Aetna U.S. Healthcare, Inc.
One Monument Square
Portland, Maine 04101

Interagency Committee for the Quality Oversight of Commercial HMO's
Final Quality Examination Report

Examination Conducted
June 12-13 2001

Survey Team

Ellen Austin Reitchel, R.N. Comprehensive Health Planner II, Quality Improvement, Bureau of Medical Services
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Respectfully Submitted December 4, 2001

Glenn Griswold, Chair
Interagency Committee for the Quality Oversight of Commercial HMO's

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December 4, 2001

Honorable Alessandro A. Iuppa, Superintendent

Dear Superintendent Iuppa,

Pursuant to the provisions of 24-A M.R.S.A. § 4215 and in conformity with instructions from the Superintendent and the Director of the Bureau of Medical Services, an examination of the quality of health care services has been made of Aetna US HealthCare of Maine, hereafter "Aetna," at its home office in Portland, Maine.

The Bureau of Insurance conducts three types of examinations: financial, market conduct, and quality oversight. The purpose of the financial examination is to test the business operations of a regulated carrier or HMO in order to assure financial stability and reasoned business practices exist. The purpose of a market conduct examination is to test for system wide problems particularly related to marketing, underwriting, and claims practices. Finally, HMO's are subject to quality oversight examinations for the purpose of testing compliance with the HMO Act, Health Plan Improvement Act, and agency rules on accessibility, grievance procedures, and similar provisions. It is the goal of the Bureau to conduct financial, market conduct and quality oversight examinations of every HMO every three years. The attached report represents the first quality oversight examination conducted of a domestic HMO.

In December of 2000, a team of four medical professionals observed the National Committee for Quality Assurance (NCQA) accreditation survey. The team reviewed the NCQA survey report to determine if sections of the state survey could be deemed. In June 2001, the team conducted a State specific examination of requirements not addressed by the NCQA survey. The Survey Team consisted of the following individuals:

Ellen Austin Reitchel, R.N. Comprehensive Health Planner II, Quality Improvement, Bureau of Medical Services
Margaret Ross, R. N. Nurse Consultant
Timothy Clifford, Medical Director, Bureau of Medical Services
Kathleen Crawford, R.N. Public Health Nurse Consultant, Maine Bureau of Insurance

The quality examination is done to evaluate Aetna's compliance with 24-A M.R.S.A. Chapters 56 and 56-A, Bureau of Insurance Rule Chapter 850, and Department of Human Services Rule Chapter 109. This report presents the analysis and findings of the Survey Team as of June 13, 2001. The team requests that you adopt the report including the recommendations.

The following information is contained in this report:
1. Findings and Recommendations
2. Explanation of Terms
3. Table of individual standards and elements.

Respectfully submitted on December 4, 2001

Glenn Griswold, Chair
Interagency Committee for the Quality Oversight of Commercial Health Maintenance Organizations

SCORING

Based on the HMO's Total Rating for all components, the HMO will have the following status and the Interagency Committee (IAC) will take the following actions:

81 - 100 *Pass*. If the HMO rates a Pass, the IAC shall identify those areas in which the HMO was not in full or significant compliance. This report will also identify follow-up steps to be taken and a date by which the HMO shall report back to the IAC. By this date the HMO shall demonstrate to the satisfaction of the IAC how the HMO has improved its performance and come into full or significant compliance with all requirements, or, if appropriate, submit a work plan for coming into full compliance within a time frame acceptable to the IAC. At its discretion, the IAC may schedule a follow-up review focused on previously identified problem areas.

51 - 80 *Provisional Pass*. For a Provisional Pass, the IAC identifies for the HMO those areas in which the HMO is not in full or significant compliance. This report will also identify follow-up steps to be taken and a date by which the HMO shall come into full or significant compliance or, if appropriate, submit a work plan for coming into full compliance within a time frame acceptable to the IAC. The IAC shall schedule a follow-up review focused on previously identified problem areas. If, upon completion of these follow-up steps and review, the IAC is not satisfied that the HMO has come into full or significant compliance on all of the items specified, or, if applicable, the HMO has no work plan for coming into full compliance, the IAC shall recommend to the Commissioner and Superintendent that proceedings to suspend or revoke the HMO's Certificate or Authority be initiated.

0 - 50 *Fail*. If the HMO fails the Desk Audit and Onsite Examination, the IAC shall recommend to the Commissioner and the Superintendent that proceedings to suspend or revoke the HMO's Certificate of Authority be initiated.

Findings and Recommendations

The Bureau of Insurance and the Bureau of Medical Services completed a joint triennial examination of Aetna US HealthCare of Maine hereafter "Aetna" for compliance with 24-A M.R.SA., Chapters 56 and 56A, Bureau of Insurance Rule Chapter 850, and Department of Human Services Rule Chapter 109. This report represents the findings of four state surveyors as of June 12-13, 2001. Aetna scored a "Pass" for this triennial examination. Acknowledgement of cooperation and assistance extended to the examiners by all Aetna representatives is hereby expressed.

Findings

This section highlights the findings associated with the examination of Aetna. A detailed report, which outlines each element and standard, is enclosed within this packet.

I. Quality Management Program, Structure and Process was found to be in full compliance with Rule 109

II. Quality Management Program Operations were found to be in full compliance with Rule 109

III. Quality Management Program Clinical Guideline development, implementation and evaluation of preventative and non-preventative conditions were found to be in full compliance with Rule 109

IV. Quality Management Program Continuity and Utilization of care/ services were determined to be in partial compliance with Rule 109. Areas of non-compliance with Rule 109 included:

- Aetna was unable to demonstrate systematic use of mechanisms to monitor the continuity or coordination of care among members. The interagency Committee for the Oversight of Commercial HMO's survey team reviewed supplemental materials submitted by Aetna and concluded that its original findings are supported. Additionally, the committee notes these findings are consistent with findings with the National Committee for Quality Assurance. This information was obtained through review of policy documents, QM meeting minutes, QI action plans for 2000 and 1999, evaluations of QI activities from 2000 and 1999 and through Staff interview. Rule 109, § 1.03-6 (A) (1) (2).
- Aetna did not monitor overall utilization to detect potential under and over utilization. The plan used provider utilization profiles with identification of outliers in areas of studies or guidelines. No evidence was available at the time of the survey to indicate the plan evaluated utilization patterns for treatment or services provided outside the realm of guidelines and studies. Additionally, there was no evidence to reflect this information was communicated back to individual practitioners. The survey team reviewed additional supplemental materials filed by Aetna and concluded that its original findings are correct. Aetna is unable to demonstrate the analysis of under and over utilization for its general delivery system. Aetna was only able to document that it monitored over and under utilization patterns for hospital services. The Committee notes that the National Committee for Quality Assurance did not review this measure. Rule 109, § 1.03-6 (A) (1)(2).

V. Quality Management Program Evaluation was determined to be in full compliance with Rule 109.

VI. Quality Management Program Studies and Analysis were determined to be in partial compliance with Rule 109. The Interagency Committee for the Oversight of Commercial HMO's survey team analyzed Aetna's three strongest studies. The committee survey team asked Aetna representatives, which of the studies were the three strongest studies. The survey team relied on the studies selected by Aetna representatives to examine against the standards set forth in Rule 109. The survey team determined that the baseline data in the immunization study was changed and measurements narrowed without any documented approval of the quality assurance committee. The survey team determined that the behavioral health study failed to analyze the size of the network in relation to the geographic distribution of its members. Areas of non-compliance with Rule 109 included:

- Aetna did not select measures related to the quality of service topic studied. Rule 109, § 1.03-4 (D).
- Measures were not all quantifiable and objective. Rule 109, § 1.03-4 (D)

VII. Quality Management Program Intervention and Assessment was determined to be in partial compliance with Rule 109. The survey team analyzed Aetna's three strongest studies. The survey team determined that these studies failed to demonstrate the use of strong interventions and re-measurement for two of the studies within the last three years. The intervention used in the adult and childhood immunization study contained only generic mailings to clients or physicians. Through review of the studies and interviews with Aetna staff, the survey team was unable to document either through interviews with Aetna staff or review of the study materials that immunization rates for either population were communicated back to providers. The National Committee for Quality Assurance also documented that Aetna's interventions for these studies were weak. Areas of non-compliance with Rule 109 included:

- Aetna did not initiate strong interventions for quality of care studies addressing acute or chronic conditions. Rule 109, § 1.03-5 (C).

VIII. Credentialing Program was determined to be in full compliance with Rule 850, § 7 G.

IX. Utilization Review Program and Structure were determined to be in full compliance with Rule 850, § 8 except sub-section E.

- Aetna received a compliance rating in sub-section 8(E) although it does not have a written policy regarding continued liability for services delivered to a member pending notification of a concurrent review determination. Reviewers determined that Aetna does assume liability in practice but has no formal policy regarding this practice. It is recommended Aetna formally adopt this policy in writing and submit the policy to the Superintendent for review.

X. Utilization Review File Review was determined to be in partial compliance with Rule 850. The Interagency Committee for the Quality Oversight of Commercial HMO's survey team reviewed the files on site with Aetna representatives and discussed the deficiencies found at the time of the survey. The state surveyor and Aetna's representative agreed that Magellan's adverse determination notice indicated the denial was made by a "physician advisor", they also agreed the notice did not include the "name, title and qualifying credentials as required by Rule 850 (8). Areas of non-compliance with this standard include:

- Utilization review determinations were not made within State specified timeframes for five of six files reviewed for behavioral health services. Rule 850, § 8 E (2) (3) (4).
- Clinical peer review was not available for one of two behavioral health files reviewed. Rule 850, § 8 (D) (2).
- Reasons for denial were not clearly specified in five of six files reviewed. Rule 850, § 8 E (5).

XI. Grievance and Appeals procedures were determined to be in significant compliance with Rule 850. The Interagency Committee for the Oversight of Commercial HMO's survey team acknowledges Aetna's expectations that participating providers are responsible to provide urgent specialty care within twenty-four hours. However, the Committee remained concerned that specific geographic areas lack sufficient numbers of participating specialists to meet Aetna's expectations. Aetna failed to demonstrate that it had taken steps to ensure that members in specific geographic areas could obtain urgent care within twenty-four hours. Additionally, no specific policy addressing this issue was evident during the survey. Areas of non-compliance with Rule 850 included:

- Aetna did not have evidence to reflect a policy/ procedure for expedited reviews that included an element addressing: "access to an authorized HMO representative 24 hours/day, 7days/week for post-evaluation or post-stabilization services or post evaluation and post-stabilization services covered without liability to covered persons until a representative is available." Rule 850, § 8 H (5).
- Two of ten files reviewed reflected the HMO did not include in its notices a statement reflecting the HMO's understanding of the member's grievance. Rule 850, § 8 G (1) (c) (ii).

XII. Access Availability and Continuity of Care in areas of member to provider ratios were determined to be in partial compliance. The Interagency Committee for the Oversight of Commercial HMO's survey team reviewed Aetna's supplemental exhibits as well as its access plan and concurs that Aetna has a system to identify the availability of primary care and four high volume specialist physicians and determine areas of low access or availability of specialists. The Committee survey team noted that while Aetna has a system it appears to be used only to track primary care physicians, and four high volume specialists (OBGYN's,

cardiologists, orthopedic and general surgery). It was noted that when the survey team members reviewed information for accessibility to neurologists, dermatologists or gastroenterlogists the survey team could not find adequate documentation. Additionally, the survey team did not find any evidence that the system is extended to determine appropriate levels of ancillary providers. The areas of non-compliance with Rule 850 included:

- Aetna lacked a system that readily identified availability of practitioners and determined areas of low access or availability of specialists. Rule 850, § 7 B (2),(4) and (5)

XIII. Access Availability and Continuity of Care in areas of rural access and barriers to access received no credit. The Interagency Committee for the Oversight of Commercial HMO's survey team reviewed Aetna's supplemental materials as well as its access plan and did not find any documentation to support the assertion that it has a plan for providing services for rural and underserved populations. The Committee did not find evidence of a written access plan for rural areas with access issues. In addition, there was no evidence that any plan had been implemented to increase access to rural areas. The Committee survey team does concur that Aetna has developed relationships with essential community providers (Rural Health Clinics and Federally Qualified Health Centers). Areas of non-compliance with Rule 850 and 24-A M.R.S.A. § 4303 included:

- Aetna did not have evidence of a written access plan for rural areas. There was no evidence that any plan (informal or formal) had been implemented to increase access to rural areas. Rule 850, § 7 A (4).

The Interagency Committee for the Oversight of Commercial HMO's survey team reviewed Aetna's supplemental exhibits and did not find any documentation that Aetna had taken anything but minimal steps to identify the language needs of its members or implemented other interventions to assist members in overcoming language barriers. The Committee was unconvinced that Aetna's reliance on 1990 census data (eleven year old data) is a good measure for the number of Maine residents that do not speak English. The committee notes that the many communities and school systems collect more recent information on the numbers of residents that speak another language. The Committee notes the CAHPS survey is written in English. If a member cannot understand the written language, they are unlikely to complete the CAHPS assessment. The Committee noted that Aetna received responses from 744 enrollees, this is a small percentage of Aetna's total enrollment in Maine.

- Aetna lists providers with foreign language skills within their provider directory. There was no evidence to reflect that Aetna had identified language needs of its members and had other interventions to assist members in overcoming this barrier. Rule 850, § 7 A (5).
- No evidence was available to reflect that Aetna had evaluated the literacy level of its members. There was no evidence that member handbooks and marketing materials were written to meet the literacy level of its members. Rule 850, § 7 A (5).

XIV. Access Availability and Continuity of Care in areas of appointment and waiting times was determined to be in partial compliance with Rule 850. The Committee remains concerned about specific geographic regions lacking sufficient numbers of participating specialists. Area of non-compliance included:

- Aetna failed to demonstrate steps had been taken to ensure that members could obtain urgent specialty care services within 24 hours. Rule 850, § 7 D (3) (b).

XV. Access Availability and Continuity of Care in areas of coordination and continuity of care policies and procedures received no credit. Aetna's policies did not describe coordination and continuity of care for new covered persons receiving care from non-participating providers in compliance with parts A through C of 24-A M.R.S.A. § 4303 (7). Aetna's Quality Management Policy 99-01 indicates that enrollees will be notified 45

days from the termination of a primary care physician instead of the 60 days required by Rule 850 (7) (F)(5). The policy did not include a description of how members with special needs or who are at special risk will be identified and continuity of care provided, nor do the supplemental letters (Primary Care Termination Letter, Other Health Care Provider Termination Letter) notify members about continuity of care. Areas of non-compliance with Rule 850 and 24-A M.R.S.A. § 4303 included:

- Aetna did not have policies providing for the continuity of care in the event of contract termination between the HMO and a provider that provided for 60 day notice of termination to covered persons, or as much notice as reasonably possible if 60 day notice is not possible. This policy needs to include a description of how members with special needs or who are at special risk will be identified and continuity of care provided. Rule 850, § 7 F (5) and 24-A M.R.S.A. § 4303 (7).
- Policies did not include a description of how the HMO will monitor the coordination and continuity of care for new covered persons receiving care from non-participating providers. Rule 850, § 7 F (3) and 24-A M.R.S.A. § 4303 (6) and (7).
- Policies did not include a requirement that the member will receive timely written notification of a referral. Rule 850, § 7 F (1) and 24-A M.R.S.A. § 4303 (6).
- Policies did not include a description of how the HMO will monitor the coordination, continuity of care and appropriate discharge planning. Rule 850, § 7 F.

Recommendations

Based on the findings of the joint Bureau of Insurance and the Bureau of Medical Services examination and pursuant to 24-A § 4221 (2) Aetna is directed to submit an improvement plan to the Superintendent of Insurance for those elements that were not in full or significant compliance with pertinent statutes and regulations. The improvement plan shall identify the procedures and processes that Aetna will take to comply with state law, identify the individuals responsible for ensuring these actions are taken, and a date by which these interventions shall be operational. The improvement plan is due to the Superintendent by January 15, 2002. Specific information that should be incorporated in the implementation plan include the following:

Utilization

- Describe how Aetna will monitor overall utilization to detect potential under and over utilization for its general delivery system.

Studies

- Describe the methods Aetna will use to monitor the studies to determine they include measures related to the quality of service topic studied.
- Describe how Aetna will determine the measures used in the studies are quantifiable and objective.
- Describe how Aetna will monitor that strong interventions for the studies are conducted.

Concurrent Review

- A written policy regarding continued liability for services delivered to a member pending notification of a concurrent review determination.

File Review

- Describe what initiatives Aetna will undertake to ascertain that Aetna staff and its delegates are appropriately including the required information in the adverse determination notice sent to enrollees.

Accessibility

- Describe the steps Aetna will take to demonstrate that those members in specific geographic areas can obtain urgent specialty care within twenty-four hours. Provide a copy of any polices that describes how Aetna addresses availability of urgent specialty care within twenty-four hours for enrollees.
- Describe how Aetna will use its current system for monitoring the four high volume provider specialists to other provider specialists including ancillary providers.
- Describe how Aetna will identify the literacy and language needs for its members and what interventions it will use to overcome language barriers.
- A copy of Quality Management Policy 99-01 that reflects the 60-day notice requirement prior to a primary care providers termination.
- Describe how Aetna proposes to identify members with special needs or who are at special risk and are provided continuity of care.

Table of Standards and Elements
Explanation of Terms

The table of individual standards and elements reflects the following information:

- Column 1 labeled "Standard and Element as identified in the Data Collection Tool Version 1/2/01," identifies the standard or element as it appears in the State's Data Collection Tool. Please note these standards and elements do not directly correspond to the standards or elements and lettering and numbering system used by NCQA.
- Columns 2, labeled "Authorizing Rule or Statute," identify the law or rule governing this element. (An example includes 109.3-1, which indicates Rule 109, section 3-1).
- Column 3, labeled "NCQA," identifies the NCQA standard or element comparable to Maine law. In situations where NCQA does not have an element or standard equivalent then "No Equivalent" is written in the column.
- Column 4, labeled "Score," identifies the individual score awarded to the plan for compliance with the element or standard. The following scores may be awarded:
    - Deemed (Full or Significant). Indicates that the plan was given credit for complying with an equivalent NCQA standard. (Credit given only for a designation of "full" or "significant" compliance with equivalent NCQA standard. The State reserves the right to review all information needed to determine compliance with promulgated rules. This includes the right to review standards, elements or components that may have an equivalent NCQA standard and which NCQA found to be in full or significant compliance with NCQA standards.)
    - Full. Indicates that the State has reviewed the standard or element and has determined that the plan is in full compliance with this element or standard.
    - Significant. Indicates that the State has reviewed the standard or element and has determined that the plan is in significant compliance.
    - Partial. Indicates that the State has reviewed the standard or element and has determined that the plan is in partial compliance.
    - No Credit. Indicates that the State has reviewed the standard or element and has determined that the plan is not in compliance.
- Column 5, labeled "Findings" provides an overview of the findings within each element or standard. This narrative section documents findings that are either compliant or non-compliant with the elements or standards.

Quality Improvement Program

Standard and Element as Identified in the Data Collection Tool Version 1/2/01	*Authorizing Rule or Statute*	*NCQA Equivalent (2000 Standards)*	*Score*	*Findings*
Quality Management Structure and Process				
QM.SP 1	109-03-1	QI 1	Full	Aetna demonstrated through documentation and interview the following elements of the Quality Management Program were available, complete and adequate: • Had a written program description • Had goals and scope • Had accountability to the highest level of government • Had substantial involvement of a physician • Had a QM committee • Had developed an annual work plan • Had adequate resources • The QM program had been in place for at least 12 months.
Quality Management Operations				
QM.OP 1 (Committee Functions)	109-03-2(A)	QI 2.1A	Deemed	Aetna received a designation of full on the equivalent standard in its final report from NCQA.
QM.OP 2 (Minutes)	109-03-2 (B)	QI 2.2B	Deemed	Aetna received a designation of full on the equivalent standard in its final report from NCQA.
QM.OP 3 (Coordinated Activities)	109-03-2(c)	No Equivalent	Full	Aetna demonstrated evidence of routine discussion by the QM committee of other performance monitoring activities. In addition the evidence reflected at least 3 types of monitoring data were used in coordination of QM activities.
QM.OP (Physician Participation)4	109-03-2 (D)	QI 2.3C	Full	Aetna demonstrated for the last 12 months active physician and non-physician participation in QM activities.

QM.OP 5 (Practitioner Contracts)	109-03-2 (E)(1) &(3)	QI 3.1 A	Deemed	Aetna received a designation of full on the equivalent standard in its final report from NCQA.
QM.OP 6 (Facility Contracts/ QM & Records)	109-03-2(E)(2)&(3)	QI 3.2B	Deemed	Aetna received a designation of full on the equivalent standard in its final report from NCQA.
QM.OP 7 (Contracts/ Confidentiality)	109-03-2(E)(4)	RR 6.3B	Deemed	Aetna received a designation of full on the equivalent standard in its final report from NCQA.
Quality Management Guidelines				
QM.GU 1 (All Non Preventative)	109-03-3(A)	QI 8.0 A	Deemed	Aetna received a designation of full on the equivalent standard in its final report from NCQA.
QM.GU 2 (All Preventative)	109-03-3(A)	PH 1.1A	Full	Aetna had at least 4 clinical guidelines that addressed preventive health
QM.GU 3 (Non-Preventative/ Development)	109-03-3 (A)	QI 8.0A ; QI 8.1B; QI 8.2C	Full	Aetna had adopted clinical guidelines for at least 2 conditions that were: • relevant to the Maine population • were based on reasonable scientific evidence • were developed, adapted or reviewed by the HMO practitioners • and were in effect for at least 12 months
QM.GU 4 (Non-Preventative/ Updated)	109-03(A)(6)	QI 8.3D	Full	Aetna demonstrated at least 2 comprehensive guidelines relating to acute or chronic conditions. These guidelines were reviewed and updated as appropriate or at least every 2 years
QM.GU 5 (Non-Preventative/ Distributed)	109-03(A)(3)	QI 8.4E	Full	Aetna demonstrated comprehensive clinical guidelines were distributed to providers through direct mailings, newsletters, and web site locations.
QM.GU 6 (Preventative/ Development)	109-03(A)	PH 1.1A; PH1.2C; PH 1.3D, PH 1.4E	Deemed	Aetna received a designation of full on the equivalent standard in its final report from NCQA.
QM.GU 7 (Preventative/ Updated)	109-03(A)(6)	PH 1.5F	Deemed	Aetna received a designation of full on the equivalent standard in its final report from NCQA.
QM.GU 8 (Preventative/	109-03(A)(3)	PH 2.0 A,B,C	Deemed	Aetna received a designation of full on the equivalent standard in its final report from

Distributed)				NCQA.
QM.GU 9 (Non-Preventative/ Measured)	109-03(B)(1)	QI 8.5F	Deemed	Aetna received a designation of full on the equivalent standard in its final report from NCQA.
QM.GU 10 (Non-preventative/ Consistency)	109-03(B)(2)	QI 8.6G	Deemed	Aetna received a designation of full on the equivalent standard in its final report from NCQA.
Quality Management Continuity and Utilization				
QM.CU 1 (Continuity and monitoring)	109-06 (A)(1)& (2)	QI 9.1A & QI 9.3.1C	Partial	Aetna was unable to demonstrate systematic use of mechanisms to monitor the continuity or coordination of care among members. This information was obtained through review of policy documents, QM meeting minutes, QI action plans for 2000 and 1999, evaluations of QI activities from 2000 and 1999 and through Staff interview.
QM.CU 2 (Utilization/ Monitoring)	109-06B1&2	UM 11.1.1A UM 11.1.2B UM11.2C	Partial	Aetna US HealthCare did not monitor **overall** utilization to detect over and under utilization. • The plan used provider utilization profiles with identification of outliers in areas of studies or guidelines. No evidence was available at the time of survey to reflect the plan evaluated utilization patterns for treatment or services provided outside the realm of guidelines and studies. Additionally there was no evidence to reflect this information was communicated back to individual practitioners.
QM.CU 3 (Continuity/ Interventions)	109-06 (A)(3)	QI 9.4.1E	Deemed	Aetna received a designation of full on the equivalent standard in its final report from NCQA.
QM.CU 4 (Utilization/ Interventions)	109-06 (B)(3)	UM 11.3D	Deemed	Aetna received a designation of full on the equivalent standard in its final report from NCQA.
Quality Management Program Evaluation				
QM.EV 1	109-07 (A)	QI 12.1A	Deemed	Aetna received a designation of full on the

(Evaluation)				equivalent standard in its final report from NCQA.
QM.EV 2 (Notification)	109-07 (B)	No Equivalent	Full	Aetna reported QM activities to members, practitioners, governing bodies and appropriate organizational staff during the past year through directed mailings, member handbooks, newsletters, telephone calls and manuals.
Quality Management Studies and Analysis				
QM.SA 1	109-04 (C)	QI 10.0A	Deemed	Aetna received a designation of full on the equivalent standard in its final report from NCQA. Aetna 's quality of care studies on diabetes outreach, asthma outreach, and follow-up after hospitalization for mental illness was reviewed for these standards.
QM.SA 2	109-04 (D)	QI 10.1.1 to QI 10.1.2B	Deemed	Aetna received a designation of full on the equivalent standard in its final report from NCQA.
QM.SA 3	109-04 (E)	QI 10.1.3	Full	Chapter 109 requires 3 quality of care studies. Aetna had 4 quality of care studies which addressed a chronic or acute condition and met the following elements: • Established benchmarks or goals • Benchmarks or goals were established from appropriate sources • Established reasonable performance goals.
QM.SA 4	109-04 (F)	QI 10.2D	Deemed	Aetna received a designation of full on the equivalent standard in its final report from NCQA.
QM.SA 5	109-04 (G) & (H)	QI 10.3E	Full	Chapter 109 requires 3 quality of care studies. Aetna had 4 quality of care studies which addressed a chronic or acute condition and met the following elements: • Quantitative analysis comparing the study results against a selected goal or benchmark • An analysis identifying the possible reasons for the results and barriers to improvement.

QM.SA 6	109-04 (C)	QI 12.2B	Deemed	Aetna received a designation of full on the equivalent standard in its final report from NCQA. Aetna's service studies on pharmacy telephone calls and behavioral health practitioner availability were reviewed.
QM.SA 7	109-04 (D)	QI 12.2B	Partial	The measures for the pharmacy telephone study were appropriate, objective and quantifiable. The measures for the behavioral health practitioner availability study were objective and quantifiable, but were not appropriate to the identified problem (lack of availability). Aetna measured only the ratio of psychiatrists to the entire behavioral health network, and did not look at the size of the network (and/ or psychiatrists) in relation to the number of members, nor the geographic distribution of the network in relation to the members. In fact, the network went from 6.6 behavioral health practitioners per 1,000 members at the baseline measurement (December 1998) to only 4.8 practitioners per 1,000 members at the last re-measurement (June 2000).
QM.SA 8	109-04 (E)	QI 12.2B	Deemed	Aetna received a designation of full on the equivalent standard in its final report from NCQA.
QM.SA 9	109-04 (F)	QI 12.2B	Deemed	Aetna received a designation of full on the equivalent standard in its final report from NCQA.
QM.SA 10	109-04 (G) & (H)	QI 12.2B	Deemed	Aetna received a designation of full on the equivalent standard in its final report from NCQA.
Quality Management Interventions and Assessments				
QM.IA 1	109-05	QI 11.1A	Partial	For 3 of the 4 quality of care studies addressing acute or chronic conditions, Aetna had selected interventions during the last 3 years. However, Aetna failed to initiate strong interventions and failed to conduct re-measurements for 2 studies during the last 3 years. The Adult and childhood immunization studies contained only generic mailings to clients and doctors. One letter in the spring of 1999 focused on increasing immunization rates. There was no evidence during the course of survey to reflect providers received feedback on immunization rates for

				either population.
QM.IA 2	109-05	QI 4.2.4E, QI 4.2.5F QI 4.2.6G QI 4.3.3K QI 4.3.4L QI 5.3C QI5.4 D QI 5.5E QI 6.3 and 6.4E QI 6.5F QI 6.6G	Deemed	Aetna received a designation of full on the equivalent standard in its final report from NCQA.

Credentialing Program

Standard and Element as Identified in the Data Collection Tool Version 1/2/01	***Authorizing Rule or Statute***	***NCQA Equivalent***	***Score***	***Findings***
CR1 (Policies and Procedures)	850 (7)(G)	CR 1.1A CR 1.2B CR 1.3C CR 1.5 to 1.9	Deemed	Aetna received a designation of full on the equivalent standard in its final report from NCQA.
CR 2 (Credentialing Committee)	850 (7) (G) (4)	CR 2.0 A,B,C	Deemed	Aetna received a designation of full on the equivalent standard in its final report from NCQA.
CR 3 (Physician File Review/ Primary Verification)	850 (7)(G)(8)	CR 3.1 to 3.7A	Deemed	Aetna received a designation of full on the equivalent standard in its final report from NCQA.
CR 4 (Physician File Review/ Secondary Verification)	850 (7)(G)(9)	CR 3.1 to 3.7A	Deemed	Aetna received a designation of full on the equivalent standard in its final report from NCQA.
CR 5 (Physician File Review / Recredentialing)	850 (7) (G) (10)	CR 7.1to 7.7A	Deemed	Aetna received a designation of full on the equivalent standard in its final report from NCQA.
CR 6 (Non-Physician File Review/ Primary Verification)	850 (7) (G) (8)	No Equivalent	Full	12 of 12 non-physician credentialing files included timely primary verification of licensure, privileges,

				DEA registration and specialty board certification.
CR 7 (Non-Physician File Review/ Secondary Verification)	850 (7) (G) (9)	No Equivalent	Full	12 of 12 non-physician-credentialing files included timely primary verification of License history, malpractice history, work history and liability coverage.
CR 8 (Non-physician File Review/ Recredentialing)	850 (7) (G) (10)	No Equivalent	Full	5 of 5 non-physician re-credentialing files included primary verification of current license, privileges and DEA registration
CR 9 (Procedures for Termination and Appeals)	850 (7) (G) (12)	CR 10.1 CR 10.2A,B	Full	Aetna had adequate procedures for terminating or sanctioning health professionals with records of poor quality and affords health care professional appeal rights.

Utilization Review Program

Standard and Element as Identified in the Data Collection Tool Version 1/2/01	***Authorizing Rule or Statute***	***NCQA Equivalent***	***Score***	***Findings***
UR 1 (Annual Evaluation)	850 (8)(A)	UM 1.4 D	Deemed	Aetna received a designation of full on the equivalent standard in its final report from NCQA.
UR 2 (Program Description)	850 (8)(C)	UM 1.1 & 1.3, A	Deemed	Aetna received a designation of full on the equivalent standard in its final report from NCQA.
UR 3 (Program Description)	850 (8)(D)	No Equivalent	Full	Aetna demonstrated that the UR program description and UR review criteria were available to the Superintendent of the Bureau of Insurance upon request. In addition a policy to collect only that personal medical information necessary to certify the treatment requested was available.

UR 4 (Clinical Review Criteria)	850 (8) (D) (1)	UM 2.1 A: & UM 2.2 E	Full	Aetna met the following elements: • Documented clinical review criteria in the UR program • Had clinical review criteria based on sound clinical evidence • Clinical review criteria are evaluated annually to assure ongoing efficacy
UR 5 (Clinical Review Criteria)	850 (8) (D) (2)	UM 3.1A; UM 3.2 B: UM 3.3 C	Full	Aetna met the following elements: • Qualified Health Professionals administer the UR program • Qualified Health Professionals oversee the review decisions • Clinical peers are used in evaluating the clinical appropriateness of adverse determination
UR 6 (Consistency of Decisions)	850 (8) (D) (3)	UM 5A; & UM 2.5G	Full	Aetna met the following elements: • Policies that identify the relevant clinical information to be collected to support UR decision making were available • Policies were in place at least 1 year • A process to ensure that both physicians and non physician UR reviewers applied clinical review criteria consistently • An evaluation of the consistency of reviewers annually • Physicians making UR decisions for similar cases confer regularly to make sure similar cases are decided consistently.
UR 7 (Assessment of Effectiveness)	850 (8) (D) (4)	UM 1.4 D	Deemed	Aetna received a designation of full on the equivalent standard in its final report from NCQA.
UR 8 (Toll Free Access)	850 (8) (D) (7)	No Equivalent	Full	Aetna met the following elements: • Providing members with access to review staff through a toll free or collect telephone line • Providing providers with access to

				review staff through a toll free or collect telephone line • Access to telephone is adequately publicized • Response time is adequate
UR 9 (Compensation Incentives/ UR Staff)	850 (8) (D) (9)	UM 11.5F	Full	Aetna was able to demonstrate that compensation for UR decision-makers does not include incentives to render inappropriate decisions.
UR 10 (Compensation Incentives/ Providers)	24-A M.R.S.A. § 4303-(3) (B)	UM 11.5F	Deemed	Aetna received a designation of full on the equivalent standard in its final report from NCQA.
UR 11 (Decision Notification)	850 (8)(E)	No Equivalent	Full	Aetna's policy 00-200-01 (concurrent review) describes the administrative denial process as secondary to inability to obtain information. Rule 850 § 8 requires carriers to obtain the necessary clinical information from contracted providers in the plan. Aetna may only deny services if the information is not forthcoming from non-contracted providers.
UR 12 (Notice Requirements)	850 (8)(E)	No Equivalent	Full	Aetna met the following elements: • A policy for notifying members and providers of adverse determinations included principal reasons for the determination in sufficient detail for the member and provider to understand, instructions for initialing an appeal or reconsideration, instructions for requesting a written statement of the clinical rationale and review criteria and phone number for obtaining assistance or information • A policy including a written notification of a concurrent review determinations that includes the number of extended days or next review date, total number of days approved, services approved and the date of admission or initiation of services.
UR 13 (File Review)	850 (8)(D)&(E)	No Equivalent	Partial	Aetna and the Behavioral Health Delegate Magellan scored a medium on file review for

				at least 7 elements and no more than one low. High scores were obtained on the following 5 elements: • Pertinent clinical information • Appropriate clinical information • Information regarding appeal process • Information regarding clinical rationale and • Phone number Medium score were obtained on the following 2 elements: • Determinations were not within the time limit (behavioral health) for 5 of 6 files reviewed • Reason for denial (behavioral health) was not available for 5 of 6 files reviewed. Low score was obtained on one element: • Appropriate clinical peer review (behavioral health) was not conducted for 1 of 2 files reviewed.
UR 14 (Liability pending concurrent review)	850 (8)(F)	No Equivalent	Full	Aetna was able to demonstrate in practice that they provide for continued liability for services pending notification of a concurrent review determination. However, Aetna did not have a written policy to address this issue.
UR 15 (Reconsideration)	850 (8)(F)	No Equivalent	Full	Aetna was able to demonstrate that providers are allowed to make requests for reconsideration with a response within one working day.
UR 16 (Emergency Room Services)	850 (8)(H)	UM 9.1 &9.2 A,B,C	Deemed	Aetna received a designation of full on the equivalent standard in its final report from NCQA.
UR 17 (Disclosure)	850 (8)(I)	No Equivalent	Full	Aetna met the following elements: • Marketing materials contained a summary of the UR process • Membership cards included a toll-

				free number for initiating UR decisions • Certificate of coverage or member handbook contained the required information.
UR 18 (Behavioral/ Protocols)	850 (8)	UM 12.1A	Deemed	Aetna received a designation of full on the equivalent standard in its final report from NCQA.
UR 19 (Behavioral/ Updating Protocols)	850 (8)	UM 12.2B	Deemed	Aetna received a designation of full on the equivalent standard in its final report from NCQA.
UR 20(Behavioral/ Decision Making)	850 (8)	UM 12.3C	Deemed	Aetna received a designation of full on the equivalent standard in its final report from NCQA.
UR 21 (Behavioral/ Decision Making)	850 (8)	UM 12.4D	Full	Decisions requiring clinical judgement were made by licensed practitioners with appropriate qualifications and experience.
UR 22 (Behavioral/ Oversight)	850 (8)	UM 12.6F	Full	Triage and referral decisions were overseen by a licensed and experience psychiatrist or doctoral-level clinical psychologist.
UR 23 (ER File Review/ Presenting Symptoms)	850 (8)	UM 9.1B	Deemed	Aetna received a designation of full on the equivalent standard in its final report from NCQA.
UR 24 (ER File Review/ Prior Approval)	850 (8)	UM 9.2C	Full	Aetna does not deny emergency room claims per policy. Emergency Room Policy (E189-0002-H), stated that Aetna "covers emergency services necessary to screen and stabilize the member."

Grievance and Appeals

Standard and Element as Identified in the Data Collection Tool Version 1/2/01	***Authorizing Rule or Statute***	***NCQA Equivalent***	***Score***	***Findings***

GA 1 (UR Appeals Procedure)	850 (8) (G) & (H)	No Equivalent	Significant	1. Currently, Aetna does not do any UR for outpatient services, (*e.g.*, PT). There is evidence of concurrent review of outpatient mental health services and according to Magellan's UM program description (G&A 3), expedited appeals are available as required by Rule 850. According to Aetna's 2000 NE regional HMO PM Program (G&A 4) expedited appeals are available for "imminent or ongoing service." Ongoing review is limited to inpatient settings. This restriction should be amended to comply with Rule 850 § (8) (G)(2). 2. We noted that Aetna's patient management 99 PMP.1, stated "a reconsideration should always precede an expedited appeal." Rule 850 § (8)(F)(3) states "reconsideration is not a prerequisite to a standard appeals or expedited appeal." Policy (PMP1) should be amended, or the Maine Addenda 2000, should stipulate deviation from the PMP1 to correspond to the requirement in Rule 850. 3. Aetna does not have a written policy stating "for concurrent review, services are continued without liability to the covered person until the covered person has been notified of the determination." Aetna's initial adverse determination letter notified the member "you are not responsible for payment of this service." Provider contracts prohibit balance billing. A policy should be drafted to correspond to Aetna's practice. Aetna should be aware under State Law the providers are allowed to balance bill for services once the enrollee has been notified that the services have been determined not to be covered and/or not medically necessary. 4. Through interview with Aetna staff and review of policies, it was determined that Aetna does not have a policy regarding post-utilization or post-stabilization services. On 6/13/01

				staff interviews verified Aetna does not perform utilization review on a 24-hour/ day, 7 day / week basis.
GA 2 (Disclosure of Procedure)	850 (9)(B)(2)	No Equivalent	Full	Aetna has provided its covered persons with a readily accessible explanation of its grievance procedures.
GA 3 (1st Level Non-UR Procedures)	850 (9)(C) 24-A M.R.S.A. § 4303 (4) (C) and 4312	No Equivalent	Full	Aetna had documented procedures for conducting first level grievances, which satisfied all 5 of the requirements listed in (GA3 BIF). The Plan documented procedures for notifying covered persons of adverse first-level grievance decisions to satisfy all 6 requirements listed in GA 3 BIF part b.
GA 4(2nd Level Procedures)	850 (9)(D) 24-A M.R.S.A. § 4303 (4)(C) and 4312	No Equivalent	Full	Aetna had documented procedures for conducting second level grievances, which satisfied all 10 of the requirements listed in (GA4 BIF part a). The Plan also had documented procedures for notifying covered persons of adverse second-level grievances decisions to satisfy all 7 requirements listed in GA 4 BIF part b
GA 5 (File Review/ 1st Level UR)	850 (8)(G)	No Equivalent	Full	Aetna had one record related to the first level UR appeals. Aetna's procedure and practice is to approve all emergency room visit claims. The plan attempted to find records to review and found one that met the criteria for this review. Subsequently scoring for this component was based on the one record available.
GA 6 (File Review 2nd Level UR)	850 (9)(D)	No Equivalent	Full	Aetna had one record related to the second level UR appeals. Aetna's procedure and practice is to approve all emergency room visits claims. The plan attempted to find records to review and found one that met the criteria for this review. Subsequently scoring for this component was based on the one record available.
GA 7 (File Review/ 1st Level Non-UR)	850 (9)(C)	No Equivalent	Significant	During the State survey on 6/13/01, ten first level grievance files were reviewed. Of these 10 files reviewed 2 files included a statement of HMO's understanding of what was being grieved.
GA 8 (File	850 (9)(D)	No	Full	During the State survey on 6/13/01, two-

Review/ 2nd Level Non-UR)		Equivalent		second level grievance files were reviewed. These files were the only second level grievance files available. Both of these files contained 11 elements required by rule 850 (9)(D).

Access and Availability

Standard and Element as Identified in the Data Collection Tool Version 1/2/01	***Authorizing Rule or Statute***	***NCQA Equivalent***	***Score***	***Findings***
AC 1 (Member/ Provider Ratios)	850 (7)(B)(2) (4) & (5)	No Equivalent	Partial	Aetna was able to demonstrate compliance with the following requirements: • Aetna had a minimum ratio of one full-time equivalent PCP to 2000 members • Had taken steps to assure that it had an adequate number of providers with hospital privileges • Had taken steps to ensure that its members had timely access to necessary admissions consistent with generally accepted practice. Aetna was unable to demonstrate compliance in the following areas: • Aetna lacked a system that readily identified availability of practitioners and determines areas of low access or availability of specialists.
AC 2 (24-Hour ER Access)	850 (7) (B) (3)	QI 5.1A	Full	Aetna was able to demonstrate compliance with the following requirements: • Aetna has taken steps to ensure that its members have access to emergency and

				urgent services at all times. • Aetna has taken steps to ensure that its members have access to PCP services 24 hours a day, 7 days a week.
AC 3 (Out of Network Coverage)	850 (7) (B) (6)	No Equivalent	Full	Aetna does not have a written policy allowing a member to obtain a covered benefit from a non-participating provider at no additional cost when the HMO does not have an appropriate participating provider. However, Member Handbooks provider directories explain the process. Interview with Aetna staff reflected Aetna has a process and follows this process covering benefits from a non-participating provider at no additional cost.
AC 4 (Geographic Accessibility)	850 (7)(C)	No Equivalent	Full	Aetna demonstrated compliance with the following requirements: • Steps had been taken to ensure that its members had access to primary care services within the required distance or had met the requirements for an exception. • Ensured that its members had access to specialty care services within the required distance or had met the requirements of an exception. • Ensured that its members had access to hospital services within the required distance or had met the requirements for and exception.
AC 5 (Rural Access)	850 (7) (A) (4)	No Equivalent	No Credit	Through review of policy, data, and interview it was determined, that Aetna did have a plan for providing services for rural and under-served populations. No documentation was available to reflect the plan had identified steps to be taken, or an evaluation of the implemented steps.
AC 6 (Barrier to Access)	850 (7) (A) (5)	QI 4.1 A	No Credit	Aetna did not demonstrate compliance with the following requirements: • Did not have a plan for identifying and addressing language and literacy barriers to accessing medical services • The plan was unable to demonstrate it had taken steps to evaluate the language

				barriers. The plan provided recipients with a directory of providers who speak secondary languages but did not take additional steps to evaluate if their members needed additional assistance. • No evidence was available to reflect Aetna evaluated data to determine the need for low literacy language and foreign language information. • The plan did not have evidence to reflect steps had been taken to evaluate the effectiveness of its plan or identifying opportunities for improvement
AC 7 (Appointment/ Waiting Times)	850 (7)(D)	No Equivalent	Partial	Aetna demonstrated compliance with the following requirements: • Steps had been taken to ensure that members could obtain symptomatic primary care services within 7 days • Steps had been taken to ensure members could obtain preventative primary care services within 90 days • Steps had been taken to ensure members could obtain urgent primary care services within 24 hours • Steps had been taken to ensure members could obtain non-urgent symptomatic or chronic care specialty services within 30 days • Steps had been taken to ensure that members were not kept waiting longer than 45 minutes for a scheduled appointment with a primary care provider or specialty provider. Aetna was unable to demonstrate compliance with the following requirements: • Failed to demonstrate steps had been taken to ensure that members could obtain urgent specialty care services within 24 hours.
AC 8 (Coordination/ Continuity of Care)	850 (7)(F) 24- A M.R.S.A. §	No Equivalent	No Credit	Aetna did not have written policies which included the following elements:

	4303 (6) (7)			• A policy providing for continuity of care in the event of contract termination between an HMO and a participating provider that described how members with special needs or who are at special risk will be identified and continuity of care provided. • A requirement that the member will receive timely written notification of a referral. • A description of how the HMO will monitor the coordination, continuity of care and appropriate discharge planning • A description of how the HMO will monitor the coordination and continuity of care for new covered persons receiving care form non-participating providers.