

APS Healthcare Bethesda, Inc

2007 Quality Improvement Evaluation

Managed Behavioral Health

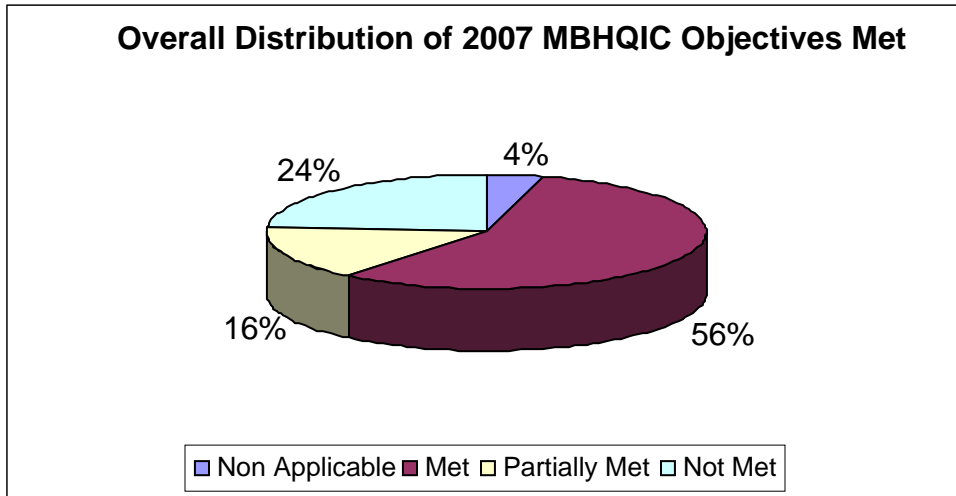
Introduction

APS Healthcare Bethesda, Inc. (APS) conducts an annual comprehensive quality improvement evaluation of the quality improvement initiatives delineated in the 2007 quality improvement work plan. It is the evaluation of whether or not we completed the activities in the work plan that is the focus of this annual evaluation. To determine compliance, we have designated the following ratings to reflect our performance; fully met, partially met, not met, or not applicable. Each goal and objective is evaluated against these performance indicators. Also, any significant administrative changes to the organization and/or quality improvement structure are noted as well to provide the context for the performance evaluation described in this document.

The overall effectiveness of the APS quality improvement program for behavioral health services is measured by the review of the following accreditation standards;

- ✚ Completion of Quality Improvement Program Description, Work Plan and Program Evaluation (Trilogy Documents)
- ✚ Policy Committee Structure, Development, Review, and Revision
- ✚ Quality Improvement Structure, Resources, and Processes
- ✚ Clinical Practice Guidelines
- ✚ Preventive Health Programs
- ✚ Treatment Record Review
- ✚ Treatment Access and Availability
- ✚ Clinical and Service Quality Improvement Activities
- ✚ Member and Provider Satisfaction Survey Results
- ✚ Demographic Analysis
- ✚ Quality of Care complaints/Adverse Incidents
- ✚ External Accreditation and Certification
- ✚ Regulatory Compliance
- ✚ Behavioral Health Coordination
- ✚ Clinical Appeals Management
- ✚ Patient Safety

APS Healthcare Bethesda, served as the managed behavioral administrative services organization for more than 41 accounts in 2007. The 2007 quality improvement work plan identified one hundred and thirty-nine (139) performance measures. An assessment of the degree APS accomplished these planned activities was conducted, assigning a determination of Met, Partially Met, Not Met, and/or Not applicable to each performance measure in the 2007 work plan. Of the 139 performance measures 79 or 56 % were met, 22 or 16% partially met, 33 or 24% not met, and 5 or 4% were not applicable.



Administrative Changes Affecting Quality Improvement in 2007

In 2007, there were a number of executive leadership changes that resulted in organizational and structural changes to the APS quality improvement program. The following activities are an indication of some of these changes:

- ✚ APS Healthcare purchased by investment company GTCR – June 2007
- ✚ New Executive Leadership appointed for Commercial Division, Sales and Marketing; Employee Assistance Program – August 2007
- ✚ Consolidation of Disease Management and Behavioral Health Medical Director roles to form Corporate Medical Director position/leadership for Quality Improvement – November 2007
- ✚ Review of Quality Improvement Resources across APS Programs

Quality Improvement 2007 Program Description, Work Plan and Program Evaluation

In 2007, the QI Program Description was developed to meet all regulatory, contractual, and accreditation requirements. The QI Program Description was reviewed and approved

by the Managed Behavioral Health Quality Improvement Committee (MBHQIC), and presented for acceptance to the Corporate Quality Improvement Committee (CQIC) in May 2007.

The QI Work Plan was developed to include a detailed outline of the 2007 goals and objectives. The Work Plan was reviewed and approved by the MBHQIC and the CQIC on May 24, 2007.

The 2007 Program Evaluation is represented by this document, and includes all data and information regarding the achievement of performance measures/initiatives/QI program activities that occurred and/or were implemented in 2007.

The Quality Improvement staff also worked with Utilization Management (UM) staff in the development of the UM program evaluation, description and work plan.

Policy Committee Structure, Development, Review and Revision

The APS policy committee met in 2007, and provided oversight to the review and revision of the 226 policies and procedures guiding APS program services/activities. The committee met regularly, discussed modifications to specific policies, and worked to ensure that all policies were reviewed and evaluated within the twelve month (12) standard required by accreditation organizations.

Quality Improvement Structure

The APS Board of Directors and the CNR Partners Board of Directors (for Texas-based risk business only) share the ultimate authority and accountability for the quality of care and service delivered to APS Behavioral Health members, and is the highest level of oversight for the Quality Improvement Program. Both Boards of Directors delegate their oversight responsibilities to the Corporate Quality Improvement Committee (CQIC). The CQIC delegates operational responsibility for the Quality Improvement Program to the Managed Behavioral Health Quality Improvement Committee (MBHQIC).

Designated Behavioral Health Care Practitioner

As required by national accreditation standards, in 2007, APS Healthcare Bethesda, Inc. designates the Corporate Medical Director to direct the implementation of the MBHQIC's quality improvement processes. The Corporate Medical Director supervises the development of the 2007 QI work plan, program description, and annual program evaluation. In addition to the development of the QI Documents, the Designated Behavioral Health Care Practitioner worked to support the QI committees, quality improvement activities, designing interventions, and assuring leadership was provided to maintaining accreditations standards throughout the year.

Input from Medical Delivery Systems

The APS behavioral health system includes input and representation from providers from the medical delivery system. The Corporate Medical Director convened the Provider Advisory Group (PAG) who functions and purpose was to provide structured input from representatives of relevant medical systems or other health care practitioners. The PAG meet on April 11, 2007, and engaged in the following activities;

- ✚ Review of the Medical Necessity Criteria to be utilized in 2007
- ✚ Review of the Clinical Practice Guidelines identified as best practice to guide the quality improvement activities.
- ✚ Review of Member & Provider Satisfaction Survey findings

QI Resources in 2007

The Office of Clinical Resources (OCR) is where the APS Healthcare's Quality Improvement Activities were implemented and monitored. Adequate staff resources were provided to support the effective implementation of the QI program and work plan. Staffing included;

- ✚ Director of Office of Clinical Resources (1 FTE)
- ✚ Corporate Medical Directors for Disease Management & Behavioral Health (2 FTE's)
- ✚ Directors of Employee Assistance Programs and Director of APS Accreditation (2 FTE's)
- ✚ Manager of Accreditation (1 FTE)
- ✚ Coordinator of Quality Improvement (1 FTE)
- ✚ Manager of Clinical and Administrative Appeals (1 FTE)
- ✚ Medical Necessity and Denial and Appeal Coordinators (2 FTE's)
- ✚ Complaint Coordinator (1 FTE)
- ✚ Quality Improvement Analyst (2 FTE's)
- ✚ Administrative Coordinator (1 FTE)

Interventions

The fourteen (14) staff dedicated to quality improvement focused on providing internal programs and staff and to our external business partners. Primary responsibilities of the OCR staff included;

- ✚ Medical Consultation to APS staff in the areas of Disease Management, Health & wellness, Behavioral Health and Case Management services
- ✚ Development of the annual Quality Improvement Program Description, Work Plan, and Program Evaluation (Trilogy Documents)

- ✚ Collaboration with our Satisfaction Survey Vendor to implement surveys for our Disease Management and Behavioral Health book of business
- ✚ Interpretation of APS Quality Improvement services with Account Executives, Marketing, and Public Programs staff
- ✚ Expert consultation related to Accreditation standards and compliance issues for our Puerto Rico, and Hawaii site programs
- ✚ Completion of four (4) NCQA Accreditation Audits
- ✚ Review of Patient Safety issues designed to improve the quality of clinical services
- ✚ Distribution of preventive Health and other related member and provider focused information
- ✚ Review of Clinical Practice Guidelines against services delivered to improve quality and effectiveness of care
- ✚ Development of Quality Improvement Activities to provide the highest level of services to members and by providers

Analysis

The quality improvement staff was able to achieve a significant number of performance measures in 2007 as identified in the work plan. Enhancing our collaboration and continuity of care initiatives, strengthening our quality improvement projects, and a re-energized focus on prevention efforts are all areas of opportunity in 2008.

Barriers

Due to organizational changes related to the structure of the quality improvement department, and subsequent mid-year correction/loss of staff in mid-August 2007, the remaining quality improvement staff managed to complete all quality improvement initiatives required to comply with national standards and account specific performance measures.

Recommendations

The new executive leadership's recommendation is to organize the quality improvement functions and designate it as a corporate level department with executive leadership. Under consideration is the implementation of a de-centralized model of quality improvement support services. With the recruitment of a Vice President Level Executive, the Quality Improvement department will have executive leadership and provide oversight of all related quality improvement functions, and report directly to the Corporate Medical Director.

Clinical Practice Guidelines

In 2007, APS Healthcare reviewed the following Clinical Practice Guidelines for applicability to quality improvement initiatives that were implemented in 2005 and substantially reviewed for relevance and value in 2007. Guidelines reviewed included:

- ✚ The treatment of Major Depression in Adults to review the percent of enrollees with moderate, severe, or unspecified severity levels of major depression. These included, monitoring enrollees who began outpatient treatment with a non-physician and who were referred for a psychiatric evaluation within 60 days of initiating treatment.

Preventive Health

In 2007, APS Healthcare engaged in substantive discussions with the Health Plan to identify opportunities for improving the preventive health initiatives implemented in past years and to refine the process and materials that would be available to members and providers. APS reviewed the preventive health materials posted on the corporate web site, and in consultation with the health plan determined to further develop the following initiative:

Identify and contact women in the post-partum period who are at risk of developing depression. The focus was to improve the number of survey responses for women who scored positive (above 8 on the Edinburgh Depression Scale and return it to APS. Upon receipt of the completed scale, APS QI staff will score the scales. A score of 8 or above determined which women were contacted with an offer of a referral for assessment and treatment of possible depression.

- ✚ Work with the health plan to ensure consistent mailings of preventive health materials to women in the post partum period
- ✚ Time mailings to occur as expeditious to post-delivery
- ✚ Document reasons why women declined referrals to treatment, and conduct a barrier analysis to determine opportunities for improvement
- ✚ Continue discussion regarding the implementation of this preventive health initiative in 2008.

Treatment Record Review

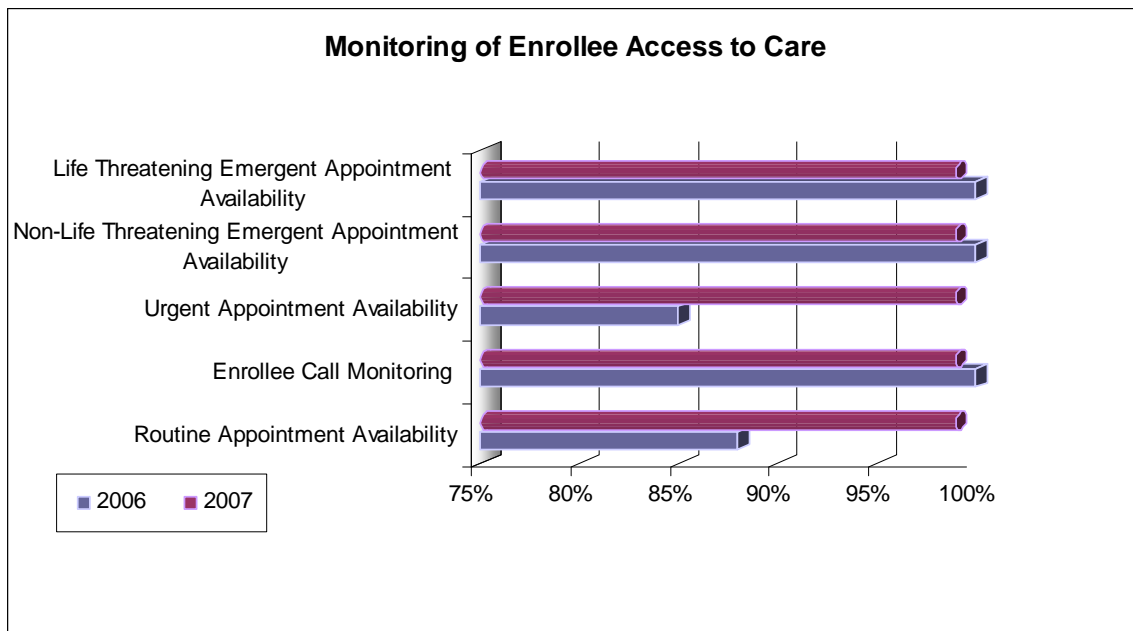
APS Treatment Record Review (TRR) promotes complete and accurate documentation of patient care within the practitioner network. The policy contains standards that require records to contain adequate information to support safe appropriate, effective, and confidential patient care and quality reviews. In 2007, APS determined that it would

terminate treatment record review activities in order to better design a records review system that would

1. Review a valid sample of provider records
2. Ensure that the record review instrument would allow for comparisons between and amongst providers
3. Included a methodology to “publish” the treatment record review results for members and providers alike.

Treatment Access (Urgent, Emergent, and Routine):

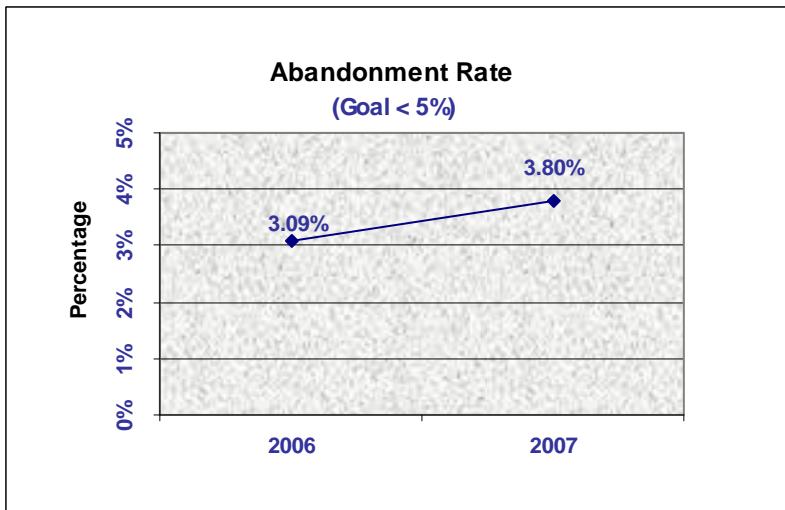
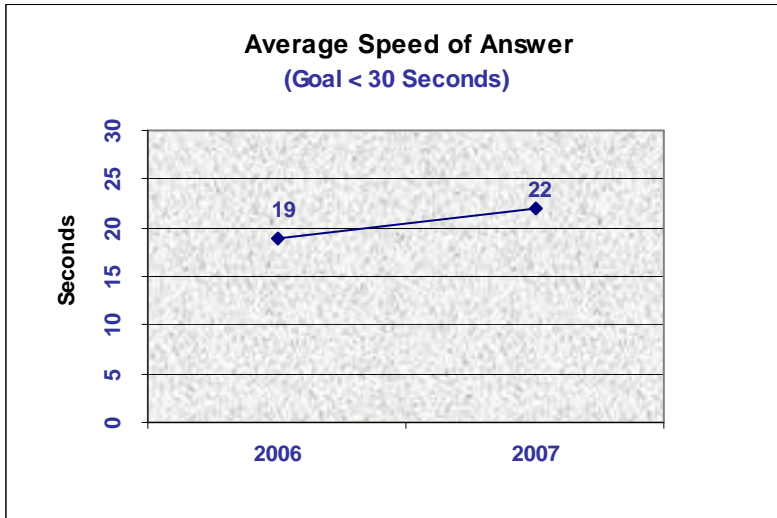
In 2007, APS responded to 280,583 calls from providers, members and others seeking information regarding services, authorizations, denials and related information. The average speed of answer to these calls was 21.75 seconds.



Key Telephone Performance Indicators

The monitoring of enrollees access to APS for referral to care or to respond to customer service issues are important aspects of the care provided. APS set a goal in 2007 to achieve an average speed of answer of not more than 5%, the industry standard. APS documents an abandonment rate of 3.8% which met the goal. In 2008, APS will continue to monitor and track the average speed of answering times and abandonment rates and report this data on a monthly basis at the Utilization Management Committee (UMC) meeting. Variances to the goals are discrepancies that will be communicated to the committee to ensure that appropriate, effective, and timely corrective action plans.

Monitor	2004	2005	2006	2007	2007 Goal
Average Speed of Answer	36 seconds	16 seconds	19 seconds	22 seconds	<30
Abandonment Rate	2.6%	1.4%	3.09%	3.8%	<5%



Monitoring of Enrollee Access for Urgent, Emergent and Routine Care

Measurement	Data Collected 2006	Data Collected 2007	Performance Goal
<u>Life Threatening Emergent Appointment Availability</u> Life Threatening Emergent Appointment (% of enrollees calling APS with a life-threatening emergency who were offered an appointment for care immediately.)	100%	99%	100%
<u>Non-Life Threatening Emergent Appointment Availability</u> Non Life-Threatening Emergency (% of enrollees calling APS with a non-life threatening emergency who were offered an appointment for care within 6 hours)	100%	99%	100%
<u>Urgent Appointment Availability</u> Percentage of enrollees who responded that they “always” or “usually” on the question, “In the last 12 months, when you needed to get counseling or treatment right away, how often did you see someone as soon as you wanted?”	85%	99%	85%
<u>Enrollee Call Monitoring</u> Urgent Appointment Availability (% of enrollees calling APS with an Urgent appointment need that were offered an appointment within 48 hours.)	100%	99%	80%
<u>Routine Appointment Availability</u> Percent of enrollee who indicated that they were seen within 10 days on the question, “In the past 12 months, not counting the times you needed to get counseling or treatment right away, how long did you usually have to wait between making an appointment and actually seeing someone?”	88%	99%	80%

Life Threatening Emergent Appointment

This monitor was measured through enrollee “call capture”. In 2007, 99% of care for one health plan client was offered within 6 hours for non-life threatening emergent, immediately for life threatening emergent, and within 48 hours for urgent care. This performance met goal.

Non-Life Threatening Emergent Appointment Availability

This monitor was measured through enrollee call capture. In 2007, 99% of calls by individuals experiencing a non-life threatening emergency were given care within six (6) hours. This performance met goal.

Urgent Appointment Availability

This monitor was measured from satisfaction survey responses and through enrollee call experience. Satisfaction results indicate that enrollee experience with urgent care access improved from 85% in 2006 and met the performance goal in 2007.

Routine Appointment Availability

This monitor was measured through satisfaction survey responses in 2007. Member satisfaction results showed an improvement in satisfaction with routine care availability from 88% in 2006, and exceeded the performance goal in 2007.

Monitoring of Geographic Availability

This monitor was measured through satisfaction survey responses in 2007. Member satisfaction results showed an improvement in satisfaction with routine care availability from 78% in 2006 to 88% in 2007, and exceeded the performance goal.

Access and Availability of Behavioral Health Services (GEO and Density)

Monitoring of Geographic Availability

Region	Provider Type	Goal	Data collected 2006 All clients	Data collected 2007 All clients
Suburban	MD/DO	95%	96.0%	99.3%
Rural			94.3%	97.9%
Urban			98.1%	99.6%
Suburban	Psychologists	95%	96.7%	99.1%
Rural			95.0%	99.9%
Urban			99.0%	99.9%
Suburban	Masters-level	95%	98.1%	100%
Rural			99.9%	99.8%
Urban			97.9%	100%
Suburban	Child/ Adolescent	95%	98.1%	100%
Rural			99.5%	99.9%
Urban			*	100%
Suburban	MH IP	95%	75.2%	95.4%

Urban	facilities		62.2%	98.9%
Rural			89.1%	99.1%
Suburban	SA facilities	95%	75.9%	99.9%
Urban			62.9%	100%
Rural			89.5%	100%
Suburban	PHP/IOP	95%	75.5%	76.1%
Urban			62.7%	78.5%
Rural			89.2%	85.9%

 **Data not collected in 2005**

In 2007, APS Healthcare exceeded its performance goals in all categories but Partial Hospitalization/Intensive Outpatient Facilities, however the sub-categories of suburban and urban members within that category generally showed improvement over 2006 percentages.

Each Medical Doctor/Doctor of Osteopathy and Child and Adolescent practitioner subcategory improved over 2006, but the most significant improvement was demonstrated in Mental Health Inpatient and Substance Abuse Facilities which not only exceeded their goals but improved over 2006 percentages. Partial Hospitalization/Intensive Outpatient Facilities did demonstrate improvement over 2006 figures but remains an opportunity for improvement in 2008.

Service Quality Improvement Activities (QIAs)

In 2007, one service Quality Improvement Activities was developed as a direct response to feedback received during an NCQA “Mock” audit. The NCQA reviewer indicated that the written reason for a clinical denial needed to be written at a sixth grade level. In response to this information, APS implemented a complete revision of the denial letter and non-certification documentation making it easier for members to understand the reason for denial, and standardizing how care managers record the information to promote inter-rater reliability amongst and between staff. In 2008, the number of accurately completed denial documentation and the appropriateness of the language included will be monitored to track improvement.

Member Satisfaction Survey

Executive Summary

The First annual Enrollee Satisfaction Survey was conducted in 2001, and has been administered to APS Healthcare enrollees annually. In 2007, APS contracted with The Myers Group (TMG) to administer a telephonic enrollee survey using the Experience of Care and Health Outcomes Survey instrument (ECHO) which is designed to collect consumer’s satisfaction ratings of their behavioral health treatment. TMG conducted phone only survey methodology to solicit enrollee responses from May 2008- June 2008.

A total of 1,421 surveys were collected and of these 1,031 responded to Q1 indicating that they had received counseling, treatment, or medicine for the reasons listed on the survey tool.

Overall, the percentage of respondents who answered in the most positive way “Always” or “Usually (commercial, Employer, State A, State B) were very good. **The APS overall satisfaction rate is 85.5%** To put the APS enrollee satisfaction data in perspective, TMG compared the APS results to their 2007 ECHO Book of Business that included summary rates for all eligible ECHO behavioral Health Enrollees which consists of 18 plans for a total of 7,677 TMG respondents. TMG ECHO book of business Benchmarks provide a side by side comparison of APS Healthcare enrollee satisfactions results with those obtained by other plans. **In a number of categories, APS enrollee satisfaction results were significantly above the TMG Plans benchmarks.**

ECHO COMPOSITES	APS 2007 SUMMARY RATES	2007TMG ECHO RESULTS
Getting Treatment Quickly	71.0%	65.2%
How well Clinicians Communicate	95.5%	88.8%
Access to Treatment and Information from Health Plan	78.3%	77.2%
Informed About Treatment Options	47.7%	49.9%
Office Wait Time	82.7%	68.3%
Informed About Medication Side Effects	86.1%	80.8%
Received Information About Managing Condition	90.2%	78.4%
Informed About Patient Rights	89.0%	86.5%
Ability to Refuse Medication and Treatment	91.5%	76.4%
Rating of Counseling and Treatment	85.5%	71.2%

Enrollee Survey Population and Sampling Methodology

APS Healthcare submitted a database of 34,327 of its Commercial, State, Employer adult members. Duplicative phone numbers and members with no phone numbers were removed from the database resulting in a sample of 17,364 members. Of the four groups, the goal was to obtain responses for 300 for each group. A total of 1,421 surveys were completed. Not all respondents indicated they used behavioral health services in the last 12 months but everyone contacted was eligible to answer the demographic questions in the category of Age, Gender, Education, and Mental Health Status.

The following chart provides a comparison between the number of members sampled and the number of responses obtained for each group.

GROUP	NUMBER IN SAMPLE 2007 (MAY-JUNE 2008)	PERCENT OF SAMPLE	NUMBER OF RESPONSES 2007 (MAY-JUNE 2008)	NUMBER OF RESPONSES 2006	PERCENT OF RESPONSES
State A	4,145	23.9%	409	338	28.8%
State B	6,558	37.8%	463	330	32.6%
Commercial	2,319	13.4%	299	495	17.6%
Employer	4,342	25%	299	410	21.0%
Total	17,364	100%	1,421	1602	100%

Profile of Survey Respondents

Characteristic of all 1,421 respondents surveyed describes demographics by Age, Gender, Overall Health Status, and Race/Ethnicity. The following charts indicate the APS enrollee respondents were:

- 75.5% were between ages forty-five (45) and age fifty-four (54) or older than fifty-five.
- 69.7% were female
- 77.1% indicated they were in excellent, very good, or good health
- 83% described themselves as being in excellent, very good, or good mental health
- 75% indicated they had an education background of college graduate or more or some college
- 87.9% of the respondents race/ethnicity was White

When comparing the above demographics to the characteristics of the 1031 respondents who answered “yes” to the question (Q1) “In the last 12 months, did you get counseling, treatment, or medicine for any of these reasons (see survey tool for detail), the results appear to support the overall demographic findings of the survey of all 1421 respondents.

- 76% were between ages forty-five (45) and age fifty-four (54) or older than fifty-five (55)
- 71% were female
- 81% indicated that they were in excellent, very good, or good health
- 78% indicated they had an educational background of college graduate or more or some college

Opportunity Analysis for Rating of Counseling or Treatment

The APS goal in administering an annual satisfaction survey is to get a better understanding of enrollee experience of care. We understand that while some enrollees

may have higher or lower expectations for certain services delivered by APS, we always wish to identify our strengths and opportunities for improvement. Key drivers of satisfaction are identified in the ECHO in two specific areas;

ECHO COMPOSITE	COMPARISON TO 2007 TMG ECHO BOOK OF BUSINESS	APS SUMMARY RATE
How Well Clinicians Communicate	Significantly Above	95.5%
Getting Treatment Quickly	Significantly Above	71.0%

These APS rates are strengths of our plan services and clinical and marketing efforts will focus on maintaining and informing enrollees on these very important clinical achievements in 2008.

Given APS achieved significant Summary Rates as compared to TMG book of business plans, there are no recommendations for investigation, improvement or areas to monitor in regard to enrollee satisfaction in 2008.

Provider Satisfaction Survey

Executive Summary

In 2007, APS contracted with The Myers Group (TMG) to administer a telephonic provider survey. TMG used phone only survey methodology to solicit provider responses from May 2008- June 2008. TMG collected 1,130 responses from a sample of 10,000 providers. The Provider Satisfaction Survey targets providers to measure their satisfaction with APS Healthcare.

The APS goal in administering an annual satisfaction survey is to get 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 always wish to identify our strengths and opportunities for improvement.

Overall Provider Satisfaction Survey Results

The result reported is the percentage of respondents giving the most favorable response(s) (i.e. Very Satisfied/Mostly Satisfied; Much Better/Slightly Better). The survey was broken out among several areas which included the following:

SATISFACTION AREA	2006	2007
Overall Satisfaction with overall manner APS handles managed health care	94%	89%
Telephone wait time	93%	86%
Accuracy of information over the phone	92%	85%

Access to psychological testing	90%	82%
Utilization management process	93%	86%
Timeliness in authorization decisions	92%	89%
Professionalism of Physician Advisor	96%	95%
Explanation of the reasons for appeal outcome decision	35%	61%
Courtesy of the APS credentialing staff	91%	96%
Time to get claims reimbursed	82%	76%
Accuracy of claims handling	83%	85%
Information on the website	88%	86%

Barrier Analysis

- The absence of an in-depth analysis has limited examination of this survey beyond a comparison of results.
- The low response rate for some questions was not addressed.

Opportunities for Improvement

A decrease in satisfaction was indicated in relationship to the 2006 measurements, although many areas of measurement resulted in the established standard of 85% being met. Several opportunities for improvement were identified including:

- Access to psychological testing – Less than 25% of the 1,130 providers responded to this question. APS will investigate this issue further.
- Explanation of the reasons for appeal outcome decision – significant improvement was evidenced during 2007, although the measurement did not reach the established standard of 85%.
- Timeliness of claims reimbursement – APS added a large volume of pre-pricing business between 2006 and 2007 and there are timeliness issues with the payers other than APS. APS will investigate this issue further.

Actions

- A subcommittee will be formed to discuss the areas for improvement and determine action plans, as necessary.
- An NCQA certified survey vendor will be conducting a provider survey in 2008. NCQA survey methodology will be utilized. Response rates and examination/validity of data will be reviewed, potential opportunities for improvement will be evaluated, and related intervention implemented.
- A more in-depth analysis of the 2008 survey will be conducted.

Complaints Analysis: Quality of Care

It is the APS policy to identify and investigate all potential Quality of Care (QOC) issues. APS defines a QOC as an “issue raised that requires a determination as to whether the competence or professional conduct of an individual practitioner adversely affects, or could adversely affect, the health or welfare of an enrollee”. APS requires our network of facilities and providers to deliver clinically appropriate and professional services to the enrollees we serve. When potential problems are identified we investigate, resolve, and track these incidents.

Findings/Analysis

Ten (10) potential QOC cases were identified and investigated by the Office of Clinical Resources (OCR)/Appeals and Complaints Department in 2007.

2007 complaints involved enrollees from twelve (7) different APS accounts:

Facilities/Hospitals: 5 Potential QOC cases were regarding services received in a facility or a hospital. 4 of these facilities were credentialed by APS, 1 was on out of network facility.

M.D. Providers: 5 Potential QOC complaints were regarding services performed by different MD providers.

There were no QOC cases initiated regarding providers of any other discipline or licensure level.

Subject of 2007 Quality of Care Complaints:

The most recurrent subject area involved medication issues. 5 of the 10 potential QOC cases related directly to medication with the following breakout:

Over Medicating- 4
Prescription Error-1

Additional subjects of the ten QOC cases included facility length of stay and provider inaccessibility.

Only one QOC outcome was rated other than Level 0: Complaint Unsubstantiated. One (1) substantiated complaints was rated Level 2: Confirmed QOC which may have adversely impacted treatment outcome.

Interventions

There were 10 Quality of Care complaints recorded for 2007. Each complaint was examined for impact on care and treatment outcomes, as well as origin of the complaint

and any other aspects of the complaint that would warrant further examination and/or intervention.

The one Level 2: Confirmed QOC which may have adversely impacted treatment resulted in the provider being terminated from the APS Network.

Level 0: Complaint Unsubstantiated

Level 1: Confirmed QOC without impact on care/treatment outcome

Level 2: Confirmed QOC which may have adversely impacted treatment outcome

Barriers

The process to identify, investigate, research, and complete an individual QOC case is lengthy.

Providers often respond slowly which requires follow up telephone calls or correspondence to obtain a complete response.

Due to the nature of Behavioral Health, many QOC complaints are unsubstantiated and Sometimes is the result of the member's symptoms.

Recommendations/Opportunities for Improvement

One clinical concern out of 10 completed was identified. This supports the assertion that the quality of clinical services provided by APS network facilities and providers is clinically sound. With the added behavioral health business that APS has implemented and will continue to implement in 2008, there is a need for additional staff resources to adequately research, investigate, and track these occurrences. The current data management tools need to be updated to streamline the organization of Quality of Care complaints, and additional resources are needed to adequately cross train the existing staff.

Quality of Service Complaints

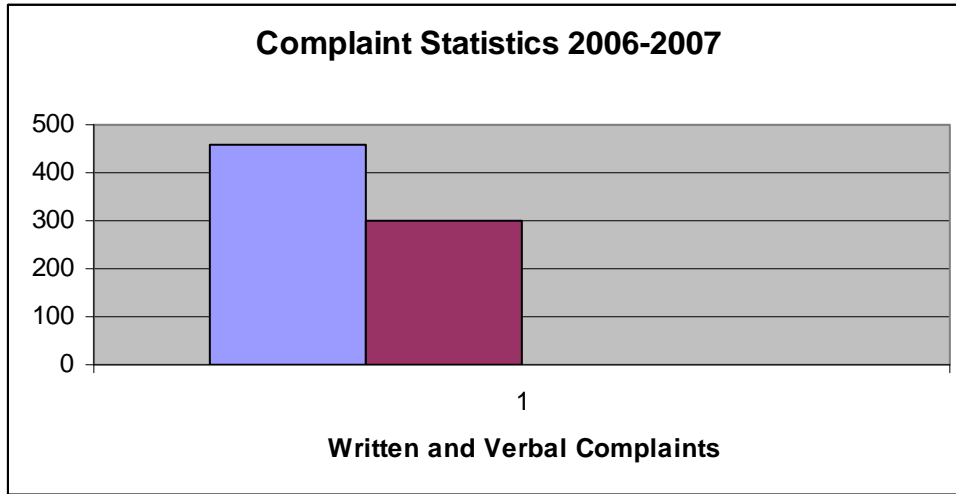
It is the policy of APS to register and respond to verbal or written complaints received from enrollees, an enrollee's representative, practitioners, providers or other interested parties. Each complaint is taken seriously and is viewed by APS as a potential opportunity for improvement.

APS follows a consistent procedure in responding to complaints, and appeals of complaint decisions.

Findings/Analysis

In 2007, all Complaints and Appeals functions merged into one unit under Behavioral Health Operations. The unit consists of 7 staff- 6 Complaints and Appeals Specialists and one Manager of Appeals and Complaints who is a Licensed RN.

Approximately 1.4 million enrollees representing 29 behavioral health client accounts were managed by the Silver Spring Maryland Corporate office in 2007, with no significant change from 2006.



The Silver Spring office received a total of 299 written and verbal complaints in 2007, a decrease from the 460 received in 2006.

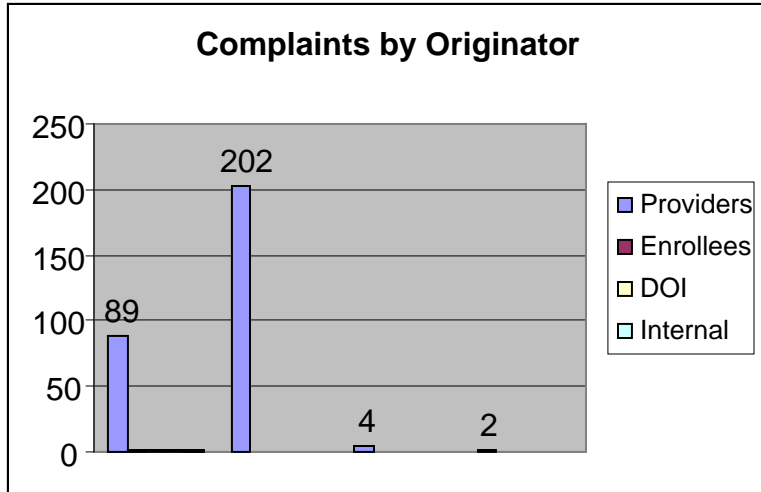
Complaints inform the organization how it is performing, how it is perceived, provides opportunities to identify issues, and to improve service levels to enrollees, practitioners, and providers.

Complaint Origination

The accounts represent four distinct product types:

- Health Plans
- Employer Plans
- State Plans
- Integrated Plans

Complaints were logged into the Facets data management systems and organized by the following categories:

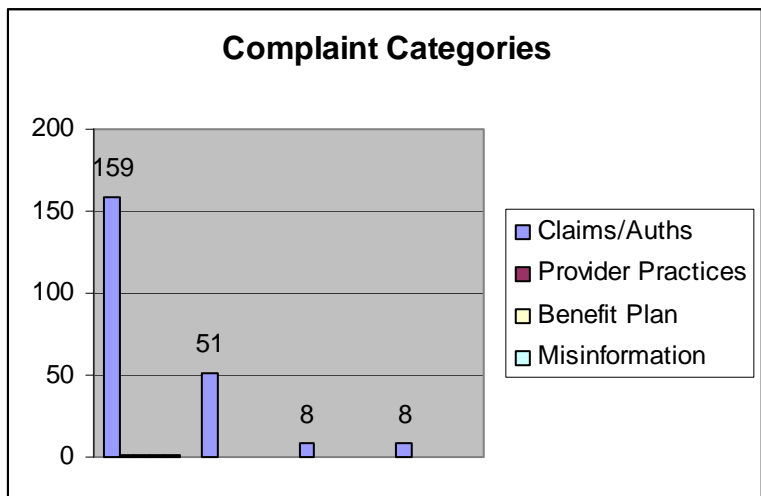


Practitioners/Providers = 89
 Enrollees = 202
 State Department of Insurance (DOI) = 4
 Internal Regarding APS = 2

DOI complaints are complaints that originate from the various state regulated departments of insurance offices. These complaints can cross clients and product lines and are handled in accordance with the various state regulations with regard to timeliness of response. DOI complaints represent a smaller percentage of complaints in 2007 compared to 2006. In 2005 2.5% of all complaints were DOI complaints, in 2007 the percentage dropped to 2%. The total number of DOI complaints has decreased from 12 in 2006 to 4 in 2007.

Complaint Trends

In 2007, the top four complaint categories include the following and totaled 226 complaints representing 75 % of total complaints:



Claims/ Authorizations– 62%
Quality of Service – 18%
Balance Billing – 11%
Provider Service – 6%

The remaining categories include HIPAA complaints, access to care, telephone wait time, credentialing, and quality of care that represented approximately 25% of the total complaints.

Areas of Greatest Frequency of Complaints – Opportunities for Improvement

Claims and Authorizations represented 53% of the total complaints in 2007, a decrease from 62% in 2006, and consist of three types of complaints:

Claims Appeals – Complaints involving claims that have been paid, however the enrollee or provider disputes the manner in which their benefits were calculated. Many of these claims involve payment of claims with special fee arrangements, out of panel referrals, and retro-authorizations. Although categorized as claim appeals, they often involve appealing the provider status, fee agreements, or authorization statuses that drive the claims payment.

Claim Denials- Complaints involving claims that have been denied. They often involve denials for failure to authorize care, services provided by an out-of-network provider when enrollee has no out- of- network benefits, claims denied for timely filing or coordination of benefits. Many of these complaints refer to the authorization process, provider network status and referral process, and process for gathering COB (Coordination of Benefits) data.

Authorization – Complaints regarding the authorization process normally drive the claims denial.

This appears to be an area of considerable opportunity, specifically in provider communications, network relations, and first call resolution.

Areas with Few or No Complaints in 2007

Telephone Responsiveness – Complaint trending in this area indicates that APS is doing well in responding to callers quickly. This category accounted for less than 1% of total complaints in 2007.

Access to Care- Complaint trending in this area indicates that APS' provider network is adequately meeting geo-access standards as complaints in this area for 2007 totaled 2%.

Confidentiality- There was 7 HIPAA related complaints in 2007, accounting for less than 3% of total complaints.

Complaint Management Timeliness for 2007

Complaint resolution is measured by the degree of enrollee or provider satisfaction. The APS complaints management policy requires that complaints are to be resolved within 30 days of receipt, unless there was a client account exception to resolve a complaint in a shorter or longer timeframe.

295 complaints were resolved within the 30-day standard in 2007. Of the complaints that were not compliant, APS responded in writing to the complainant within 30 days and requested an extension in order to complete the investigation. The percentage responded to within 30 days is 98%, a 3% increase from 2006.

Recommendations & Opportunities for Improvement

Claims and balance billing complaints continue to account for the largest percentage of complaints. The majority of these complaints result from members and providers not understanding the benefit plan or the authorization process. Continued improvement in member and provider communication and training, as well as easier access to information on the APS website, should result in fewer complaints in this area. With the added behavioral health business that APS has implemented and will continue to implement in 2008, there is a need for additional staff resources to adequately research, investigate, and track these occurrences. The current data management tools need to be updated to streamline the organization of Quality of Care complaints, and additional resources are needed to adequately cross train the existing staff.

2007 Denial & Appeal Documentation Audits

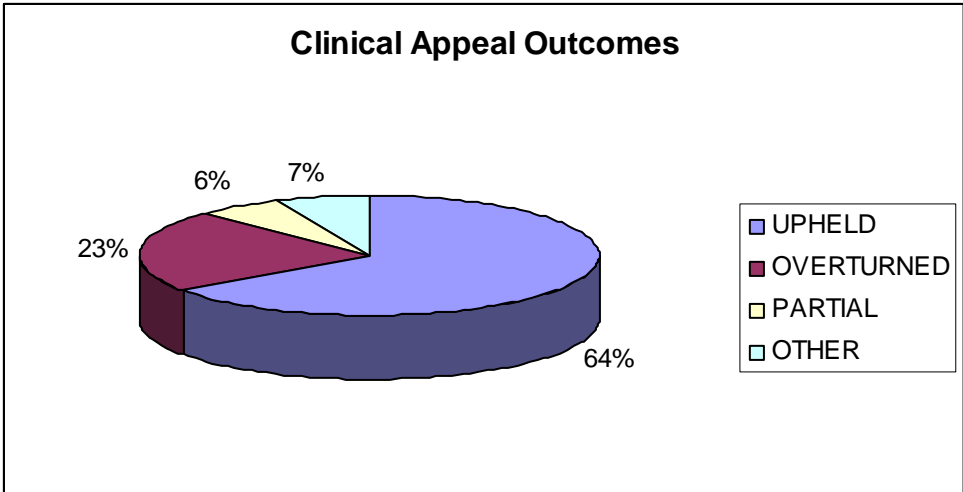
The processing of all initial administrative and medical necessity non-certification decisions made by the Utilization Management (UM) department is handled by the Appeals and Complaints Department. This office also coordinates the appeal requests generated by these decisions, and a log of these requests is maintained in this department. The numbers and disposition of these requests is recorded below.

Findings/Analysis

2007 Initial Non Certification Determinations involved enrollees from 38 different APS accounts:

- * Total: 1,869 Initial Non Certification Letters were issued.
- * 1380 Medical Necessity (74%) and 489 Administrative Non Certifications (26%)

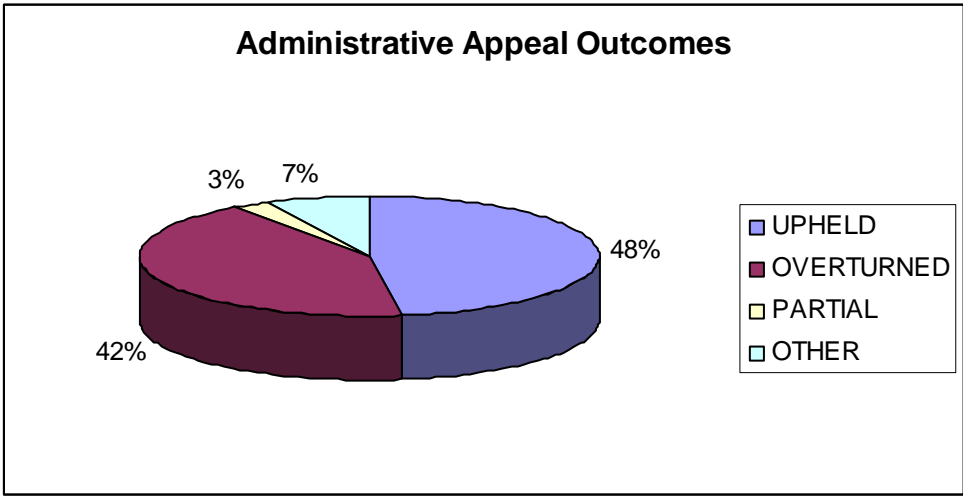
A total of 824 Clinical Appeals were received and processed in 2007



535 Upheld (65%)
 187 Overturned (23%)
 47 Partially Overturned (6%)
 55 Did Not Process for various reasons including forwarded to health plan, appeal request exceeded timeframe, or no longer servicing the client (9%)

2007 Administrative Appeal Outcomes

A total of 1,234 Administrative Appeals were received and processed in 2007. Of these;



526 were overturned
 34 were partially overturned
 90 were not processed (exceed timeframe for appeal/ or plan did not provide appeal option)
 596 were upheld

Interventions

Administrative Appeals received and processed according to industry best practices and plan benefits. Continue activity in 2008.

Barriers

Identification of correct criteria utilized in the determination and the level of care being denied

Clear, complete and concise clinical rationale must be consistently provided that is understandable to the enrollee

In some instances Physician Advisor documentation should contain more complete and detailed information regarding the reason for denial

Recommendations and Opportunities for Improvement

Consult Regional Medical Director to discuss how to best work cooperatively with UM to meet processing times, and send accurate and clinically sound decision letters. With the added behavioral health business that APS has implemented and will continue to implement in 2008, there is a need for additional staff resources to adequately research, investigate, and track these occurrences. The current data management tools need to be updated to streamline the organization of Quality of Care complaints, and additional resources are needed to adequately cross train the existing staff.

Adverse Incidents

APS defines adverse occurrences as suicides, attempted suicides, homicides, attempted homicides, and physical or sexual abuse. If an APS enrollee experiences such an occurrence, the provider is to report the incident to APS immediately. APS will supply the provider with a risk management protocol to assist the provider in an intervention. Notification to APS does not substitute for nor take precedence over state or federally mandated reporting requirements for abuse, neglect or danger to self or others.

APS tracks and trends adverse incidents for enrollees in the Behavioral Health and EAP Programs. The Corporate Medical Director for Behavioral Health and an interdisciplinary panel of board-certified physicians investigates adverse incidents/sentinel events. The protocol is to identify systems issues that contribute to poor patient safety to eliminate factors that can negatively impact an enrollee's care and/or services and put into place measures to ensure patient safety.

APS reviews quality of care complaints to identify trends that could lead to an adverse incident through a barrier analysis to study the safeguards that can prevent or mitigate future sentinel events or adverse incidents.

To further mitigate a potential sentinel or adverse event, APS conducts quality reviews between credentialing cycles when a provider has had either a serious complaint or an

over threshold number of complaints lodged against them, and/or an adverse incident has occurred that raises questions regarding quality of care.

Findings/Analysis

There were a total of two adverse events in 2007. All cases were investigated by the Corporate Medical Director for Behavioral Health. There were no trends from which to draw conclusions on what barriers existed and corresponding interventions appropriate to reduce quality of care or patient safety violations.

The APS Credentialing Committee, which investigates quality of care and adverse incidents, conducted no corrective actions on a practitioner or provider of services in 2007. While each event is tragic individually, the observed events are far less than would be expected statistically and represent no identifiable trends. There were no identified interventions that could systematically eliminate these events.

Provider/Enrollee Input (PAG)

The Provider Advisory Group (PAG) provides for structured input from external practitioners to be utilized in the development and implementation of the APS Behavioral Health QI Program. APS PAG members are drawn from a variety of APS networks where APS has health plan business. Practitioners participate via teleconference.

Findings/Analysis

The APS PAG met in April 2007 to review the following clinical issues:

- ✚ Review of Clinical Practice Guidelines
- ✚ Discuss the process for obtaining the 2007 Enrollee and Provider Satisfaction survey results being conducted by The Myers Group
- ✚ Discuss and approved the 2007 Medical Necessity & Level of Care Determination Criteria
- ✚ Review and discuss Preventive Health Initiatives for 2007/2008

External Accreditation and Certification/Regulatory Compliance

APS seeks to provide the highest quality of services to enrollees, providers, and practitioners in the service network. To assure compliance with national industry standards for the provision of behavioral health services, the Silver Spring site completed URAC Health Utilization Management (UM) Accreditation in June 2007. APS received full Accreditation from URAC for UM.

Recommendations & Opportunities for Improvement

Quality Improvement Structure

The new executive leadership's recommendation is to organize the quality improvement functions and designate it as a corporate level department with executive leadership. Under consideration is the implementation of a de-centralized model of quality improvement support services. With the recruitment of a Vice President Level Executive, the Quality Improvement department will have executive leadership and provide oversight of all related quality improvement functions, and report directly to the Corporate Medical Director.

Clinical Practice Guidelines

Continued review, revision and approval of appropriate Clinical Practice Guidelines

Preventive Health

Continue to review, revise and implement Preventative Health Programs utilizing web-based resources and evaluate potential measurement opportunities related to participation and outcomes.

Treatment Record Review

Complete review, revision and implementation of an improved methodology to complete and analyze treatment record review activities to assure a valid sample of provider records, that the instrument utilized allows for comparison between and amongst providers, and that the results are available for review internally and externally.

Treatment Access (Urgent, Emergent, and Routine)

Continue monitoring methodology for treatment access measurement and maintain status of results above the 95% in all categories.

Key Telephone Performance Indicators

Continue to monitor and track the average speed of answering times and abandonment rates, maintain within identified standards, and report this data on a periodic basis to identify any potential opportunities for improvement.

Monitoring of Geographic Availability

Continue to monitor this measurement through satisfaction survey responses. Maintain satisfaction levels above the performance goal established.

Access and Availability of Behavioral Health Services (GEO and Density)

Two continuing opportunities for improvement were identified including:

- Partial Hospitalization; and
- Intensive Outpatient Facilities.

Continuing identification and recruitment activities were conducted in 2007 with marked improvement, although measurements continued to indicate levels below the related performance goals. Such interventions will continue in 2008 to increase and reach the performance goal for these specific levels of care.

Service Quality Improvement Activities (QIAs)

Continue to monitor the number of accurately completed documentation of denial determinations and the appropriateness of the related language.

Complaints Analysis: Quality of Care and Quality of Service

Claims and balance billing complaints continued in 2007 to account for the largest percentage of complaints. The majority of these complaints result from members and providers not understanding the benefit plan or the authorization process. The results indicate that the following potential opportunities for improvement:

- Provider and Member training specifically including information related to benefit plan and authorization processes;
- Improved ease of access for providers and members to the APS website;
- Evaluation of resources dedicated to complaint processing; and
- Evaluation and possible improvement of related data management tools.

2007 Denial & Appeal Documentation Audits

This measurement indicated the potential for two potential opportunities for improvement involved consultation with related UM Medical Directors and Physician Advisors to:

- Increase compliance with processing time requirements; and
- Improve the accuracy and wording provided in UM decision determination correspondence.

Adverse Incidents

Review of the two adverse incidents reported and investigated in 2007 indicated that there were no identified interventions that could have systematically eliminated these events. No opportunities for improvement were identified.

Provider/Enrollee Input (PAG)

Continue to involve multiple, diverse participating providers at each of the related licensure levels in the Provider Advisory Group to provide input related to clinical and administrative processes, clinical criteria, satisfaction measurement, and other areas as appropriate.

External Accreditation and Certification/Regulatory Compliance

Continue compliance with national, state and local industry standards for the provision of behavioral health services, as evidenced by continued full accreditation through URAC for UM.