



2010 Utilization Management (UM)

Program Evaluation

Accounts under the Direction of CNR Partners, Inc.

In 2010, the APS Health Plan Division, Texas Medicaid membership, under the direction of CNR Partners, Inc. continued to increase to a total of 120,765, in contrast to 2009 at 109,719.

The total APS Health Plan Division commercial membership, under the direction of CNR Partners, Inc., decreased in 2010. The total commercial membership in 2010 was 11,456 in contrast to 2009 with a membership of 24,481. This decrease was related to a commercial HMO, supported by CNR Partners/APS discontinuing its health plan in Texas during 2010.

Primary activities in 2010 entailed identification of best practices in a number of areas and continuation of clinical improvement initiatives.

UM Program Structure

The APS UM Program focused on continuous quality improvements of initiatives throughout 2010. Quality improvements included:

- An initiative to ensure accuracy and consistency in Care Manager and Physician Advisor application of medical necessity criteria. The target inter-rater reliability score was $\geq 85\%$. When appropriate, the inter-rate reliability exercise results were used to develop clinical staff training.
- An initiative to provide current and emerging evidenced based information that enabled Care Managers to facilitate provision of effective, efficient behavioral health services through regular clinical trainings.

UM Program Resources

The APS UM Program continued under the oversight of the CNR Partners Board of Directors, and the leadership of the Executive Director/Medical Director, Managed Behavioral Health. BH Care Managers and Aftercare Coordinators continued to provide care management functions including initial, concurrent and discharge clinical review activities, interventions with members seeking behavioral health care services, and follow-up activities related to discharge planning. Specialized care management interventions were conducted related to specific member needs and severity of presentation and previous clinical history.

Program Accreditation

The APS Behavioral Health UM program again achieved URAC Health Utilization Management accreditation in 2010.

Program Focus in 2010

The UM program focused on providing access to high quality, medically necessary behavioral health services in the most appropriate setting, including outpatient, home-based, intensive outpatient, partial hospitalization residential and inpatient treatment.

Behavioral Health Utilization Performance

During 2010, APS provided behavioral health care management for several commercial health plans, and a Medicaid product, under the direction of the CNR Partners Board of Directors. Due to the differing benefit structures, along with account and regulatory requirements, analysis of utilization was completed separately for commercial and Medicaid accounts. Measures of Inpatient admissions per 1000 members, bed days per 1000 members and average length of stay are reported, in addition to similar measures for Alternative Care (including Residential, Partial Hospitalization and Intensive Outpatient treatment). The 2010 APS Healthcare Commercial and Medicaid utilization measurements are also provided spanning all related accounts.

Commercial Health Plan Accounts

Measure	Inpatient Care Admission/1000 members	Inpatient Care Bed Days/1000 members	Inpatient Care Average Length of Stay
2010 CNR Partners <i>**11,456 members</i>	1.83	10.39	5.67
2009 CNR Partners <i>* 24,481 members</i>	2.21	12.13	5.50
2008 CNR Partners <i>*27,296 members</i>	2.78	14.25	5.12
2008 APS Commercial Book of Business <i>*1,552,459</i>	3.35	20.01	5.97
2007 CNR Partners <i>* 31,078 members</i>	3.44	18.08	5.25
2007 APS Commercial Book of Business <i>*1,560,000 members</i>	3.49	19.4	5.30
2006 CNR Partners <i>*31,792 members</i>	2.64	15.76	5.96
2006 APS Commercial Book of Business <i>*824,343 members</i>	3.10	18.87	6.09
Milliman Care Guidelines	2.4-3.65	9.6-28.45	4.1-7.2

During 2010, Commercial Behavioral Health Inpatient utilization for the membership under the direction of CNR Partners, was somewhat lower than that of 2009. This demonstrates the continuing focus on utilization of alternatives to Inpatient care including Partial Hospitalization and Intensive Outpatient Programs and may have also been impacted by a shift in the composition of the commercial lives covered during 2010. The commercial membership was reduced in 2010 and the remaining commercial lives, under the direction of CNR Partners during 2010, were an average age of 62 years, with a majority of the membership being retirees and a minority of membership being child, adolescent or younger adults.

Texas Commercial

Measure	Partial Hospitalization Admits/1000 members	Partial Hospitalization Days/1000 members	Partial Hospitalization Average Length of Stay	Intensive Outpatient Admits/1000 members	Intensive Outpatient Days/1000 members	Intensive Outpatient Average Length of Stay
2010 CNR Partners <i>*11,456 members</i>	.26	1.92	7.33	.35	6.02	17.25
2009 CNR Partners <i>* 24,481 members</i>	.82	5.02	6.15	.98	9.12	9.29
2008 CNR Partners <i>*27,296 members</i>	.55	4.21	7.67	1.17	13.81	11.78
2008 APS Commercial <i>*1,552,459</i>	1.00	7.65	7.66	1.14	14.42	12.61
2007 CNR Partners <i>* 31,078 members</i>	.67	4.28	6.70	1.21	14.22	11.89
2007 APS Commercial <i>**1,560,000 members</i>	.91	7.3	7.5	2.5	10.8	12.3
2006 CNR Partners <i>*31,792 members</i>	.44	3.43	7.79	.79	9.56	12.16
2006 APS Commercial <i>*824,343</i>	.86	6.95	8.06	1.21	13.38	11.09

It was the CNR Partners belief that improving the availability of a complete continuum of care and utilizing that continuum would provide a more comprehensive treatment intervention approach for its members. The above data would indicate the continuing successful execution of a comprehensive treatment intervention approach.

Texas Commercial

Measure	Residential Admission/1000 members	Residential Bed Days/1000 members	Residential Average Length of Stay
2010 CNR Partners <i>* members</i>	.17	1.76	10.00
2009 CNR Partners <i>* 24,481 members</i>	.25	2.66	10.83
2008 CNR Partners <i>*27,296 members</i>	.18	1.28	7.00
2008 APS Commercial <i>*1,552,459</i>	.12	1.85	15.41
2007 CNR Partners <i>* 31,078 members</i>	.16	2.03	12.59
2006 CNR Partners <i>*31,792 members</i>	.25	3.02	12.00

Residential behavioral health utilization was decreased during 2010.

Medicaid Health Plan Accounts

During 2010, APS, under the direction of the CNR Partner Board of Directors, administered behavioral health care for a Texas-based HMO serving a Medicaid product in the Harris Service Area (SA). The Harris SA includes metropolitan Harris County (including Houston, TX) and several contiguous Texas counties including Montgomery, Fort Bend, Brazoria, Waller, Liberty, Chambers and Galveston. This is the most populated SA in the State of Texas.

Expansion of the current Harris Service Area (SA) is planned for implementation September 1, 2011, to include three additional counties, Austin, Wharton and Matagorda. This expansion will also enlarge the STAR Medicaid managed care program into the Jefferson SA which includes Chambers, Liberty, San Jacinto, Walker, Jefferson, Hardin, Tyler, Polk, Orange, Newton and Jasper Counties, in southeastern Texas.

Texas Medicaid

Measure	Inpatient Care Admission/1000 members	Inpatient Care Bed Days/1000 members	Inpatient Care Average Length of Stay
2010 CNR Partners <i>*120,765 members</i>	3.13	15.83	5.06
2009 CNR Partners <i>* 100,081 members</i>	2.77	13.33	4.82
2008 CNR Partners <i>*93,861 members</i>	2.34	11.04	4.71
2007 CNR Partners <i>* 80,000 members</i>	3.42	16.65	4.86
2006 CNR Partners <i>*60,395 members</i>	2.19	11.57	5.30

Inpatient utilization measurements in 2010 indicate a slight increase from 2009.

Texas Medicaid

Measure	Partial Hospitalization Admits/1000 members	Partial Hospitalization Days/1000 members	Partial Hospitalization Average Length of Stay	Intensive Outpatient Admits/1000 members	Intensive Outpatient Days/1000 members	Intensive Outpatient Average Length of Stay
2010 CNR Partners <i>*120,765 members</i>	.55	2.81	5.06	.45	2.68	6.00
2009 CNR Partners <i>*100,081 members</i>	.49	2.68	5.47	.46	3.21	6.98
2008 CNR Partners <i>*93,861 members</i>	.50	2.96	5.91	.42	4.12	9.92
2007 CNR Partners <i>* 80,000 members</i>	.69	3.26	4.75	.83	7.15	8.67
2006 CNR Partners <i>*60,395 members</i>	.28	1.92	6.89	.31	3.31	10.53

Partial hospitalization and intensive outpatient treatment evidenced similar measurements in 2010, in contrast to 2009. As indicated previously, APS continues to seek to utilize alternative levels of care to inpatient hospitalization which is evidenced in these measurements.

Texas Medicaid

Measure	Residential Care Admission/1000 members	Residential Care Bed Days/1000 members	Residential Care Average Length of Stay
2010 CNR Partners * 120,765 members	.07	.88	11.78
2009 CNR Partners * 100,081 members	.09	1.12	12.44
2008 CNR Partners *93,861 members	.05	.46	8.60

Residential behavioral health utilization indicated a slight increase in Admissions per 1000 Members between 2009 and 2010, and a slight decrease in Bed Days per 1000 Members in 2010, in contrast to 2009 and 2008. The Average Length of Stay for residential treatment for Texas Medicaid members was similar to 2009, although also slightly lower. The significantly lower measurements in 2008 are believed to have been impacted by Hurricane Ike, which occurred in the later portion of 2008. Most residential treatment centers in the service area discharged and evacuated their patients previous to landfall in 2008 and did not resume operations for a period due to damage and restoration.

Under and Over Utilization

The 2010 analysis of behavioral health care utilization for both the Commercial and Medicaid populations, would indicate a balanced utilization pattern along the complete continuum of care provided for the membership under the direction of CNR Partners, Inc

Denial and Appeal Activities

During 2010 those accounts served by APS, under the direction of CNR Partners, evidenced 32 Standard Clinical Appeals, 55 Expedited Clinical Appeals and 110 Administrative Appeals, for a total of 197 total appeals.

Type of Appeal

<i>Appeal Type</i>	Total 2010	Total 2009
Administrative	110	98
Standard Clinical	32	41
Expedited Clinical	55	47
Totals	197	186

Appeal Requests by Program Type

Program Type	Total 2010	% 2010	Total 2009	% 2009	Total 2008	% 2008	Total 2007	% 2007
Inpatient Care	109	55%	122	66%	105	55%	110	44%
Alternative Care (RTC, PHP, IOP)	6	3%	11	6%	13	7%	20	8%
Outpatient	82	42%	51	27%	72	37%	115	46%
Other	0	0%	2	1%	2	1%	4	0

Inpatient appeals during 2010 represented the majority of the requests, for 55% of all appeals by type with a decrease of 11% -% from 2009. Alternative levels of care decreased by 3%% from 2009 (RTC, PHP, IOP), while outpatient appeals evidenced an increase in 2010 at 42% %. This is in contrast to % in 2009, 27% in 2008 and 37% in 2007.

Appeals Requests by Denial Rationale

<i>Rationale</i>	<i>Total 2010</i>	<i>% 2010</i>	<i>Total 2009</i>	<i>% 2009</i>	<i>Total 2008</i>	<i>% 2008</i>	<i>Total 2007</i>	<i>% 2007</i>
Medical Necessity	87	44%	83	45%	82	43%	99	40%
Exhaustions of Benefits	0	0%	8	4%	7	4%	20	8%
Lack of Information	0	0%	0	0	0	0%	0	0%
No Out-of-Network Benefit	3	1%	11	6%	10	5%	2	1%
Failure to Certify	80	41%	58	31%	86	45%	68	28%
Not a Covered Benefit	27	14%	26	14%	7	3%	60	24%
Totals	197	100%	186	100%	192	100%	249	100%

44% of the overall percentages of denials were due to Medical Necessity with is very similar to the 2009 measurement at 45%. 41% of the overall percentages were related to a failure to pre-certify treatment during 2010, in contrast to 2009 they represented 31% of the total appeals. Failure to pre-certify treatment indicated a 10% increase in 2010 from the 2009 percentage. .

A total of 14% percent of the denials represented cases in which the service was not a covered benefit which was equal to the percentage in 2009. This finding resulted in an % increase from 2009. % percent represented no out of network benefit which is a % increase from 2009. No appeals in 2010 were related to exhaustion of benefits which is possibly due to the implementation of federal parity legislation and the decrease of commercial lives in 2010.

All clinical adverse determinations (denials) were completed by an APS Healthcare Behavioral Health Medical Director or a Psychiatric Physician Advisor who is licensed and actively practicing.

Appeals Determinations Completed

<i>Outcome</i>	<i>Total 2010</i>	<i>% 2010</i>	<i>Total 2009</i>	<i>% 2009</i>	<i>Total 2008</i>	<i>% 2008</i>	<i>Total 2007</i>	<i>% 2007</i>
Authorized	45	23%	27	15%	77	40%	96	39%
Denied	142	72%	143	77%	105	55%	138	55%
Modified	9	5%	12	6%	10	5%	15	6%
Other	1	0%	4	2%	0	0%	0	0%
Totals	197	100%	186	100%	192	100%	249	100%

The highest percentage overall for appeal determinations were denials which were 72% of the total appeal determinations in 2010. The total number of denials increased an additional 10 denials from the 2009 total. The percentage of appeals that resulted in an authorization was 23% indicated an increase from 2009. The percentage of appeals that were modified in 2010 was 5% % which is a slightly higher percentage than that of 2009 which was 6%.

Summary of Appeal Activity

The total number of appeals for 2010 was 197 which was a small increase from 2009. Appeals are reviewed in a number of categories from Clinical, Expedited, Standard, and Administrative. These appeals are reviewed based on the member's account specific and regulatory oversight requirement.

The highest percentages of denials in 2010 were due to a lack of meeting medical necessity criteria, which is similar to previous year measurements. The second highest percentage of appealed denials in 2010 was for lack of pre-certification.

During 2010 the Provider Operations Department continued to offer multiple training opportunities for participating providers through on-site, telephonic, and web-based training. Requirements and processes related to pre-certification were stressed in each of these provider training events. The goals of Provider Training include, but are not limited to, increasing provider knowledge and understanding of pre-certification processes and requirements and this will continue in 2011.

During 2010 and continuing into 2011 there has also been an increase in newly credentialed and contracted, behavioral health practitioners, group practices, agencies and treatment facilities in Texas. Many of these providers have not traditionally participated in managed care provider networks, nor have they had experience or knowledge of managed care processes. This increase has been due to multiple initiatives launched by governmental oversight entities in which previous funding sources for treatment from the public sector now been shifted to state Medicaid, CHIP and other programs. The impact on such traditional providers has been a rapid need to educate themselves' concerning managed care processes, trends and procedures. This occurrence may have had an impact upon appeal requests during 2010 and will possibly continue in 2011.

Complaints

Type of Complaint	Total Number 2010	Percentage 2010	Total Number 2009	Percentage 2009	Total Number 2008	Percentage 2008
Timeliness	13	59%	0	0%	2	13%
Provider Complaint	5	23%	2	18%	6	40%
Claims Payment	4	18%	8	72%	7	47%
Totals	22	100%	10	100%	15	100%

There were a total of 22 complaints in 2010; which included complaints categorized as Provider Complaints and Claims Payment Complaints. Complaints related to timeliness increased to 13 in 2010, while Provider Complaints increased to 5, and Claims Payment Complaints decreased to 4, related to 2009 levels.

During 2010 an significant increase in complaints classified as related to Timeliness were indicated (a total of 13 in 2010, in contrast to 0 in 2009 and 2 in 2008). Further review of the complaints classified under Timeliness indicated that this classification was utilized also for complaints about the appeal process and reviewer qualifications, many from one specific facility. It was determined that this did not indicate a potential opportunity for improvement.

Care Management File Audit Results

During 2010, the Behavioral Health (BH) Care Management Documentation Audit process was continued with an average total score 95.9% (increasingly from 2009 with an average score of 95.3%) across BH Care Managers, which exceeded the established performance standard of 90%. Documentation audit processes were audited including pre-authorization, concurrent review and discharge planning functions. Findings were favorable and met regulatory and client requirements.

Accessibility of Routine Care Appointments

To assure that members have appropriate access to routine care, accessibility to routine care appointments was measured monthly. Below is a table of the 2010 results.

Accessibility is measured by a count of less than and more than 10 days. During 2010 APS achieved 99.9% access within 10 days for routine care.

Provider Appointments Offered						
2010						
	Total	>10 days	Total # (minus)	Total Within	>10 days	% within
	Initial Auths.	Member choice	# Mbr. Choice	10 days	Provider choice	10 days (- member choice)
Jan	4001	0	4001	4001	0	100%
Feb	3982	0	3982	3981	1	99.9%
March	3899	0	3899	3898	1	99.9%
April	3387	0	3387	3387	0	100%
May	2719	0	2719	2719	0	100%
June	2574	0	2574	2574	0	100%
July	2679	0	2679	2679	0	100%
Aug	2635	0	2635	2635	0	100%
Sept	2544	1	2543	2543	0	99.9%
Oct	2171	0	2171	2171	0	100%
Nov	2441	0	2441	2440	1	99.9%
Dec	3514	0	3514	3512	2	99.9%
Total	36,546	1	36,545	36,540	5	99.9%

APS seeks to assure accessibility to routine care is 95% or better

Accessibility of Urgent Appointments

To assure that members have appropriate access to urgent care, on a monthly basis, the number of urgent care requests was measured. Requests for urgent services were coded in FACETS (electronic care management system) as Urgent. Care managers consistently made one or more attempts to assure that members followed the recommended plan for access to services. Only members who were compliant in seeing a mental health professional within 48 hours were counted as successful. 85% of total cases for 2010 were successful, which indicates an increase from 2009 when 80% were successful.

Urgent Care Requests	Total Cases	Successful	Percentage Successful
Jan-10	4	2	50%
Feb-10	4	4	100%
Mar-10	8	7	88%
Apr-10	4	4	100%
May-10	3	3	100%
Jun-10	4	2	50%
Jul-10	5	5	100%
Aug-10	4	3	75%
Sep-10	1	1	100%
Oct-10	1	1	100%
Nov-10	1	1	100%
Dec-10	1	1	100%
Total 2010	40	34	85%

APS seeks to assure that a minimum of 80% of urgent requests for care are successful.

Accessibility of Emergency Appointments

To assure that members have appropriate access to emergency care, when members contact APS, the initial phone scripts direct the member to call 911 or are connected to a clinician for assessment and intervention in any life threatening emergency situations. There was one life threatening emergency call in 2010 and a Behavioral Health Care Manager maintained contact with the member while APS had an ambulance dispatched transport the member to an area Emergency Room.

Inter Rater Reliability

The objective of the inter-rater reliability exercise is to ensure accuracy and consistency in care manager and physician advisor application of the medical necessity criteria. Inter-rater reliability exercises were conducted in 2010. The results were reported to the MBH Quality Improvement Committee during 2011. The results are displayed in the following table. The inter-rater reliability target score is $\geq 85\%$.

2010 IRR	Score
Physician Advisors	100%
Care Managers	100%

Provider and Member Satisfaction with UM Processes

In 2010, APS contracted with TMG to administer its Provider Survey. TMG used phone only survey methodology to solicit provider responses. TMG collected responses from a sample of providers. The Provider Satisfaction Survey targets providers to measure their satisfaction with APS in multiple areas including Utilization Management.

The APS goal in administering an annual satisfaction survey is to gain a better understanding of provider experience with APS. We understand that while some providers may have higher or lower expectations for certain services delivered by APS, we strive to identify our strengths and opportunities for improvement.

Provider Satisfaction

For 2010, APS contracted with TMG to administer its 2010 provider survey. TMG used phone only survey methodology to solicit provider responses. TMG collected 523 responses from a sample of 3,760 active providers who had claims and/or authorization activity in 2010. Results were collected in February 2011. The Provider Satisfaction Survey targets providers to measure their satisfaction with APS in the following areas:

- Calling APS Referrals
- Utilization Management
- Communication Process
- Credentialing and Recredentialing
- Reimbursement Process
- Behavioral Health Program
- Comparison to APS
- Overall Satisfaction and Loyalty

The APS goal in administering an annual satisfaction survey is to gain a better understanding of provider experience with APS. We understand that while some providers may have higher or lower expectations for certain services delivered by APS, we strive to identify our strengths and opportunities for improvement.

UM SATISFACTION OVERALL BY AREA OF INQUIRY	2011	2010	2009
Referrals <i>type and appropriateness of referrals, number of referrals received, access of psychological testing, access to a psychiatrist for med evaluation</i>	84%	85%	78%
Utilization Management <i>Amount of treatment authorized, clinical knowledge of care managers, courtesy of customer service, satisfaction with medical necessity criteria, amount of paperwork, timeliness of decisions</i>	91%	92%	90%
UM Appeals <i>timeliness to complete process, professional manner in which conducted, explanation of the reasons for outcome</i>	66%	66%	70%
Overall Satisfaction and Loyalty <i>overall service, over manner in which APS handles the health care of its members, recommend participation in APS to colleagues</i>	91%	82%	81%

In many areas there was not a significant change in satisfaction results. In comparing data from 2009 to the current survey, the following showed a change in results.

Satisfaction Elements	2011	2010	2009	2008
Referrals	84%	86%	78%	80%
Type and appropriateness of referrals	91%	94%	92%	89%
ACCESS TO PSYCHOLOGICAL TESTING	87%	81%	83%	82%
Number of referrals received	79%	76%	65%	70%
Access to a psychiatrist for medication evaluation	83%	92%	74%	80%
UTILIZATION MANAGEMENT	91%	92%	91%	89%
Overall Satisfaction with utilization management process	88%	90%	88%	86%
Utilization requirements	87%	91%	93%	85%
AMOUNT OF TREATMENT AUTHORIZED	85%	85%	83%	82%
Clinical knowledge of care manager	95%	95%	96%	94%
Courtesy of customer service representative	98%	98%	97%	96%
Timeliness in getting notification regarding authorization decisions	89%	86%	87%	85%
UM Appeals	66%	66%	70%	70%
Amount of time to complete the appeal process	62%	46%	60%	65%
PROFESSIONAL MANNER IN WHICH APPEAL PROCESS WAS CONDUCTED	77%	80%	86%	86%
Communication Process	87%	89%	87%	88%
Information on the web site	87%	87%	94%	86%
Overall Satisfaction and Loyalty	91%	82%	77%	70%
Overall service provided by APS	91%	79%	77%	70%
Overall manner in which APS handles the managed healthcare of its members	91%	79%	78%	73%

The areas highlighted above in yellow represent areas of significant improvement from 2009 to 2010. The areas highlighted above in purple represent areas of significant drop in satisfaction from 2009 to 2010.

Opportunities for Improvement – Provider Satisfaction

Based on the results listed above, the following opportunities for improvement were identified:

- Access to psychiatrists
- Amount of time to complete the appeal process*
 - *The reliability and validity of this measurement requires additional review. Each of the respondents to this item was involved in an appeal process, as the result of a medical necessity denial determination, which may have negatively impacted the finding.

Member Satisfaction

The Member Satisfaction Survey (ECHO®) was administered telephonically by The Myers Group from December 2009 to January 2010. The target number of completed surveys was. The Myers Group obtained 1,447 completed surveys. The following table provides a comparison of composite scores for 2008, 2009 and 2010.

Composites	2010	2009	2008
Getting Treatment Quickly	71.8%	70.6%	71.0%
How Well Clinicians Communicate	94.6%	94.3%	95.5%
Access to Treatment and Information from Health Plan	77.1%	79.5%	78.3%
Informed About Treatment Options	52.9%	48.7%	47.7%

The following table provides a comparison of scores for select questions related to member experience with the organization. Three of the composites indicated an increase from 2009 to 2010 including Getting Treatment Quickly, How Well Clinicians Communicate and being Informed About Treatment Options, while one composite titled Access to Treatment and Information from Health Plan decreased slightly between 2009 and 2010.

Question	2010	2009	2008
Q27A. What is your overall experience when you've called customer service to get information about benefits?	87.1%	81.9%	74.8%
Q27B. What is your overall satisfaction when you've called APS customer service to obtain a referral?	88.6%	85.7%	82.4%
Q27C. What is your overall satisfaction when you've called APS customer service to obtain information about eligibility?	87.0%	84.7%	79.7%
Q27D. What is your overall satisfaction when you've called APS customer service to obtain assistance with claims?	69.7%	76.3%	74.0%
Q28. In the past 12 months, how much of a problem, if any, was it to get the help you needed when you called customer service?	69% (not a problem)	71.3% (not a problem)	66.4% (not a problem)

This measurement of member satisfaction consistently indicated an increase in satisfaction in three of the areas measured in 2010, and a decrease in satisfaction for two of these areas.

Opportunity for Improvement – Member Satisfaction

A potential opportunity for improvement may have been identified with item Q27D (What is your overall satisfaction when you've called APS customer service to obtain assistance with claims?) which decreased by 6.6% between 2009 and 2010.

Medical Necessity Criteria

Five (5) clinical criteria sets were utilized for behavioral health care management activities related to the accounts under the direction of CNR Partners in 2010. Review and approval processes required review of current scientific literature, review and involvement by the APS Provider Advisory Group (including all major levels licensure of behavioral health care practitioners and facility providers), and approval by the Corporate Quality Improvement Committee (CQIC) and the CNR Partners Board of Directors. The next review of clinical criteria sets will be conducted in 2011.

The following clinical criteria sets were utilized in 2010 for those populations served by APS, under the direction of CNR Partners:

- The APS Medical Necessity and Level of Care Determination Criteria: There were minimal changes to the APS criteria incorporating input and suggestions from APS Medical Directors
- ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders – latest edition
- Texas Administrative Code - Standards for Utilization Review for Chemical Dependency Treatment Centers
- Resiliency and Disease Management Utilization Management Guidelines – Children Services
- Resiliency and Disease Management Utilization Management Guidelines – Adult Services

Summary of UM Activities and Performance

Multiple measurements of UM activities conducted by APS, during 2010 under the direction of CNR Partners, were reviewed in this document. In each area of performance reviewed, data analysis was conducted and identification of possible opportunities for improvement was identified.

- **Behavioral Health Utilization Performance**

APS successfully sustained growth in the Medicaid population and experienced a decrease in membership in the commercial accounts during 2010. There was a similar utilization of inpatient and alternative care across all accounts. No opportunities for improvement were indicated.

- **Under and Over Utilization Analysis**

APS continued to focus upon continuum of care utilization which indicated a positive effect in limiting over and under utilization. Under nor over utilization of behavioral health services was not indicated during 2010.

- **Denial and Appeal Activities**

The highest percentages of denials in 2010 were due to a lack of meeting medical necessity criteria, which is similar to previous year measurements. The second highest percentage of appealed denials in 2010 was for lack of pre-certification.

During 2010 the Provider Operations Department continued to offer multiple training opportunities for participating providers through on-site, telephonic, and web-based training. Requirements and processes related to pre-certification were stressed in each of these provider training events. The goals of Provider Training include, but are not limited to, increasing provider knowledge and understanding of pre-certification processes and requirements and this will continue in 2011.

*During 2010 and continuing into 2011 there has also been an increase in newly credentialed and contracted, behavioral health practitioners, group practices, agencies and treatment facilities in Texas. Many of these providers have not traditionally participated in managed care provider networks, nor have they had experience or knowledge of managed care processes. This increase has been due to multiple initiatives launched by governmental oversight entities, in which previous funding sources for treatment have now been shifted to state Medicaid, CHIP and other programs participating in managed care programs. The resulting impact on such traditional providers has been a need rapidly educate themselves' concerning managed care processes, trends and procedures and APS has been at the forefront of providing related provider educational opportunities and assistance during 2010. This occurrence may have had an impact upon appeal requests during 2010 and will possibly continue in 2011.

- **Complaints**

During 2010 a significant increase in complaints classified as related to Timeliness were indicated. Further review of the complaints classified under Timeliness, indicated that this classification was utilized also for complaints about the appeal process and reviewer qualifications, many from one specific facility. It was determined that this did not indicate a potential opportunity for improvement.

- **Care Management File Audit Results**

Findings were favorable and met the establish performance standard, regulatory and account requirements.

- **Accessibility of Routine Care Appointments, Urgent and Emergency Appointments**

Measurement of routine, urgent and emergency appointment accessibility met performance standards during 2010.

- **Inter Rater Reliability**

Inter-rater reliability results for 2010, for both Behavioral Health Care Managers and Psychiatric Physician Advisors, were found to be 100%.

- **Provider and Member Satisfaction with UM Processes**

Two potential opportunities for improvement were identified in 2010, related to the results of the annual Provider Satisfaction Survey, which included:

- Access to psychiatrists
- Amount of time to complete the appeal process*

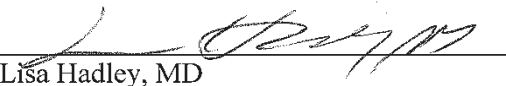
*The reliability and validity of this measurement requires additional review. Each of the respondents to this item were involved in an appeal process, as the result of a medical necessity denial determination, which may have negatively impacted the finding.

Member Satisfaction measurement in 2010 also indicated a potential opportunity for improvement, involving satisfaction with customer service related to claims resolution. Related data will be evaluated internally to determine possible causation and potential related interventions.



Donald Hauser, MD
Chairman, CNR Partners Board of Directors

4/5/11
Date



Lisa Hadley, MD
Executive Director, Managed Behavioral Healthcare

4/18/11
Date