under- and inappropriate utilization of services)
- Chronic conditions that are known to be responsive to evidence-based treatment guidelines
- Historical costs

GRM also promotes the facilitation of care coordination between all Medical Management functions (Concurrent Review, Prior Authorization, Case Management and Quality Management), and provides our DM personnel specific guidance as to where the member may have a potential gap in compliance with evidence-based care guidelines.

### ***Surveillance Data***

In addition to reviewing the results of GRM and the HRQ, our DM personnel will review member surveillance data if it is available. This real time or surveillance data will include, but not be limited to:

- Information received as part of the referral to Care Management (e.g., caregiver, PCP, or other providers’ concerns or issues)
- Enrollment transition information from each member’s caregiver, PCP or other provider as appropriate
- Recent prior authorizations for hospital admissions or other services that require prior authorization
- Discharge plan from an inpatient setting

***Member and Stakeholder Referral***

In addition to the administrative methods described above, members may also be identified to the DM Program through a variety of sources. These sources include but are not limited to:

- Self/member referral
- Referral from family/caregiver
- Member Services
- PCP or other health providers who identify members in need
- Concurrent Review
- Prior authorization
- Quality management
- Maternal Child Health/EPSDT Coordinator
- Grievance and appeals
- Referral from Carved-out Behavioral Health Vendor
- Review of GRM reports
- Review of Health Risk Questionnaire (HRQ) scoring
- Enrollee Special Needs Report (from the Enrollment Broker)

**Disease Management Program Components by Risk Level**

***Overview of Disease Management Programs***

Schaller's DM Programs make DM services available to all enrolled members who are identified as "at risk" for future complications of their diseases, based on current behaviors as identified by our GRM and DM personnel experience. We firmly believe that outcomes will improve if routine services are supported and enhanced by behavior modification interventions that effectively address the specific needs or condition of the individual member. Upon identification, the member is referred to the DM Department for assessment and follow-up by DM personnel.

**Targeted Disease States for Chronic Care Disease Management Programs**

***Asthma***

The goal of the asthma DM Program is to improve the member's functional status and the member's capacity to self-manage their asthma. The purpose of the Asthma program is to promote the member's self management skills to minimize the extent that the disease interferes with their life. The Asthma program also identifies any co-morbid condition, environmental, or social situation that should be addressed to improve the member's quality of life.

A member's improvement is measured by:

- Reductions in inpatient admissions and avoidable ED utilization
- Improvement in HEDIS<sup>®3</sup> measures:

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<sup>3</sup> HEDIS<sup>®</sup> is a registered trademark of the National Committee for Quality Assurance.

- Increase the number of members using their asthma medications correctly, in both frequency and dosing
- Reduce longer-term premature morbidity (complications) and mortality of the disease
- Enlist family/caregiver or other support entities as possible to aid in maintenance of wellness activities
- Verify, when possible that the member is making:
  - Appropriate use of preventive measures like influenza vaccines
  - Improvements in the adherence to evidence-based, clinical practice guidelines

**Program Components**

- Assessments and care planning
  - Referral to PCP/PCMH and/or provider for a full clinical assessment (e.g., allergist, pulmonologist)
  - Facilitate ease of obtaining Durable Medical Equipment (DME) (e.g. Peak Flow Meter, Nebulizer)
  - Consideration of co-morbidities: members who are identified as possibly having other medical issues that may complicate their condition, or interfere in treatment are referred to ICM programs for Case Management assessment
  - If necessary or appropriate, the member is referred to local community agencies, support groups, or faith-based programs for assistance
- Member education
  - Targeted member specific educational mailings
  - Quarterly education mailings
  - Individual member health profile
  - Website with access to searchable data for additional information and education (i.e., Medline Plus)
  - Access to the member's care plan in our web-based care management business application (Dynamo<sup>TM</sup>)
- Provider involvement
  - Notification of member enrollment
  - Collaboration on goals and care plan by individual member
  - Provider follow up on member appointments and compliance with care plans
  - Sharing of individual member health profile
  - Website with access to searchable data for additional information and education (i.e., Medline Plus)
  - Access to the member's care plan in our web-based care management business application (Dynamo<sup>TM</sup>)
  - Adequate dose/duration of treatment

**Stratification:**

- Low Risk
  - Members who do not initially stratify for high risk DM, but do have a diagnosis of asthma in GRM, are placed in low risk DM
  - Members who have made progress with their asthma, who no longer require high risk DM, are moved to low risk DM
  - The member has entered remission and continues to receive continuation and/or maintenance treatment
- High Risk
  - Members with gaps in evidence-based asthma treatment (poor compliance with appropriate medications, no evidence the member is in possession of a peak flow meter, etc.)
  - Members who are high utilizers of the ED
  - Members with co-morbid conditions complicating their asthma (allergies, pneumonia, alcohol/substance abuse, etc.)
  - Members who have not entered remission

***Diabetes***

The goal of the diabetes DM Program is to improve the member's functional status and their ability to self-manage their diabetes so they minimize the extent to which the disease interferes with their lives, as well as identify and manage co-morbid conditions as needed.

Improvements in care of diabetes are measured by:

- Reductions in inpatient admissions and avoidable ED utilization
- Improvement in HEDIS measures:
  - Cholesterol LDL level, Dilated Retinal Eye Exam (DRE), HgbA1C, Urine Protein Microalbumin, Blood Pressure
- Reduce longer-term premature morbidity (complications) and mortality of the disease
- Increase the number of members using their diabetic medications correctly, in both frequency and dosing
- Improvement in member adherence to diabetes treatment guidelines, participation in community diabetic education programs, and use of an assessment scale to monitor treatment response
- Enlist family or other support entities as possible to aid in maintenance of wellness activities
- Verify, where possible:
  - Appropriate use of preventive measures like influenza vaccines
  - Better methods of adherence, aimed at resulting in better perceived quality of life

**Program Components**

- Assessments and care planning
  - Referral to PCP/PCMH and/or provider for a full clinical assessment (e.g., endocrinologist and podiatrist)
  - Consideration of co-morbidities: members who are identified as possibly having other medical issues that may be complicating their condition, or interfering in their treatment, are referred to programs and resources such as Case Management
  - Referral to community agencies including, but not limited to, diabetic programs for support
- Member education
  - Targeted member specific educational mailings
  - Quarterly education mailings
  - Individual member health profile
  - Website with access to searchable data for additional information and education (i.e., Medline Plus)
  - Access to the member's care plan in our web-based care management business application (Dynamo™)
- Provider involvement
  - Notification of member enrollment
  - Collaboration on goals and care plan by individual member
  - Provider follow up on member appointments and compliance with care plans
  - Sharing of individual member health profile
  - Website with access to searchable data for additional information and education (i.e., Medline Plus)
  - Access to the member's care plan in our web-based care management business application (Dynamo™)
  - Adequate dose/duration of treatment

**Stratification:**

- Low Risk
  - Members who do not initially stratify for high risk DM, but do have a diagnosis of diabetes in GRM are placed in low risk DM.
  - Members who have made progress with their diabetes, who no longer require high risk DM, are moved to low risk DM.
- High Risk
  - Members with gaps in evidence-based diabetes treatment (poor compliance with appropriate medications, absence of a hemoglobin A1c test, etc.)
  - Members who are high utilizers of the Emergency Room

- Members with co-morbid conditions complicating their diabetes (CHF, CAD, HTN, etc.)

***Congestive Heart Failure (CHF)***

The goal of the CHF DM Program is to improve the member's functional status and their ability to self-manage their CHF so that they can minimize the extent that the disease interferes with their lives, as well as identify and manage co-morbid conditions as needed.

Improvements in care of CHF are measured by:

- Reductions in inpatient admissions and avoidable ED utilization
- Improvement in HEDIS<sup>®4</sup> measures:
  - Increase the number of members using their CHF medications correctly, in both frequency and dosing (e.g. ARBS, ACE Inhibitors)
  - Increase the number of members obtaining LDL screening
- Reduce longer-term premature morbidity (complications) and mortality of the disease
- Enlist family or other support entities as possible to aid in maintenance of wellness activities
- Assure, where possible:
  - Appropriate use of preventive measures like influenza vaccines
  - Better methods of adherence, aimed at resulting in better perceived quality of life

**Program Components**

- Assessments and care planning
  - Referral to PCP/PCMH and/or provider for a full clinical assessment (e.g., cardiologist)
  - Facilitate ease of obtaining DME (e.g. digital scales)
  - Consideration of co-morbidities: members who are identified as possibly having other medical issues that may be complicating their condition, or interfering in their treatment, are referred to programs and resources such as Case Management
  - Referral to community agencies including, but not limited to, CHF programs for support
- Member education
  - Targeted member specific educational mailings
  - Quarterly education mailings
  - Individual member health profile
  - Website with access to searchable data for additional information and education (i.e., Medline Plus)
  - Access to the member's care plan in our web-based care management business application (Dynamo<sup>™</sup>)
- Provider involvement
  - Notification of member enrollment
  - Collaboration on goals and care plan by individual member

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4 HEDIS<sup>®</sup> is a registered trademark of the National Committee for Quality Assurance.

- Provider follow up on member appointments and compliance with care plans
- Sharing of individual member health profile
- Website with access to searchable data for additional information and education (i.e., Medline Plus)
- Access to the member's care plan in our web-based care management business application (Dynamo™)
- Adequate dose/duration of treatment

**Stratification:**

- Low Risk
  - Members who do not initially stratify for high risk DM but do have a diagnosis of CHF in GRM are placed in low risk DM
  - Members who have made progress with their CHF, who no longer require high risk DM, are moved to low risk DM
  - Member has entered remission and continues to receive continuation and/or maintenance treatment
- High Risk
  - Members with gaps in evidence-based CHF treatment (poor compliance with appropriate medications, absence of a flu shot, etc.)
  - Members who are high utilizers of the ED
  - Members with co-morbid conditions complicating their CHF (diabetes, CAD, HTN, etc.)
  - Members have not entered remission

***Chronic Obstructive Pulmonary Disease (COPD)***

The goal of the COPD DM Program is to improve the member's functional status and their ability to self-manage their COPD so that they can minimize to the extent that it interferes with their lives, as well as identify and manage co-morbid conditions as needed.

Improvements in COPD care are measured by:

- Reductions in inpatient admissions and avoidable ED utilization
- Improvement in HEDIS measures:
  - Increase the number of members using their respiratory medications correctly, in both frequency and dosing
  - Increase the number of members obtaining spirometry testing
- Reduce longer-term premature morbidity (complications) and mortality of the disease
- Enlist family or other support entities as possible to aid in maintenance of wellness activities
- Verify, where possible:
  - Appropriate use of preventive measures like influenza vaccines
  - Better methods of adherence, aimed at resulting in better perceived quality of life

**Program Components**

- Assessments and care planning
  - Referral to PCP/PCMH and/or provider for a full clinical assessment (e.g., pulmonologist)
  - Facilitate ease of obtaining DME (e.g., peak flow meter, nebulizer)
  - Consideration of comorbidities: members who are identified as possibly having other medical issues that may be complicating their condition, or interfering in their treatment, are referred to programs and resources such as Case Management
  - Referral to community agencies including, but not limited to, COPD programs for support (e.g., American Lung Association)
- Member education
  - Targeted member specific educational mailings
  - Quarterly education mailings
  - Individual member health profile
  - Website with access to searchable data for additional information and education (i.e., Medline Plus)
  - Access to the member's care plan in our web-based care management business application (Dynamo™)
- Provider involvement
  - Notification of member enrollment
  - Collaboration on goals and care plan by individual member
  - Provider follow up on member appointments and compliance with care plans
  - Sharing of individual member health profile
  - Website with access to searchable data for additional information and education (i.e., Medline Plus)
  - Access to the member's care plan in our web-based care management business application (Dynamo™)
  - Adequate dose/duration of treatment

**Stratification:**

- Low Risk
  - Members who do not initially stratify for high risk DM but do have a diagnosis of COPD in GRM are placed in low risk DM.
  - Members who have made progress with their COPD, who no longer require high risk DM, are moved to low risk DM.
  - Member has entered remission and continues to receive continuation and/or maintenance treatment

- High Risk
  - Members with gaps in evidence-based COPD treatment (poor compliance with appropriate medications, absence of spirometry, etc.)
  - Members who are high utilizers of the Emergency Room
  - Members with co-morbid conditions complicating their COPD (sleep apnea, CHF, CAD, etc.)
  - Members have not entered remission

**Exclusions from High Risk Disease Management for Any Condition:**

Members who are receiving or are targeted for case management services (member who either fell in the top 1% risk of plan's population or had a mandatory CM condition).

***Summary Table of DM Programs***

The following table represents a summary of the DM Programs that Aetna Better Health will offer through its affiliate Schaller Anderson, L.L.C.

**Disease States/Recipient Types Targeted for the Chronic Care/Disease Management Programs**

Factor	Asthma	Diabetes	COPD	CHF
NCQA Certified	YES	YES	YES	YES
<b>High Risk</b>				
DM Personnel	Health Coach Consultant (Disease Manager)	Health Coach Consultant (Disease Manager)	Health Coach Consultant (Disease Manager)	Health Coach Consultant (Disease Manager)
Plan of Care	YES	YES	YES	YES
Frequency of Contact	At least monthly	At least monthly	At least monthly	At least monthly
Types of Intervention	Specifically designed for each member's situation, need and disease state	Specifically designed for each member's situation, need and disease state	Specifically designed for each member's situation, need and disease state	Specifically designed for each member's situation, need and disease state
Evaluation Method	Claims and contact analysis	Claims and contact analysis	Claims and contact analysis	Claims and contact analysis
<b>Low Risk</b>				
DM Personnel	Available for support	Available for support	Available for support	Available for support
Frequency of Contact	Initial welcome letter and quarterly mailings	Initial welcome letter and quarterly mailings	Initial welcome letter and quarterly mailings	Initial welcome letter and quarterly mailings
<b>Members Targeted to Participate</b>				
	All Louisiana CCN program eligible members	All Louisiana CCN program eligible members	All Louisiana CCN program eligible members	All Louisiana CCN program eligible members

## Section E: Chronic Care/Disease Management

## Coordination of Information and Services with the PCP/PCMH

Aetna Better Health coordinates information with PCPs/PCMHs to monitor and facilitate compliance with the disease management process by tracking/trending established benchmarks. These include:

- Sharing quarterly member profiles to providers to promote PCP/PCMH education concerning gaps in the members care, absence of evidence-based care, new diagnoses, and medications. The member DM specific profiles also provide the PCP/PCMH a unique perspective on the PCP/PCMH practice patterns. Additionally, PCP profiles provide the DM program team with information to closely PCP/PCMH monitor each PCPs/PCMHs specific CCN members. Based on these data, we are able to identify PCPs/PCMHs whose practice patterns are inconsistent with clinical practice guidelines. A sample quarterly member profile report is shown below.

### Aetna Better Health - Medicaid and CHIP

80000208-0002

#### Patient Health Record

Name:	PCP:	DOB :
Member ID:	Gender:	Disease Management Condition(s): Asthma

This data is based on claims over the preceding 12 - month period, and medical codes submitted by multiple medical sources.

#### Most Frequently Diagnosed Conditions by Claim Count - Top 6

Other Upper Respiratory Disease 5

Excludes sensitive diagnosis as defined by state and federal guidelines

Medical claims maybe delayed up to 120 days

Health System Use	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Total
Enrolled In Health Plan	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Emergency Room Visits	0	1	0	0	0	1	1	0	0	0	0	0	3
Primary Doctor Visits	2	0	1	1	1	5	1	3	1	1	1	3	20

Key: 0 = No Claim Reported Y = Enrolled N = Not Enrolled

Medical claims maybe delayed up to 120 days

Diagnosis Specific RX Summary	Form	Strength	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Total
prednisolone	bott	15mg	0/0	0/0	0/0	0/0	0/0	15/3	0/0	0/0	0/0	0/0	60/3	0/0	2
pulmicort	amp	.25mg/2 ml	0/0	0/0	0/0	0/0	0/0	30/30	0/0	0/0	30/30	0/0	0/0	0/0	2
albuterol	vial	0.083%	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	25/4	0/0	0/0	1
budesonide	susp	.25mg/2 ml	0/0	0/0	0/0	0/0	0/0	60/15	0/0	0/0	0/0	0/0	0/0	0/0	1
milipred	sol	10mg/5ml	0/0	0/0	0/0	0/0	0/0	25/3	0/0	0/0	0/0	0/0	0/0	0/0	1

Key: # of units denotes: # of canisters for Inhalers; # of ml for liquids, injectables and insulin; # of tablets

Drug claims maybe delayed up to 30 days

OTHER RX Summary	Form	Strength	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Total
bromfed dm	bott	10mg 30mg	0/0	0/0	240/48	0/0	0/0	180/30	0/0	120/24	0/0	0/0	0/0	0/0	4
amoxicl clav	bott	200mg/5ml	0/0	100/10	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	1
amoxicillin	bott	400mg/5ml	75/10	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	1
brovex peb	bott	4mg 10mg	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	120/8	0/0	0/0	0/0	1
cedax	susp	90mg/5ml	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	65/10	0/0	0/0	0/0	1
ceftinir	bott	125mg/5ml	0/0	0/0	0/0	0/0	0/0	100/10	0/0	0/0	0/0	0/0	0/0	0/0	1
ceftizine	syrp	1mg/ml	0/0	0/0	0/0	120/48	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	1
cpm/ptolox/	bott	2.5mg/5ml	0/0	0/0	0/0	0/0	0/0	180/24	0/0	0/0	0/0	0/0	0/0	0/0	1
hydrocort	tube	1%	0/0	0/0	0/0	0/0	0/0	0/0	0/0	1/30	0/0	0/0	0/0	0/0	1
nupirocin	tube	20mg	0/0	0/0	0/0	0/0	0/0	0/0	0/0	1/7	0/0	0/0	0/0	0/0	1
ocean nasal	spry	0.65%	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	1/20	0/0	0/0	1

Key: # of units denotes: # of canisters for Inhalers; # of ml for liquids, injectables and insulin; # of tablets

Drug claims maybe delayed up to 30 days

- Sharing Disease Management Dashboard Reports: Also available at the member, physician, and Case Manager level, these reports provide a summary of gaps in care by disease condition and by member. A sample dashboard report is shown below.

<b>Name</b>	<b>Rank</b>	<b>Plan(Lob)</b>
<b>Carrier Member Id</b>	<b>Dob(Age)</b>	<b>Ratecode Desc</b>
<b>Member Id</b>	<b>Gender</b>	<b>PCP</b>
<b>Status</b>	<b>Program</b>	<b>PCP Affiliation</b>

### Condition(s)

Condition Type	Condition Name	Impact	ColMorb Weight	Condition Rank	Cond Rpt Count
P	CHF	HIGH	1	4	2
S	Cerebrovascular Disease	HIGH	2	17	6
S	Epilepsy, Convulsions	MODERATE	0	20	22
S	Moderate or Severe Liver Disease	MODERATE	3	21	5
S	Diabetes	HIGH	2	24	15

### Utilization(s)

Utilization	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Yr Total
Member Months	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	12.00
ED Visits	0.00	5.00	0.00	1.00	1.00	1.00	2.00	1.00	1.00	1.00	0.00	0.00	3.00
Admits	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.00
IP Paid Days	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
PCP Visits Op	2.00	7.00	0.00	0.00	0.00	3.00	1.00	0.00	1.00	3.00	4.00	0.00	21.00

### Rx Summary(s)

Rx Summary	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Yr Total
Anticonvulsants - Misc.	3.00	2.00	3.00	0.00	1.00	0.00	1.00	1.00	0.00	1.00	1.00	0.00	14.00
BH-Tricyclic Agents	1.00	1.00	0.00	1.00	1.00	0.00	0.00	2.00	0.00	0.00	0.00	0.00	6.00
BH-Benzodiazepines	1.00	2.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00	0.00	0.00	6.00
Calcium Channel Blockers	1.00	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	5.00
Thiazides and Thiazide-Like	...	...	...	...	...	...	...	...	...	...	...	...	...

### Open Authorization(s)

Open Authorization	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Yr Total
Med Inpatient	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.00	0.00	0.00	0.00	0.00	1.00
Medical	0.00	0.00	0.00	0.00	1.00	0.00	0.00	1.00	0.00	0.00	0.00	0.00	2.00
Outpatient	0.00	0.00	0.00	0.00	0.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	1.00
Radiology	0.00	0.00	0.00	0.00	0.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	1.00

Additional monitoring activities include monthly updates from GRM. This information allows our Health Coach Consultants (Disease Managers) to assess a member's progress toward meeting agreed upon objectives, and to re-assess members who may not have been previously engaged. In the event that a member is not progressing toward identified goals, Aetna Better Health works with the member and PCP to identify any obstacles and develop a revised strategy and care plan.

Health Coach Consultants (Disease Managers) also work with PCPs by:

- Addressing cultural, economic or social barriers to care
- Facilitating communication with them about treatment regimens, diagnostic testing and specialist consultations
- Educating them about evidence-based guidelines for treatment
- Coordinating continuity of care during the transition from one level of care to another (e.g., inpatient to outpatient or inpatient to nursing facility) and discharge planning
- Developing individualized care plans and care plan updates, and conducting periodic reassessments of members
- Communicating with members, member's families/caregivers and principal PCPs to follow-up on any outstanding issues

Should a PCPs/PCMHs practice patterns continue to reflect a failure to adhere to clinical practice guidelines, Aetna Better Health Medical Management department will meet with the PCP/PCMH to develop a corrective action plan. When the Health Coach Consultant (Disease Manager) identifies a concern related to a PCP's/PCMH's practice patterns that indicates a member may be "at risk", the Health Coach Consultant (Disease Manager) immediately notifies Aetna Better Health CMO. The CMO, to protect the health and safety of the member, will advise the Medical Management Coordinator and the Quality Management Coordinator that immediate action is needed. Depending on the circumstances, this action may include visiting the provider's office to assess the situation including analysis of the member's medical record or requesting the provider to send the member's medical record to Quality Management for evaluation. In accordance with Aetna Better Health's P&P, the incident is reported to the QM/UM Committee for tracking and resolution.