



June 28, 2010

Lou Felice, Chair
Health Care Reform Solvency Impact Subgroup, NAIC

Steve Ostlund, Chair
Accident & Health Working Group

National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, Missouri 64198-2662

Re: MLR Quality Definition

Dear Mr. Felice and Mr. Ostlund:

We appreciate the extensive and inclusive process that the NAIC has undertaken to develop the minimum loss ratio formula. We are submitting these comments regarding three of the remaining discussion areas of the quality definition: utilization review; provider contracting/network management; and ICD-10. We believe that the pending decisions on the quality definition will impact the ability of insurers to advance evidence based medicine on the behalf of health care consumers. If we are going to be able to get at the issue of insurance affordability we need to ensure these elements of the MLR definition are valued.

I. UTILIZATION REVIEW

Utilization review (UR) is the process by which Aetna ensures that health care consumers are provided with evidence-based medical treatments which are best suited to their specific needs, conditions and situations. The methodologies we use for our utilization review programs are based on clinical guidelines, evidence based medicine, peer review literature and methods, and are credentialed programs. Our goal is to ensure patients get the care they need.

UR activities protect consumers from undergoing unnecessary procedures that could threaten their health and ensure they get the procedures and medical protocol they need to stay well. Utilization review uses medically-approved standards of care to identify and reduce unnecessary services – which according to some experts, such as Dartmouth physicians Elliot Fisher and John Wennberg estimate, constitute up to 30% of health care. These unnecessary services can cause otherwise preventable adverse events. In fact, deaths due to preventable adverse events exceed the deaths attributable to motor vehicle accidents (43,458), breast cancer (42,297) or AIDS (16,516). U.S. estimates of the combined effect of errors and adverse effects that occur because of iatrogenic damage not associated with recognizable error, include 12,000 deaths per year from unnecessary surgery.

Additionally, the benefits associated with UR are consistent with the *Affordable Care Act* text, specifically, Section 2717, which cites quality improvement as implementing activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices and evidence based medicine.

Government programs also recognize the quality improvement impact of utilization review. The *Department of Defense Medical Management Guide* issued by the Office of the Assistant Secretary of Defense defines utilization management as a "...key process within Medical Management ...for improving the quality of health care...." Additionally, government contracts with insurers generally require performance of utilization review (e.g., FEHBP, TRICARE, state contracts).

There are many specific activities that comprise the Utilization Review function, as a whole, and contribute directly to quality improvement. They fall within the categories of clinical policy development, policy awareness generation, and clinical guideline implementation, which are described in detail below.

Clinical Policy Bulletin Development: Aetna's clinical policies and guidelines, known as its Clinical Policy Bulletins (CPBs), define the appropriate management of medical conditions and the indications for a medical intervention that are supported by reliable evidence. Health technology assessment and clinical guideline development are recognized among diverse healthcare systems worldwide as an important public health function. Including health technology assessment and clinical policy/guideline development in the definition of quality improvement activities will better ensure that adequate resources are devoted to these activities to ensure their continued rigor and integrity.

Creating and maintaining these policies involves highly specialized, clinical support to:

- Critically and exhaustively review the medical literature:* Aetna has dedicated, medically trained staff to conduct an intense review of the peer-reviewed published medical literature, as well as FDA notices and approvals.
- Develop policies that are supported by reliable evidence:* Guideline development helps to determine a procedure's or therapy's proven effectiveness, since the use of procedures or treatments without such demonstration can delay the use of effective interventions. As a result, our CPBs have been recognized as a reliable source of medical technology assessment by the Institute for Health Economics and the Alberta Heritage Foundation for Medical Research (independent research agencies funded by the Canadian government that periodically publish a guide to reliable sources of health technology assessment), and by Health Technology Assessment International, the leading international health technology assessment society. Aetna's assessments have also been cited in technology assessments of national and international technology assessment agencies, including assessments for the Centers for Medicare & Medicaid Services, the Institute for Clinical Effectiveness and Health Policy, the Washington State Department of Labor and Industries Technology Assessment Program, the Veterans Administration Technology Assessment Program, and the Canadian Coordinating Office for Health Technology Assessment. Aetna currently has over 650 active medical CPBs, as well as dental policy bulletins, Pharmacy Commercial Clinical Policy Bulletins, Pharmacy Medicare Clinical Policy Bulletins, and pharmacy formulary evaluations.
- Conduct independent procedure and technology assessments:* To support the development of our guidelines, Aetna also conducts our own assessments of procedures and technologies. These assessments have been cited in technology assessments of national and international technology assessment agencies, including assessments for the Centers for Medicare & Medicaid Services, the Institute for Clinical Effectiveness and Health Policy, the Washington State Department of Labor and Industries Technology Assessment Program, the Veterans Administration Technology Assessment Program, and the Canadian Coordinating Office for Health Technology Assessment. Health technology assessment and clinical guideline development is recognized among diverse healthcare systems worldwide

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- *Convening Medical Review Panels and Vetting Proposed Policies:* Aetna convenes several groups of clinical experts to create policies and oversee regular updates. Aetna's Clinical Policy Council (CPC) is composed of Aetna medical directors representing the various clinical functions and regions within the company. The Quality Advisory Committees (QACs), organized in each region, are composed of independent physicians who participate in Aetna's networks. One of the responsibilities of the QACs is to review and provide feedback on new and revised Clinical Policy Bulletins, both before and after the CPB is published. Aetna's Clinical Policy Unit provides responses to their feedback, and one potential result is additional revisions to the CPB.
- *Incorporating external feedback:* Evidence submitted by providers and members in appeals is forwarded to Aetna's Clinical Policy Unit for consideration and fed into the CPB review process. Aetna reviews the outcomes of appeals to external review organizations, where cases are reviewed by a physician in the relevant specialty that is not employed or selected by Aetna, which may result in a change to our clinical policies. Changes to our clinical policies may be the result of feedback from Aetna medical directors who are involved in review of individual cases.
- *Conducting regular reviews of CPBs:* As noted above, Aetna has more than 650 active medical CPBs, all of which are reviewed and updated at least once each year. Last year alone, Aetna had more than 300 new and revised medical policies (i.e., new policies or changes to existing policies), while the remainder of the policies were reviewed and maintained. All Pharmacy Clinical Policy Bulletins also are updated each year.

Generating CPB Awareness: These clinical policies and guidelines are made available to members, providers, and the general public, and are used to support utilization management activities and other Aetna clinical programs. Awareness of these policies serves to better ensure that the care that is provided to Aetna members is consistent with evidence-based medicine, and thereby "improve health outcomes." Generating this awareness involves:

- *Informing providers and consumers about policies and their supporting literature:* The primary vehicle for provider education on Aetna's evidence-based policy are the Clinical Policy Bulletins themselves. Aetna CPBs are published on the internet, making them available to members and providers, as well as the general public. Members, providers, manufacturers, medical professional organizations and other constituents can submit evidence or other information for consideration in our CPB review, which may result in a revision to Aetna's CPB policy. The annual CPB review schedule is also publicly available and published on the internet.
- *Communicating guidelines to professional groups:* Aetna also receives inquiries or other input on CPBs from state regulatory agencies. Additionally, Aetna medical directors serve as liaisons to each of the leading medical professional organizations, and Aetna actively solicits input from these organizations on controversial or complex medical policy issues. Aetna also has specific transplant advisory committees, such as the Solid Organ Transplant Advisory Committee and the Stem Cell Transplant Advisory Committee. One of the functions of these committees is to provide input on Aetna's transplant policies

CPBs Implementation: Clinical utilization review represents the implementation of clinical policies, guidelines and care pathways. Aetna employs hundreds of physicians and thousands of nurses to accomplish this clinical review, with the goal of better ensuring that the care provided to its members is consistent with evidence-based medical practice.

- *Pre-certification:* Pre-certification is the process by which clinical review prospectively determines the medical appropriateness of the care that is provided to members. This activity is performed by clinicians (physicians, nurses and pharmacists), and improves clinical quality by assessing whether the care that is provided to members is medically appropriate and of proven clinical effectiveness. It is important to note that Aetna's pre-certifications are based on our CPBs and are therefore procedure, not dollar based.
- *Concurrent Review:* Concurrent review provides guidance about the appropriate site of care for a clinical condition (intensive care unit, general inpatient care, rehabilitation facility, outpatient care, etc.), as well as the appropriate interventions and their sequence. Aetna uses Optimal Care Guidelines for this portion of the UR process, which are based on published evidence and empirical data and offer the opportunity to improve the quality and appropriateness of the care that a member is receiving. For example, if a person is admitted to the hospital for a hip replacement, the guideline will indicate when a person undergoing hip surgery should begin physical therapy. If on concurrent review, the utilization review nurse finds out that the member has not begun physical therapy at the appropriate time, he or she can alert the member's physician. By ensuring that physical therapy is initiated, utilization review has the potential to both decrease the duration of hospitalization and facilitate earlier recovery.
- *Retrospective Review:* It has also been suggested in some of the Subgroup discussions that post-service reviews (claims and post-service medical record reviews) should not be considered quality improvement activities, while pre-service reviews may be included in the definition. This sentiment is reflected in the new alternative proposal exposed at the June 24 Subgroup meeting. Aetna believes that the pre-service review and post-service reviews are directed at accomplishing the same goals, albeit with different mechanisms, and is therefore an inappropriate dichotomy to lay out in the quality improvement definition. A rule that would include only pre-service reviews as quality improvement activities would create incentives to prefer one type of utilization review mechanism over another, even in situations where post-service review would be the most appropriate mechanism for accomplishing utilization review. It would mean the loss of an important tool to drive provider behavior. This process attracts the attention of aspects of the provider community that may not have responded to the other aspects of the transparent CPB education process.

In addition, retrospective review can help identify adverse events that were not reported and signals the need for processes that will reduce their incidence in the future. In this way, retrospective reviews influence future behavior, helping to improve the quality and safety of future care delivery.

II. NETWORK MANAGEMENT / PROVIDER CONTRACTING

Network Management activities improve health care quality for members and advance the delivery of patient care by establishing provider measurement criteria; forming networks and programs that require or encourage providers to deliver evidence based and safe care that is aligned with recognized clinical guidelines; and monitoring adherence to the criteria. These functions are performed to achieve optimal health outcomes.

Provider Credentialing and Quality Management:

- *Validating provider credentials for patient safety*, includes performance of due diligence of appropriate provider licensure, training, education, work history and malpractice claim history; recredentialing occurs every three years.
- *Monitoring adverse actions rendered by regulatory authorities for patient safety*, includes reviewing all state license boards weekly and federal actions monthly (e.g., Office of Inspector General and Office of Personnel Management, etc.) for any adverse actions against providers.
- *Conducting professional review* (e.g., peer review) involving professional competence or conduct of practitioners; determines whether a provider's conduct (e.g., provider's health issues, malpractice claim, etc.) adversely affects or could adversely affect the health of members.
- *Monitoring member complaints against providers* regarding quality of care, or professional competence; triggers a review of whether a provider's delivery of care could adversely affect the health of members.

Performance-Related Networks:

- *Determining standards for network inclusion creates the baseline for quality health care delivery*, requiring delivery of health care designed to improve patient outcomes, including:
 - Use of technology (electronic medical records, etc.); Board certification/re-certification; alignment with Institutes of Quality; certification by external entity (e.g., NCQA); and claims based measures, among other standards for inclusion in *Aexcel Network*.
 - Use of clinical performance, access and efficiency metrics for bariatric, orthopedic, or cardiac care for inclusion in *Institutes of Quality*.
 - Meeting specific criteria such as volume of transplants and outcomes measures for facilities to be approved on a transplant-specific basis for *Institutes of Excellence*.
 - Meeting scorecard measures designed by comprehensive Aetna working groups (e.g., medical directors, peer providers, informatics experts, etc.), and based on NCQA recognition programs that include breast cancer screening rates, drugs for lowering LDL cholesterol, among many other measures for participation in *NYC and Illinois Performance Networks* by select large multispecialty medical groups and faculty practices or IPAs.
 - Identifying and quantifying the value of clinical integration models such as the *Patient-Centered Medical Home*, to replace episodic care based on illness and patient complaints with a coordinated, long-term care program through a personal physician and an integrated healthcare team. See Attachment 1.
- *Determining whether providers or facilities meet the quality standards for these programs*, to implement the delivery of higher quality care for our members.

Pay for Performance:

- *Creating performance-based components for physicians who will measure whether their patients are getting standard of care, improves patient outcomes.* Clinical effectiveness measures are evidence based; recognized clinical guidelines; administratively efficient; safe; member-focused; and achieve optimal health outcomes. They are nationally recognized; National Quality Forum endorsed, and meet NCQA Physician Hospital Quality standards when applicable or feasible.
 - o Benefits include quality of life improvements and savings associated with prevention, early detection and treatment of illness that averts long-term, high-cost health needs.
 - o Specific Programs are attached as Attachment 1.

III. ICD-10

The Subgroup specifically requested our projections for the amount Aetna will spend on ICD-10 adoption. We expect to spend on average between \$50 million and \$70 million on ICD-10 adoption *each* year for 2011, 2012 and 2013. This represents a significant cost for us that could squeeze out the ability for investment in other innovations – if the MLR penalizes insurers for ICD-10 adoption.

Additionally, it is during this same time frame in which we will, for the first time, have to meet minimum loss ratio requirements and will be expending significant administrative sums on ACA implementation. In this way, we would like to clarify that we are only requesting including ICD-10 adoption as part of the quality definition on a transitional basis, after which we agree that it can be considered a systems maintenance, and therefore, administrative, cost.

There are many quality aspects of ICD-10 adoption. Among its improvements, it will enable providers with clinical trend data on which they can base their medical decisions. ICD-10 will also provide a significantly increased granularity of data and in turn, enhance clinical effectiveness research. By more effectively capturing data about signs, symptoms, risk factors, and co-morbidities, its adoption will better describe clinical issues, as well. Not only will it facilitate quality improvement inside the United States, but it will allow the exchange of information across country borders, as the United States is the only industrialized country that has not yet adopted ICD-10. In turn, it will vastly improve our collective understanding of disease states and better address public health concerns such as epidemics and disease outbreaks.

Thank you for your continued willingness to receive and consider our comments during your process. Please let me know if you have any questions or we can be of assistance.

Thank you,



Christina Nyquist
Vice President

ATTACHMENT 1

Specific Quality Performance Programs (Pay-For-Performance) described below:

High Performance Provider Initiatives (HPPI)

HPPIs represent the next generation of network options to use physician and provider performance measurement. They are an innovative, strategic move to work together with doctors and hospitals to bring about substantive improvement in the delivery of health care. These long-term initiatives have a great potential to deliver higher quality, more affordable health care. Examples include: practice variation in the management of ischemic heart disease, hypertension, and ears, nose and throat (ENT) conditions; optimizing generic drug prescription; appropriate use of high-tech imaging; appropriate use of NICU; and appropriate post-partum hospital confinement.

Medicare Provider Collaborations

These collaborations focus on strong partnerships between Aetna case managers and providers for case management of complex and chronically ill Medicare members. Aetna provides an on-site case manager for these providers. Offices are paid a bonus by meeting certain quality measures and member visit requirements.

Local Market Program (for IPAs, Medical Groups, and Hospitals)

Our internally-developed program began in 2005 by contracting with IPAs, several large physician groups, and hospitals in several states. In order for providers to earn additional compensation, they must achieve improvements in measures of clinical effectiveness and efficiency. Targets for these measures are set collaboratively with each physician group using baseline information on members of all network-based plans, including full-risk and self-funded HMO, POS and PPO plans (excluding Medicare). We use specific Aetna member experience with these physicians to show a more direct benefit for our members and provide a return for our customers.

Components of our Provider Quality Program (PQP) are:

- Use standardized, industry-accepted measures that are integrated into our core business as well as our unique quality performance initiatives;
- Reward both Top Performers and those showing improvement;
- Provide tools and strategies for Health Delivery (network, medical leadership, quality management);
- Promote continuous improvement in all programs and initiatives;
- Use Population based approach, encompassing all product lines and funding types.

Patient Centered Medical Home

Multi-Health Plan collaboratives were established to integrate performance and payment reform to achieve better outcomes from more and better use of health information technology. The Patient Centered Medical Home (PCMH) is a model of care that is designed to improve quality and achieve efficiencies by recognizing and supporting the value of care that is provided to patients by PCPs, working in practices that have the information systems needed to achieve the best outcomes. The 7 Principles of Patient Centered Medical Home are:

- Personal Physician (ongoing relationship)
- Physician-directed medical practice (lead team that is collectively responsible)
- Whole Person Orientation (all stages of life)
- Coordinated / Integrated Care (across entire health system – acute, non-acute, etc.)
- Quality and Safety (evidence-based medicine, use of HIT, continuous improvement, require Recognition status)
- Enhanced Access (non-visit care, expanded hours, e-mail, web portal)
- Payment (3 components: Coordination of Care, FFS, Reward share of lower costs and improved outcomes)

Bridges to Excellence

Our overall Provider Quality Performance Programs framework includes an ongoing commitment to improving the quality and efficiency of care. In 2006, we entered into a licensing agreement with Bridges to Excellence (BTE) to encourage quality care by providing financial rewards to providers delivering safe, timely, effective, efficient, equitable and patient-centered care.

As a licensee, we are implementing programs as first to market and joining other health plans in collaborative efforts in various markets across the country. From our executive management to local network leads, we have embraced BTE as an industry-leading program and are actively pursuing programs in all our regions.

We currently participate in the Diabetes Care Link and Cardiac Care Link which focus on meeting evidenced-based standards for treating chronic conditions. To participate in BTE, physicians must meet NCQA's criteria for its Physician Recognition Programs: the Diabetes Physician Recognition program and the Heart/Stroke Physician Recognition Program.

Integrated Healthcare Association

IHA is a partnership with several other plans in California. Through this initiative, we have contracts with many IPAs that are assessed on a variety of measures within clinical performance, member satisfaction and technological advances. The IHA consists of health plans, physician groups, hospitals and healthcare systems, as well as purchaser, pharmaceutical, technology, consumer and academic representatives.