2015 Quality Management Medical and Behavioral Health Program Description
HMO and PPO – Based* Products
(Commercial and Medicare) with State Amendments

For Internal use only

Aetna: Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies. (Aetna) means:

"Aetna" is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. The Aetna companies that offer, underwrite or administer benefit coverage include Aetna Health Inc., Aetna Health of California Inc., Aetna Life Insurance Company, Aetna Health Insurance Company of New York, and Aetna Health Insurance Company, and Aetna Pharmacy Management, an internal business unit of Aetna Health Management, LLC.

Original Date for combined HMO and PPO (Commercial and Medicare Products): December 2009
Most Recent Revision Date: December 2014
Next Scheduled Revision Date: December 2015

2015 HMO and PPO QM Program Description *Includes Exchanges and Texas Fully Insured EPO

For Internal Use Only
# 2015 Quality Management Program Description
## HMO and PPO Based Products (Commercial and Medicare)

<table>
<thead>
<tr>
<th>Table of Contents</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I. Introduction</strong></td>
<td>3</td>
</tr>
<tr>
<td><strong>II. Quality Strategy Statement</strong></td>
<td>3</td>
</tr>
<tr>
<td><strong>III. Quality Management Process</strong></td>
<td>4</td>
</tr>
<tr>
<td><strong>IV. Quality Management Program Goals</strong></td>
<td>4</td>
</tr>
<tr>
<td>A. Regulatory Compliance</td>
<td>5</td>
</tr>
<tr>
<td>B. Racial and Ethnic Disparities in Health Care</td>
<td>5</td>
</tr>
<tr>
<td>C. Patient Safety</td>
<td>12</td>
</tr>
<tr>
<td>D. Members with Complex Health Needs</td>
<td>12</td>
</tr>
<tr>
<td><strong>V. Quality Management Program Scope</strong></td>
<td>12</td>
</tr>
<tr>
<td>QM Work Plan</td>
<td>13</td>
</tr>
<tr>
<td>QM Program Evaluation</td>
<td>13</td>
</tr>
<tr>
<td><strong>VI. Quality Management Calendar and Cycle</strong></td>
<td>14</td>
</tr>
<tr>
<td><strong>VII. Quality Management Program Resources</strong></td>
<td>14</td>
</tr>
<tr>
<td><strong>VIII. Accountability and Committee Structure</strong></td>
<td>16</td>
</tr>
<tr>
<td>A. Board of Directors</td>
<td>16</td>
</tr>
<tr>
<td>B. National Quality Oversight Committee</td>
<td>16</td>
</tr>
<tr>
<td>C. National Quality Advisory Committee</td>
<td>18</td>
</tr>
<tr>
<td>D. National Vendor Delegate Oversight Committee</td>
<td>19</td>
</tr>
<tr>
<td>E. Credentialing and Performance Committee</td>
<td>19</td>
</tr>
<tr>
<td>F. Practitioner Appeals Committee</td>
<td>20</td>
</tr>
<tr>
<td>G. Behavioral Health Quality Oversight Committee</td>
<td>20</td>
</tr>
<tr>
<td>H. Behavioral Health Quality Advisory Committee</td>
<td>21</td>
</tr>
<tr>
<td>I. National Quality Management Policy Committee</td>
<td>22</td>
</tr>
<tr>
<td>J. National Quality Management Policy Team</td>
<td>22</td>
</tr>
<tr>
<td>K. National Care Management Policy Committee</td>
<td>23</td>
</tr>
<tr>
<td>L. National Guideline Committee</td>
<td>23</td>
</tr>
<tr>
<td>M. Aetna Pharmacy Management Quality Oversight Committee</td>
<td>24</td>
</tr>
<tr>
<td>N. National Pharmacy and Therapeutics Committee</td>
<td>26</td>
</tr>
<tr>
<td>O. Corporate Appeals Committee</td>
<td>27</td>
</tr>
<tr>
<td>P. External Review Oversight Committee</td>
<td>28</td>
</tr>
<tr>
<td>Q. Medicare External Review Oversight Committee</td>
<td>28</td>
</tr>
<tr>
<td>R. National Risk and Delegation Oversight Committee</td>
<td>29</td>
</tr>
<tr>
<td><strong>IX. Quality Management Program Components</strong></td>
<td>30</td>
</tr>
<tr>
<td>A. Practitioner/Provider Selection and Retention</td>
<td>30</td>
</tr>
<tr>
<td>Credentialing/Recredentialing</td>
<td>30</td>
</tr>
<tr>
<td>Ongoing Monitoring</td>
<td>31</td>
</tr>
<tr>
<td>Facility Assessments</td>
<td>31</td>
</tr>
<tr>
<td>Potential Quality of Care Concerns Management</td>
<td>32</td>
</tr>
<tr>
<td>Delegation Oversight and Management</td>
<td>33</td>
</tr>
<tr>
<td>B. Member Rights</td>
<td>33</td>
</tr>
<tr>
<td>Rights and Responsibilities</td>
<td>33</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>34</td>
</tr>
</tbody>
</table>

2015 HMO and PPO QM Program Description *Includes Exchanges and Texas Fully Insured EPO

---

For Internal Use Only

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies. (Aetna)
## Table of Contents

<table>
<thead>
<tr>
<th>Item</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaint and Appeal Process and Management</td>
<td>34</td>
</tr>
<tr>
<td>External Review Program</td>
<td>36</td>
</tr>
<tr>
<td>C. Access and Availability</td>
<td>36</td>
</tr>
<tr>
<td>Access</td>
<td>36</td>
</tr>
<tr>
<td>Availability</td>
<td>37</td>
</tr>
<tr>
<td>Member Experience</td>
<td>37</td>
</tr>
<tr>
<td>D. Clinical Care Improvement</td>
<td>40</td>
</tr>
<tr>
<td>Clinical Practice/Preventive Services Guidelines, Programs, and Monitoring</td>
<td>40</td>
</tr>
<tr>
<td>Behavioral Health Preventive Health Programs</td>
<td>41</td>
</tr>
<tr>
<td>Continuity and Coordination of Medical Care</td>
<td>41</td>
</tr>
<tr>
<td>Continuity and Coordination between Medical and Behavioral Health Care</td>
<td>42</td>
</tr>
<tr>
<td>Coordination of Behavioral Health Care</td>
<td>43</td>
</tr>
<tr>
<td>Clinical Improvement Workgroups</td>
<td>43</td>
</tr>
<tr>
<td>Technology Assessment and Clinical Policy Bulletins Reviews</td>
<td>44</td>
</tr>
<tr>
<td>E. Medicare Quality Improvement (QI) Process</td>
<td>44</td>
</tr>
<tr>
<td>Chronic Care Improvement Program (CCIP)</td>
<td>44</td>
</tr>
<tr>
<td>Quality Improvement Program</td>
<td>44</td>
</tr>
<tr>
<td>Standard Medicare Reporting Requirements for HEDIS®, HOS and CAHPS®</td>
<td>45</td>
</tr>
<tr>
<td>Signature Page</td>
<td>46</td>
</tr>
<tr>
<td>Attachment A – Accountability</td>
<td>50</td>
</tr>
<tr>
<td>State Amendments</td>
<td>51</td>
</tr>
</tbody>
</table>

® HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

® CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

2015 HMO and PPOQM Program Description *Includes Exchanges and Texas Fully Insured EPO

For Internal Use Only

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies.

(Aetna)
I. Introduction
The Quality Management (QM) Program focus is the ongoing assessment and improvement of clinical care and service. 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 National Strategy for Quality Improvement in Health Care (National Quality Strategy). Aetna’s 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. We do not view quality management as an isolated, departmental function, rather quality management and metrics are integrated into all that we do. Our quality activities are coordinated across different functional areas, not just in the quality department. For example, the quality department works closely with many other business areas so that the quality measures used for our provider measurement, pay-for-performance programs and high performance networks are consistent with nationally recognized metrics.

Aetna is committed to Health Plan Accreditation, as well as, Managed Behavioral Healthcare Organization (MBHO) accreditation by the National Committee for Quality Assurance (NCQA) as one means of demonstrating a commitment to CQI, meeting customer expectations, and establishing a competitive advantage among HMOs and PPOs. 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.

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,
2015 Aetna Quality Management Program Description  
HMO and PPO Based Products (Commercial and Medicare)

Evidence-based guidelines. We are committed to supporting transparency by providing participating physicians and members with credible clinical information and tools to make informed decisions.

Aetna was the first health care organization to sign on and embrace the Health and Human Services Four Cornerstones of the President’s Executive Order to further health care transparency. Aetna was one of the first health plans to support the Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs (Patient Charter). The Patient Charter creates a national set of principles to guide measuring and reporting to consumers about doctors’ performance. Embracing the Patient Charter will facilitate consumers’ and physicians’ understanding and trust as to how health plans rate doctors’ performance. Aetna's support includes a commitment to review by an endorsed independent reviewer to assess compliance with the Patient Charter.

III. Quality Management Process

Aetna utilizes QCI 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. Examples of Aetna’s quality committees include the National Quality Oversight Committee (NQOC) and Behavioral Health Quality Oversight Committee (BH QOC) which are empowered to oversee and address quality improvement activities and the National Quality Advisory Committee (NQAC) and Behavioral Health Quality Advisory Committee (BH QAC), which set direction for clinical quality improvement initiatives. Quality reports are used to monitor, communicate and compare key indicators.

Finally, Aetna develops 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 promulgate the principles and spirit of QCI.
- 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 company-wide 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 to facilitate communication, collaboration and integration among key functional areas relative to implementing a sound and effective QM program.

2015 HMO and PPO QM Program Description *Includes Exchanges and Texas Fully Insured EPO

For Internal Use Only

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies. (Aetna)
2015 Aetna Quality Management Program Description  
HMO and PPO Based Products (Commercial and Medicare)

- To measure and monitor (previously identified issues, evaluate the QI program), and to improve performance in key aspects of quality and safety of clinical care, including behavioral health, 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 recredentialing activities.

A. Regulatory Compliance

The QM Program is designed to comply with all applicable state laws and regulations and with CMS requirements. The QM department, in collaboration with the Medicare Compliance department, monitors CMS/ Federal laws and regulations specific to quality and is accountable for implementation of actions needed to assure compliance. The appropriate Board of Directors is ultimately accountable for compliance with CMS/Federal laws and regulations. State laws/regulations may exceed the requirements of the QM Program Description and policies. When there are state regulations that apply to the QM Program or national policy, these are documented in a state amendment, as applicable.

Measurement and reporting of performance includes using the measurement tools required by CMS to report performance. Information on quality and outcome measures that will enable beneficiaries to compare health coverage options and select among them is made available to CMS.

Aetna does not discriminate based on a person’s race, mental or physical disability, religion, gender, 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 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, 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.

Aetna believes 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. Aetna’s Racial and Ethnic Equality Initiative is an ambitious and multifaceted program. Aetna’s senior leadership team supports the program. The Racial and Ethnic Equality business unit in the Office of Chief Medical Officer manages the initiative. And internal and external experts in the field serve as advisers. Our goal is to improve access to quality health care services for all of our members - regardless of race or ethnicity.

2015 HMO and PPO QM Program Description *Includes Exchanges and Texas Fully Insured EPO

For Internal Use Only

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies.

(Aetna)
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. So 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.

As of October 2014, more than 6 million members (35 percent) of our currently active medical members have volunteered their race and ethnicity information via enrollment forms or our Aetna Navigator® member website. We evaluate this data to get a precise view of where disparities exist among our members, permitting us to develop targeted approaches to meet the diverse health needs of our members. As we continue to develop programs, we will focus on those areas where we can have the greatest impact to improve our members’ health.

Our success in overcoming perceived barriers to collecting data on race and ethnicity is a result of communicating
- with employers and members on the important need for this information
- how it will be used
- the safeguards in place to protect the privacy of the information members provide.

However, to increase the number of members who voluntarily provide race and ethnicity information, we implemented focus groups and surveys with our Employee Resource Groups (ERGs) to understand potential barriers. ERGs are company-supported and employee-managed groups that share an affinity, a common background or a set of experiences. Examples include Hispanic, African American, Asian, and Veterans, and Working Women ERGs. Key findings of the focus groups included:
- Generally, individuals were comfortable and willing to provide race and ethnicity information if the purpose for requesting such information was clearly described.
- Individuals believed that it was just as important to articulate how Aetna would not use the information.
- The individuals believed it was important to clearly describe the line of sight between the data that is collected and specific quality improvement activities.

Therefore, we have built these key messages into our on-going communication plans.

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

Beginning Right Program
Our Beginning Right® Maternity Program aims to decrease the risk of premature delivery. The program offers services that help prevent preterm labor for African-American women through education, case management and pre-natal care. Among self-identified African-American women enrolled in the Beginning Right Maternity Management Program, those who accepted preterm labor education and prevention services tended to have more full-term deliveries than those who declined these services. Since its inception through 2013, more than 10,500 African American women have enrolled in the preterm labor program.

Breast Health Initiative
The burden of disease for breast cancer is greater in African American and Hispanic women regarding stage of diagnosis, mammography screening rates and mortality. To address this disparity, we implemented the Breast Health Ethnic Disparities Initiative (BHEDI). The goals of this program are to identify and address barriers to screening and increase mammography screening rates in African American and Hispanic women. This initiative used voluntary self-reported data on race and ethnicity combined with claims data to identify Latina and African American women who have not had their annual screening mammogram. We reach out to these members either with targeted telephone calls from a bilingual nurse case manager or educational mailings in English and Spanish.

Our outreach stresses the importance of mammography screening, discusses the risk of breast cancer to Latina and African American women, and offers suggestions on how to find a mammography center. Results of the initiative demonstrated that personalized culturally appropriate member mailings coupled with nurse outreach by telephone increased mammography screening rates. From 2011 through June 2014, we reached out to more than 46,600 at-risk women who received the BHEDI personalized culturally competent member mailings and telephone call from BHEDI staff. This program is now part of our standard outreach to at-risk African American and Hispanic women who have not had their annual mammogram.

Provider focused Diabetes Program
Our data showed that African American and Hispanic members in Texas had rates of poor diabetic control evidenced by HbA1c levels that were nearly double those of white members. The troubling reality this data suggests is that African American and Hispanic members are roughly twice as likely to suffer the health consequences of uncontrolled diabetes from amputations, to blindness to other extremely debilitating or life-threatening complications.

To address this disparity, we developed a two-year provider-focused pilot program for African American and Hispanic diabetic members with the Medical Clinic of North Texas, a large provider practice in the Dallas area. The program includes the addition of a bilingual diabetic educator to assist in diabetic education and coaching with the target population and the use of culturally and linguistically appropriate patient education materials. The goal is to improve levels of diabetic control and health outcomes. Results showed a significant improvement in diabetic control in the pilot participants. Over the two-year pilot program, there has been an overall improvement (reduction) in Hemoglobin A1c or HbA1c, which is a blood test used to measure diabetic control, of
2015 Aetna Quality Management Program Description
HMO and PPO Based Products (Commercial and Medicare)

1.6 points. We are exploring the transferability of the program to Accountable Care Organizations/Patient-Centered Medical Home models. To put this into context, according to a major study, just a one point improvement in HbA1c means 21% fewer deaths from strokes and 14% fewer heart attacks.

Emergency room (ER) utilization in Minority Asthmatic Populations
It is a common misperception that health care disparities are primarily a problem among the uninsured population. But we have found that disparities exist in both cost and clinical quality in the insured population. One disease where these disparities exist is asthma. We analyzed asthma services utilization among our membership to determine to what extent disparities existed in Aetna’s population.

Specifically, we assessed asthma emergency room (ER) utilization over a one-year period to determine if there were differences in ER utilization by race or ethnicity in our insured population. This is what we found
- For African Americans, ER utilization was more than three times higher for both adults and children.
- For Hispanics, ER utilization was nearly two times higher for both adults and children.

Based on the striking differences in asthma ER utilization by race and ethnicity, we sought to address and reduce this disparity by developing a culturally appropriate, evidence-based program targeting high-risk populations.

We engaged in a pilot program for our Medicaid members in Delaware to address ER use by minority members with asthma. This initiative combines culturally appropriate activities, such as age-appropriate member educational materials, nurse outreach by telephone, optional home assessments and physician engagement. The program goal is to improve health outcomes of Hispanic and African American patients who struggle with asthma. We determined the pilot’s success by a reduction asthma-related ER visits and inpatient hospital admissions. Results from the first year of outreach show a 24% reduction in ER visits and a 37% reduction in inpatient utilization. Due to these positive results, the program has been incorporated into our disease management approach for our fully insured customers.

Aetna Rx Healthy Outcomes – Enhanced Program
A study co-authored by Aetna and published in the New England Journal of Medicine (NEJM) in 2011 proved how medication adherence could be achieved for members with heart disease when co-pays were eliminated. As a result of this study, the Aetna Rx Healthy Outcomes program was developed in 2013. The program goal is to drive meaningful improvements in adherence, cost and outcomes for patients who have had heart attacks. The program reduces or eliminates copays for statins and other cardiovascular drugs; provides pharmacist support; and engages members early.

As a follow on to the earlier NEJM study, we sought to evaluate if providing full drug coverage had differential effects by race and ethnicity. The results were published in Health Affairs in May 2014. This study showed:
- Providing full drug coverage increased medication adherence in both whites and non-whites.
Rates of medication adherence were significantly higher for non-white patients than for white patients.

Among non-white patients, rates of adverse events were reduced by 35 percent and total health care spending by 70 percent.

As a result of these findings the Aetna Rx Healthy Outcomes program (described above) was enhanced in 2014 for members following a heart attack, coronary artery syndrome, coronary artery stent placement with a goal to fully engage all members including those who may be non-white. The members in the enhanced program receive:

- Culturally and linguistically appropriate welcome letter
- Copay reduction set in claims system focused on cardiovascular medications
- Pharmacist outreach by phone for patient consultation. The pharmacist will be trained in cultural competency, using culturally and linguistically appropriate scripting for member outreach consultations.

**Depression Initiative**

Depression is a significant issue for Aetna members. The Racial and Ethnic Equality (REE) Dashboard data for members with depression shows disparities for minority members’ access of behavioral health services as well as lower medication adherence to anti-depressant medications. We are working on a two-pronged approach to address this issue. One element is focused on minority members with a diagnosis of depression, and the other is focused on primary care physician (PCP) engagement. We are focusing on primary care physicians as they are the first line of treatment for behavioral health issues and most patients would rather be treated by their PCP for behavioral health issues. Our approach will include:

- Culturally and linguistically appropriate educational outreach about depression for members with a depression diagnosis and the importance of staying on their medications.

**Cultural Competency Training**

Our objectives for serving a culturally and linguistically diverse membership include the following.

*Provide information, training and tools to staff to support culturally competent communication.*

We recognize the critical need for our clinical staff to be culturally competent in order to serve our diverse membership. We were the first national health plan to offer cultural competency training to our employees. Goals of this training are to:

- deepen our clinical community’s understanding of disparities among racial and ethnic groups,
- provide ongoing education on cultural competency in healthcare for Aetna clinicians and other healthcare providers.

Since 2003, Aetna has mandated completion of the Quality Interactions®: A Patient-Based Approach to Cross Cultural Care for its internal clinical staff. Quality Interactions® is a series of interactive online courses that teach health care professionals:

- how to identify cross-cultural issues,
- conduct a culturally competent patient history and medical exam,
- work effectively with interpreter services,
• increase patient understanding of diagnosis and treatment options, and
• elicit greater patient cooperation and compliance with the prescribed treatment plan.

We added a Cultural Competence, Mental Health and Depression course in 2013. This module provides health care professionals with a cross-cultural approach to the diagnosis and management of depression in diverse patient populations. This approach is essential in the diagnosis, treatment, and ongoing management of individuals with mental health conditions, especially depression. Social and cultural factors impact an individual’s presentation of conditions such as depression. And they influence their perspectives around treatment and ongoing care management. So it’s critical that health care professionals possess the tools and skills of cultural competence and cross-cultural communication.

In addition a course entitled “Improving Adherence in Diverse Populations: Tools for Pharmacists” was added in 2014. This course is for clinical pharmacists and others who work at health plans and hospitals that focus on medication adherence issues in diverse populations.

The courses are accredited by Tufts University School of Medicine for one hour CME/CEU/CM credit.

Provide information, training and tools to practitioners to support culturally competent communication
We also offer cultural competency training to network providers and to nonparticipating providers who have filed a claim with Aetna. As part of our comprehensive strategy to improve the quality of care for racial and ethnic groups, we have conducted broad outreach to increase awareness within the physician community of our commitment to diversity in health care.

Facilitate linking members with practitioners who can meet their needs
Our goal is to ensure all members have access to the right medical care at all times. So we facilitate linking members with practitioners who can meet their cultural, racial, ethnic and linguistic needs and preferences. We provide many services to assist members who have limited English proficiency including:
• Provider directories and website listings at www.aetna.com 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.
• Our language line translation service that includes 170 languages. We offer in-person interpreter services on a case-by-case basis.
• Written communication with our members and prospective members in their language with messages that are meaningful and relevant to them.
• An industry leading medical terminology glossary in Spanish and Chinese to support communication with members.
• A strategy to implement on-line multilingual consumer experience on key tools. The first was a robust version of DocFind tool in Spanish that makes it simple for members and potential members to find a doctor. There's also a mobile version available in Spanish.

Clinical Improvement Materials

2015 HMO and PPO QM Program Description *Includes Exchanges and Texas Fully Insured EPO

For Internal Use Only
Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies. (Aetna)
We provide some of our clinical quality improvement materials in languages other than English. Examples include:

- Our Member Health Education (MHE) reminders are bilingual: English and Spanish. The translation vendor transcreates to ensure our communications are culturally and linguistically appropriate. Additionally, members are referred to additional resources in English and Spanish. For example, the Numbers to Know® hypertension and cholesterol reminder includes reference to websites where members can find ethnic recipes.
- Some of our other communication pieces developed by our Clinical Improvement team are bilingual: English and Spanish. Those that are English only are developed for a multicultural audience using plain language and favorable diverse artwork.

Culture Competency Plan

- The purpose of a Cultural Competency plan is to prepare the organization to provide quality services to, racial/ethnic groups whose language, cultural attitudes, beliefs and practices are diverse. The Culture Competency Plan also insures that our membership has access to practitioners and providers that meet their cultural, racial, ethnic and linguistic needs and/or preferences. Failure to understand this diversity may contribute to less than quality care.
- In keeping with the mission of providing quality services to our members, the Health Plan is committed to integrating culturally and linguistically appropriate services (CLAS) into their healthcare delivery system(s).
- The purpose of the Health Plan’s Cultural Competency Plan is to implement enterprise-wide methodologies and processes that measure and improve clinical care and services that are mindful of the language and cultural needs of the plan’s members.
- The Cultural Competency Plan (CCP) has been developed to outline the methods used by Aetna, hereafter referred to as “the Health Plan” to address its members cultural, racial, ethnic, and linguistic needs and preferences. The plan is developed to ensure that members receive care that is delivered in a culturally and linguistically sensitive manner. The CCP is comprehensive and incorporates all members, employees and providers. The Health Plan recognizes that respecting the diversity of our members has a significant and positive effect on outcomes of care and have adopted the Culturally and Linguistically Appropriate Services (CLAS) Standards, as developed by the Department of Health and Human Services, Office of Minority Health, as guidelines for providing culturally and linguistically competent services. These 15 standards are organized by themes:
  * Principle Standard (Standard 1)
  * Governance, Leadership, and Workforce (Standards 2-4)
  * Communication and Language Assistance (Standards 5-8)
  * Engagement, Continuous Improvement and Accountability (Standards 9-15)

The standards are intended to be inclusive of all cultures and not limited to any particular population group or sets of groups; however, they are especially designed to address the needs of racial, ethnic, and linguistic population groups that may experience unequal access to health services.

Aetna’s Cultural Competency Plan document provides the detailed information and is reviewed annually and approved by the NQOC.

2015 HMO and PPO QM Program Description *Includes Exchanges and Texas Fully Insured EPO

For Internal Use Only
Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies. (Aetna)
C. Patient Safety
Patient/member safety is an important component of the QM Program. Aetna’s commitment to improving the quality of care 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 these. Aetna’s ongoing activities include efforts to educate members, employees, and physicians/providers about Aetna’s patient safety efforts and to provide information that can help constituents make informed health choices. Aetna’s patient safety programs are detailed in the Patient Safety Strategy document that is developed annually and approved by NQOC.

D. Members with Complex Health Needs
Aetna’s approach to managing members with complex health needs is described within the Aetna Care Management Program Description. These programs include the Aetna In Touch CareSM and the Aetna Health ConnectionsSM (AHC) Case Management, Disease Management, BH, National Medical Excellence, and women’s health programs, such as the Beginning Right Maternity Program. These programs support members with complex needs such as physical or developmental disabilities, multiple chronic conditions and mental health conditions.

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 medical practice;
- Development, implementation and monitoring of patient safety initiatives, and preventive and clinical practice guidelines;
- Monitoring of medical, behavioral health, case and disease management programs;
- Achievement and maintenance of regulatory and accreditation compliance;
- Evaluation of accessibility and availability of network providers;
- Establishing standards for, and auditing of medical and behavioral health record documentation;
- Monitoring for over and underutilization of services (Medicare);
- Performing credentialing and recredentialing activities;
- Oversight of delegated activities;
- Evaluation of member experience and practitioner satisfaction;
- Supporting initiatives to address racial and ethnic disparities in health care; and
- 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.

2015 HMO and PPO QM Program Description *Includes Exchanges and Texas Fully Insured EPO

For Internal Use Only
Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies. (Aetna)
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, QM Program Description, QM Work Plan, and the HMO/PPO QM Program Evaluation.

A variety of mechanisms are used to encourage providers to participate in CMS and HHS QI initiatives. These activities are promoted through several mechanisms including provider contract provisions, the provider manual, provider newsletters, etc.

**QM Work Plan**
The QM Work Plan is a schedule of planned activities throughout the calendar year. The QM Work Plan is developed largely from recommendations from the annual QM Program Evaluation or other program requirements. The QM Work Plan activities reflect 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 activity and sub-activities, the specific time frame and the party responsible for conducting the activity. Activities and outcomes are compared to predetermined goals, if applicable. The QM Work Plan is a dynamic document and improvement activities identified during the year and other changes may be made to the QM Work Plan.

**QM Program Evaluation**
The QM Program Evaluation will be reviewed and approved by the NQOC and then submitted to the appropriate Board of Directors. 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 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 regulatory requirements and accrediting entities.

**VI. Quality Management Calendar and Cycle**
Quality improvement activities that support the goals and objectives of the QM program are coordinated on an annual basis. The QM program cycle is based on the calendar year. Interim modifications are made to the QM program documents as needed.

VII. Quality Management Program Resources
Aetna has dedicated computer/data and human resources at the national, regional, and local levels sufficient to meet QM plan objectives and complete annual and on-going activities. NQM and behavioral health QM staff work in close partnership to coordinate completion of required activities. The National Medical Director for Quality and Provider Performance Measurement, who reports to the Chief Medical Officer, provides clinical leadership for quality activities. The Office of the Chief Medical Officer (OCMO) also is accountable for Medical Management Analysis and Reporting; Business Management and Planning including the Chairman’s initiatives; Medicare Strategy and Program Innovation; Racial and Ethnic Equality Initiatives; and Pharmacy Policy and Strategy.

NQM is part of the National Care Management (NCM) organization. The Head of NQM reports directly to the Head of NCM. NQM is responsible for accreditation, credentialing, delegation oversight, regulatory reporting and compliance, RFIs/RFPs, quality of care reviews, CAHPS and HEDIS reporting and improvement, and quality outcome measures for ACOs. The quality staff works collaboratively with each other and with many functional areas to support Aetna quality activities.

Behavioral Health QM is responsible for Aetna’s behavioral health QM program infrastructure and BH QM improvement initiatives. They work very closely with NQM to ensure consistency and coordination.

The medical director for Quality and Provider Performance Measurement, and the BH Chief Medical Officer are also 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, such as the Health Profile Database, Inpatient Performance Measurement System (IPMS), and Comprehensive Member List (CML). They also create the mapping logic of our clinical data, such as clinical groupings, Medical Case and DRG logic so that it can be stored and analyzed by others who use the Data Warehouse.

Aetna Informatics is part of the Innovation, Technology and Service Operations (ITSO) organization. This team combines our industry leading Information Technology, Health Information Technology, and Service Operations capabilities in one area, allowing us to better anticipate and adapt to the needs of our customers. Aetna Informatics is the critical business area that supports data retrieval from the Data Warehouse. The Data Warehouse incorporates data and information from multiple sources that is used to stratify member population by risk in order to derive patient outcomes and assess effectiveness of QM initiatives. Aetna Informatics staff provides analysis, performance measurement and statistical review of study results. They continually evaluate constituents' needs as they evolve and introduce creative solutions to best serve them. Aetna Informatics works closely with quality management to provide support for quality management projects.
National Care Management and Behavioral Health are closely linked to the 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 Care Management (NCM) is responsible for all member-facing clinical program design, development and delivery functions. NCM, the BH Chief Medical Officer 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. National quality management coordinates development and review of national QM policies with input from NQM, BH QM and other departmental representatives as needed. They provide support for and monitoring of 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 satisfaction survey and analysis.

National and behavioral health QM staffs are involved in the implementation of the QM Program. NQM and BH staffs work collaboratively to ensure that QM program goals are met. Joint participation in regularly scheduled workgroups and the Behavioral Health Quality Oversight Committee (BH QOC) 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 of the NQOC, NQAC, Behavioral Health Quality Oversight Committee (BHQOC), Behavioral Health Quality Advisory Committee (BHQAC), Credentialing and Performance Committee (CPC), Practitioner Appeals Committee (PAC) and National Vendor Delegate Oversight Committee (NVDOC) meetings. They may also be participants of national committees.

Other Aetna functional areas including, but not limited to the following, support the QM Program at all levels:

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

2015 HMO and PPO QM Program Description *Includes Exchanges and Texas Fully Insured EPO
2015 Aetna Quality Management Program Description
HMO and PPO Based Products (Commercial and Medicare)

- Compliance
- Legal
- Information Technology

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

VIII. Accountability and Committee Structure

A. Board of Directors

Aetna Life Insurance Company Board of Directors (ALIC) (PPO* Commercial and Medicare) and the HMO Boards of Directors (HMO Commercial and Medicare)

The ALIC and HMO Boards of Directors have delegated ultimate accountability for the management of the quality of clinical care and service provided to members to the Chief Medical Officer (CMO). The CMO is responsible for providing national strategic direction and oversight of the QM Program for Aetna members except in California (CA) and Texas (TX) HMO. For the HMO in CA and TX, a Medical Director licensed in the respective state holds this responsibility.

B. National Quality Oversight Committee (NQOC)

The Medical Directors referenced above delegate authority for oversight of the national QM Program to the NQOC. It facilitates the sharing of 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 QM Program.

The NQOC is a multidisciplinary committee composed of representatives from the following areas but not limited to:
- Health Care Management (HCM) Medical Director, (Chairperson)
- Office of Chief Medical Officer
- Chief Medical Officer, Innovation Health
- HCM Medical Director staff
- National Quality Management
- National Medicare Medical Management Ops
- Behavioral Health Quality Management
- Pharmacy Management
- Regional Health Care Management
- Network Management
- Customer Service
- Claims
- Complaints, Grievance and Appeals
- National Accounts
- Medicare Compliance
- Texas HMO Enrollee
- Texas HMO Participating Practitioner
- Texas EPO Participating Practitioner

2015 HMO and PPO QM Program Description *Includes Exchanges and Texas Fully Insured EPO

For Internal Use Only

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies. (Aetna)
The role of the NQOC includes the following:

- Approval of the following documents:
  - QM/BH Program Description
  - QM Work Plan
  - HMO/PPO QM Program Evaluation (includes Exchanges and Texas Fully-Insured EPO)
  - Aetna Care Management Program Description
  - Behavioral Health (BH) QM Work Plan
  - BH QM Program Evaluation
  - National Patient Safety Strategy
  - Cultural Competency Plan
- Adopt clinical criteria and protocols with consideration of recommendations from the National Quality Advisory Committee (NQAC) and as appropriate the Behavioral Health Quality Advisory Committee (BHQAC).
- Monitor QM and Aetna Care Management activities for consistency with both national and regional program goals.
- Establish priorities for the QM and Aetna Care Management programs, evaluate clinical and operational quality and integrate quality improvement activities among all departments.
- Review and adopt QM, NCM, and selected policies and procedures and approval of state amendments; as outlined in QM-01, Policy and Procedure Development and Review Procedure and the NCM 501-01/02, National Care Management Policy Development Policy and Procedure.
- Review regular reports from national workgroups and committees for discussion and feedback as necessary; approve as applicable.
- Evaluate identified potential quality of care concerns related to facilities/vendors.
- Adopt medical clinical practice guidelines (CPGs) and preventive services guidelines (PSGs).
- Oversees, coordinates and institutes company-wide initiatives to improve the safety of Aetna members and our communities. Additionally, foster communications about these safety programs to members, employees, physicians, hospitals and other health care professionals and plan sponsors. Patient safety activities include the following:
  - Discuss and make recommendations, if appropriate, to operational areas focusing on patient safety;
  - Provide updates on patient safety initiatives identified within the company, and the health care industry;
  - Prioritize new patient safety initiatives;
  - Provide oversight of ad hoc workgroups that are convened to identify patient safety issues and activities including communications, provider recognition or adverse events occurring in the inpatient or ambulatory areas.

The NQOC meets at least ten times a year.

The NQOC delegates’ authority to the:

- National Quality Advisory Committee (NQAC) and the Behavioral Health Quality Advisory Committee (BHQAC) to provide direction on clinical quality.
National Vendor Delegation Oversight Committee (NVDOC) for oversight and approval of delegated activities.

- Credentialing and Performance Committee (CPC) for the decision-making for credentialing, recredentialing and the review of professional conduct.

- Practitioner Appeal Committee (PAC) to conduct and render decisions on professional review hearings.

- Behavioral Health Quality Oversight Committee (BH QOC) to provide guidance and direction on Behavioral Health administrative, clinical and quality issues and utilization management activities.

- National Quality Management Policy Committee (NQMPC) and the National Care Management Policy Committee (NCMPC) for policy development and approval.

- National Guideline Committee (NGC) to review and approve clinical practice guidelines (CPGs) and preventive services guidelines (PSGs).

The NQAC, NVDOC and BH QOC provide reports to the NQOC at least annually.

The NQMPC, NCMPC and NGC present policies, procedures, CPGs and PSGs to the NQOC for adoption as they are developed or revised.

The Aetna Pharmacy Management Quality Oversight Committee is the designated committee to provide guidance and direction on pharmacy administrative, clinical and quality issues. It provides program documents annually to the NQOC.

Comprehensive reports on QM and the Aetna Care Management Program activities are provided to the respective Boards at least annually. State laws/regulations may exceed the requirements of the QM Program Description; when there are State regulations that apply to the QM Program these are documented in the State amendment.

C. 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, QM Program Description, QM Work Plan, the HMO/PPO QM Program Evaluation (includes Texas Fully-Insured EPO) (Executive Summaries).

- Review of clinical criteria such as, UM Criteria, Pharmacy and Medical Clinical Policy Bulletins and protocols for adoption by the NQOC.

- Make recommendations to the NGC regarding medical clinical practice and preventive services guidelines.

- Provide feedback to the National Pharmacy and Therapeutics Committee regarding the Preferred Drug Lists.

- Provide feedback to the BH QAC regarding the integrated medical and behavioral care health programs.

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

2015 HMO and PPO QM Program Description *Includes Exchanges and Texas Fully Insured EPO
D. 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, UM, CM and DM, 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.
- Overall monitoring and reporting of risk and delegate performance.

The NVDOC meets monthly and membership includes the following:

Voting Members:
- National Quality Management Director over Delegation, Chairperson
- NCM Regional Medical Director Staff
- Quality Management Managers over Credentialing and Medical Management (UM, CM, DM, clinical programs etc.) Oversight
- Senior Manager Finance/Senior Finance Auditor
- Claims Audit Manager
- Network Market Head/Senior Network Managers
- Medicare Compliance

Attendees representing the following areas:
- Network
- Patient Management
- NCM Regional Medical Director Staff
- Quality Management (Credentialing and Medical Management Delegation Oversight)
- Finance
- National Delegation Team

E. 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 the following:
- Medical Director, Facilitator
2015 Aetna Quality Management Program Description
HMO and PPO Based Products (Commercial and Medicare)

- Representatives from a range of participating practitioners in specialties that include primary care and high volume specialists. Other specialty practitioners may be included as necessary for peer review, e.g., dentists, chiropractors.
- Behavioral health practitioners including a psychiatrist, a psychologist and a masters level behavioral health clinician.

F. Practitioner Appeals Committee (PAC)
The PAC is responsible for practitioner appeals/hearings of adverse determinations related to quality of care concerns and credentialing decisions from CPC determinations.

The PAC meets on an ad hoc basis and is facilitated by a HCM Medical Director. The committee is composed of three to seven participating network practitioners;
- A majority of members are peers of the affected physician
- At least one peer must be licensed in the same state as each practitioner reviewed by the committee, and
- At least one voting member of the PAC shall practice in a specialty substantially similar to the specialty of the practitioner, if specialty knowledge is required by the nature of the appeal.

No voting member of the PAC may have had substantial prior involvement in the matter under appeal. However, this does not preclude PAC members who have participated in prior appeals by the same practitioner from voting.

G. Behavioral Health Quality Oversight Committee (BH QOC)
The BH QOC is a multidisciplinary committee that provides guidance and direction to the Aetna NCM BH staff and senior management who are accountable for behavioral health administrative, clinical and quality issues and utilization management activities. The BH QOC provides an environment for collaborative initiatives and facilitates the integration of behavioral health with primary medical services.

The role of the BH QOC includes the following:
- Establish priorities for behavioral health related QM and Care Management activities, evaluate clinical and operational quality and integrate quality improvement activities across Behavioral Health;
- Review and approval of behavioral health clinical and service quality indicator/monitors and quality improvement initiatives;
- Identify, select and monitor behavioral health prevention programs and oversee their implementation;
- Review and approval of behavioral health clinical specialty program reports;
- Monitor behavioral health related QM and Care Management activities for consistency with national program goals;
- Review and evaluate feedback from the BH QAC;
- Review regular reports from Behavioral Health national workgroups and committees for discussion and feedback as necessary;

2015 HMO and PPO QM Program Description *Includes Exchanges and Texas Fully Insured EPO

For Internal Use Only
Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies. (Aetna)
2015 Aetna Quality Management Program Description
HMO and PPO Based Products (Commercial and Medicare)

- Oversee BH QM department review of annual Aetna Care Management and QM Program Descriptions, and preparation and review of the BH QM Work Plan and BH QM/Care Management Program Evaluation for submission to the NQOC for approval;
- Provide summary reports on behavioral health related activities to the NQOC semi-annually;
- Adopt behavioral health clinical criteria and protocols based on recommendations from BH QAC;
- Review and adopt all behavioral health CPGs;
- Approve and provide oversight of behavioral health delegated activities;
- Review activities and recommendations of workgroups including the National Patient Safety Work Group; and,
- Review and adopt QM, National Care Management and selected policies and procedures as outlined in the QM-01 Policy and Procedure Development and Review Procedure and the NCM 501-01/02 Policy and Procedure Development and Review Procedure and reviews and adopts applicable state specific amendments.

The BH QOC meets at least ten times a year.

It is composed of the following members:
- BH Chief Medical Officer
- Manager, BH QM, Chairperson
- BH NCM Senior Medical Directors
- BH Clinical Services Heads
- BH National Head of Network or designee
- BH Quality Management staff
- Head of Customer Service and Call Operations or designee
- National QM Representatives

H. BH Quality Advisory Committee (BH QAC)
The BH QOC delegates the following functions to the BH QAC:
- Manage and provide direction on BH clinical quality improvement initiatives;
- Provide input into the QM Program through review and feedback on behavioral health quality improvement studies and surveys, clinical indicators, member, practitioner and organizational provider initiatives, preventive health programs, practitioner and organizational provider communications, BH QM Work Plan, and Program Evaluation (Executive Summary)
- Review BH clinical criteria and protocols for adoption by the BH QOC;
- Review BH CPGs for adoption by the BH QOC;
- Provide feedback to the NQAC regarding medical CPGs related to behavioral health;
- Make recommendations to the NGC on BH CPGs; and,
- Provide feedback to the National Pharmacy and Therapeutics Committee regarding the Preferred Drug Lists.

The BH QAC meets at least twice a year and membership includes the following:

2015 HMO and PPO QM Program Description *Includes Exchanges and Texas Fully Insured EPO

For Internal Use Only
Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies. (Aetna)
2015 Aetna Quality Management Program Description
HMO and PPO Based Products (Commercial and Medicare)

- BH Chief Medical Officer, Chairperson (or designee)
- Manager, BH QM
- BH NCM Senior Medical Directors
- BH QM Managers
- BH Clinical Services Heads
- Six to eight participating behavioral health practitioners to include at least one psychiatrist, one psychologist, one social worker, one other masters prepared clinician, one representative from a behavioral health organizational provider and one primary care physician. Other specialty practitioners may be included as necessary for clinical input.

I. National Quality Management Policy Committee (NQMPC)
The NQMPC serves as the review and policy approval body for all National QM and credentialing policies based on recommendations from an internal policy work group, the National Quality Management Policy Team.

The NQMPC meets eight to ten times per year. Membership includes, but is not limited to the following:
- National Medical Director, Quality Performance Measurement, Chairperson
- Head National Quality Management
- Head National Accreditation, NQM
- Behavioral Health National Quality Designee

J. National Quality Management Policy Team (NQMPT)
The NQMPT is a workgroup that serves as the review body for all National QM and credentialing policies, providing recommendations for updates to the National Quality Management Policy Committee.

The NQMPT meets eight to ten times per year. Membership includes, but is not limited to representation from the following areas:
- National Quality Management, Chairperson
- National Quality Management
- Behavioral Health Quality Management
- Aetna Government Programs
- Aetna Medicaid National Quality Management
- Credentialing
- @ CREDENTIALS, Inc. (ACI)
- National Network
- Regional Quality Management Compliance

K. National Care Management Policy Committee (NCMPC)
The NCMPC serves as the review and policy approval body for all National Care Management policies and procedures based on recommendations from an internal policy work group.

The NCMPC meets five times per year.

---

2015 HMO and PPO QM Program Description *Includes Exchanges and Texas Fully Insured EPO

For Internal Use Only
Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies. (Aetna)
Membership includes, but is not limited to the following staff or areas:
- VP National Medical Policy and Operations, Chairperson
- HCM Medical Director from each region
- National Accounts Care Management Solutions Team or (NACMST) Medical Director
- Regional Patient Management
- National Accounts Care Management Solutions Team or (NACMST) Patient Management
- BH Senior Medical Director
- BH Quality Management
- National Quality Management
- National Precertification
- Medical Policy and Program Support
- Women’s Health, Oral Surgery, Disease Management and Pharmacy (periodically)

L. National Guideline Committee (NGC)
The NGC serves as the review and approval body for CPGs and PSGs taking into consideration feedback received from the NQAC and the BH QAC.

The CMO is responsible for the review and final approval of all CPGs and PSGs. The NQOC reviews and adopts medical CPGs and PSGs. The BH QOC reviews and adopts the behavioral health related CPGs.

The NGC meets on an as-needed basis to conduct ongoing review and approval of CPGs and PSGs.

Membership may include Medical Directors or designees from the following areas:
- HCM Medical Director, Chairperson
- National Medical Director Quality and Provider Performance Measurement, Office of CMO
- HCM Regional Medical Directors
- Active Health Management
- Medical Policy Operations
- Women’s Health
- National Accounts
- Informatics and Strategic Alignment
- Behavioral Health Chief Medical Officer
- Medicare Program
- Pharmacy
- Aetna Medicaid National Quality Management Director

Additional national, regional, and local staff is asked to participate on specific ad hoc work groups, as indicated. These work groups may also include external consultants, hospital representatives, and practitioners.

M. Aetna Pharmacy Management Quality Oversight Committee (APM QOC)
Aetna Pharmacy Management (APM) has established the Aetna Pharmacy Management Quality Oversight Committee (APM QOC) to facilitate monitoring and oversight of clinical care, service
issues, and overall quality of care pertaining to Aetna Pharmacy Management enrollees as
specified in the committee description that follows. The APM QOC annually reviews and
approves the APM QM Program Description prior to submission to Pharmacy senior
management for approval.

The Aetna Pharmacy Management Quality Oversight Committee (APM QOC) is an internal
Pharmacy committee delegated authority by the Pharmacy Senior Management Team to
provide guidance and direction on Pharmacy administrative, clinical, service and quality issues.

The APM QOC membership is composed of cross-functional representation within APM and
from other functional areas within Aetna including, but not limited to:
- APM National Medical Director (Co-Chair)
- Head, Formulary Development and Pharmacy Clinical Policies
- Head, Pharmacy Compliance
- Pharmacy Compliance consultants
- Head, Aetna National Delegation and Risk
- Medicare Compliance managers
- Head, Pharmacy Quality & Oversight (Co-chair)
- Pharmacy Network Oversight manager
- Pharmacy Strategic Planning
- Pharmacy Product manager
- Manager, Pharmacy Business Development
- Managers of Clinical Pharmacy Audit/Quality team
- Manager of Pharmacy Clinical Programs
- Head, Medicare Clinical Programs
- Managers, Pharmacy Regional Business and Compliance
- Head, Clinical Account Management-National Accounts
- Marketing manager
- Manager, Pharmacy Complaints, Grievances and Appeals
- Manager, National Quality Management
- Aetna Rx Home Delivery representative
- Aetna Specialty Pharmacy representative
- Manager, Medicare Service Operations

Ad hoc cross-functional work teams or committees may be created by the APM QOC to address
specific issues. These teams may include other employees from within Pharmacy or from other
departments outside of Pharmacy whose knowledge and expertise would facilitate the cross-
functional work.

The NQOC and NRDOC include an APM QOC representative as a voting member to encourage
ongoing communication between these three (3) committees. The APM QOC additionally
includes a voting member from the NQOC and the NRDOC.
The role of the APM QOC includes the following:

- Oversee development, review, and approval of APM’s QM Program Description, Work Plan, and Program Evaluation prior to submission to Pharmacy Senior Management for approval;
- Review and approve annual amendments to APM QM Program Description, Work Plan, Program Evaluation, and periodic work plan updates;
- Evaluate clinical, service and operational quality data;
- Ensure quality improvement activities are integrated among all pharmacy activities within Aetna;
- Monitor APM QM activities for consistency and progress with department-wide program goals;
- Review and evaluate services to providers and members, including establishing standards for measurement, monitoring and ongoing auditing of pharmacy clinical and customer service activities, and member and provider satisfaction data;
- Review and evaluate potential quality of care concerns regarding pharmacy providers;
- Monitor Pharmacy compliance with state, federal and accreditation standards, and assist the Pharmacy Compliance department with implementing compliance action plans;
- Review and approve APM policies and procedures; Note: Targeted clinical and Medicare policies are also reviewed and approved by Aetna’s National P&T Committee;
- Monitor and oversee pharmacy record audits and analyses;
- Review subcontracting relationships to determine whether the arrangement is a delegation.
- Oversee Pharmacy delegated activities, quality and service metrics, with trending. Recommend and approve corrective actions, where applicable
- Review and supply comments and recommendations on the development, implementation and monitoring of Pharmacy clinical programs and Pharmacy patient safety initiatives within Aetna;
- Review the analysis of Complaint, Appeal and Grievance data; recommend and approve corrective actions, where applicable;
- Review and consider reports and feedback from other Aetna committees, such as the National P&T Committee, the NRDOC, NQOC and NQAC for input on Pharmacy policies and procedures;
- Oversee and monitor Pharmacy quality improvement studies and initiatives;
- Provide reports as necessary related to Pharmacy activity to other committees within Aetna.

The APM QOC meets at least six times yearly.

N. National Pharmacy & Therapeutics Committee (P&T)

Functions of the (P&T) Committee include:

- Reviews the Aetna formularies (Preferred Drug Lists) for all pharmacy benefit plans, including the National Commercial, Medicare and Health Care Marketplace Formularies. Aetna conducts reviews of medications based on P&T Committee’s clinical determinations (see below) and information regarding overall value (including cost and manufacturer rebate arrangements) and other factors before a decision on Preferred Drug List status is made.
• Makes recommendations regarding whether a drug represents an important therapeutic advance, is therapeutically similar to other available products, or has significant disadvantages in safety or efficacy when compared to other similar products in the same therapeutic class;
• Reviews and approves drug Medical Exception, Precertification, quantity limitations and Step-Therapy (Commercial) criteria;
• Reviews and approves Clinical Pharmacy policies and procedures; and
• Reviews and provides feedback and recommendations on pharmacy clinical programs.

The clinical information used by the P&T Committee comes from literature and database searches from a number of sources and includes, but is not limited to: DrugPoints® System, American Hospital Formulary Service Drug Information (AHFS-DI), and MicroMedex’s DrugDex, Clinical Pharmacology, National Comprehensive Cancer Network (NCCN) Drug & Biological Compendia, Medline and other databases, including relevant findings of Federal government agencies (e.g., National Institutes of Health, guidelines developed by federal government agencies, Agency for Healthcare Research and Quality, Centers for Disease Control and Prevention), medical professional associations (e.g., American Medical Association, American Academy of Pediatrics, American College of Cardiology), national commissions (e.g., Institute of Medicine, Expert Panel on Detection, Evaluation and Treatment of High Blood Cholesterol in Adults), and peer-reviewed journals (e.g., Journal of the American Medical Association, New England Journal of Medicine, Annals of Internal Medicine, Drugs, Annals of Pharmacotherapy). An AMCP Format for Formulary Submission dossier, if available, will also be utilized with new drugs to the market, and other currently available drugs.

The P & T Committee will have regular meetings not less than once a quarter, with ad hoc meetings as necessary. The Committee may invite to its meetings persons outside or within Aetna who can contribute specialized or unique knowledge, skills, and judgment.

The membership includes the following members, both internal employees and external members who are practicing physicians and pharmacists:
• Geriatrician Physician Specialist (Board-certified) – external
• Geriatric Clinical Pharmacist Specialist (Board-certified) – external
• Physician Specialty in Internal Medicine – external
• Physician Specialty in Cardiology – external
• Physician Specialty in Endocrinology – external
• Physician Specialty in Gastroenterology – external
• Clinical Policy Medical Director (Chair)
• Head, Clinical Strategy (Co-Chair)
• Medical Director, Behavior Health
• Medical Director, Commercial/Medicare
• Medical Director for Pharmacy
• Clinical Pharmacy Director and Managers, Clinical Strategy
• Clinical Pharmacy Director and Managers, Specialty Strategy
• Chief Pharmacist, Medicare

2015 HMO and PPO QM Program Description *Includes Exchanges and Texas Fully Insured EPO

For Internal Use Only
Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies. (Aetna)
2015 Aetna Quality Management Program Description
HMO and PPO Based Products (Commercial and Medicare)

- Clinical Pharmacy Directors and Managers, Medicare

Aetna Medical Director Specialists and other employees, who may be knowledgeable in a particular area to be discussed, maybe invited by the Co-Chairs, as non-voting guests.

All committee members must disclose any factors that may create a real or apparent conflict of interest or financial stake related to any of the manufacturers whose products are being considered in Preferred Drug List determinations.

A Physician Specialists Consultant Board of practicing physicians/clinicians will be used on a consultant/advisory ad hoc basis to contribute specialized or unique knowledge, skills, and judgment. Physician Specialists may be invited by the Co-Chairs to the Committee meetings as necessary. Specialists from the Consultant Board will not have voting privileges.

O. Corporate Appeals Committee (CAC)
The CAC handles all appeals identified as appropriate by the HCM Regional Medical Directors regarding commercial non-behavioral health second and/or final level appeals of clinical adverse determinations (including medical necessity, experimental and investigational and/or cosmetic) in addition to clinical denials regarding any of the Aetna Health Connections National Medical Excellence® (NME) (AHC NME) programs. The CAC also handles commercial final level appeals of benefit denials and benefit level reductions for NME issues when there is a clinical component to the review.

The CAC will meet on a regular weekly schedule with emergency meetings held as necessary for expedited cases and membership includes representatives from following areas:
- Chief Medical Officer (chairperson)
- VP, National Medical Director for Quality Performance
- VP, National Medical Policy and Operations
- VP, National Accounts Medical Director
- VP, Chief Medical Officer Government Services
- VP, Chief Medical Officer Local and Regional Businesses
- VP, Medicare Medical Operations
- VP, National Medical Director Clinical Thought Leadership
- VP, National Medical Director Pharmacy Strategy
- Senior Director, Medical Policy Research & Development
- National Medical Excellence Medical Director
- National Medical Director Oncology Strategies
- Senior Medical Director, MPO
- Regional Medical Director – rotating position
- Deputy Chief Legal Counsel, Health Delivery (non-voting)
- Regional Counsel or National Accounts Counsel, when appropriate (non-voting) Communications (non-voting)
- Executive Response Team representative (as needed for ERT cases) (non-voting)
P. **External Review Oversight Committee (EROC)**

The (EROC) provides feedback on outcomes, identifying areas of improvement and assists in facilitating process changes related to initial coverage decisions, appeals and external review by:

- Identifying trends in medical technology and community standards of medical care that may result in modifying Aetna Clinical Coverage Policies.
- Formulating recommendations and assisting to operationalize process improvements related to pre-authorization and appeal handling.
- Evaluating the processes related to rendering coverage decisions and recommending action steps to achieve national consistency and compliance.
- Identifying internal training needs.
- Providing feedback on external review outcomes to local/regional and national medical management teams.
- Developing policy and/or procedures to ensure compliance with regulatory agencies and accrediting bodies’ requirements for independent external review.
- Providing feedback and or recommendations on plan design and potential benefit changes/modifications.
- Compliance with Aetna’s National Complaint and Appeal Policy and Aetna’s National External Review Policy.

The EROC meets bi-annually. Membership includes, but is not limited to representation from the following areas:

- NCM Senior Medical Director (Chairperson)
- HCM PM/QM Medical Director from each Aetna Region
- Medical Director Behavioral Health
- NCAU
- Medical Director Clinical Policy and Research

**Committee Support:**
- External Review Unit Staff
- Legal

Q. **Medicare External Review Oversight Committee (MEROC)**

The Medicare External Review Oversight Committee (MEROC) provides feedback on outcomes, identifying areas of improvement and assists in facilitating process changes related to initial coverage decisions by:

- Formulating recommendations and assisting to operationalize process improvements related to pre-authorization and appeal handling.
- Evaluating the processes related to rendering coverage decisions and recommending action steps to achieve national consistency and compliance.
- Identifying internal training needs.
- Providing feedback on Maximus external review outcomes to local/regional and national medical management teams.
- Developing policy and/or procedures to ensure compliance with regulatory agencies.
• Providing feedback and or recommendations on plan design & potential benefit changes/modifications.
• Compliance with Aetna’s Medicare Complaint and Appeal Policy.

The Medicare EROC meets quarterly. Membership includes, but is not limited to representation from the following areas:
– Director of Appeals and Dedicated Appeal Medical Director (Chairperson)
– Medicare Compliance
– HCM PM/QM Medical Director from each Aetna Region
– Medicare Clinical Appeals Unit
– Medicare Grievance and Appeals Unit

R. National Risk and Delegation Oversight Committee (NRDOC)
The NRDOC has oversight of the national delegation arrangements for the following:
• National Risk and Delegation policies, procedures and processes;
• Overall monitoring and reporting of risk entity and delegate performance;
• Performance metrics and accountability; and
• Approval and oversight activities delegated to external (non-Aetna) entities under National Delegation Agreements including:
  o Claims arrangements (national)
  o Claims Pass-through arrangements (both national and regional)
  o TPA arrangements
  o Customer Service (both national and regional)
  o Telesales and marketing

The NRDOC meets quarterly and is a multidisciplinary group composed of members representing the following functions:
– Deputy Chief Counsel (Health Delivery)
– Co-chair, National Delegation Management
– Co-chair, Finance for HCM
– Sr. Compliance Director - Law and Regulatory Compliance
– Advisory Members:
  1. Medicare Compliance
  2. Network
  3. Quality Management - Delegation

IX. Quality Management Program Components

A. Practitioner/Provider Selection and Retention
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 business criteria include business criteria, and professional, competence and conduct criteria.
2015 Aetna Quality Management Program Description  
HMO and PPO Based Products (Commercial and Medicare)

_Credentialing/Recredentialing_

The credentialing/credentialing 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;
- Rental network practitioners who are used as a part of the organization’s primary network and the organization has members who reside in the rental network area;
- Rental network practitioners who are specifically for out-of-area care and members may see only those practitioners;
- Rental network practitioners who are specifically for out-of-area care and there is an incentive communicated to members to see rental network practitioners;

The credentialing/credentialing 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 CPCs have 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 RMDC 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.
- Potential qualities of care (PQOC) issues 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 a recredentialing 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.
- Practitioners participating with Medicare are monitored quarterly for changes to their opt-out status.

**Facility Assessments**
Aetna staff assesses the following categories of contracted facilities including 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.

Additionally, in networks where the Medicare Advantage products are offered, the organizational providers must include: laboratories, rehabilitation agencies (comprehensive outpatient rehabilitation facilities, outpatient physical therapy and speech pathology providers) and renal disease services, outpatient diabetes self-management training providers, portable x-ray suppliers, rural health clinics and federally qualified health centers.

2015 HMO and PPO QM Program Description *Includes Exchanges and Texas Fully Insured EPO*
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 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, Aetna evaluates potential quality of care concerns. All Aetna staff is responsible and accountable for the identification and communication of potential quality of care concerns to the appropriate QM staff responsible for the geographical location where the practitioner or provider practices 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 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.

*Includes Exchanges and Texas Fully Insured EPO*
An oversight or delegation pre-assessment questionnaire is used in the decision-making process. Aetna’s oversight/delegation process includes a review of the prospective organization’s program for adherence to health plan and NCQA standards, as well as, compliance with applicable federal and state laws and regulations. The NVDOC is responsible for the approval and ongoing oversight and delegated activities, variances will be 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 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, 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 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 members’ rights and responsibilities policies.
Members’ responsibilities include the responsibility to provide, to the extent possible, information needed by Aetna 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**
Aetna considers member protected health information (PHI) private and confidential, and has 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, Aetna uses PHI internally, shares it with Aetna affiliates, and discloses 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. Aetna provides 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**
Aetna provides a mechanism for members to express and resolve disagreements concerning services, claims, benefits, participating practitioners and providers, and administrative contract policies. The Aetna Member Complaint and Appeal policy defines a clear framework for resolution of member complaints and appeals in a timely and efficient manner. The policy addresses pre-service, post-service, and expedited appeals. The member complaint and appeal procedures have been established to support implementation of the Aetna Member Complaint and Appeal policy.

Every effort is made to resolve a member’s complaint at the Customer Service department level. If a Customer Service Representative is unable to resolve a complaint to the member’s satisfaction, the issue is forwarded to a Customer Resolution Team for handling. All member appeals are investigated and resolved by the appropriate Customer Resolution Team. All members receive information on the procedures governing complaints and appeals.
All complaints and appeals are tracked, trended and reported to the NQOC at least annually. Also, complaints regarding Medicare Disenrollment are tracked, trended and reported to the NQOC at least annually. Analysis is performed to determine root cause and to improve plan performance.

The Aetna Medicare Advantage Plan and Aetna Prescription Drug Plan are governed by the Centers for Medicare and Medicaid Services (CMS). The resolution of Medicare member complaints, also known as grievances, and member and non-contracted provider appeals are regulated by federal law. CMS requirements for grievance and appeal review are outlined in the Medicare Managed Care Manual, Chapter 13, and the Medicare Prescription Drug Benefit Manual, Chapter 18. The Aetna Medicare Grievance and Appeal Policies and the Aetna Medicare Non Contracted Provider Payment Appeal Policy outline Aetna’s adherence to CMS regulatory guidelines and review timeframes. These policies address grievances, potential quality of care issues, expedited grievances, expedited appeals, pre-service appeals, and post-service appeals. The Medicare member grievance and the Medicare member and non-contracted provider appeal procedures have been established to support implementation of the Aetna Medicare Grievance and Appeal Policies and the Aetna Medicare Non-Contracted Provider Payment Appeal Policy.

Every effort is made to resolve a Medicare member’s verbal grievance at the Customer Service department level. The grievance is then submitted to the Medicare Grievance Team for handling. If the member elects to file a formal written grievance, the issue will be resolved by the Medicare Grievance Team. The Medicare Grievance Team also facilitates member appeals being forwarded for external review per the Medicare Appeal Process. Additionally, Medicare members receive information annually on the procedures governing grievances and appeals.

Aetna provides a mechanism for practitioners/organizational providers to express and resolve disagreements concerning payment and benefit decisions. Aetna policies define a uniform approach for resolution of practitioner/provider complaints and appeals in a timely and efficient manner. Every effort is made to resolve the practitioner/provider complaint at the Provider Service department level. All practitioners/providers have access to Aetna’s description of the procedures governing complaints and appeals. This includes Medicare providers’ disagreements that do not fall under a program regulated by CMS.

**External Review Program**

Aetna offers an external review program for all members enrolled in insured and self-funded health benefit plans who have exhausted the applicable appeal process. Self-funded plan sponsors who maintain fiduciary status must elect the external review program for their members to be eligible for this process.

Aetna handles external review for insured plans following state mandates and/or the Health & Human Services (HHS) process where applicable. For our self-funded plans, Aetna administers the federal DOL external review process on behalf of plan sponsors, upon request. The external review process is available in most instances to eligible members when an adverse or final internal adverse benefit determination based upon medical judgment has been rendered. In
some states, a simultaneous expedited external review and an internal appeal is available for urgent care cases.

Aetna’s National External Review Unit facilitates the external review process and refers eligible cases to one of three URAC accredited vendors on a rotational basis and is responsible for choosing the physician reviewer with the appropriate expertise to examine clinical issues. Physician reviewers are required to be board certified by the appropriate American Medical Specialty Board in the clinical specialty/area at issue. Members are not charged a professional fee for external review. The decision of the independent external review expert is binding on Aetna and when applicable, the plan sponsor.

**Note:** The process outlined above does not apply to Medicare Advantage member appeals, which are governed by the Medicare appeals process (including review by an independent entity) pursuant to federal regulations.

Aetna Medicare Advantage member’s appeals are referred to an external review organization following the processes established by the Centers for Medicare and Medicaid Services. The Medicare Appeal Teams serve as the liaison between Aetna and the external review organization.

**C. Access and Availability**

**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 Aetna accessibility standards is measured using valid methodology and analyzed on an annual basis utilizing the following mechanisms:

- Primary Care Physician 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, member experience survey data (CAHPS 5.0H Adult Commercial Consumer Satisfaction Survey, Medicare Advantage Prescription Drug Plan CAHPS® 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 Aetna Behavioral Health accessibility standards is measured using valid methodology and analyzed on an annual basis utilizing the following mechanisms:

- Behavioral Health 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, satisfaction survey data (CAHPS 5.0H Adult Commercial Consumer Satisfaction Survey, Behavioral Health Member Experience Survey, Behavioral Health Provider Satisfaction Survey) and/or telephonic surveys.
2015 Aetna Quality Management Program Description  
HMO and PPO Based Products (Commercial and Medicare)

- 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 Behavioral Health 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, and high volume specialties,
- Number and distribution of Organizational and Institutional Providers in Commercial and Medicare networks,
- Public Transportation Assessment in Medicare networks, and
- 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 QOC 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 Behavioral Health Representative.

**Member Experience**

Aetna is 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 patients to create a culture of better health: connected, simpler, intuitive, convenient, affordable and powerful.

Providers influence consumer satisfaction, 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, Aetna encourages members to offer suggestions and express their concerns through the customer services telephone lines, as well as, Aetna’s secure member website.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS 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 and patients’ experiences

2015 HMO and PPO QM Program Description *Includes Exchanges and Texas Fully Insured EPO

37

For Internal Use Only

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies. (Aetna)
with the health care system. NCQA compiles the CAHPS® data in the NCQA Quality Compass®, which compares consumer satisfaction data across health plans and over time.

Among the surveys utilized are:

- The CAHPS Health Plan Survey, version 5.0H Adult Questionnaire. The CAHPS survey is a standardized patient questionnaire sent to consumers to rate providers and health plans on a number of criteria, but they differ in that they go beyond the ratings questions to ask consumers to report on their personal experiences with health care services. This information is regarded as more specific, understandable, objective and actionable than general rating alone.

CAHPS evaluates plans on the following criteria:

- Rating of Health Care
- Rating of Doctor
- Rating of Specialists
- Rating of Health Plan
- Getting Needed Care (ease of appointments with specialists; care, tests, treatment easy to get through plan)
- Getting Care Quickly
- How Well Doctors Communicate (doctors listened, good health literacy)
- Customer Service (got needed information; treated with courtesy)
- Claims processing (claims handled quickly and correctly)

- Medicare Advantage CAHPS® Survey – CMS administers a version of the CAHPS® survey, the MA CAHPS® survey, to beneficiaries in Medicare Advantage programs. The survey is administered annually to eligible member samples as defined by Centers for Medicare & Medicaid Services (CMS). The purpose is to collect information on members’ perception of access, utilization, and satisfaction. The survey collects many of the same measures as the Commercial CAHPS®.
  - Flu Shots for Older Adults,
  - Pneumonia Vaccination Status for Older Adults,
  - Medical Assistance w/Smoking Cessation.

- The Medicare Health Outcomes Survey (HOS) – The HOS is a longitudinal outcomes survey that measures the change in physical and mental functioning of a cohort of Medicare beneficiaries over time. Health plans are responsible for contracting for and paying the cost of the HOS survey. The following measures are collected through the survey:
  - Management of Urinary Incontinence in Older Adults,
  - Physical Activity in Older Adults,
  - Fall Risk Management, and
  - Osteoporosis Testing in Older Women.
• **BH Member Experience Survey:** Aetna administers this survey 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.

• **Disease Management Experience Survey:** The Disease Management Survey is administered annually. The objectives of this study are to monitor and evaluate the experience among Aetna members who have utilized Disease Management services and to determine the key drivers of satisfaction with the program. Insight into how well the AHC-DM program is meeting member expectations helps to identify areas where the program is performing well and areas in need of improvement.

The survey focuses on the member’s program experience, interaction with program representative, and quality of written materials. Survey topics include:
- Satisfaction that program helps members better manage health
- Likelihood to recommend the program
- Assessment of program impact on:
  - Health knowledge
  - Productivity at work/school
  - Health status
  - Quality of life
  - Behavior change
- Phone interaction with program representatives
- Clarity and quality of written or electronic program materials
- Comments/suggestions for program improvement

• **Case Management Satisfaction Survey:** The Case Management Survey is administered at least annually. The objectives of this survey are as follows:
- Assess member’s experience with Aetna medical management programs across all employers and products.
- Create a member experience benchmark for the program whereby employers who choose the sponsor-specific survey option will be able to compare their specific results to the overall norm.
- Determine key drivers of member’s experience with the case management program.

• **Nurse Line (Informed Health) Experience Survey:** The Informed Health Line Survey is administered annually. The objectives of this research are as follows:
- Assess satisfaction with Aetna medical management programs across all employers.
- Create a satisfaction benchmark for each program whereby employers who choose the sponsor-specific survey option will be able to compare their specific results to the overall norm.

**D. Clinical Care Improvement**

2015 HMO and PPO QM Program Description *Includes Exchanges and Texas Fully Insured EPO*

For Internal Use Only

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies. (Aetna)
Clinical Practice and Preventive Services Guidelines, Programs, and Monitoring
The Aetna process has been designed to adopt guidelines relevant to the enrolled membership for the provision of preventive, acute, chronic and behavioral health services. Aetna’s CPGs and PSGs are adopted and made available to practitioners to facilitate improvement of health care.

Aetna adopts 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).

Aetna adopts 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, Aetna may adopt recommendations from other nationally recognized sources.

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

The information content of these guidelines may be broadly distributed to practitioners and members. Members receive information about health promotion, health education and preventive health services on a regular basis. In addition, members within certain age and risk groups are targeted and made aware of health promotion and preventive services available to them. Also, this information is available to members through the Aetna secure member website. In order to assess whether prevention and early detection health services are provided appropriately, the health plan annually monitors and evaluates its performance as part of the QM Program using such indicators as HEDIS and CAHPS.

Behavioral Health Preventive Health Programs
Aetna maintains behavioral healthcare screening programs based on the needs of the covered population. The screening programs are designed to detect or prevent the incidence, emergence or worsening of behavioral disorders. Aetna behavioral healthcare programs address Perinatal and Postpartum Depression and Substance Abuse Screening for Adolescents with Depression and/or Anxiety (SASADA). Practitioners and providers who participate on the BH QAC provide input into the program design and implementation on an annual basis. Information for screening programs and any program revisions 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.

The Perinatal and Postpartum Depression Screening and Prevention Program is also a tertiary prevention program targeting members who have used or are using their MBHO services,
members who are receiving behavioral health care from their primary care physician, and all members not receiving behavioral health care services who are in need of them. The targeted population is all pregnant female members who screen positive for depression using the Two Question Prime MD tool. Members are provided with case management services including but not limited to appointment coordination, member engagement through motivational interviewing, coordination with the Beginning Right Nurse, and provision of educational materials.

The SASADA Screening Prevention Program is also a secondary prevention program aimed at reducing the duration of an episode of care and preventing future recurrences. The targeted population is all adolescents (ages 12 to 17 and those who turn 18 while in treatment) being treated in a higher level of care with depression, cyclothymic, anxiety or mood disorder.

Members are identified through clinical case management data, use of the LOCAT tool, facility assessment and, where possible, urine drug screen. Behavioral health staff working in conjunction with the facility staff determine if the adolescent screens positive for substance use/abuse issues. Members who are positive are offered chemical dependency services in accordance with their clinical presentation. Chemical dependency services may include but are not limited to education, formalized substance abuse treatment, self-help groups or community based resources.

**Continuity and Coordination of Medical Care**

Aetna collects and analyzes data to assess coordination of care across settings or transitions in care to identify opportunities to improve coordination of medical care such as:

- Evaluating how effectively and consistently other practitioners and providers are communicating with the PCP through the Physician Practice Survey.
- Monitoring performance against clinical practice and preventive health care guidelines through HEDIS measurement.
- Evaluating member satisfaction with case management in regard to assistance received around coordination of care needs through the Case Management Satisfaction Survey.
- Assessing member perception of whether their physician seems informed of care they are receiving from other practitioners through a question on the CAHPS survey.

Aetna collaborates with practitioners to improve continuity and coordination of medical care through activities such as:

- UM and Post-discharge Call Programs;
- Readmission Risk Reduction Programs;
- Discharge planning;
- Case management;
- Continued access of members to practitioners who no longer participate in the network under certain circumstances; and
- Targeted quality outreach initiatives e.g. reminders to members and/or practitioners regarding missed services such as retinal eye exams or osteoporosis screening.

2015 HMO and PPO QM Program Description *Includes Exchanges and Texas Fully Insured EPO

For Internal Use Only

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies. (Aetna)
Continuity and Coordination between Medical and BH Care
Aetna monitors continuity and coordination of care between medical physicians and behavioral health practitioners under five specific areas. The specific areas and identified data sources that may be used to monitor collaboration of care are listed below.
2015 Aetna Quality Management Program Description
HMO and PPO Based Products (Commercial and Medicare)

Exchange of Information
- Physician Practice Survey;
- Behavioral Health Provider Satisfaction Survey Questions related to PCP Communication;
- Behavioral Health Member Experience Survey Questions related to PCP Communication;
- Behavioral Health Practitioner Treatment Record Audits.

Appropriate Diagnosis, Treatment and Referral of Behavioral Health Disorders Commonly Seen in Primary Care & Appropriate Use of Psychopharmacological Medications
- HEDIS Antidepressant Medication Measures;
- HEDIS Follow-Up Care For Children Prescribed Attention Deficit Hyperactivity Disorder Medication;
- HEDIS Initiation and Engagement of Alcohol and Other Drug Dependence Treatment; and
- Primary Care-BH Initiatives (Depression in Primary Care-DPC; Screening, Brief Intervention and Referral to Treatment-SBIRT; and Integrated Program).

Screening and Management of Treatment Access and Follow-up for Members with Coexisting Medical and Behavioral Health Disorders
- Med Psych Case Management Program enrollments, completions and PHQ-9 outcome measures;
- Trigger Diagnosis Program Outcome Measures (BH Ambulatory Follow Up and Specialty Program Enrollment).

Primary or Secondary Preventative Behavioral Health Program Implementation
- Beginning Right Perinatal and Postpartum Screening and Prevention Program;
- Behavioral Health Depression Disease Management Program enrollments, completions and PHQ-9 outcome measures;
- Depression Screening for Medicare Members with High Risk Medical Comorbidity Program.

Special needs of Members with Severe and Persistent Mental Illness
- Aetna internal administrative data using HEDIS specifications (internal data) Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

**Coordination of Behavioral Health Care**
Aetna 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
- Outpatient Care Management Program
- Intensive Case Management (ICM) Program
- Utilization Management Clinician (UMC) Chart Audits

2015 HMO and PPO QM Program Description *Includes Exchanges and Texas Fully Insured EPO

For Internal Use Only
Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies. (Aetna)
Aetna

2015 Aetna Quality Management Program Description
HMO and PPO Based Products (Commercial and Medicare)

- BH Practitioner Treatment Record Review (TRR) Audits
- BH Provider Satisfaction Survey

Access and Follow Up
- Follow Up after Mental Health Inpatient Hospitalization (FUH) Program
- Substance Abuse Screening for Adolescents with Depression and/or Anxiety Program (SASADA)

Psychotropic Medication Use
- HEDIS Antidepressant Medication (AMM)Measures
- HEDIS Follow-Up Care For Children Prescribed Attention Deficit-Hyperactivity Disorder (ADHD)Medication

Antipsychotic Medication Adherence Rates

Severe and Persistent Mental Illness
- Internal Data Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
- Antipsychotic Medication Adherence Rates

Clinical Improvement Teams
National QM staff work collaboratively with other business areas, such as Medicare, disease 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
Aetna has mechanisms in place to evaluate the appropriate use of medical technologies. Aetna’s CPBs express Aetna’s 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) for the purpose of making coverage decisions under Aetna administered health benefits plans. CPBs are used in conjunction with the terms of the member’s benefits plan and other Aetna-recognized criteria to determine health care coverage for Aetna members. Aetna’s 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 Aetna’s Clinical Policy Council, external practicing clinicians, and review and final approval by Aetna’s Chief Medical Officer or designee. CPBs are reviewed and updated 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.

2015 HMO and PPO QM Program Description *Includes Exchanges and Texas Fully Insured EPO

For Internal Use Only

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies. (Aetna)
E. Medicare Quality Improvement(QI) Programs

Annual Chronic Care Improvement programs (CCIPs) and Quality Improvement Projects (QIPs) are implemented and maintained for Medicare Advantage (MA) HMO and PPO members in accordance with CMS requirements. These quality improvement programs are designed and conducted to have a beneficial effect on health outcomes and beneficiary satisfaction.

An annual evaluation of the impact and effectiveness of the QI Programs will be conducted using the Plan, Do, Study, Act cycle for problem-solving and process improvement. Information systems are maintained to allow the data to be collected, analyzed and integrated to implement the QI Programs using approved data sources. This process will ensure that all information received from the providers of services is complete, reliable and available to CMS. This will allow for correction of any problems and adjustments to interventions that have come to the plan’s attention. The measurement tools required by CMS are used to report performance.

Chronic Care Improvement Program (CCIP)

This Chronic Care Improvement Program has a clinical focus. It is relevant to the plan population and is designed to improve health outcomes and quality of care for Medicare Advantage members with chronic conditions. The program has a process for identifying MA enrollees with chronic conditions who would benefit from participating in the program and established mechanisms for monitoring the MA enrollees participating in the CCIP.

The program design is supported by evidence-based medical practice guidelines and standards, multidisciplinary care teams and member and/or provider focused education.

Specific, measurable goals and valid, relevant benchmarks are identified for program analysis. Data is reviewed and analyzed annually. The Health Plan Management System (HPMS) is used to document general information about the project, relevance to the population, performance indicators, data sources, improvement methodology, interventions and results. Report status and results of each project are reported to CMS as requested.

Quality Improvement Projects (QIP)

The Quality Improvement Project(s) (QIP) will focus on a significant aspect of clinical and non-clinical care and measurement and improvement of performance based upon established guidelines.

To assess performance, the quality indicator(s) will be objective, clear and defined, based on current clinical knowledge or health services research.

Quality indicator(s) will be measured and directed at measuring outcomes such as changes in health status, functional status and/or enrollee satisfaction. Data will be collected annually.

System interventions will be focused on achieving demonstrable improvement, including the establishment or alteration of practice guidelines. The results of the project will be reported to CMS as requested.

2015 HMO and PPO QM Program Description *Includes Exchanges and Texas Fully Insured EPO

45

For Internal Use Only

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies. (Aetna)
Performance assessment will be based on systematic ongoing collection and analysis of valid and reliable data.

QIP interventions are designed to achieve demonstrable improvement. This includes systematic and periodic follow-up on the effect of the interventions which will allow for correction of any problems and adjustments to interventions that have come to the plan’s attention.

CMS’ QIP template is used to document general information about the project, relevance to the population, performance indicators, data sources, improvement methodology, interventions and results. Report status and results of each project are reported to CMS as requested.

**Standard Medicare Reporting Requirements for HEDIS, HOS and CAHPS**

In order to assess whether prevention and early detection health services are provided appropriately, performance will be monitored annually using such indicators as:

- CMS administers a version of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, the MA CAHPS survey, to beneficiaries in MA programs. The CAHPS 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 and patients’ experiences with the health care system.
- The Healthcare Effectiveness Data and Information Set (HEDIS) is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of healthcare organizations. HEDIS is audited in accordance with NCQA specifications. Reports are produced annually and results are submitted to NCQA for public reporting and accountability.
- The Medicare Health Outcomes Survey (HOS) directed by CMS is a longitudinal outcomes survey that measures the change in physical and mental functioning of a cohort of Medicare beneficiaries over time.
# 2015 Aetna Quality Management Program Description

### Signature Page

This document has been approved by the National Quality Oversight Committee, Chief Medical Officer, Aetna Life Insurance Company (ALIC) Board of Directors and respective HMO Board of Directors.

<table>
<thead>
<tr>
<th>PREPARED BY:</th>
<th>1/23/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nancy Frerker</td>
<td></td>
</tr>
<tr>
<td>National Quality Management QM Program Team</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SUBMITTED BY:</th>
<th>1/23/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kimberly Carpenter</td>
<td></td>
</tr>
<tr>
<td>Kimberly Carpenter, MBA</td>
<td></td>
</tr>
<tr>
<td>National Quality Management</td>
<td></td>
</tr>
<tr>
<td>Head of QM Program and Accreditation</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RECOMMENDATION FOR APPROVAL BY:</th>
<th>2/4/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Robison</td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Quality Oversight Committee, Chair</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>APPROVED BY:</th>
<th>2/16/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harold L. Paz MD</td>
<td></td>
</tr>
<tr>
<td>Chief Medical Officer</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2/4/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dennis Harston, MD, West Region Medical Director (Nevada) Chairperson, National Quality Oversight Committee</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Date</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2/16/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milton Sakamoto, MD, West Region Medical Director (Nevada and California)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Date</td>
</tr>
</tbody>
</table>

### 2015 HMO and PPO QM Program Description

*Includes Exchanges and Texas Fully Insured EPO*

---

For Internal Use Only

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies.

(Aetna)
2015 Aetna Quality Management Program Description
HMO and PPO Based Products (Commercial and Medicare)

Signature Page, continued
This document has been approved by the National Quality Oversight Committee, Chief Medical Officer, Aetna Life Insurance Company (ALIC) Board of Directors and respective HMO Board of Directors.

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grant Tarbox, DO, Mid America Region Senior Medical Director (Texas)</td>
<td>2/4/2015</td>
</tr>
<tr>
<td>Laurie Brubaker, Local Market Head – Northeast Chairperson, Pennsylvania Board of Directors</td>
<td>6/23/2015</td>
</tr>
<tr>
<td>Hoyland Ricks, MD, Southeast Medical Director (Tennessee)</td>
<td>2/5/2015</td>
</tr>
<tr>
<td>Brian Ternan, Local Market Head Aetna Health of California Inc. Board of Directors</td>
<td>4/28/2015</td>
</tr>
</tbody>
</table>

2015 HMO and PPO QM Program Description *Includes Exchanges and Texas Fully Insured EPO

For Internal Use Only
Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies.
(Aetna)
2015 Aetna Quality Management Program Description
HMO and PPO Based Products (Commercial and Medicare)

Signature Page, continued
This document has been approved by the National Quality Oversight Committee, Chief Medical Officer, Aetna Life Insurance Company (ALIC) Board of Directors and respective HMO Board of Directors.

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gilbert E. Keegan</td>
<td>5/18/2015</td>
</tr>
<tr>
<td>Connecticut/Maine Board of Directors</td>
<td>Date</td>
</tr>
<tr>
<td>Chris Ciano, President, Local Market Head</td>
<td>6/29/2015</td>
</tr>
<tr>
<td>Florida Board of Directors</td>
<td>Date</td>
</tr>
<tr>
<td>Angela Meoli, President, Local Market Head</td>
<td>6/15/2015</td>
</tr>
<tr>
<td>Georgia Board of Directors</td>
<td>Date</td>
</tr>
<tr>
<td>Greg Martino, Senior State Government Relations Specialist</td>
<td>6/11/2015</td>
</tr>
<tr>
<td>Aetna Health Inc. Michigan Board of Directors</td>
<td>Date</td>
</tr>
<tr>
<td>John Lawrence, Local Market Head – Northeast</td>
<td>5/7/2015</td>
</tr>
<tr>
<td>New Jersey Board of Directors</td>
<td>Date</td>
</tr>
<tr>
<td>Terry Golash, MD, Northeast Medical Director (New York)</td>
<td>2/5/2015</td>
</tr>
<tr>
<td>Member, National Quality Oversight Committee</td>
<td>Date</td>
</tr>
</tbody>
</table>

2015 HMO and PPO QM Program Description *Includes Exchanges and Texas Fully Insured EPO

For Internal Use Only
Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies. (Aetna)
<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Steven S. Logan</td>
<td>President, Local Market Head</td>
<td>6/16/2015</td>
</tr>
<tr>
<td></td>
<td>New York Board of Directors</td>
<td></td>
</tr>
<tr>
<td>Michael Mesoras, MD</td>
<td>Northeast Medical Director (Pennsylvania)</td>
<td>2/4/2015</td>
</tr>
<tr>
<td></td>
<td>Member, National Quality Oversight Committee</td>
<td></td>
</tr>
<tr>
<td>Ralph Holmes, President</td>
<td>Local Market Head</td>
<td>6/9/2015</td>
</tr>
<tr>
<td></td>
<td>Texas Board of Directors</td>
<td></td>
</tr>
<tr>
<td>Leah Jacobson, MD</td>
<td>Northeast Medical Director (Vermont)</td>
<td>2/13/2015</td>
</tr>
<tr>
<td>Todd Trettin</td>
<td>Local Market Head</td>
<td>5/7/2015</td>
</tr>
<tr>
<td></td>
<td>Utah Board of Directors</td>
<td></td>
</tr>
</tbody>
</table>

2015 HMO and PPO QM Program Description *Includes Exchanges and Texas Fully Insured EPO

For Internal Use Only

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies. (Aetna)
The following national committees support the QM Program and may exchange information and reports with the NQOC:

- National Pharmacy and Therapeutics Committee (P&T)
- Corporate Appeals Committee (CAC)
- External Review Oversight Committee (EROC)
- Medicare External Review Oversight Committee (MEROC)
- National Risk and Delegation Oversight Committee (NRDOC)

2015 HMO and PPO QM Program Description *Includes Exchanges and Texas Fully Insured EPO

For Internal Use Only
Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies. (Aetna)
### State Amendments

The following amendments have been made to the QM Program Description.

<table>
<thead>
<tr>
<th>Rationale</th>
<th>Page</th>
<th>Revision</th>
<th>Applicability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulatory <strong>Arkansas</strong> 23-99-412</td>
<td>18</td>
<td>National Quality Advisory Committee</td>
<td>HMO: X</td>
</tr>
<tr>
<td>Regulatory <strong>California</strong> 28 CCR 1300.70 (b)(2)(D)&amp;(E)</td>
<td>16</td>
<td>The chair of the NQOC shall be a medical director licensed in the state of California.</td>
<td>PPO: X</td>
</tr>
<tr>
<td>Regulatory <strong>California</strong> Knox Keene Act §1369 CA Health and Safety Code §1369 CA Code of Regulations §1300.69</td>
<td>16</td>
<td>The California Public Policy Committee (PPC) makes consumer advisory recommendations to the health plan. The committee advocates for the consumer and issues recommendations such as benefit changes or enhancements and language changes on member literature. Membership includes members, plan sponsors (employer group representatives), an insurance consultant/broker, a network physician and Aetna Health of California management representatives. The PPC reports to the California Board of Directors.</td>
<td>HMO: X</td>
</tr>
<tr>
<td>Regulatory <strong>California</strong> Technical Assistance Guide (TAG for QM-002) 40 Clinical Practice and Preventive Services Guidelines, Programs and Monitoring</td>
<td>40</td>
<td>The QM Evaluation shall include a report including demographic, mortality and morbidity parameters which are relevant to the California Commercial HMO population.</td>
<td>PPO: X</td>
</tr>
<tr>
<td>California only: Aetna Employee Assistance Program Quality Oversight Committee (Aetna HHRC EAP QOC) Business Note: HHRC EAP in California is filed under the California HMO license.</td>
<td>16</td>
<td>In California, the HHRC EAP QOC is authorized by the NQOC. The Aetna HHRC EAP QOC is a multidisciplinary group that provides guidance and direction to the Aetna Employee Assistance Program on administrative, clinical and quality issues; and member services activities. The Aetna HHRC EAP QOC provides an environment for collaborative initiatives among the Aetna regions, BH, and Aetna HHRC EAP; it also facilitates the integration of employee assistance program services. It is composed of the following members:</td>
<td>HMO: X</td>
</tr>
</tbody>
</table>

2015 HMO and PPO QM Program Description *Includes Exchanges and Texas Fully Insured EPO
State Amendments
The following amendments have been made to the QM Program Description.

<table>
<thead>
<tr>
<th>Rationale</th>
<th>Page</th>
<th>Revision</th>
<th>Applicability</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>16</td>
<td>Documents related to QM and the Aetna Care</td>
<td>X</td>
</tr>
</tbody>
</table>

The role of the Aetna HHRC EAP QOC includes the following:
- Establish priorities for Aetna HHRC EAP QM, evaluate clinical and operational quality and integrate quality improvement activities across Aetna HHRC EAP;
- Review and approval of clinical and service quality indicator/monitors and quality improvement initiatives;
- Identify and recommend prevention programs and oversee their implementation;
- Review and evaluate identified potential quality of care concerns related to providers and members;
- Monitor Aetna HHRC EAP QM activities for consistency with program goals;
- Review regular reports from Aetna HHRC EAP;
- Oversee Aetna HHRC EAP QM staff preparation of the annual Aetna HHRC EAP QM Program Description, and submission to NQOC for approval, including applicable amendments;
- Verify submission of Aetna HHRC EAP QM Program Description by Aetna HHRC EAP QM staff to HMO governing bodies for approval annually;
- Review and adopt QM, Complaint and Appeals policies and procedures with applicable state specific amendments.

Aetna HHRC EAP QOC meets at least quarterly and is chaired by the Aetna HHRC EAP Quality Mgr.
State Amendments

The following amendments have been made to the QM Program Description.

<table>
<thead>
<tr>
<th>Rationale</th>
<th>Page</th>
<th>Revision</th>
<th>Applicability</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>Accountability and Structure</td>
<td>Management Program activities are provided to the Florida, Georgia and Oklahoma HMO Boards annually and quarterly for the California HMO Board for review and approval.</td>
<td></td>
</tr>
<tr>
<td>Florida</td>
<td>Florida</td>
<td>Requires that the risk management program will be the responsibility of the governing body.</td>
<td>XX</td>
</tr>
<tr>
<td>Georgia</td>
<td>Florida</td>
<td>The Board has ultimate accountability for the Risk Management Program’s effectiveness, plan operations and finance. The Board will review and approve the Risk Management Program Description and activities.</td>
<td></td>
</tr>
<tr>
<td>Oklahoma</td>
<td>Florida</td>
<td>The Board has delegated the responsibility for oversight of the Risk Management Program to the NQOC.</td>
<td></td>
</tr>
<tr>
<td>Regulatory</td>
<td>Florida</td>
<td>Risk Management</td>
<td>XX</td>
</tr>
<tr>
<td>Florida</td>
<td>Florida</td>
<td>The Risk Management Program is designed to comply with state specific requirements for HMOs. The objectives of the Risk Management Program are to:</td>
<td></td>
</tr>
<tr>
<td>FS §641.55(2)</td>
<td>16</td>
<td>• Establish a process by which potential liability exposures may be identified, analyzed, controlled and monitored in a cost effective manner;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Support the Quality Management Program in the evaluation of the performance of the health delivery system, physicians and facilities providing medical care and services to members;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Establish mechanisms for reporting risk management activities and coordinating those activities with the Quality Management Program;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Establish a system for documenting and reporting incidents and educating employees on the system;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Minimize the risk of future similar incidents, through trending analysis, development, implementation and monitoring of corrective</td>
<td></td>
</tr>
</tbody>
</table>

2015 HMO and PPO QM Program Description *Includes Exchanges and Texas Fully Insured EPO

54

For Internal Use Only

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies. (Aetna)
## State Amendments

The following amendments have been made to the QM Program Description.

<table>
<thead>
<tr>
<th>Rationale</th>
<th>Page</th>
<th>Revision</th>
</tr>
</thead>
</table>
| **Regulatory Illinois** (215 ILCS §134/75) | 16 | The Consumer Advisory Committee – Illinois market only meets at least quarterly to identify and review consumer concerns. This committee makes advisory recommendations to the NQOC. The Plan may request that the committee provide feedback to propose changes in Plan policy and procedures that affect enrollees (including Behavioral health and Pharmacy issues). The Plan randomly selects eight enrollees. The following departments participate and are represented at the CAC meetings:  
- Quality Management  
- PR/Network Representatives  
- Member Services/Claims/Operations Pharmacy  
- Sales/Marketing Management |
| | | X | X |
## State Amendments

The following amendments have been made to the QM Program Description.

<table>
<thead>
<tr>
<th>Rationale</th>
<th>Page</th>
<th>Revision</th>
<th>Applicability</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nevada</strong> Regulatory NRS 695G.180</td>
<td>16</td>
<td>The chair of the NQOC shall be a medical director licensed in the state of Nevada.</td>
<td>X X</td>
</tr>
<tr>
<td><strong>Nevada</strong> Regulatory NAC §695C.240</td>
<td>16</td>
<td>The Nevada Joint Board of Consumer Satisfaction is a Nevada state-mandated committee to afford members the opportunity to participate in program content and to advise on consumer satisfaction. Membership includes an Aetna Medical Director, Network/Contracting, Account Manager, Quality Management, a network physician, a Sales Broker, Human Resource Director and an Aetna member. The Committee meets at least annually and reports to the Board of Directors. Additional ad hoc committees or work groups may be created to meet specific QM Program needs.</td>
<td>X</td>
</tr>
<tr>
<td><strong>New York</strong> Regulatory Title 10 New York State Dept of Health Chapter II Administrative Rules Subchapter R. Part 98 Section 98-1.12</td>
<td>16</td>
<td>The internal quality management program shall be supervised by a New York licensed medical director.</td>
<td>X</td>
</tr>
<tr>
<td><strong>North Carolina</strong> <strong>Tennessee</strong> <strong>Texas</strong> Regulatory Complaint and Appeal Process Management</td>
<td>34</td>
<td>State specific complaint and appeal reports to be reviewed and approved by the NQOC annually.</td>
<td>X X</td>
</tr>
</tbody>
</table>
### State Amendments

The following amendments have been made to the QM Program Description.

<table>
<thead>
<tr>
<th>Rationale</th>
<th>Page</th>
<th>Revision</th>
</tr>
</thead>
</table>
| Regulatory **Oklahoma** OAC §310:659-1-5 Accountability and Structure – Board of Directors (the Board) HMO | 16 | The Board reviews and approves the following documents:  
- QM Executive Summary Report with attachments as necessary  
- QM Program Description, QM Work Plan and QM Program Evaluation  
The Board delegates the duty for selection of NQOC members to the Head of National Quality Management. The Board delegates the development, approval, implementation, and enforcement of policies and procedures to the NQOC. The Board receives reports from Quality Management at least twice a year. |
| Regulatory **Oklahoma** §36-6907 G. National Quality Advisory Committee | 16 | An Oklahoma-licensed participating physician must be included in the review and adoption of clinical practice guidelines or clinical care standards. |
| Regulatory **Pennsylvania** 28 Pa. Code §9.674 (b) and 28 Pa. Code §9.633 (3) National Quality Oversight Committee | 16 | A Pennsylvania licensed medical director shall be a member of the NQOC. |
| Regulatory **Tennessee** 1200-8-33-.06 (e) 2. & 3. Board of Directors | 16 | The Board reviews and approves the following documents:  
- QM Executive Summary Report with attachments as necessary  
- QM Program Description, QM Work Plan and QM Program Evaluation  |
| Regulatory **Tennessee** 1200-8-33.06 (11) (b) 2 National Quality Oversight Committee | 16 | The internal quality management program shall be supervised by a Tennessee licensed medical director. |
| Regulatory **Tennessee** 1200-8-33-.06 (2) (d) 1. (i) National Quality Advisory Committee | 18 | A Tennessee-licensed participating physician must be included in the review and adoption of medical necessity criteria. |

2015 HMO and PPO QM Program Description *Includes Exchanges and Texas Fully Insured EPO

For Internal Use Only

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies. (Aetna)
## State Amendments

The following amendments have been made to the QM Program Description.

<table>
<thead>
<tr>
<th>Rationale</th>
<th>Page</th>
<th>Revision</th>
<th>Applicability</th>
</tr>
</thead>
</table>
| Regulatory Texas 28 TAC §11.1901(b) (2)(3) & (5) | 16 | The Board reviews and approves the following documents:  
- QM Executive Summary Report with attachments as necessary  
- QM Program Description, QM Work Plan and QM Program Evaluation  
The Board is composed of the following members:  
- President  
- Regional Financial Officer  
- Regional Medical Director  
Other Aetna staff are present as non-voting members  
The Board delegates the duty for selection of NQOC members to the Head of National Quality Management.  
The Board delegates the development, approval, implementation, and enforcement of policies and procedures to the NQOC. The Board meets at least twice a year. | X |
| Regulatory Texas TIC 1301.0051 (a)(7)(A) | 16 | The Board reviews and approves the following documents: QM Program Description, QM Work Plan and QM Program Evaluation.  
The Board delegates the duty for selection of NQOC members to the Regional Quality Management Director.  
The Board delegates the development, approval, implementation, and enforcement of policies and procedures to the NQOC. The Board meets at least annually | EPO |
| Regulatory Texas 28 TAC §11.1901(a) [member] 28 TAC §11.1901 (b)(1) [practicing physicians and individual providers] | 16 | The NQOC membership will include practicing physicians, individual providers and an enrollee who is not an employee of the HMO. | X |
### State Amendments

The following amendments have been made to the QM Program Description.

<table>
<thead>
<tr>
<th>Rationale</th>
<th>Page</th>
<th>Revision</th>
<th>Applicability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulatory <strong>Texas</strong> 28 TAC §3.3724 (b)(1)(B))</td>
<td>16</td>
<td>National Quality Oversight Committee</td>
<td>The NQOC membership will include practicing physicians, individual providers and may include an enrollee who is not an employee of the EPO.</td>
</tr>
<tr>
<td>Regulatory <strong>Texas</strong> TIC §843.102(e)(2)</td>
<td>18</td>
<td>National Quality Advisory Committee (NQAC)</td>
<td>The National Quality Advisory Committee conducts drug utilization reviews at least annually.</td>
</tr>
<tr>
<td>Regulatory <strong>Texas</strong> 28 TAC 11.1606 (a) and (c) (1) and (4)</td>
<td>16</td>
<td>Quality Management Program Resources</td>
<td>The internal quality management program shall be supervised by a Texas licensed medical director.</td>
</tr>
<tr>
<td>Regulatory <strong>Texas</strong> TAC §11.1902 (2) (B) (iv) (I)</td>
<td>18</td>
<td>National Quality Advisory Committee</td>
<td>A Texas-licensed participating physician must be included in the review and adoption of clinical practice guidelines or clinical care standards.</td>
</tr>
<tr>
<td>Regulatory <strong>Texas</strong> TIC 1301.0051 (a)(4)</td>
<td>18</td>
<td>National Quality Advisory Committee</td>
<td>A Texas-licensed participating physician must be included in the review and adoption of clinical practice guidelines or clinical care standards.</td>
</tr>
<tr>
<td>Regulatory <strong>Vermont</strong> Rule H-2009-03 Part 5 Section 5.4</td>
<td>16</td>
<td>National Quality Oversight Committee</td>
<td>The internal quality management program shall be supervised by a Vermont licensed medical director.</td>
</tr>
<tr>
<td>Regulatory <strong>Virginia</strong> 12VAC5-408-230(C)(2) Program Requirements</td>
<td>18</td>
<td>National Quality Advisory Committee</td>
<td>A Virginia-licensed board-certified physician must be a member of the National Quality Advisory Committee (NQAC). A Virginia HMO and PPO enrollee/member must be member of the National Quality Advisory Committee (NQAC).</td>
</tr>
</tbody>
</table>