# Specialty Quality Improvement Program Description



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## Specialty Quality Improvement Program Description

## I. Program Content:

**Humana's Vision:** "To help people achieve life-long well-being"

Dental disease can be categorized into two major areas, dental decay and periodontal disease. Comprehensive Oral Exams and Ongoing Periodic Exams are a key to early detection of periodontal disease and associated systemic diseases such as diabetes, cardiovascular disease, cancer, and hypertension. While adults are more at risk for periodontal disease, all populations are at risk for dental decay. Preventive procedures such as regular dental exams, dental prophylaxis, fluoride, and sealants act to inhibit bacterial pathogens through various mechanisms. By increasing the percentage of members receiving these procedures, through member outreach and education, Humana Specialty Benefits is working to reduce the disease rate in both adults and children.

### Purpose:

The purpose of the Quality Improvement Program is to evaluate, monitor, and facilitate improvement in the quality of care and services provided to Humana Specialty Benefits' members by promoting quality, affordable dental and vision care, and services.

### Scope:

Humana Specialty Benefits offers a competitive product portfolio featuring network-based, traditional, and voluntary dental and vision plans. All dental plans are easy to use and administer and provide a wide range of coverage for preventive services, standard benefits, and major treatment procedures. Dental and vision benefits are provided to commercial and Medicare lines of business.

All member services provided by Humana Specialty Benefits are subject to quality improvement activities. These activities include the evaluation of the delivery system (provider network), the outcomes of the care delivery, and the effectiveness of administrative services in all states where Humana Specialty Benefits provides dental and vision services.

The scope includes monitors or processes to review, at a minimum, the following areas:

- Accessibility and availability of services;
- Customer service;
- Delegated entities;

- Member services and satisfaction;
- Claim processing standards;
- Complaint and grievance process;
- Provider Contracting and Credentialing;
- Provider peer review;
- Compliance and coordination with external Quality Assurance Programs and Regulations.

**Goals/Objectives:**

The goals and objectives of our Quality Improvement Plan are:

- To facilitate improvement in the services afforded our members and provide value to our customers and partners.
- To promote integration of management activities that will result in increased inter-departmental communication and improved services for members, providers and associates.
- To facilitate access and availability to appropriate care services.
- To provide customer service that is effective in responding to member and provider needs and requests.
- To maintain a system through which pertinent information relating to member care is collected and presented for review, analyses and implementation of actions by committee.
- To provide guidance to staff on quality improvement priorities and projects.

**Process:**

Each year, Humana Specialty Benefits will establish annual objectives and a work plan to address important aspects of care and services for Humana Specialty Benefits membership. This analysis will be completed as part of an annual evaluation of the Quality Improvement Program. The annual Specialty Quality Improvement Committee (SQIC) work plan defines performance monitors, key actions and targeted completion dates for achieving the improvement objectives. This process includes:

- Identifying opportunities for improvement.
- Determining the root cause(s).
- Exploring alternatives and developing a plan of action.
- Activating the plan, measuring the results, evaluating effectiveness of actions, and modifying the approach as needed.

## II. Accountability:

The Corporate Quality Improvement Committee (CQIC) oversees the quality improvement program, as delegated by Humana's Executive Management Team.

Humana Specialty Benefits' Quality Improvement Committee (SQIC) has responsibility for the implementation of the Quality Improvement Program. This committee is also responsible for service quality issues and oversight of the Credentialing and Grievance Committees. The SQIC will draft an annual SQIC Program Description, SQIC Work plan and SQIC Evaluation. These documents are evaluated annually and revised as necessary. The Humana Executive Management Team, through the Corporate Quality Improvement Committee (CQIC) must approve these documents.

Protected Health Information and Vendor Ethics (PHIVE) Committee is a corporate committee created to protect the privacy of Humana members and direct the ethical behavior of vendors. The PHIVE Committee reviews the handling of identifiable and de-identifiable member data and monitors interaction with vendors to promote the highest ethical standards. The PHIVE Committee meets monthly and members of the PHIVE Committee may include representatives from:

- Privacy Officer (chair)
- Pharmacy Solutions
- Physician Review
- Market Vice President
- Law Department
- Regulatory Implementation
- National Network Operations
- Technical Services Group
- Personal Nurse
- Insurance and Risk Management

## III. Accountability of the Specialty Plan:

The Humana Specialty Benefits President has overall responsibility for the Quality Improvement Committee. The Humana Specialty Chief Dental Officer for Dental and Vision is responsible for the oversight and implementation of the Quality Improvement Committee for Humana Specialty Benefits.

The Dental and Vision Medical Directors are responsible for the oversight and implementation of the clinical aspects of the quality improvement program.

## IV. Program Structure:

**Humana Specialty Benefits' Quality Improvement Committee**:
***Purpose:*** To oversee the implementation and evaluation of the Specialty Quality Improvement Program.

***Responsibilities*:**
The Specialty Quality Improvement Committee is responsible for:

- Developing, implementing, overseeing, and approval of the QI Program Description, Work Plan, and QI Evaluation.
- Recommending policy.
- Reviewing and evaluating results of QI activities.
- Instituting actions.
- Ensuring follow-up and evaluation of actions taken.
- Involving network practitioners in clinical QI activities and decision-making of member appeals and grievances, member satisfaction, and dental record review.
- Monitoring, trending, analyzing, and improving customer service to members.

Meetings are held quarterly, with a minimum of 2 meetings per year. Minutes are available at the next meeting for review and approval.

***Voting Members***

- Chief Dental Officer for Dental and Vision
- Associate Vice President for Dental and Vision Networks
- Manager of Systems Development and Support
- Director of Grievance and Appeals
- Manager of Vision Network Development and Relations
- Senior Compliance Professional

***Committee members:***

- Customer Care Frontline Leader

- Clinical Quality Professional
- Claims Frontline Leader
- Director Claims Research and Resolution
- Manager of CompBenefits Customer Care
- Clinical Vision Specialist
- Dental and Vision Network Professional
- External DDS TX
- Covered Person (a Virginia member)
    - Qualifications for the Covered Person include: Insurance coverage through Humana Specialty Benefits
- Covered Person (a Texas member)
    - Qualifications for the Covered Person include: Insurance coverage through Humana Specialty Benefits

Key members of the Quality Improvement Committee are voting members. A quorum for the Quality Improvement Committee consists of 50% of the voting members plus one. The Committee may change its members at any time based on the needs of the Quality Improvement Program.

The responsibilities of the individual members of the Quality Improvement Committee as they relate to the Quality Improvement Program are:

- The Chief Dental Officer is responsible for oversight of clinical review, quality management, compliance of the credentialing process, and the credentialing and peer review committee activities and for providing strategic direction, leadership, and resources for the operation of the quality improvement program.
- Each member is responsible for achieving the relevant objectives of the annual work plan and for coordinating committee activities with other committees and management functions.

Humana Specialty Benefits departments with specific input and impact on the QI Program include but are not limited to:

- Dental/Vision Networks and Network Administration are responsible for maintaining quality providers and provider networks, including reviewing, and verifying pertinent data regarding credentialing and recredentialing.
- Dental/Vision Network Development is responsible for assessing and maintaining an adequate practitioner and provider network, addressing individual access issues as needed.
- Claim Processing is responsible for the accurate and timely handling of member and provider claims activities.
- The Dental Medical Directors are responsible for clinical review of dental claims, quality of care complaints, and

management of the Provider Quality Review process.

- Grievance and Appeals is also responsible for processing appeals and grievances according to policy and regulatory body guidelines. This includes tracking and trending of data to identify areas of improvement.
- Humana Specialty Benefits has processes in place to protect data integrity, security & confidentiality.

**Humana Specialty Benefits' Credentialing Committee:**

***Purpose/Responsibilities:***

The purpose of the Credential Committee is to evaluate credentialing and recredentialing documentation to determine participation status in Humana Specialty Benefits' networks. This process ensures that the Company selects and retains quality providers who will provide quality services to its members.

Two participating providers constitute a quorum to hold committee meetings. Only participating providers have a vote. The Dental or Vision Medical Director, or designee, is the chairperson of the Credentialing Committee. The chairperson oversees the committee voting procedures and verifies the approval of each report and file. The Dental or Vision Medical Director, or designee, does not have voting privileges except in the event of a tie vote by the committee; in that event, the chairperson may vote to break the tie. Provider members serve two-year terms and may succeed themselves in office. The credentialing committee may seek clinical peer input from non-committee members when discussing standards of care for specific specialties. Staff members who participate on the committee are non-voting members. Meetings are scheduled monthly.

All members of the committee sign confidentiality agreements with Humana Specialty Benefits annually. Meeting minutes are signed by the Chairperson. Minutes are available at the next meeting for review and approval. The Credentialing Committee reports to the Specialty QIC.

***Members:***

- Dental or Vision Medical Director, Chairperson
- Director of Networks
- Participating Providers (minimum of 2) – voting members
- Network Administration Manager
- Network Administration Coordinator
- Network Administration Supervisor
- Risk Manager

Credentialing/Recredentialing for Vision has been delegated to Eyemed. Delegation Compliance has oversight of credentialing/recredentialing activity and will report to the Chief Dental Officer for Dental and Vision.

**Humana Specialty Benefits' Peer Review Committee:**

***Purpose****:*

To conduct review activities evaluating the quality of care provided to dental and vision members and take action as appropriate to improve the quality and safety of health care services provided to members.

***Members:***

- Dental or Vision Medical Directors, Chairperson
- Participating Providers (minimum of 2) – voting members

***Responsibilities****:*

- Review quality of care and patient safety concerns submitted by the Dental or Vision Medical Director.
- Ratify or modify interventions or actions taken by the Dental or Vision Medical Director.
- Recommend interventions or corrective actions to improve quality of care or member safety including; suspension, restriction or limitation of provider participation and termination of provider status in the dental or vision networks

The committee consists of at least two participating providers, and the Dental or Vision Medical Director as Chairperson. Only the providers have voting privileges with two providers constituting a quorum to hold a meeting. Providers serve two-year terms and may succeed themselves in office. Staff support for the committee includes the Dental or Vision Medical Directors, who are eligible to vote only in the case of a tie. Meetings are scheduled as needed. All Peer Review information, documents, records, and reports received or created in the course of quality review activities is confidential. Each member of the committee signs a confidentiality statement at least annually. The Peer Review Committee reports to the Specialty QIC.

## V. Assessment and Improvement Activities:

Humana Specialty Benefits provides comprehensive dental and vision services through networks of contracted dental

and vision providers to all ages and gender groups.

Humana Specialty Benefits Quality Improvement Committee incorporates the following types of performance monitoring:

- Access to dental/vision care
- Clinical quality of care
- Overall satisfaction
- Administrative service quality
- Provider Peer review

**Access to Care**:

Access to care is monitored via member satisfaction surveys, complaint/grievance monitoring, geo-access, and indirectly through service indicators, and credentialing.

**Clinical Quality of Care:**

Clinical quality of care is monitored via complaints and grievances, credentialing and recredentialing, and quality reviews. Quality of care concerns are addressed by the Dental and Vision Medical Directors and the Peer Review Committee.

**Overall Satisfaction**:

Overall satisfaction is assessed via member and provider satisfaction surveys, as well as complaints and grievance monitoring.

**Administrative Service Quality**:

Administrative service quality is monitored via random service audits. Some of the data systems available to assist in the monitoring process are:

- Geo-access
- Claims
- Credentialing System
- Individual Databases

Humana Specialty Benefits also monitors its effectiveness in performing administrative services and continually looks for opportunities to improve the services provided to and on behalf of our members and their employers. Measurements that are routinely tracked include telephone service levels (speed to answer and percent of calls abandoned), timeliness of complaint resolution, and the efficiency of claims processing. Humana Specialty Benefits' grievance process is a state-specific formal process to resolve member complaints or appeals not previously resolved to a member's satisfaction. Humana Specialty Benefits also has a grievance committee responsible for conducting a review and providing a recommendation on grievance cases in which a member is dissatisfied with the resolution of a grievance and has submitted a written and/or verbal complaint appeal request for review. This information is documented and tracked.

**Provider Peer Review**:

Identifying, monitoring and resolving potential quality of care concerns is important to achieving desired outcomes for Humana members. The Humana Dental and Vision Medical Directors review potential quality concerns and refers concerns to the Peer Review Committee, as appropriate. Potential quality concerns may be identified through member complaints and grievances, Special Investigations Unit (SIU) investigations, and utilization management activities. Improvement actions are implemented as warranted.

**Internal Records:**

Humana Specialty Benefits records essential Quality Improvement information in various formats. Items discussed in committee meetings reflect documentation of a finding, conclusion, recommendation, action, follow-up, and evaluation. Minutes are dated and signed by the Chairperson or acting Chairperson. The minutes must be available at the next meeting for review and approval.

**External Records:**

Humana Specialty Benefits supplies plan providers, delegates, and member's information via letters, bulletins, Internet, Intranet, as well as other forms of communication. All associates are educated regarding HIPAA privacy requirements and adhere to these guidelines in both internal and external communication.

## VI. Resources:

Humana Specialty Benefits ensures that resources are provided to ensure continuous quality improvement (QI) activities:

- Resources for QIC activities are evaluated annually;
- All Humana Specialty Benefits associates are involved in QIC activities;
- Corporate resources are available to assist Humana Specialty Benefits in meeting QIC goals;
- Staff receives adequate orientation and continuing education/training in their job responsibilities.

## VII. Information Management

Humana Specialty Benefits has information systems that are used to collect data, maintain and analyze information.

- The systems provide:
  - Data integrity
  - Data confidentiality
- Disaster Recovery Plan
- Database of all participating providers
- Database of all members
- Record of grievances appeals and complaints.
- Results of satisfaction surveys
- Data regarding access to care within Humana Specialty Benefits network of providers
- Record of billed charges, member copayments/deductibles and paid claims related to covered dental care services.
- Reports that assist Humana Specialty Benefits to provide service as required by Humana Specialty Benefits' contracts.

Humana Specialty Benefits follows the corporate policy that contains an Information Security Agreement Form that outlines parameters for using Humana property, electronic mail, Internet, Intranet, and voice mail, stressing security and confidentiality of information.

## VIII. Evaluation and Trending:

Humana Specialty Benefits' QI program:

- The QI Program is broad in scope to monitor the quality of care and service received by members.
- Data is tracked and trended monthly, quarterly and/or annually as delineated in the QI Work Plan.
- Opportunities for improvement are identified.
- Root cause analysis is conducted.
- Barriers are identified.
- Interventions are selected and implemented plan wide.
- Re-measurement is conducted in accordance with the QI Work Plan calendar.
- An analysis of resources is performed to ensure appropriate allocation of human and other resources.
- Continued follow-up and trending are assured through committee minutes, the annual QI evaluation, and quarterly reports.

## IX. Delegation:

Delegation is the formal process by which Humana Specialty Benefits gives a provider (delegate) the authority to perform certain functions on its behalf such as credentialing. Although the authority to perform a function may be delegated, the responsibility for assuring the function is performed appropriately remains with Humana Specialty Benefits.

The pre-delegation activities include:

- Review of proposed delegates policies and procedures.
- Pre-assessment review to determine if the proposed delegate can adequately perform the function to be delegated.
- Complete Humana Specialty Benefits delegation pre-assessment tool for the proposed delegated function.
- Review a copy of the proposed delegates credentialing application.

Contract language includes:

- The delegated activities and those activities retained by the plan.
- The responsibilities of the plan and the delegate
- Notification to the plan of any material change
- Type and frequency of required reporting to the plan
- Feedback from the plan to the delegate
- Process by which the delegate will be evaluated.
- Remedies available to the plan if the delegate does not fulfill its obligations.

Oversight activities include:

- Reports required.
- Site visits / audits
- Annual evaluation
- Plan committee accountable for ongoing oversight
- Plans accountability for both the delegate and the sub-delegate, if applicable

## X. Confidentiality:

All committee proceedings, minutes and memorandums concerning plan activities are considered confidential and proprietary. All discussions within the committee forum are viewed as confidential and not to be shared outside the meeting, particularly regarding clinical and peer review. All committee members and associates must sign confidentiality agreements and conflict of interest statements. Patient information is confidential. Any documents containing patient names and other information are handled with procedures to ensure confidentiality. These documents are secured from public access.

In 2001 the federal government publicized the HIPAA standards for privacy of individually identifiable health information. During 2001, to facilitate compliance with HIPAA Guidelines, Humana appointed a corporate Privacy Officer to oversee the development, implementation and auditing of policies, procedures and processes to safeguard member protected health information (PHI). This position has expanded into a Privacy Department that is also responsible for education of Humana associates across the company via an Intranet-based HIPAA educational session, which is a part of Humana's Ethics Program. Privacy and Ethics education is required annually for all Humana associates. The Privacy Officer is also a voting member of the PHIVE Committee.

## XI. Compliance with Regulators and Accrediting Agencies:

Humana Specialty Benefits has a process to maintain appropriate federal, state, and local licenses, certifications, contracts, or other forms of qualifications and renewals. This may include, but is not limited to:

- Obtaining necessary regulatory approvals of service areas, forms, rates, and marketing materials.
- Participating in and/or cooperating with site visits, quality and market conduct examinations, inquiries, or investigations.
- Preparing, implementing, and monitoring Quality Improvement Plans as needed. o Monitoring and implementing changes based on state and federal legislation, rules, or policies.
- Preparing and submitting required reports and other filings in a timely manner

## XII. Other:

**QI Work Plan**

The QI work plan describes the scheduled activities for quality improvement within Humana Specialty Benefits. The work plan is a working document that functions as a guide for various QI activities. Humana Specialty Benefits reviews and updates this document annually within the Humana Specialty Benefits Quality Improvement Committee (SQIC) to ensure its completeness and Humana Specialty Benefits' adherence to the plan.

The work plan includes those quality improvement activities that have been determined through the annual QI evaluation to be priorities for the upcoming year. The work plan is approved by the SQIC prior to being sent to the Corporate Quality Improvement Committee (CQIC) for review and approval.

**QI Evaluation:**

The annual QI Evaluation (QIE) is a comprehensive review of Humana Specialty Benefits' success in meeting the goals of the Quality Improvement Committee (QIC). All processes of the QIC, barriers/limitations, results, and recommendations are examined. The data is tracked, trended, and re-measured as reflected in the work plan. Indicator results are analyzed to determine if interventions were effective in meeting program goals. Root cause analysis of critical components is completed and areas for improvement and revision are identified. Follow-up is reflected in meeting minutes, annual evaluations, and reports.

The QIC approves the evaluation prior to it being sent to the Corporate Quality Improvement Committee (CQIC).

The annual QIC documents are provided to appropriate Humana Specialty Benefits managers and staff. Information regarding the Quality Improvement Program and results of the annual evaluation are available to members and providers upon request.