



Quality Management Program Description 2018

Adapted for the
Federal Employee Health Benefits Program (FEHBP)
Fee-for-Service (FFS)

Approved
4/26/2018

Last Revised
4/23/2018

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I. Introduction

The Aetna FEHBP FFS Quality Management (QM) Program focus is the ongoing assessment and improvement of clinical care, service, and safety. Among the benefits derived from the implementation and maintenance of a quality management program are:

- The impetus to work toward continuous quality improvement (CQI) as a means to conduct business;
- A framework by which to monitor and strengthen all functional processes of the organization;
- The measurement of performance in service and quality of care;
- An emphasis on team work and a multi-departmental approach to quality improvement; and
- The provision to the health plan of comparative information (internal and external).

II. Quality Strategy Statement

The quality strategy is to provide value by facilitating more effective member-plan-provider relationships to promote desired health outcomes. The strategy is consistent with the core set of principles of the U.S. Department of Health and Human Services (HHS) National Quality Strategy. Our strategy includes:

- Promoting better health and health care delivery focusing on engagement;
- Attending to health needs of all members;
- Eliminating disparities in care;
- Aligning public/private sectors;
- Supporting innovation, evaluation and rapid-cycle learning and dissemination of evidence;
- Utilizing consistent national standards and measures;
- Focusing on primary care and coordinating and integrating care across the health care system and community; and
- Providing clear information so constituents can make informed decisions.

The distinguishing factor in our strategy is our view towards quality itself. Quality management is not an isolated departmental function. Quality activities and metrics are integrated and coordinated across different functional areas to ensure consistency with nationally recognized metrics. Insert information about shared services for our plan.

We are committed to Health Plan and Managed Behavioral Healthcare Organization (MBHO) accreditation by the National Committee for Quality Assurance (NCQA) as one means of demonstrating a commitment to continuous quality improvement (CQI) and meeting customer expectations. Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) reports are produced annually and submitted to NCQA for public reporting and accountability. HEDIS is audited in accordance with NCQA specifications by NCQA-Certified HEDIS auditors. CAHPS is executed by approved survey vendors according to published technical specifications.

Our clinical programs and initiatives are designed to enhance the quality of care delivered to our members and to better inform members through reliance on clinical data and industry accepted, evidence-based guidelines. We are committed to supporting transparency by providing participating practitioners and members with credible clinical information and tools to make informed decisions.

III. Quality Management Process

The organization utilizes CQI techniques and tools to improve the quality and safety of clinical care and service delivered to members. This includes systematic and periodic follow-up on the effect of interventions which allows for correction of problems identified through internal surveillance, analysis of complaints or other mechanisms. Quality improvement is implemented through a cross functional team approach, as evidenced by multidisciplinary committees. Quality reports are used to monitor, communicate and compare key indicators.

Finally, we develop relationships with various professional entities and provider organizations that may provide feedback regarding structure and implementation of QM program activities or work collaboratively on quality improvement projects.

IV. Quality Management Program Goals

QM Program goals include the following:

- To promote the principles and spirit of CQI.
- To operate the QM program in compliance with and responsive to applicable requirements of plan sponsors, federal and state regulators, and appropriate accrediting bodies.
- To address racial and ethnic disparities in health care that could negatively impact quality health care.
- To institute initiatives to improve the safety of members and our communities and to foster communications about the programs.
- To implement a standardized and comprehensive QM program that addresses and is responsive to the health needs of our population including, but not limited to, serving members with complex health needs across the continuum of care.
- To increase the knowledge/skill base of staff and contracted providers, to facilitate communication, collaboration, and integration among key functional areas relative to implementing a sound and effective QM program.
- To measure and monitor previously identified issues, evaluate the QM program, and to improve performance in key aspects of quality and safety of clinical care, including behavioral health (BH), quality of service for members, customers, and participating practitioners/providers.
- To maintain effective, efficient and comprehensive practitioner/provider selection and retention processes through credentialing and re-credentialing activities.
- To ensure collaboration with behavioral healthcare networks to improve continuity and coordination of care between behavioral health specialists and primary care practitioners.

- To encourage the development and use of services and activities that support public health goals.

A. Regulatory Compliance

The QM Program is designed to comply with all applicable state and federal laws, and with the Office of Personnel Management (OPM) requirements. The QM department, in collaboration with FEHBP Compliance department and the Business Integrity Unit, monitor federal laws and regulations specific to quality. QM and business units are accountable for implementation of actions needed to assure compliance.

Aetna FEHBP does not discriminate based on a person's race, color, mental or physical disability, religion, gender, gender identity or gender expression, sex, sexual orientation, health status, ethnicity, creed, age, claims experience, medical history, genetic information, evidence of insurability, geographic location within the service area or national origin.

Federal law mandates that Aetna/FEHB FFS comply with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, the Genetic Information Nondiscrimination Act of 2008, 45 CFR Part 92 which implements Section 1557 of the Affordable Care Act and other laws applicable to recipients of federal funds and all other applicable laws and rules.

B. Racial and Ethnic Disparities in Health Care

Studies show that racial and ethnic minorities in the United States tend to receive a lower quality of health care than non-minorities, even when factors like having health insurance and income levels are comparable. Such disparities in health care have clear consequences on the health and longevity of America's growing minority populations.

We believe that health plans have an important role to play in raising awareness of health care disparities and decreasing the related and persistent gaps that exist in our health care delivery system today. For more than ten years, Aetna has been identifying and addressing racial and ethnic disparities in health care. Our goal is to improve access to quality health care services for all of our members regardless of race or ethnicity.

Aetna takes an aggressive approach to addressing health care disparities through a coordinated, multi-dimensional program comprised of a variety of research, education, customer service, data collection, and general awareness initiatives. We have designed and implemented programs which have been successful in improving clinical and quality outcomes for minority members.

Data collection:

Experts agree that one of the most important tasks a health insurer can implement to reduce health care disparities, is to know the race and ethnicity of each member. Evidence shows that different racial and ethnic groups are at higher risk for certain diseases and conditions. This information helps us create more culturally focused disease management and wellness programs. It also allows us to identify disparities and pilot new approaches to reduce disparities.

To monitor cultural and linguistic needs and to ensure processes are in place to serve a diverse membership, both analyses are used to identify overall population needs. Individual member needs are addressed through various resources, such as the language translation line and letter translation. Cultural needs are addressed through practitioner assistance.

In addition, we collect information from providers regarding additional languages spoken. This data helps us analyze the diversity of network physicians in relation to member preferences and needs.

We provide many services to assist members who have limited English proficiency including:

- Provider directories and website listings detail the language(s) spoken by each provider. Customer service representatives can also assist members in finding a physician that speaks his or her language.
- Aetna has developed a companywide Language Access Plan to support limited English proficient members.
- Members interacting with Aetna can self-identify at any point to request language assistance services.
- Our language line translation service includes over 200 different languages, American Sign Language, Braille and Large Print.
- Written communication with our members and prospective members in their language with messages that are meaningful and relevant.
- A strategy to implement on-line multilingual consumer experience on key tools.
- All clinical services staff receives training in services required for compliance with the requirements of the Affordable Care Act, Section 1557, for limited English proficient members.

C. Patient Safety and Risk Management

Patient/member safety is an important component of the QM Program. Our commitment to improving the quality of care and service delivered to members by practitioners and providers is demonstrated by identifying potential safety problems within the American healthcare system and developing processes to help reduce them. Ongoing activities include efforts to educate members, employees, and physicians/providers about our patient safety efforts and to provide information that can help constituents make informed health choices. The Aetna FEHBP FFS Risk Management Committee investigates tracks, analyzes and takes action on adverse incidents or complaints filed against the organization. Numerous policies and procedures are in place to ensure that facilities of contracted providers (e.g., hospitals, provider offices and clinics, skilled nursing facilities, etc.) meet basic requirements to meet the health care needs of our members. Coordination between various support areas such as Legal, Customer Service, Account Management, Special Investigations Unit and Networks are in place to ensure consistent application of risk management procedures, as well as ongoing staff training to ensure that the most current practices are applied.

Activities in place to ensure and/or monitor aspects of patient safety include, but are not limited to:

- Verify practitioner credentials in accordance with NCQA, URAC, State and federal guidelines.
- Monitor disciplinary actions against physicians on an ongoing basis.
- Identify, investigate and monitor potential adverse events referred from any part of the health care delivery system including all staff, members, and practitioners, Quality Improvement Organizations (QIO) and/or External Quality Review Organizations (EQRO).
- Pharmacy Benefit Manager uses a drug utilization review (DUR) program in conjunction with retail pharmacy computer systems, to alert pharmacies of potential drug to drug interactions and adverse effects at the point of dispensing.

D. Members with Complex Health Needs

Our approach to managing members with complex and special health needs is described within the care management programs. The program supports the objectives aimed at the development, monitoring, and servicing of members with complex and special health needs, such as physical or developmental disabilities, socioeconomically challenges, comorbid conditions, multiple chronic conditions and mental health conditions through the following:

- Annual population assessments to identify population and relevant sub-populations can be effectively utilized to enhance member care needs and satisfaction through evaluation of the care management processes and resources.
- A case management program that identifies members for whom intensive management goals include improving the quality of care and assisting individuals to reach the optimum level of wellness and/or palliative comfort.

- Promotion of preventive health services and the management of chronic diseases through an integrated case management and disease management approach (e.g., In Touch Care Premier) that encourage the use of services to decrease future morbidity and mortality in health plan members.

V. Quality Management Program Scope

The scope and content of the QM Program are designed to continuously monitor, evaluate and improve the quality and safety of clinical care and service provided to members.

Specifically, the QM Program includes, but is not limited to:

- Review and evaluation of preventive and behavioral health services; ambulatory, inpatient, primary and specialty care; high volume and high-risk services; and continuity and coordination of care;
- Development of written policies and procedures reflecting current standards of clinical practice;
- Development, implementation and monitoring of patient safety initiatives, risk management and preventive and clinical practice guidelines;
- Monitoring of medical and behavioral health care management programs;
- Achievement and maintenance of regulatory and accreditation compliance;
- Evaluation of accessibility and availability of network providers;
- Evaluation of network adequacy;
- Establishing standards for, and auditing of medical and behavioral health record documentation;
- Monitoring for over and underutilization of services
- Performing credentialing and re-credentialing activities;
- Oversight of delegated activities;
- Evaluation of member experience and practitioner satisfaction;
- Supporting initiatives to address racial and ethnic disparities in health care;
- Following these guidelines in the development of provider performance programs: standardization and sound methodology; transparency; collaboration; and taking action on quality and cost, or quality only, but never cost data alone except in unique situations where there are not standardized measures of quality and/or there is insufficient data.
- Develop, maintain and review a complaint and appeals process that covers the submission of complaints and appeals, and includes guidelines for prompt review and response.
- Ensure proper and sufficient interconnection between departments with regard to quality improvement activities.
- Assure that the focus of quality and improvement evaluation includes a review of structure, process and outcomes of care.

External practitioners provide input into the QM program through review and feedback on quality improvement studies and surveys, clinical indicators, member and practitioner/provider initiatives, practitioner/provider communications, the QM Program Description and the QM Work Plan.

A variety of mechanisms are used to encourage providers to participate in OPM and Health & Human Services (HHS) QI initiatives. These activities are promoted through several mechanisms including but not limited to: provider contract provisions, the provider manual and provider

newsletters.

VI. Quality Management Calendar and Cycle

Quality improvement activities that support the goals and objectives of the QM program are coordinated on an annual, quarterly, and as needed basis. The QM program cycle is based on the calendar year. Quality improvement activities are evaluated continuously and adjusted to meet set goals as needed.

VII. QM Work Plan

The QM Work Plan is a schedule of planned activities throughout the calendar year. The QM Work Plan, for the most part, is developed from recommendations from the annual QM Program Evaluation and/or other program requirements. The QM Work Plan activities detail the scope of the QM Program and address the needs of the members, as reflected in our data (i.e. member experience, demographics and epidemiological data). Areas of significant focus include partially resolved and unresolved activities from the prior year. These activities include clinical and service improvement activities that have the greatest potential impact on quality of care, service and patient safety.

At a minimum, the QM Work Plan includes a clear description of the monitoring and improvement activities, the specific timeframes and the parties responsible for conducting the activities. Activities and outcomes are compared to predetermined goals, where applicable. The QM Work Plan is reviewed at least annually and is a dynamic document; therefore, improvement activities identified during the year, and other changes, are incorporated as needed.

VIII. QM Program Evaluation

An evaluation of the QM Program will be completed at least annually to determine the following and is not limited to:

- Review of structure and functions to evaluate the adequacy of resources, committee structure, practitioner participation, leadership involvement and determine whether to restructure or change the QM program for the following year based on its annual evaluation findings.
- Assess the effectiveness of the QM Program and determine the progress of meeting its goals as well as establish revised/new goals and objectives for the following year.
- Assess the appropriateness of care delivered to members.
- Assess the overall effectiveness of the QM Program and its activities that address network wide quality and patient safety practices implemented during the year through analyzing outcome data, trending of measures and identifying quantifiable improvements within the designated care and service activities.
- Identify limitations, root causes, barrier analyses and make recommendations for the upcoming year including the evaluation of activities that will carry over into the next year.
- Assess compliance with state and federal/OPM regulatory requirements, and accrediting entities.

IX. Quality Management Program Resources

We have dedicated computer/data and human resources at the national, regional, and local levels sufficient to meet QM objectives and complete annual and on-going activities. National Quality Management (NQM) and behavioral health QM staff work in close partnership with the FEHBP FFS Quality Management (FEHBFFS QM) department to coordinate completion of required activities. Behavioral Health Quality Management (BH QM) is responsible for the BH QM program infrastructure and BH QM improvement initiatives. The BH QM Department works very closely with NQM and FEHBFFS QM to ensure consistency and coordination.

FEHBFFS QM, like NQM, is part of the Network and Clinical Services (N&CS) organization within Aetna. FEHBFFS QM is a shared team of analysts, nurse consultants, and medical directors who support three self-insured FEHB health plans: MHBP, Foreign Service Benefit Plan and Rural Carrier Benefit Plan.

FEHBFFS QM works collaboratively with National Quality Management and Behavioral Health QM to accomplish quality improvement goals specific to self-insured FEHB health plans and goals aligned with national quality management objectives.

The FEHBP FFS Medical Director is responsible for supporting provider performance measurement activities, the clinical logic for the data warehouse clinical applications, and the activities of the clinical support team for Health Plan and Behavioral Health, respectively. The clinical support team provides key clinical and technical support in building and maintaining unique tools using the data warehouse. The data warehouse serves as the central repository for member and provider data. The data warehouse includes, but is not limited to, medical claims, encounters, pharmacy claims, behavioral health encounters/claims; lab encounters and results; as well as encounters and claims from delegated vendors.

The data is aligned and integrated into key performance measures that are evaluated and communicated for tracking operations and performance. The key performance measures include, but not limited to:

- Utilization and Quality improvement initiatives
- Credentialing activities
- Member Rights, Responsibilities, Safety and Customer experience
- Accreditation and Compliance
- Internal processes
- Provider Relations and Network Operations

Performance and capabilities are routinely reviewed and compared to baseline and national standards or benchmarks, where applicable, to project future performance and develop priorities for continuous improvement and innovation.

Network and Clinical Services (N&CS) and Behavioral Health are closely linked to the Office of the Chief Medical Officer (OCMO) for the development and implementation of all clinical policy decisions. This provides for direct oversight of a broad range of areas that guide and support clinical policy.

National Clinical Services (NCS) is responsible for all member-facing clinical program design, development and delivery functions. N&CS, NCS, the BH Chief Medical Officer/BH Corporate Medical Director and the OCMO all work closely together to ensure alignment and execution of shared strategic goals.

Medical Directors, QM, and other medical and professional staff from across the organization monitor, facilitate, and support the QM program and initiatives focused on improving quality of care and service. NQM and BH staffs work collaboratively with other functional areas to implement QM program activities. This includes facilitating quality improvement efforts through clinical improvement workgroups, development of QM tools and templates and the development of national service and clinical indicators. NQM coordinates development and review of national QM policies with input from NQM, BH QM and other departmental representatives as needed. They provide support and monitor activities for consistent implementation of processes impacting QM program goals and provide support relative to accreditation strategies. NQM coordinates administration of the Physician Practice Site Survey and CAHPS. Review of survey results, analysis and the development of improvement plans are conducted by the NQM staff. BH conducts its own annual behavioral health experience survey and analysis.

FEHBFFS QM, NQM and behavioral health QM staffs are involved in the implementation of the QM Program. Staff members work collaboratively to ensure that QM program goals are met. Joint participation in regularly scheduled workgroups and the Behavioral Health quality oversight committees results in the sharing of information and is a critical component of this collaborative integrated strategy.

Aetna Medical Directors have a central role in implementation of the QM Program. In addition to their responsibilities regarding communications with participating practitioners and providers, they also facilitate and/or are active participants on, including but not limited to, the NQOC, NQAC, Behavioral Health quality committees, Behavioral Health Quality Advisory Committee (BHQAC), Credentialing and Performance Committee (CPC), Practitioner Appeals Committee (PAC) and National Vendor Delegate Oversight Committee (NVDOC) meetings.

Collaboration occurs across functional areas to ensure the ongoing assessment and improvement of clinical care and service provided to members. Other functional areas including, but not limited to the following, support the QM Program at all levels:

- Network and Provider Services
- Utilization, Case and Disease Management
- National Medical Policy and Operations
- Complaints, Grievances and Appeals
- Member Communications
- Customer Service
- Pharmacy
- Compliance
- Legal

- Information Technology

The QM Program is supported by the following national committees, national work groups, and regional committees.

X. Accountability and Committee Structure

A. FEHB FFS Quality Management Committee (FEHB FFS QMC)

The Senior Medical Director has assigned responsibility for overseeing quality management, medical management, utilization management, peer review and any delegated functions to the FEHB FFS QMC. The QMC evaluates the results of quality improvement activities, utilization results, and outcomes and takes actions. The QMC has distinct goals and objectives to accomplish its primary function of oversight of the medical and operational systems as they affect care provided by contracted providers to members. The QMC oversees the development, implementation, and effectiveness of the Quality Management, Utilization Management, Case Management, and Disease Management programs and is accountable to the Senior Medical Director.

The FEHB FFS QMC is responsible for:

1. Ensuring that quality accessible medical care is available in a satisfying and medically appropriate manner.
2. Conducting and integrating quality improvement and continuous quality improvement activities.
3. Initiating, monitoring, and approving studies, establishing baselines, outcomes, goals, comparison of performance to goals, and evaluations.
4. Reviewing findings, conclusions, and recommendations of all quality improvement activities and studies.
5. Recommending policy or system changes and/or corrective action, re-evaluating as needed based on findings or outcomes from quality improvement activities.
6. Taking appropriate action to solve problems and improve the clinical care and administrative services provided to members.

a. Functions

As they relate to quality improvement activities, the functions of the QMC are, as follows:

1. Monitor and oversee the QM Program that is implemented by the Quality Management Department and staff of CHCNA.
2. Review and approve the programs, and policies and procedures, of the National Accounts Federal Employee Health Benefits Programs, Quality Management, Credentialing, and Health Services Departments on an annual basis.
3. Review and approve the annual QM Program Description, QM Program Evaluation, Quality Management Work Plan, and the Care Management Program Descriptions
4. Monitor and evaluate the operation and activities of the Credentials Committee.
5. Review and approve relevant standards of practice, quality indicators, and explicit criteria used in the performance of the QM.

6. Recommend improvements to the QM Program.
7. Review and monitor potential and actual quality issues, focused review studies and findings, trends either on an individual or plan/client basis.
8. Approve and monitor the implementation and effectiveness of corrective action plans and revise the plans as needed.
9. Review aggregate reports to identify trends or effects of our policies.
10. Review and approve clinical and behavioral health practice guidelines
11. Review and approve clinical audit criteria, including clinical guideline audits and/or other special focus studies.
12. Annual review and approval of utilization management review criteria and scripted guidelines.
13. Review areas/incidences of over or under utilization of health care services.
14. Monitor performance of delegated vendors, as appropriate.

b. Data Sources

Agendas are distributed to each member prior to each scheduled meeting for review and identification of possible trends, areas of concern, or problems. Areas of reporting include but are not limited to:

- Sub-committee reports
- Complaints
- Member satisfaction surveys (e.g., CAHPS®, UM/CM/DM Program surveys, etc.)
- Credentialing reports
- Medical record studies and monitoring activities
- Client feedback through regularly scheduled meetings
- Utilization Management reports (e.g., HEDIS, Population Health Management, etc.)
- Disease Management reports
- Case Management reports
- Appeals
- Contracted Provider profiles
- CSO Quality and Service Indicators including the Disease Management Call Center
- Accreditation

The Quality Management Program measures performance, both baseline and re-measurement at least annually using reports including but not limited to the QMC Key Indicator Report, Disease Management Reports, and the results of surveys of member and client satisfaction.

c. Frequency of Meetings

The QMC meets quarterly, with at least one meeting occurring each quarter and may meet more frequently as needed. Minutes (approved) are taken.

d. Committee Composition

Membership may include, but is not limited to:

- Senior Medical Director (Chairperson)
- Medical Directors (including Behavioral Health)
- In-Network Provider Representation (1 primary care, 1 behavioral health)
- Health Services Directors/Managers
- Sales and Marketing Representative(s)
- Network Management Representative(s)
- Pharmacy Representatives as applicable
- Customer Service Representatives
- Legal/Compliance Department Representative
- QM Manager

B. Risk Management Committee (RMC)

a. Scope and Authority and Responsibility

The Senior Medical Director has assigned responsibility for overseeing risk management functions to the RMC. The RMC has distinct goals and objectives to accomplish its primary function of oversight of risk management activities that include but not limited to:

1. Consistent application of the risk management program throughout the organization, including all supporting departments and service locations.
2. Periodic review of all litigation involving the organization, its staff and employed health care professionals.
3. Reporting, reviewing, and analysis of all incidents reported by staff, members, health care professionals, and others that may include all deaths, trauma, or other adverse incidents.
4. Review of member complaints
5. Handling of impaired health care professionals.
6. Methods for prevention of unauthorized prescribing or by which a member may be dismissed from care or refused care.
7. Monitoring of health care fraud, waste and abuse.
8. Processes for routine clinical records audits that include risk management review principles.
9. Establishment and documentation of coverage after normal working hours.

b. Functions

As they relate to risk management activities, the functions of the RMC are, as follows:

1. Review and monitor potential and actual quality of care issues.
2. Review of analysis and evaluation of member or provider complaints.
3. Review of analysis of clinical audit results to understand the differences in care provided and outcomes achieved.
4. Serve as a resource to organizational staff on risk management issues and questions.
5. Coordinate, plan and implement educational programs to minimize the risk of harm to health plan members.

6. Train all health plan staff on critical aspects of the risk management program with 30 days of initial employment, and annually thereafter.

c. Data Sources

Agendas are distributed to each member prior to each scheduled meeting for review and identification of possible trends, areas of concern, or problems. Areas of reporting include but are not limited to:

- Complaints filed with Customer Service or the QM department
- Member satisfaction surveys (e.g., CAHPS®, UM/CM/DM Program surveys, etc.)
- Medical record studies and monitoring activities
- Client feedback through regularly scheduled meetings
- Utilization Management reports (e.g., HEDIS, Population Health Management, etc.)

d. Frequency of Meetings

The RMC meets quarterly at minimum, and may meet more frequently as needed. Minutes (approved) are taken and reported to the QMC on a quarterly basis.

e. Committee Composition

Membership may include, but is not limited to:

- QM Manager (Chair)
- Medical Directors
- Health Services Directors/Managers
- Sales and Marketing Representative(s)
- Network Management Representative(s)
- Customer Service Representatives
- Legal/Compliance Department Representative
- Special Investigations Unit (SIU) Representative
- Pharmacy Representatives as applicable

C. Aetna National Quality Committees

National Quality Oversight Committee (NQOC)

The NQOC facilitates the sharing of corporate QM best practices for accreditation, survey management and other areas as appropriate. Delegated responsibility includes but is not limited to development, implementation and evaluation of the national/corporate QM Program. CHCNA participates and reports its own QM program and evaluations up to the NQOC at least annually.

National Quality Advisory Committee (NQAC)

The NQAC activities include but are not limited to the following:

- Provide input into the QM program through review and feedback on quality improvement studies and surveys, clinical indicators, member and practitioner/provider initiatives, practitioner/provider communications, etc.
- Review of clinical criteria such as, UM Criteria, and Medical Clinical Policy Bulletins and protocols for adoption by the NQOC.
- Make recommendations to the NGC (National Guideline Committee) regarding medical clinical practice and preventive services guidelines.

The NQAC meets at least five times a year and membership includes the following:

- HCM Medical Director, Facilitator
- A behavioral health practitioner
- Representatives from a range of participating practitioners in specialties that include primary care and high volume specialists.

Credentialing and Performance Committee (CPC)

The CPC makes determinations for those applicants being considered for exceptions to Aetna's established requirements for professional competence and conduct. The committee conducts professional review activities involving the professional competence or conduct of practitioners whose conduct adversely affects, or could adversely affect the health or welfare of members for the purpose of evaluating continued participation in the Aetna network. The CPC meets at least every 45 days and membership includes a Medical Director, Facilitator, representatives from a range of participating practitioners in specialties that include primary care and high volume specialists.

National Vendor Delegate Oversight Committee (NVDOC)

The NVDOC has oversight of the following:

- Delegation and Vendor policies, procedures and processes;
- Review and approval of Delegated Credentialing, Claims, Customer Service, Medical Management Programs (i.e. UM, CM and DM) and Access, Availability and Member Experience which includes approval of Delegate's program descriptions;
- Review of Delegates related to General Controls, Finance and Network Management as appropriate;
- Review of oversight activities required by CMS but not limited to Fraud Waste and Abuse (FWA), Business Conduct and Integrity (BCI)/Code of Conduct (COC), or other regulators.

XI. Quality Management Program Components

A. Practitioner/Provider Selection and Retention

FEHBP FFS utilizes the Aetna POS II network. Aetna has established a standardized approach to the selection, credentialing and retention of participating practitioners and providers. Practitioner and provider selection is guided by Aetna's participation criteria. The participation criteria include business criteria, and professional, competence and conduct criteria.

Credentialing/Recredentialing

The credentialing/recredentialing process is designed to evaluate the qualifications of practitioners who participate in the network. Credentialing is conducted prior to participation and is repeated on a periodic three year basis.

The process is designed to assess the practitioner's ability to deliver quality care and service to members. Aetna credentials practitioners when an independent relationship exists with:

- Practitioners (whether or not they are facility-based) who provide care to members as a result of participating practitioners making a direct referral to the practitioner;
- Practitioners who provide care outside of the inpatient or out-patient hospital setting or freestanding facilities;
- Practitioners who are facility-based, but who are providing care as primary care physicians to Aetna members;
- Practitioners who are facility-based, but also provide consultation in an office-based practice outside the hospital;
- Telemedicine practitioners who provide treatment services under the medical/behavioral healthcare benefits;
- Dentists who provide care under the organization's medical benefits;

The credentialing/recredentialing process includes primary source verification consistent with NCQA, URAC and CMS standards, as well as, Aetna national credentialing requirements. Primary source verification is performed by Aetna's Credentialing Department, a NCQA certified and URAC accredited CVO.

Medical Directors or their physician designees have authority to make determinations of practitioner compliance with business requirements, along with exceptions to requirements for education, unrestricted Drug Enforcement Administration (DEA) certification or state mandated controlled drug certification, and compliance with unrestricted hospital privileges.

The CPC has authority for making final determinations for those applicants being considered for exceptions to Aetna's established requirements for professional competence and conduct. The committee conducts peer review during the credentialing process, as it reviews the credentials of individual practitioners and makes credentialing decisions. A separate appeal process is available to practitioners through the ad hoc PAC.

Aetna Medical Director credentialing is conducted in accordance with QM Policy 70 Medical Director Credentialing, Recredentialing and Peer Review Policy.

Delegated practitioners must meet the credentialing requirements of Aetna, the Health Plan, NCQA and CMS. Oversight of delegated credentialing is the responsibility of the NQOC. The NQOC delegates approval of oversight of delegated activities to the National Vendor Delegation Oversight Committee (NVDOC).

Ongoing Monitoring

Practitioner ongoing monitoring includes a continuous process of identifying sanctions, complaints and quality issues between recredentialing cycles so appropriate action can be taken for instances of poor quality. Monitoring includes:

- Office of Inspector General (OIG) Sanction Lists and *the Government-wide List of Parties Excluded from Federal Procurement and Non-procurement Programs* (i.e., the OPM Debarment Reports) and state board sanction lists are reviewed according to regulatory and accreditation requirements.
- Concerns of potential quality of care (PQOC) are reviewed by QM Staff and appropriate issues are forwarded to the Medical Director and when appropriate to the CPC. PQOC issues identified for peer review trigger an off cycle event and include the practitioner's trended history. Actions may be taken if issues or trends of poor quality are identified or if there are other issues of Professional Competence and Conduct that adversely affects or could adversely affect the health or welfare of a member if the practitioner continues to participate in the Aetna network.
- Office site visits are made to network practitioners if a member complaint is received regarding physical accessibility, physical appearance, or adequacy of waiting and exam room space related to the settings in which member care is delivered. Reviews triggered by a complaint, consist of a structured, documented visit to a practitioner's office to determine compliance with selected Aetna Business Participation Criteria, physical appearance, physical accessibility including handicapped access, adequacy of waiting and examining room space, and Aetna medical record keeping practice policies.

Facility Assessments

Aetna staff assesses the following categories of contracted facilities: hospitals, nursing homes, skilled nursing facilities, home care agencies, free standing surgical centers (including free standing abortion centers), as well as, behavioral health facilities including mental health and chemical dependency hospitals, residential treatment facilities and ambulatory settings including, Partial Hospital Programs (PHP), intensive outpatient programs (IOP) crisis stabilization centers and clinics and community mental health centers. BH organizations can be freestanding or hospital-based.

Prior to participation in the network, and every three years thereafter, Aetna evaluates whether the organization:

- Has a current, unencumbered license, certification or certificate of occupancy from the state in which the organizational provider is located, and
- Is in good standing with Medicare and Medicaid, as appropriate, i.e., the organizational provider is not on the Office of Inspector General (OIG) sanctions or Office of Personnel Management (OPM) debarment reports, and
- Has advance directive policies when appropriate, and
- Is currently accredited or certified in all its service locations where services are provided to Aetna members by at least one of the Aetna recognized accrediting agencies.

In instances where a facility is not accredited or certified by an Aetna-recognized

accrediting agency, an on-site quality assessment is required. Aetna will accept a compliant CMS or State survey (no more than three years old) in lieu of accreditation. A non-compliant CMS or State survey must be reviewed by the NQOC for a credentialing determination. The NQOC reviews all facility and vendor potential quality of care concerns that involve events on the Further Investigation Grid, involve immediate suspension, or are referred by the Medical Director.

Potential Quality of Care Concerns Management

In addition to the systematic monitoring and management of clinical care and service activities applicable to a large portion of the membership, we evaluate potential quality of care concerns. All staff is responsible and accountable for the identification and communication of potential quality of care concerns to the appropriate QM staff or in the case of Behavioral Health, to the appropriate BH QM staff. Potential quality of care concerns may also be identified by external sources, through mail, e-mail or verbal communication (complaints) including: members, practitioners, providers, Quality Improvement Organizations (QIO) or External Quality Review Organizations (EQRO). QM staff is responsible for initiating an investigation that includes an evaluation of the factual clinical information surrounding the event and the facilitation of review and follow-up action, if indicated by their assigned Medical Director reviewer and/or appropriate committee.

Delegation Oversight and Management

As part of the QM Program, a comprehensive set of policies and procedures manage the oversight and delegation of responsibility for any program function that may be delegated or conducted by a First Tier, Downstream or Related Entity (FDR) as defined by CMS. Prior to making a decision to delegate, Aetna FEHBP FFS assesses:

- The business need for delegation;
- The cost/benefit and the delegate's readiness to assume the delegation (includes financial integrity, management expertise, and Information Technology (IT))

- capabilities of the delegate); and
- The potential impact on clinical care and service to members.

An oversight or delegation pre-assessment questionnaire is used in the decision-making process. FEHBP FFS's oversight/delegation process includes a review of the prospective organization's program for adherence to health plan, OPM, and NCQA standards.

The NVDOC is responsible for the approval and ongoing oversight and delegated activities, except for the variances as noted in the state amendment. Relevant documentation is reviewed by the appropriate staff prior to an assessment. The assessment of the prospective FDR or delegate's program is evaluated and documented using standardized Aetna's audit tools.

The completed report serves as documentation of the strengths and opportunities for improvement of the prospective FDR or delegate's program, and is utilized by the NVDOC for approval of oversight or delegated relationships. An assessment of each FDR or delegated entity is performed at least annually with results reported to the NVDOC. In addition to the annual assessment, there is ongoing monitoring and oversight through review and analysis of periodic reporting.

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

When a FDR or delegated entity in turn contracts with another entity (that is not a wholly owned or a sister organization to the contracted entity) to perform a delegated function, it is considered sub-delegation and requires oversight on the part of Aetna, as well as, reports of oversight from the contracted entity. Sub-delegated arrangements must be approved by Aetna, who retains ultimate accountability and is subject to the same oversight requirements of the contracted entity. Sub-delegation arrangements must be approved by Aetna, who retains ultimate accountability.

**B. Member Rights
Rights and Responsibilities**

Aetna FEHBP FFS utilizes a Member Rights and Responsibilities statement to define and establish a foundation for cooperation among members, practitioners and the health plan. This statement is communicated to members, contracted practitioners, providers, and employees annually.

Members' rights include the right to information about Aetna FEHBP/FFS, its services, and its practitioners and providers. Members have a right to privacy and to be treated with dignity when receiving health care. In addition, members have a right to

participate in decision making regarding their health care, to be given information about treatment options, and how their practitioners are compensated.

Aetna FEHBP FFS recognizes that when the health plan does not meet a member's expectations, the member has a right to voice complaints or appeals about the health plan or care provided, without fear of recrimination. Members have the right to make recommendations regarding Aetna's FEHBP FFS members' rights and responsibilities policies.

Members' responsibilities include the responsibility to provide, to the extent possible, information needed by Aetna FEHBP FFS and participating practitioners in order to carry out their respective responsibilities to members. Members have a responsibility to follow plans and instructions, which they have agreed to with their practitioners. Members have the responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.

Confidentiality

We consider member protected health information (PHI) private and confidential, and have policies and procedures in place to protect the information against unlawful use and disclosure. Participating network practitioners/providers, vendors, and consultants who help administer the health plan are required by contract to keep PHI confidential, as required by applicable law and/or regulation. Health care practitioners and providers also must give members access to their medical records within a reasonable time after any request.

When necessary for a member's care or treatment, the operation of a health plan, or other related activities, we use PHI internally, share it with our affiliates, and disclose such information to health care practitioners/providers, payers (employers who sponsor self-funded health plans, health care provider organizations, and others who may be financially responsible for payment for the services or benefits a member receives under a plan), vendors, consultants, government authorities, and their respective agents. These parties are required to keep PHI confidential, as provided by applicable law. We provide members notice of our privacy practices as required by law. Members can also obtain policies concerning use and disclosure of their PHI, and how they can access or amend information about themselves.

All committee minutes and reports are considered confidential. All external committee members are required to sign a confidentiality and conflict of interest statement prior to serving on a committee. All health plan employees receive annual training regarding HIPPA and confidentiality policies.

Complaint and Appeal Process and Management

We provide a mechanism for members to express and resolve disagreements concerning services, claims, benefits, participating practitioners and providers, and administrative contract policies. The member complaint and appeal policy defines a clear framework for resolution of member complaints and appeals in a timely and efficient manner. The policies address pre-service, post-service, and expedited

appeals.

Every effort is made to resolve a member's complaint by the staff member receiving the complaint. If a staff member is unable to resolve a complaint to the member's satisfaction, the issue is forwarded to the appropriate resolution team for handling. All member appeals are investigated and resolved by the appropriate resolution team.

All members receive information on the procedures governing complaints, grievances and appeals as appropriate.

An annual complaint and appeal analysis is performed to determine the root cause and to improve member experience. As a part of the annual assessment, a comprehensive barrier analysis is completed and the annual analysis is reported to the National Quality Oversight Committee.

There is a mechanism for practitioner/organizational providers to express and resolve disagreements concerning payments and benefit decisions.

External Review Program

FEHBP FFS members or their authorized representative can make an appeal through OPM. This process is free to all enrollees. OPM will review whether the denial was justified by examining the terms of coverage and the specific circumstances surrounding the denial. If medical expertise is needed for review of a denial, OPM will seek the opinion of a contracted Independent Review Organization (IRO). In most cases, OPM will reach a decision within 30 days.

Except in certain circumstances, members will have to exhaust internal appeals processes before they can ask for External Review. In the event a member is denied emergency services or if their doctor has determined that the denial of care would seriously jeopardize their life or jeopardize their ability to regain maximum function, the member may request External Review without first exhausting the internal appeal process. In the case of an urgent/emergent appeal, OPM generally will make a decision within 72 hours.

C. Access, Availability and Network Adequacy

Access

Standards for access to care and service are established by the NQOC and monitored on a routine basis, the frequency depending upon the standard. The NQOC establishes goals for each standard. If opportunities for quality improvement actions are identified, they are prioritized and actions implemented to improve performance. Compliance with the accessibility standards is measured using valid methodology and analyzed on an annual basis utilizing the following mechanisms:

- Primary Care Physician and Specialty Care Physician; OB/GYN (high volume) and Oncology (high impact) access standards are established for regular/routine care appointments, urgent care appointments and for after-hours care. Access is monitored through several avenues: member complaints, telephonic provider surveys or member experience survey data (CAHPS 5.0H Adult Commercial

Consumer Satisfaction Survey,

- Member Services telephone access is monitored using statistical data regarding call abandonment rate, average speed of answer and total service factor. Member complaint data is tracked and trended.

Compliance with the BH accessibility standards is measured using valid methodology and analyzed on an annual basis utilizing the following mechanisms:

- BH provider access standards are established for regular/routine care appointments, urgent care appointments and for after-hours care. Access is monitored through several avenues: member complaints, BH member experience survey data, BH provider experience survey data and/or telephonic surveys.
- Member Services telephone access is monitored using statistical data regarding call abandonment rate, average speed of answer and total service factor. Member complaint data is tracked and trended.

On an annual basis, results of the BH accessibility study are provided to the NQOC by the BH representative.

Availability

The NQOC establishes standards for network adequacy for meeting the healthcare needs of current membership. These standards include at a minimum the:

- Number and distribution of practitioners including Primary Care Physicians, Ob/Gyns (high volume) and Oncology (high impact) specialties,
- Assessment of cultural and linguistic needs and preferences of members.

Indicators are used to evaluate at least annually network adequacy based on member needs. Results of availability assessments are used in developing and implementing market contracting plans.

The NQOC delegates authority to the BH quality committee to monitor compliance with the behavioral health practitioner and provider availability standards. On an annual basis, results of BH Availability Analyses are provided to the NQOC by the BH representative.

Network Adequacy

Network Adequacy refers to the ability of a health plan to provide enrollees with timely access to a sufficient number of in-network providers, including primary care and specialty physicians, as well as other health care services included in the benefit contract.

The NQOC establishes standards for network adequacy for meeting the healthcare needs of the enrollees. These standards include at a minimum the:

- Assessment of member complaints based off of network adequacy codes
- Assessment of member satisfaction survey
- Review of Accessibility and Availability outliers

Indicators are used to evaluate at least annually network adequacy based on member needs. Trends and gaps discovered during the Network Adequacy assessments are presented as

opportunities of improvement to the Member Experience Workgroup. The Member Experience Workgroup develops interventions based off of the opportunities. On an annual basis, the effectiveness of interventions will be assessed through a re-measurement of network adequacy. Analysis of findings will include a comparison of results against standards or goals trended over time to determine effectiveness.

The NQOC delegates authority to the BH quality committee to monitor compliance with the behavioral health practitioner and provider network adequacy standards. On an annual basis, results of BH Network Adequacy Analyses are provided to the NQOC by the BH representative.

D. Member Experience

We are committed to a better health care system. We continue to solicit feedback from consumers, doctors, hospitals, employers, and government and regulatory organizations to provide information in a way that is clear, useful and relevant.

We work hard to support providers and members to create a culture of better health: connected, simpler, intuitive, convenient, affordable and powerful.

Providers influence the consumer experience, and we are empowering them with better tools, information and payment models.

The monitoring, evaluation and improvement of member experience is an important component of the QM Program. This is accomplished through the use of surveys and through the aggregation, analysis, and trending of member complaints. In addition, we encourage members to offer suggestions and express their concerns through the customer services telephone lines, as well as, our secure member website.

Aetna is responsible to contract annually with a NCQA CAHPS vendor to field the respective surveys. FEHBP//FFS provide audited Commercial CAHPS member files to the certified vendor for random sampling following standardized protocols. FEHBP FFS Plan incurs all associated expenses.

Among the surveys utilized are:

NCQA Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey (Commercial)

The NCQA CAHPS survey is a public/private initiative of the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality (AHRQ) to provide standardized surveys of consumers' experiences with the health care system. Health plans report survey results as part of HEDIS data collection. NCQA uses survey results in health plan performance reports, to inform accreditation decisions and to create national benchmarks for care. NCQA compiles the Commercial CAHPS Health Plan Survey 5.0H Adult Version data in the NCQA Quality Compass[®] which compares consumer satisfaction data across health plans and over time.

BH Member Experience Survey

This survey is administered annually in accordance with NCQA guidelines to a sample drawn from the adult (ages 18 years and older) commercial and Medicare BH population who have accessed behavioral health care. The survey is designed to measure members'

experience of care, both in the delivery of BH services and administrative services.

Member Experience Surveys with Care Management Services

The Member Experience Survey is administered annually to members in our Management, integrated programs that provide a combined CM/DM approach. The objectives of this study are to monitor and evaluate the experience among members who have utilized case management and/or disease management services and to determine the key drivers of satisfaction with the program. Insight into how well the program offerings are member expectations helps to identify areas where the program is performing well and areas in need of improvement.

E. Clinical Care Improvement

Clinical Practice and Preventive Services Guidelines, Programs, and Monitoring

The process has been designed to adopt guidelines relevant to the enrolled membership for the provision of preventive, acute, chronic and behavioral health services. The CPGs and PSGs are adopted and made available to practitioners to facilitate improvement of health care.

We adopt nationally accepted evidence-based clinical practice guidelines from recognized professional sources such as the American Diabetes Association (ADA), the American Heart Association (AHA), the American College of Cardiology (ACC), and the American Psychiatric Association (APA).

We adopt nationally accepted evidence-based preventive services guidelines from the U.S. Preventive Services Task Force (USPSTF) and the Centers for Disease Control and Prevention (CDC). Where there is lack of sufficient evidence to recommend for or against a preventive service by these sources, or there is a conflicting interpretation, we may adopt recommendations from other nationally recognized sources.

The review and adoption process is implemented for each adopted guideline at least every two years and when new scientific evidence or national standards are published prior to the two-year review date.

The National Guideline Committee (NGC) manages and provides direction on CPGs and PSGs, which are approved by the CMO or designee. Additionally, the CMO or designee is a voting member of the NGC. The NQAC reviews and makes recommendations for the adoption of medical guidelines and the BH QAC reviews and makes recommendations for the adoption of BH guidelines to the NGC. The NQOC adopts the final medical guidelines and the BH quality committee adopts final BH guidelines. The guidelines are broadly distributed to practitioners.

In order to assess whether prevention and early detection health services are provided appropriately, the health plan annually monitors and evaluates performance using such indicators as HEDIS and CAHPS.

Behavioral Health Preventive Health and Screening Programs

Aetna maintains behavioral healthcare programs based on the needs of the covered population. Screening and prevention programs are designed to detect or prevent the incidence, emergence or worsening of behavioral disorders and adverse outcomes.

Practitioners and providers who participate on the BH QAC provide input annually into the design and implementation of these programs. Information for designated screening programs are communicated to new and existing practitioners and providers as appropriate and at least annually. Additionally, all members are informed about the availability of screening programs annually, and are encouraged to participate in the programs.

Continuity and Coordination of Medical Care

We collect and analyze data to assess coordination of care across settings and between practitioners, as we manage members through care transitions. Data collected and reviewed comes from a variety of sources. Through analysis of the data, we are able to identify opportunities to improve the coordination of medical care for members.

We collaborate with practitioners to improve continuity and coordination of medical care through activities such as:

- UM and Post-discharge calls
- Readmission Avoidance Programs
- Discharge planning
- Case management
- Targeted quality outreach initiatives to members and/or practitioners
- Practitioner and member communication
- Assist members' transition to other care when benefits end and/or assist members during transition from pediatric to adult care.

Continuity and Coordination between Medical and BH Care

Aetna/FEHBP FFS monitors continuity and coordination of care between medical physicians and BH practitioners under specific areas. The specific areas and identified data sources that may be used to monitor collaboration of care are listed below.

Exchange of Information

- Physician Practice Survey;
- BH Provider Experience Survey Questions related to PCP Communication;
- BH Member Experience Survey Questions related to PCP Communication;
- BH Practitioner Treatment Record Audits:

Appropriate Diagnosis, Treatment and Referral of Behavioral Health Disorders Commonly Seen in Primary Care & Appropriate Use of Psychotropic Medications

- HEDIS Antidepressant Medication Measures;
- HEDIS Follow-Up Care For Children Prescribed Attention Deficit Hyperactivity Disorder Medication;

Screening and Management of Treatment Access and Follow-up for Members with Coexisting Medical and Behavioral Health Disorders

- BH Condition Management Program referrals, enrollments, completions and PHQ-9 outcome measures;
- Coordination of Care with Clinical Case Management.

Coordination of Behavioral Health Care

BH monitors the continuity and coordination of care that members receive across the behavioral

healthcare network and takes action, as necessary, to improve and measure the effectiveness of these actions across four different areas. The specific areas and identified data sources that may be used to monitor collaboration of care are listed below:

Exchange of Information

- BH Condition Management Program
- Utilization Management Clinician (UMC) Chart Audits
- BH Practitioner Treatment Record Review (TRR) Audits

Access and Follow Up

- Follow Up after Mental Health Inpatient Hospitalization (FUH) Program
- Opioid Overdose Risk Reduction (OORS) Program

Clinical Improvement Teams

FEHBP FFS QM staff work with national QM staff,, pharmacy, disease management and other internal constituents, as appropriate. They critically analyze clinical indicators and HEDIS results, perform barrier analyses, and design and implement targeted improvement activities. They may also collaborate with external organizations to seek guidance and utilize existing resources and tools. This process focuses resources in the most efficient manner. Our clinical priorities are determined annually after rigorous analyses of data.

Technology Assessments and Clinical Policy Bulletins (CPBs) Reviews

Mechanisms are in place to evaluate the appropriate use of medical technologies. CPBs express our views regarding the experimental and investigational status, cosmetic status and medical necessity of medical and behavioral health technologies (e.g., medical and surgical procedures, devices, pharmaceuticals, and biological products).

CPBs are used in conjunction with the terms of the member’s benefits plan and other recognized criteria to determine health care coverage. CPBs are based on evidence in peer-reviewed published medical literature, technology assessments and structured evidence reviews, evidence-based consensus statements, expert opinions of health care providers, and evidence-based guidelines from nationally recognized professional health care organizations and government public health agencies.

Both new and revised CPB drafts undergo a comprehensive review process. This process includes review by the Clinical Policy Council and external practicing clinicians. The CMO or designee reviews and provides final approval of all CPBs. Review and updates to the CPBs occur on a regular basis to support the coverage of new advances as soon as appropriate, and to prevent unproved, ineffective and obsolete technologies from receiving coverage.