Quality Management Program Description 2019

Adapted for

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

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2/1/2019

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 teamwork 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, andto 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 CRF 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 growingminority 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 **c**oordinated, 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.

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 evaluationof 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.

Adoption

Aetna FEHB FFS Quality Management Committee:

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QM Review/Approval

05/06/2019

Date